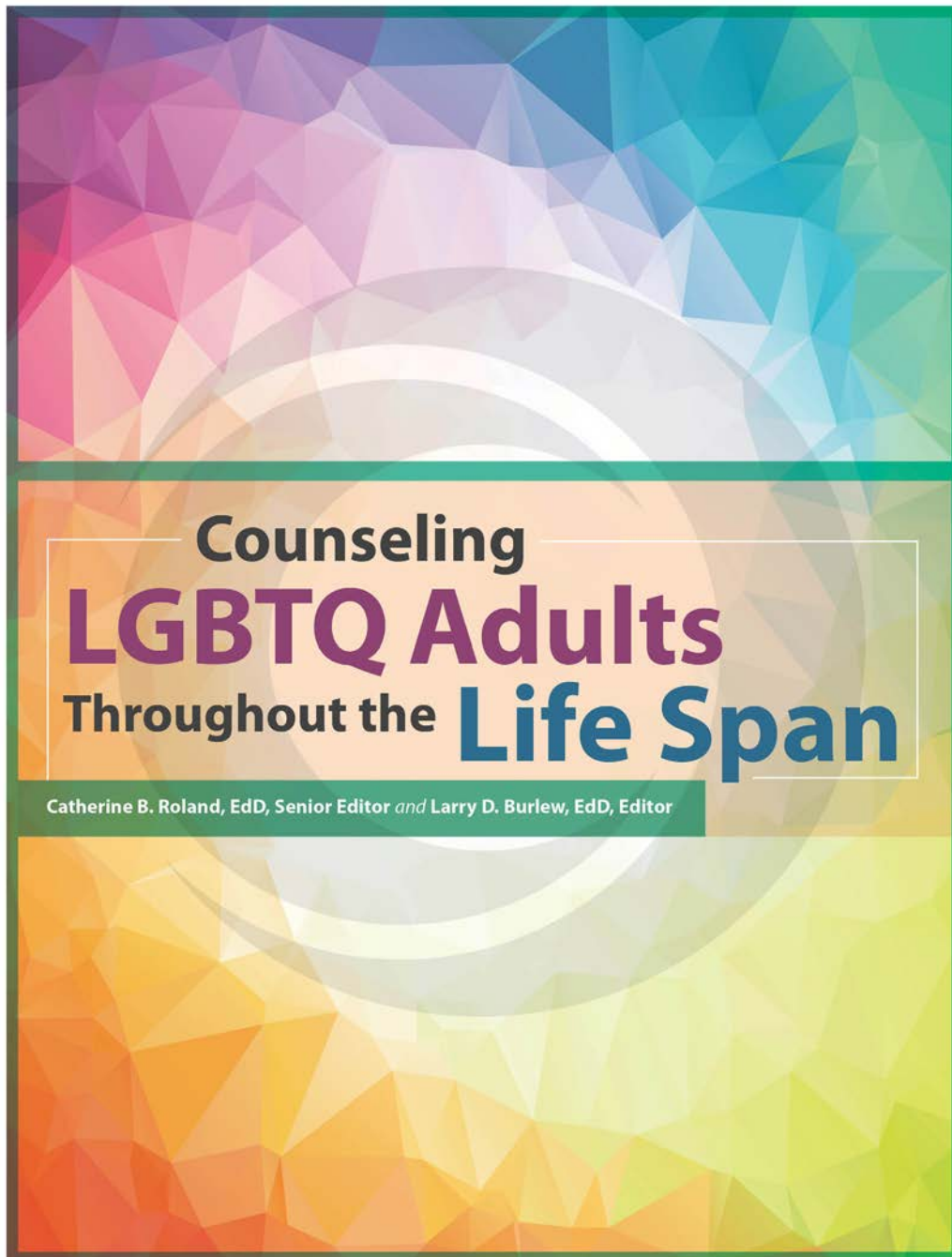## American Counseling Association

Counseling
LGBTQ Adults
Throughout the Life Span

Catherine B. Roland, EdD, Senior Editor *and* **Larry D. Burlew, EdD, Editor**

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Introduction

Catherine B. Roland, Senior Editor

Counseling LGBTQ Adults Throughout the Life Span is a training and conceptual guide that can supplement the literature and practice knowledge for those working with adults who identify as a member of the LGBTQ community. The guide is a compilation of experiences of many professional counselors, counselor educators, counseling supervisors, and leaders in the counseling profession, and it is the hoped that the guide will illuminate the diverse views within the adult developmental process as it pertains to issues of mental health, life satisfaction, and a focus on the uniqueness of the LGBTQ adult population. We focused on the intersectionality of living as an adult who identifies as a lesbian, gay, bisexual, transgender or queer and the process of growing and aging as a young, midlife and older adult. The challenges are as unique as they are similar. This may be due to the broader developmental process, with stages and tasks that may appear similar for all adults; however, the specific timing and intensity around the developmental process that may surface due to the intersection of identity and all other aspects of developmental growth can be profound. Mental health professionals, advisors, supervisors and those who teach counselors must become familiar with the differences in the developmental process in order to understand the intersections, or the factors of each LGBTQ individual, that play into the successful counseling process. Professionals must also embrace the pure difference of experience that can manifest from times in the life of an LGBTQ adult, from young adulthood to older, such as the very personal coming out process, career confusion about acceptance and safety, family banishment or acceptance, partnering, and spiritual or religious acceptance, to name several. Awareness of intersectionality provides both an exceptional window into who is really within that physical body, as well as the multiple roles that are played out every day of the life of an LGBTQ individual.

Intersectionality as a mental health concept is a fairly recent addition to our literature; however, intersectionality as a political/social concept is not. The idea for this guide, as well as the ILLUMINATE Symposium, was generated through a belief that all parts of each of us are important and should be respected and inform our work as counseling professionals. A bit of history may assist in understanding the etiology of the concept of intersectionality and inform best practice as we incorporate the concept into our daily work with clients, supervisees, advisees, and students. Emerging from the Black feminist movement during the late 1980s and 1990s, Crenshaw (1989) discussed the experience of the individuals' overlapping identities shaped by race, gender/gender identity, class, and culture. Several years later, the intersection of other personal factors began to be seen as important in mental health treatment. Acknowledging the differences within each person, especially with specific and unique aspects such as gender identity, race and class, and spirituality and religion, has become vital to the process of working with midlife LGBTQ adults. Although connecting the links between gender, race, sexuality, and class is not always simple or at times even comfortable, it has become a necessary skill to effective counseling of the LGBTQ community, across all stages of young, midlife, and older adulthood (Salazar & Abrams, 2005). Giving credit and homage to the early creators of the concept of intersecting parts of our multiple identities is not only important in connecting the mental health process and the historical experience of many marginalized groups, it is the right thing to do.

In conceptualizing the guide from the first, it was important to include an example of pertinent case studies, and there are two such cases that can be found following the final section of that stage. A suggestion might be to use these, or cases that a reader may bring forward, to inform the practice and strategies to be included in a treatment plan, a counseling session or teaching moment.

I would like to thank some courageous and giving individuals who comprised the core group and served as coeditors of the developmental sections of this Guide. Robtrice Brawner, Nicole Pulliam, Sandra Lopez-Baez, I offer thanks and praise for all the good work, the patience and the commitment. Without the expertise of Larry Burlew, the conceptual brilliance of Jane Rheineck, and the support, commitment, dedication, doggedness, and genius of Monica Osburn, trust when I share that the Guide wouldn't exist today. There are no words, only appreciation, respect and admiration.

References

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *The University of Chicago Legal Forum, 140,* 139–167.

Salazar, C. F., & Abrams, L. P. (2005). Conceptualizing identity development in members of marginalized groups. *Journal of Professional Counseling: Practice, Theory and Research, 33,* 47–59.

SECTION 1:
YOUNG **LGBTQ** ADULTS

Coming Out and Gay Identity Development

Colleen Logan and Adam Carter

LGBTQ youth face the same tasks and challenges that all adolescents do, but they must do so through the lens of homo- and transprejudice, and they must face societal bias toward cisgender, heteronormative identity development. Fortunately, society has advanced to some degree, and in recent years, an emerging appreciation for different orientations and identities is evident. Unfortunately, homo- and transprejudice are real and ubiquitous; LGBTQ youth still face difficulty across many fronts including at home, in school, and in religious organizations as they strive to develop healthy and positive self-identities. These challenges are particularly evident as adolescents seek to question and explore gender identity and sexual orientation, as well as to decide whether to come out and live out at home, at school, and in the community at large.

Developmental Lens

Recognizing that coming out is an ongoing process is critical to understanding the identity development of LGBTQ young adults (Rhoads, 1995). Because society at large assumes most people to be heterosexual and cisgender, coming out is a never-ending process as an identity/orientation is solidified, internally accepted, and revealed layer by layer. No matter how many people know about a person's sexual orientation or gender identity, there will be others to whom that individual has yet to come out (Rhoads, 1994). LGBTQ young adults are regularly in contact with new people, and the opportunity to come out or share a non-heteronormative/cisgender orientation or identity is frequently present. This adds a layer of decision making for LGBTQ young adults not typically faced by heterosexual, cisgender peers.

Evans and Broido (1999) found that coming out to others during this stage of development is more the exception than the rule. LGBTQ young adults are inclined to adopt symbols (e.g., rainbows, a pink triangle, equality symbols) and ways of being or presenting themselves that indicate a non-heterosexual orientation rather than repeatedly share with others their LGBTQ orientation or gender identity. Rhoads (1997) shared that among the gay male college students he interviewed, some had begun incorporating language or gestures that others could identify as "stereotypically gay" to communicate a queer identity rather than overtly saying, "I am not heterosexual." The use of symbols, gestures, or specific language was primarily used to indicate to other non-heterosexual individuals of a LGBTQ identity and thus portray a sense of 'sameness.' Building community within a sometimes hostile and often unwelcoming society is another challenge faced uniquely by LGBTQ young adults.

Even after coming out to some, LGBTQ young adults are faced with the choice on how visible they want to be within the queer community (Rhoads, 1997). An increased LGBTQ presence may escalate heterosexist reactions, resulting in greater conflicts for this population. Diversity within the LGBTQ community is also recognized, noting that there is a plethora of gender and orientation presentations that are, at times, judged within the community depending on the continuum of heteronormative or cisgender-appearance presented to the world. As more conflict is experienced, more LGBTQ young adults may seek support from licensed mental health professionals in order to successfully meet the demands of this developmental stage in a challenging climate as well as seek support regarding being different with respect to sexual orientation and/or gender identity. Many will seek support due to the psychological consequences of persistent harassment and need help dealing with reactions to incidents of emotional and physical violence (D'Augelli, 1993). Sadly, despite the gains of the last decade, this continues to be true today, maybe even more so.

Strengths and Challenges

Strengths

Studies have shown that coming out increases self-esteem even when considering the negative impact of bullying and pervasive homoprejudice (San Francisco State University, 2010). There is also data to suggest that coming out while an adolescent leads to less depression and anxiety as an adult. The bottom line is that the ability to be open and authentic about who one is and who one loves is positive and leads to higher levels of satisfaction and positive self-esteem.

Challenges

Dan Savage, a LGBTQ advocate and author, and his husband Terry Miller, in response to the death of Tyler Clementi, a gay college student, posted a message to LGBTQ youth on YouTube. In this video, Savage and Miller shared that they had both experienced bullying surrounding their sexual orientation throughout their youth but that life had gotten better as they got older (Savage & Miller, 2010). This video was the first of over 50,000 videos posted on YouTube on the It Gets Better Project's channel. Celebrities, politicians, teens, and grandparents alike spoke eloquently into their webcams and shared with the LGBTQ youth watching that life was worth living and they are not alone. These videos altruistically pleaded with those watching to remain alive for the *good things* that life had in store for them, but are these promises of a brighter future enough to support LGBTQ youth and young adults through the coming out process, particularly given today's political and social climate?

A core supposition of the It Gets Better campaign is that the current social environment for LGBTQ youth and young adults is not only unaccommodating but also dangerous. Cross-sectional data support this belief by indicating that when compared with heterosexuals, LGBTQ individuals experience elevated levels of multiple negative outcomes such as victimization and bullying, drug use, and mental health difficulties (Bontempo & D'Augelli, 2002). Youth and young adults who were questioning their sexual orientation reported being mocked more often, having greater drug use, and experiencing more feelings of depression and suicide than either heterosexual or LGBTQ students (Espelage, Aragon, Birkett, & Koenig, 2008). Prior empirical work further suggests that non-heterosexual males, African Americans, and transgender individuals report greater levels of victimization as youth into adulthood (Poteat, Aragon, Espelage, & Koenig, 2009).

In a longitudinal study of LGBTQ identified youth, Birkett, Newcomb, and Mustanski (2015) concluded that although current social support was significantly associated with lower levels of psychological distress, prior social support did have a significant impact on later levels of psychological distress. This longitudinal evidence suggests that experiences of victimization impact psychological distress more, over time, than support. In other words, supportive relationships might not be enough to buffer psychological distress if experiences of victimization still occur.

Upon studying the lived experiences of gay men, Bachmann and Simon (2014) reported that victimization regularly occurs past adolescence into adulthood. This study underscored the fact that while it is important to understand the relevance and impact of physical harm and psychological distress obtained through the victim–perpetrator relationship, the greatest instances of victimization of LGBTQ young adults occur through a perceived lack of social recognition in society. The denial or withdrawal of social recognition as a respected and esteemed member of society negatively impacted LGBTQ young adults' life satisfaction. Those who had yet to publicly divulge their sexual identity also reported decreased life satisfaction, indicating that this level of victimization does not rely on the individual's level of "outness."

According to the findings of Bachmann and Simon (2014), the It Gets Better campaign is correct in the assumption that LGBTQ individuals are coming out in a rather unsupportive social environment. For some, experiencing the support of at least one person will help address the adverse experiences endured as a result of their sexual orientation or gender identity. For others, the victimization experienced during adolescence can never be fully mediated with familial or social support. Regardless of the negative experiences LGBTQ youth and young adults are experiencing, many still consider coming out as vital to their personal development. In order to study the coming out experience in adolescence, it is important to understand the factors that both support and inhibit coming out during this developmental time.

Intersectionality

For LGBTQ individuals of color, coming out is compounded by the intersection of multiple aspects of self. Racist attitudes tend to complicate the developmental process; this population often has to maneuver through homoprejudice in racial communities and racial prejudice in LGBTQ communities (Stevens, 2004). Whereas Rosario, Schrimshaw, and Hunter (2004) found that race did not impact the timing of coming out, the level of involvement in the LGBTQ community by people of color was less than that of White individuals. Grov, Bimbi, Nanin, and Parsons (2006) hypothesize that this is the result of LGBTQ people of color prioritizing the development of a racial and ethnic identity over a sexual identity, as their racial identity cannot be hidden. LGBTQ individuals of color are therefore choosing to less often publicly identify as LGBTQ while addressing racial identity developmental concerns.

Counseling Considerations

Counselors need to understand and appreciate differences in coming out versus living out. These terms are not mutually exclusive. Coming out is a choice but it is not always the best choice or the safe one within a particular context. For example, coming out to nonsupportive parents who still provide financial support may not be appropriate or reasonable. Counselors must affirm decisions not to come out when doing so is not safe, healthy, or indicated. Remember, not coming out is no longer seen as pathology or unhealthy. It is not a linear process, and one does not have to come out in order to be deemed "healthy."

Counselors must explore their own internalized homoprejudice and beliefs related to a cisgender biased society. Obtaining consultation and supervision from a peer who has expertise working with the LGBTQ community is an essential tool. In addition, counselors must educate themselves and develop a resource list such as the Human Rights Campaign, Gay, Lesbian, & Straight Education Network, and Parents and Friends of Lesbians and Gays. It is the counselor's responsibility and indeed obligation to become educated about and develop clinical competency with the issues facing LGBTQ youth.

Additional tips for counselors include allowing for and expecting ambiguity from LGBTQ clients. Counselors need to be prepared to accept and affirm experimentation, allowing clients to employ self-determination related to sexual orientation and gender expression. Counselors should avoid over-sexualizing LGBTQ youth; sexual and romantic feelings are just one aspect of the developmental challenge, just as with any other young adult. Sexuality and gender expression may be fluid for a multitude of reasons. Counselors also need to position themselves as advocates, challenging any negative and/or derogatory language, even that used by the client, to explore the internalized bias that may be present as the young adult struggles to live authentically while also trying to master traditional developmental stages in an unwelcoming environment. Confidentiality is critical; if a LGBTQ young adult trusts a counselor with information about his or her orientation or identity, it is an indication of trust and a tentative step toward determining if the counseling relationship is a safe place to explore these issues.

In general, counselors need to challenge any tendencies to assume heterosexuality with any client and to allow open exploration of sexual orientation and gender identity even when a client does not "look" like he or she belongs to the LGBTQ

community, as this is evidence of a heteronormative and cis-gender bias. Young adults may also need advocacy, as they are still closing out the adolescent developmental stage and are not yet fully individuated or independent; the risk of suicide for LGBTQ youth is 2 to 3 times higher than the risk for other adolescents and young adults. Signs of hopelessness need to be taken very seriously and explored, particularly when the individual is operating in a hostile or bullying environment.

References

Bachmann, A. S., & Simon, B. (2014). Society matters: The meditational role of social recognition in the relationship between victimization and life satisfaction among gay men. *European Journal of Social Psychology, 44,* 195–201. doi:10.1002/ejsp.2007

Birkett, M., Newcomb, M. E., & Mustanski, B. (2015). Does it get better? A longitudinal analysis of psychological distress and victimization in lesbian, gay, bisexual, transgender, and questioning youth. *Journal of Adolescent Health, 56,* 280–285. doi:10.1016/j.jadohealth.2014.10.275

Bontempo, D. E., & D'Augelli, A. R. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health, 30,* 364–374. doi:10.1016/s1054-139x(01)00415-3

D'Augelli, A. R. (1993). Preventing mental health problems among lesbian and gay college students. *The Journal of Primary Prevention, 13,* 245–261.

Espelage, D. L., Aragon, S. R., Birkett, M., & Koenig, B. W. (2008). Homophobic teasing, psychological outcomes, and sexual orientation among high school students: What influence do parents and schools have? *School Psychology Review, 37,* 202–216. doi:10.1007/s10964-008-9389-1

Evans, N. J., & Broido, E. M. (1999). Coming out in college residence halls: Negotiation, meaning making, challenges, supports. *Journal of College Student Development, 40,* 658–668.

Grov, C., Bimbi, D., Nanin, J., & Parsons, J. (2006). Race, ethnicity, gender, and generational factors associated with the coming-out process among gay, lesbian, and bisexual individuals. *Journal of Sex Research, 43,* 115–121.

Poteat, V. P., Aragon, S. R., Espelage, D. L., & Koenig, B. W. (2009). Psychosocial concerns of sexual minority youth: Complexity and caution in group differences. *Journal of Consulting and Clinical Psychology, 77,* 196–201. doi:10.1037/a0014158

Rhoads, R. A. (1994). *Coming out in college: The struggle for a queer identity.* Westport, CT: Bergin & Garvey.

Rhoads, R. A. (1995). Learning from the coming-out experiences of college males. *Journal of College Student Development, 36,* 67–74.

Rhoads, R. A. (1997). Implications of the growing visibility of gay and bisexual male students on campus. *NASPA Journal, 34,* 275–286.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2004). Ethnic/racial differences in the coming-out process of lesbian, gay, and bisexual youths: A comparison of sexual identity development over time. *Cultural Diversity and Ethnic Minority Psychology, 10,* 214–228. doi:10.1037/1099-9809.10.3.215

San Francisco State University. (2010, December 6). *Family acceptance of lesbian, gay, bisexual and transgender youth protects against depression, substance abuse, suicide, study suggests.* Retrieved from www.sciencedaily.com/releases/2010/12/101206093701.htm

Savage, D., & Miller, T. [It Gets Better Project]. (2010, September 21). *It Gets Better: Dan and Terry.* [Video file]. Retrieved from http://www.youtube.com/watch?v=7IcVyvg2Qlo

Stevens, R. A. (2004). Understanding gay identity development within the college environment. *Journal of College Student Development, 45,* 185–206.

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Career Development

Dawn Norman, Quentin Hunter, and Margaret O'Hara

When a counselor is working with individuals from different cultural backgrounds, it is important to consider how behaviors and communication may have different meaning and interpretations. This is understood by many people who have a natural inclination to derive all they can know about those with whom they work; for clinicians, there is an ethical obligation to do so. The development of cultural competence is not a "one-and-done" learning experience but rather ongoing professional development. It includes supervision, consultation, research, attendance at workshops, conferences, and webinars, and more.

This article addresses work with LGBTQ individuals across the life span, with the outcome being a user-friendly resource to assist in the development of cultural competence for those working with this population. Young adults and matters related to careers are the focus.

Developmental Lens

According to many career theories, individuals in early adulthood begin to actively engage in the world of work and develop their career and work goals. Ginzberg, Ginsburg, Axelrad, and Herma's (1951) Stages of Career Development theory postulates that occupational choice occurs developmentally and includes multiple choices made throughout childhood and continuing into adulthood. According to the theory, children begin to engage in vocational behaviors as part of their fantasy of career (e.g., playing mechanic). In early adolescence, individuals begin to understand the requirements related to particular careers and begin to relate those requirements to their interests and abilities. Finally, in middle adolescence and young adulthood, the crystallization of the occupational patterns that will lead to a realistic career identity begins. Super's (1980) career development theory states that the primary career task of early adulthood is the exploration of career dimensions and later the initial establishment of the individual's occupational identity. During this time, the individual develops a tentative career plan while storing alternatives for possible pursuit and testing the idea of commitment to a career path.

For LGBTQ individuals, the development of their LGBTQ identities may coincide with their career identity development. The process of recognizing and establishing one's LGBTQ identity during young adulthood, including making decisions about coming out and/or pursuing romantic relationships, requires considerable psychological resources, and, as a result, individuals may delay development in their career identity in favor of focusing attention on their LGBTQ identity formation (Belz, 1993). Additional factors such as demographic variables, social supports, and access to LGBTQ-identified career role models, all stressors related to LGBTQ identity development, also may impact the career development journey of young adults (Dunkle, 1996). In short, career development cannot be considered in isolation and must be understood as only one dimension of identity development in young adulthood.

Strengths and Challenges

Strengths

LGBTQ individuals may employ a variety of coping strategies while trying to establish themselves in a profession. In Chung's (2001) model, LGBTQ individuals cope with potential work discrimination before entering a career path through critical vocational choice. Individuals may feel empowered to track jobs and learn about the degree of affirmation associated with a company or career path. They may explore self-employment, devising new enterprises or beginning their own businesses. LGBTQ individuals may also engage in risk taking in their vocational choice, weighing degree of acceptance with career goals to make intentional choices to compromise in some areas. Once in a workplace, LGBTQ individuals cope with encountered or potential work discrimination by engaging in various degrees of confrontation, utilizing social supports, or employing nonassertive responses such as silence or quitting (Chung, 2001; Chung, Williams, & Dispenza, 2009).

Two major strengths for young LGBTQ adults entering the workforce include the current inclusive movement in professional organizations and the global human rights movement (Chung, 2003). As organizations—vocational and avocational, LGBTQ-focused and non-LGBTQ-focused—work toward becoming more inclusive to all sexuality and gender expressions, LGBTQ individuals have increased opportunities to be active in creating, occupying, and maintaining affirming spaces. Additionally, the global human rights movement has resulted in increased visibility of the human and civil rights movement for LGBTQ individuals. While the work still continues, as some states in the United States have moved to limit the rights of LGBTQ individuals, these individuals and their allies are active in creating change. These actions may empower young adults entering the workforce to exercise their individual strengths in efforts to promote human rights.

While research into the career development experiences of transgender young adults is scant (Chung, 2003), recent literature indicates that transgender individuals possess similar strengths to lesbian, gay, and bisexual individuals, including actively defining self, awareness of oppression, maintaining social supports, embracing self-worth, and cultivating hope for the future (Singh, Hays, & Watson, 2011). These resilience

strategies can translate into the career development process, and transgender individuals may rely on these strategies at multiple points in their transitions and in their careers.

Social support is another key strength for LGBTQ individuals in the world of work. LGBTQ individuals may find supportive coworkers and advocates in their work environments, which can help to mediate external stressors. Additionally, supportive romantic relationships can be a source of support for individuals who may feel isolated or discriminated at work (Prince, 2013). LGBTQ individuals benefit from social supports, which can be a key source of strength, especially in work environments where they experience significant discrimination, heterosexism, and transphobia.

Challenges

Some of the most significant decisions individuals make in their lifetimes will be career related. For some young adults, this decision-making process can appear relatively uncomplicated. However, many others experience various challenges connected to the same process. The career decision-making process can be impacted greatly by these challenges (Lipshits-Braziler, Gati, & Tatar, 2016).

LGBTQ young adults with aspirations of career and professional growth may be concerned about workplace discrimination and the concept of the lavender ceiling. The lavender ceiling has been described as an awareness that some companies may limit opportunities of leadership and promotion for non-heterosexual employees (Gedro, 2010).

Some additional noted career and workplace challenges experienced by the young adult LGBTQ population include:

- isolation and rejection;
- harassment; and
- fear of disclosure.

Intersectionality

Ethnic and sexual minority young adults face many of the same challenges as those of heterosexual individuals in the majority. These include decisions about what to do with the rest of their lives once secondary education is completed. This decision-making process typically begins in adolescence with support from counselors, teachers, family, and friends. Though there are many paths one might select, among the most common are whether to attend college or university or receive other career-related training, serve in the military, enter the workforce directly, work in a family business, or become self-employed.

Regardless of the career path chosen, there are pressures and potential obstacles that many young adults experience that may interfere or block successful attainment of desired career goals. LGBTQ individuals may experience additional stressors and lack support to ameliorate them. Meyer's (2003) Minority Stress Model contends that in addition to the daily stressors that everyone experiences, those who are marginalized have added stress related to their minority status. This includes prejudice, discrimination, microaggressions, threats, and violence. It's important that those working with LGBTQ individuals have an understanding of the stressors of being oppressed in a hostile environment and acknowledge the need for allies and advocates.

When working with others, one's competence level should be assessed, and if it is determined to be low, ways to increase competence should be sought. Problems may be viewed through various lenses. Cultural sensitivity is vital. At the very least, it is important that, when working with LGBTQ individuals, the ethical principle of maleficence (i.e., "do no harm") be followed.

There is a long history of marginalization of the LGBTQ population by professionals and institutions. Fortunately, overall, there seems to be a trend of increased societal support and understanding. A unique feature for those working with LGBTQ individuals to consider is that other minority students are likely to have similar cultural backgrounds as their parents and therefore may have support to deal with the stress of oppression, whereas LGBTQ students often experience family rejection and therefore are left to navigate oppression as well as adult responsibilities on their own. A Williams Institute study (Durso & Gates, 2012) found that family rejection was the top reason given for why 40% of LGBTQ youth are homeless. The high rejection rates from family provides further support for the need for caring professionals to support the growth and development, including career development, of LGBTQ young adults.

Increased attention is also being given to intersectionality and the oppression experienced when there are intersecting identities. The double jeopardy hypothesis contends that, in comparison to members of a single minority group, members of multiple minority groups experience greater distress (Ferraro & Farmer, 1996). Hayes, Chun-Kennedy, Edens, and Locke (2011) reported that "among ethnic minority students, sexual minority status was associated with heightened psychological distress," and the reverse was not true (p. 117). A factor discussed was "heterosexism within communities of color" (Hayes et al., 2011, p. 117), as reported by Lemelle and Battle (2004) and Pachankis and Goldfried (2004).

Hayes and colleagues (2011) reported that "relative to their heterosexual ethnic minority peers, LGB clients of color experienced more distress related to depression, substance use, generalized anxiety, and family concerns" (p. 124). On the contrary, members of multiple minorities may develop enhanced coping skills to deal with oppression as well as increased hardiness and resiliency (Wilson & Miller, 2002). Individuals may transfer what was learned in navigating complex situations and relationships to novel encounters experienced. When working with LGBTQ individuals it is important to have awareness but not attach preconceived notions (i.e., stereotype). Every person is unique in his or her own right.

Theories of student development exist for racial and ethnic identity development as well as gay, lesbian, and bisexual identity development, yet none addresses intersectionality. Until a model addressing multiple identities is formulated, Ford, Beighley, and Sanlo (2015) stress the need for assessing each student. They wrote, "We believe it is helpful to find many ways of viewing LGBT students in order to better understand and help them navigate the intricate and beautiful kaleidoscope of identities they embody" (Ford et al., 2015).

Two studies on intersectionality with the young adult population were reviewed. In their national school climate report, Rankin, Blumenfeld, Weber, and Frazer (2010) reported that rather than using college LGBTQ resources, students sought trusted students of color. This was consistent with a study by Goode-Cross and Tager (2011) at a predominantly White university, where gay and bisexual male students "reported that their racial identity was more salient than their sexual orientation in creating social support" as some form of racism on campus was reported by all participants (p. 1235). These results imply the need for LGBTQ services to be more culturally responsive to ethnic minorities and for more education regarding sexual orientation and gender identities within organizations for students of color.

Counseling Considerations

Several key concerns and possible challenges should be considered when working with the young adult LGBTQ population regarding career decisions.

A Pew Research Center (2016) study found that 12 years is the median age at which lesbian, gay, and bisexual adults first felt they might be something other than heterosexual or straight. The study also reports that 17 years was the median age for those adults who now definitively identify as lesbian, gay, bisexual, or transgender (Pew Research Center, 2016). Therefore, at the young adult stage in the life span, many LGBTQ individuals may be recognizing their sexual identities and identifying their career interests simultaneously. Possible implications may exist in the potential concurrency of sexual identification and preliminary career exploration by LGBTQ young adults. While these implications will vary, they may be worthy of examination and consideration in the counseling relationship.

Belonging to sexual and gender identity minority groups is recognized as putting an individual under increased stress. This increased stress may possibly lead to increased mental and physical health difficulties (Institute of Medicine, 2011). Thus, awareness of these increased difficulties may facilitate understanding of self-care needs during the LGBTQ youths' process of career development.

LGBTQ young adults will need to decide whether they should disclose their sexual orientation or gender identity in the workplace. Those who choose not to disclose their orientation or identity may experience feelings of incongruence and stress, while those who choose to disclose their identity may risk discrimination, harassment, loss of employment, or violence (Benozzo, Pizzorno, Bell, & Koro-Ljungberg, 2015). Thus, career development among the LGBTQ young adult population may involve considerations of professional, emotional, and physical risk assessment.

It is imperative that counselors, advisors, and other helping professionals who work with young adult LGBTQ individuals understand how these strengths and challenges may impact career decision-making. Professionals should also be knowledgeable about workplace discrimination and bullying and how those realities impact young adult LGBTQ individuals and their career decision-making processes.

One goal of professionals who work with LGBTQ young adults regarding career issues should be to assist them in distinguishing and prioritizing their career values to make knowledgeable choices. This can be done through the use of career inventory tools and various other personal exploration methods. This assistance may help the LGBTQ young adult make more effective and congruent career/personality matches. The career guidance provided to this population should be empirically based (National Academic Advising Association, 2016).

References

Belz, J. R. (1993). Sexual orientation as a factor in career development. *The Career Development Quarterly, 41,* 197–200.

Benozzo, A., Pizzorno, M., Bell, H., & Koro-Ljungberg, M. (2015). Coming out, but into what? Problematizing discursive variations of revealing the gay self in the workplace. *Gender, Work and Organization, 22,* 1–16. doi:10.1111/gwao.12081

Chung, Y. B. (2001). Work discrimination and coping strategies: Conceptual frameworks for counseling lesbian, gay, and bisexual clients. *The Career Development Quarterly, 50,* 33–44. doi:10.1002/j.2161-0045.2001.tb00887.x

Chung, Y. B. (2003). Career counseling with lesbian, gay, bisexual, and transgendered persons: The next decade. *The Career Development Quarterly, 52,* 78–86. doi:10.1002/j.21610045.2003.tb00630.x

Chung, Y. B., Williams, W., & Dispenza, F. (2009). Validating work discrimination and coping strategy models for sexual minorities. *The Career Development Quarterly, 58,* 162–170. doi:10.1002/j.2161-0045.2009.tb00053.x

Dunkle, J. H. (1996). Toward an integration of gay and lesbian identity development and Super's life-span approach. *Journal of Vocational Behavior, 48,* 149–159.

Durso, L. E., & Gates, G. J. (2012). *Serving our youth: Findings from a national survey of service providers working with lesbian, gay, bisexual, and transgender youth who are homeless or at risk of becoming homeless.* Los Angeles, CA: The Williams Institute with True Colors Fund and The Palette Fund.

Ferraro, K. F., & Farmer, M. M. (1996). Double jeopardy to health hypothesis for African Americans: Analysis and critique. *Journal of Health and Social Behavior, 37,* 27–43.

Ford, M. E., Beighley, C. S., & Sanlo, R. (2015). Student development: Theory to practice in LGBT campus work. In J. C. Hawley (Ed.), *Expanding the circle: Creating an inclusive environment in higher education for LGBTQ students and studies* (pp. 187–207). Albany, NY: State University of New York Press.

Gedro, J, (2010). The lavender ceiling atop the global closet: Human resource development and lesbian expatriates. *Human Resource Development Review, 9,* 385–404. doi:10.1177/1534484310380242

Ginzberg, E., Ginsburg, S., Axelrad, S., and Herma, J. (1951). *Occupational choice: An approach to general theory.* New York, NY: Columbia University Press.

Goode-Cross, D. T., & Tager, D. (2011). Negotiating multiple identities: How African-American gay and bisexual men persist at a predominantly white institution. *Journal of Homosexuality, 58,* 1235–1254. doi:10.1080/00918369.2011.605736

Hayes, J. A., Chun-Kennedy, C., Edens, A., & Locke, B. D. (2011). Do double minority students face double jeopardy? Testing Minority Stress Theory. *Journal of College Counseling, 14,* 117–126.

Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.* Washington, DC: National Academies Press.

Lemelle, A. J. & Battle, J. (2004). Black masculinity matters in attitudes toward gay males. *Journal of Homosexuality, 47,* 39–41.

Lipshits-Braziler, Y., Gati, I., & Tatar, M. (2016). Strategies for coping with career indecision. *Journal of Career Assessment, 24,* 42–66. doi:10.1177/1069072714566795

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674–697. doi:10.1037/0033-2909.129 .5.674

National Academic Advising Association. (2016, September 29). *Advising gay, lesbian, bisexual, and transgendered students.* Retrieved from http://www.nacada.ksu.edu/Resources/Academic-Advising-Today/View-Articles/Advising-Gay-Lesbian-Bisexual-and-Transgender-Students.aspx

Pachankis, J. E., & Goldfried, M. R. (2004). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychotherapy: Research, Practice, Training, 41,* 227–246.

Pew Research Center. (2016, September 29). *A survey of LGBT Americans.* Retrieved from http://www.pewsocialtrends.org/2013/06/13/a-survey-of-lgbt-americans/

Prince, J. P. (2013). Career development of lesbian, gay, bisexual, and transgender individuals. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (2nd ed., pp. 275–297). Hoboken, NJ: Wiley

Rankin, S., Blumenfeld, W. J., Weber, G. N., & Frazer, S. (2010). *State of higher education for LGBT people.* Charlotte, NC: Campus Pride.

Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling & Development, 89,* 20–27. doi:10.1002/j.1556-6678.2011.tb00057.x

Super, D. E. (1980). A life-span, life-space approach to career development. *Journal of Vocational Behavior, 16,* 282–298.

Wilson, B. D. M., & Miller, R. L. (2002). Strategies for managing heterosexism used among African American, gay, and bisexual men. *Journal of Black Psychology, 28,* 371–391.

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Religion and Spirituality

Dawn Norman and Adam Carter

Spirituality involves having a personal connectedness with a higher power that is non-institutional and includes morals, purpose, and coping. Spirituality may also consist of transcendental experiences. Some LGBTQ individuals may identify more with spirituality rather than institutional religion due to a need to decrease feelings of discomfort and dissonance promoted by prejudice, discrimination, and hostility in many religious institutions. Cognitive dissonance may develop due to conflict between individuals' emerging sexual orientation and gender identity and their religious identities developed earlier in life (Fetzer Institute/National Institute of Aging Workgroup, 1999; Yip, 2002).

The relationship between the LGBTQ community and spirituality has been found to vary greatly across time and place, and within and between different religions and sects (Whitehead, 2014). Just as people vary widely in terms of sexual experience, attraction, and identification, their religious views of non-heterosexuality and gender expression also vary widely. The "born gay" and "sinful choice" views are perhaps the most familiar and widespread, although these are not the only two views held in religious communities (Moon, 2014).

Developmental Lens

Homopositive (born gay). Believing that it is wrong to shut people out of communities of faith, people with homopositive views find same sex-attractions to be a good thing (Moon, 2014). Proponents with these views see the scriptural passages commonly used to prohibit same-sex attraction as needing to be understood in their historical context and irrelevant to contemporary, egalitarian, committed same-sex relationships (Cheng, 2011; Cornwall, 2011). They also see homonegative interpretations of scripture as oversimplifications that justify contemporary prejudice.

Homonegative (sinful choice). The homonegative view finds no place for same-sex attractions among the faithful (Cobb, 2006; Sayeed, 2006). Verse 22 of Chapter 18 of the book of Leviticus, which is found in both the Christian Bible and the Torah, has been used to condemn same sex relationships: "Do not have sexual relations with a man as one does with a woman; that is detestable." Later in the book of Leviticus, it is revealed that the consequence for engaging in sexual acts with a member of the same sex is death. Religious leaders have used this section of scripture to distinguish between a person's inner feelings of same-sex attraction and that person's sexual actions. In other words, a person with non-heterosexual thoughts and feelings could possibly be a member of a faith-based community as long as he or she does not act on that inclination (Gold, 1992).

Researchers have noted the existence of a generally positive relationship between mental health and religion. However-er, Koenig, King, and Carson (2012) acknowledge that most studies on religiosity and well-being have used sample populations that identified as heterosexual and Christian. The small amount of existing data regarding the relationship between mental health and religiosity/spirituality for LGBTQ individuals indicates that religiosity has a negative relationship with emotional well-being, while spirituality does not (Harari, Glenwick, & Cecero, 2014).

Unlike heterosexual young adults, who have numerous role models in positions of leadership and advocacy in faith-based communities, LGBTQ individuals have little to no opportunity to learn how to manage their sexuality and spirituality in an affirming manner. The lack of lifelong models of queer involvement in spiritual groups, including organized religions, perpetuates the belief that they will forever be shut out of these groups and are not welcome to explore their spirituality in these groups (Patterson, 1994). These young adults will find it difficult to positively integrate their sexual orientation into their self-concept and sense of identity. As a result, LGBTQ young adults could be deprived of peers, positive role models, and support groups that could disconfirm negative and frightening stereotypes, and they have only stereotypes and myths from which to learn what it means to be a spiritually active LGBTQ person (Radkowsky & Siegel, 1997).

If LGBTQ young adults do choose to join a faith-based community, they are faced with choices on how visible they want to be within the faith-based community itself and within the larger queer community (Rhoads, 1997). An increased LGBTQ presence may escalate heterosexist reactions, resulting in greater conflicts for LGBTQ individuals. As more conflict is experienced, more LGBTQ young adults may seek mental health services in an attempt to reconcile their quest to be spiritually active and their reaction to their community of faith's perception of their sexual orientation. Many will seek support as a result of the psychological consequences of persistent harassment and need help dealing with reactions to being perceived as less than within their faith-based community (D'Augelli, 1993).

Strengths and Challenges

Strengths

Effective counseling services for the young adult LGBTQ population include acknowledgment of religion and spirituality as important components of many LGBTQ individuals' culture and personal identity. Counseling professionals should provide an affirmative environment that acknowledges the unique challenges young adult LGBTQ individuals may encounter during this stage of the life span. Individuals who experience

some of the challenges and key considerations discussed in this section may best be supported in professional counseling environments that provide information regarding coping resources, support groups, and various counseling strategies that embrace the young adult LGBTQ individual's connection with spirituality and religion.

Challenges

Some LGBTQ young adults may make an effort to manage their religious, spiritual, and sexual identity conflict in various ways outside of counseling. This may include decreasing religiousness, practicing abstinence, or engaging in efforts to change sexual orientation through "reparative" or "conversion" therapy (Harari, Glenwick, & Cecero, 2014). According to Yarhouse and Carrs (2012), transgender Christians may choose to remain closeted if attending a traditional or conservative church setting to avoid the experience of congregants creating an unfavorable environment. This may be done purposely or unknowingly by Christians who lack understanding of the transgender person's experience.

Some noted challenges related to spirituality and religion experienced by the young adult LGBTQ population include:

- family discourse;
- difficulty coming out;
- limited access to helpful resources;
- rejection from religious affiliations; and
- fear of religious or spiritual consequences.

Intersectionality

Critical treatment implications exist in the comprehension of the intersectionality between sexual and religious/spiritual identity. It is important to note that the way a client incorporates spirituality into his or her life is influenced by a multitude of personal factors or intersections. For example, clients may see their current views on spirituality or religion as being directly opposed to their LGBTQ identity and may outright reject religion, or they may adjust their views so that these aspect of self are more congruent. A 26-year-old queer women in Beagan and Hattie's (2015) study on spiritual integration in the queer community commented, "Queerness is about querying our sexuality but also querying everything that we do, which is about really thinking critically and not accepting the *status quo*" (p. 106).

Researchers have found that an increased capacity to achieve the integration of spirituality and sexuality increases a person's mental wellness (Wagner, Serafini, Rabkin, Remien, & Williams, 1994). The homophobic atmosphere present in some religious cultures may make it difficult for LGBTQ young adults to integrate these spiritual and sexual identities. LGBTQ young adults may find themselves faced with the decision to reject their sexual identity to maintain established relationships within their places of worship which in turn may result in emotional distress. Those individuals who previously found their spirituality and faith as a source of support may now find this intersection to be one of great stress and emotional upheaval.

Consideration of intersectionality in the counseling relationship includes understanding the counselor's sexual and spiritual intersectionality as well as the client's sexual and spiritual intersectionality. The intersectionality between the counselor's beliefs about sexual identity and his or her beliefs about religion has been examined by various researchers (Balkin, Schlosser, & Levitt, 2009; Bowers, Minichiello, & Plummer, 2010) and a connection between religiosity and homophobia among counselors has been noted. For clients who seek to explore the intersection of their sexual and spiritual identity, counselors who are unaware of their own biases surrounding these issues may place undue harm on the client. A critical skill set of counselors working with LGBTQ young adults is the capability to assist the client in negotiating any conflict that may exist and facilitate integration between their spiritual and sexual identities (Sherry, Adelman, Whilde, & Quick, 2010).

Counseling Considerations

A culturally competent counselor understands the feelings of isolation and rejection that clients may experiences as they seek to reconcile their faith and their sexuality. It is imperative that counseling professionals who work with the LGBTQ young adult population resist the inclination to separate these vital aspects of the individual in fear of further distressing the client (McGeorge, Carlson, & Toomey, 2014). Clients who choose to address spirituality in counseling are looking to do so in a safe space that allows for the questioning of well-established spiritual norms. Counselors should seek to create this safe space all the while being knowledgeable of the way their spirituality impacts their work with clients. Barriers to providing effective and ethical services to the young adult LGBTQ population may include counseling professionals' own beliefs related to spirituality and religion (Bowers, Minichiello, & Plummer, 2010), particularly if the counseling professional's beliefs are not affirming to the LGBTQ individual's identity and interactions.

Drawing from their experiences as counselors for LGBTQ clients and as professional clergy, Bozard and Sanders (2011) created the Goals, Renewal, Action, Connection, and Empowerment (GRACE) model as a way to address spiritual dissidence when counseling non-heterosexual clients. This model was designed to be used with clients who are actively exploring their spirituality and can prove to be useful to young adults who report that their spirituality was previously a source of personal strength. The GRACE model assists clients in identifying the specific aspects of their faith and spirituality that proved to be empowering and aides them in reconnecting with LGBTQ-affirming places of worship. It is to be noted that although this model was developed contextually within the Christian tradition, the authors believe that the model "may be adapted for clients of other religious faiths" (Bozard & Sanders, 2011, p. 53).

References

Balkin, R. S., Schlosser, L. Z., and Levitt, D. H. (2009). Religious identity and cultural diversity: Exploring the relationships between religious identity, sexism, homophobia, and multicultural competence. *Journal of Counseling & Development*, 87, 420–427. doi:10.1002/j.1556-6678.2009.tb00126.x

Beagan, B. L., & Hattie, B. (2015). Religion, spirituality, and LGBTQ identity integration. *Journal of LGBT Issues in Counseling, 9*, 92–117. doi:10.1080/15538605.2015.1029204

Bowers, R., Minichiello, V., & Plummer, D. (2010). Religious attitudes, homophobia, and professional counseling. *Journal of LGBTQ Issues in Counseling, 4,* 70–91. doi:10.1080/15538605.2010.481961.

Bozard, R. L., & Sanders, C. J. (2011). Helping Christian lesbian, gay, and bisexual clients recover religion as a source of strength: Developing a model for assessment and integration of religious identity in counseling. *Journal of LGBTQ Issues in Counseling, 5,* 47–74. doi: 10.1080/15538605.2011.554791

Cheng, P. S. (2011). *Radical love: An introduction to queer theology.* New York, NY: Seabury Books.

Cobb, M. (2006). *God hates fags: The rhetoric of religious violence.* New York, NY: New York University Press.

Cornwall, S. (2011). *Controversies in queer theology.* London, UK: SCM Press.

D'Augelli, A. R. (1993). Preventing mental health problems among lesbian and gay college students. *The Journal of Primary Prevention, 13*, 245–261.

Fetzer Institute/National Institute of Aging Working Group. (1999). *Multidimensional measurement of religiousness/spirituality for use in health research: A report of the Fetzer Institute/National Institute on aging working group.* Kalamazoo, MI: Author.

Gold, M. (1992). *Does God belong in the bedroom?* Philadelphia, PA: Jewish Publication Society.

Harari, E., Glenwick, D., & Cecero, J. (2014). The relationship between religiosity/spirituality and well-being in gay and heterosexual Orthodox Jews. *Mental Health, Religion & Culture, 17*, 886–897. doi:10.1080/13674676.2014.942840

Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health* (2nd ed.). New York, NY: Oxford University Press.

McGeorge, C., Carlson, T., & Toomey, R. (2014). The intersection of spirituality, religion, sexual orientation, and gender identity in family therapy training: An exploration of students' beliefs and practices. *Contemporary Family Therapy, 36,* 497–506. doi:10.1007/s10591-014-9312-8

Moon, D. (2014). Beyond the dichotomy: Six religious views of homosexuality. *Journal of Homosexuality, 61,* 125–1241. doi:10.1080/00918369.2014.926762

Patterson, C. (1994). Lesbian and gay families. *Current Directions in Psychological Science, 3,* 62–64.

Radkowsky, M., & Siegel, L. J. (1997). The gay adolescent: Stressors, adaptations, and psychosocial interventions. *Clinical Psychology Review, 17,* 191–216.

Rhoads, R. A. (1997). Implications of the growing visibility of gay and bisexual male students on campus. *NASPA Journal, 34*, 275–286.

Sayeed, A. (2006). Making political hay of sex and slavery: Kansas conservatism, feminism and the global regulation of sexual moralities. *Feminist Review, 83,* 119–131. doi:10.1057/palgrave.fr.9400284

Sherry, A., Adelman, A., Whilde, M., and Quick, D. (2010). Competing selves: Negotiating the intersection of spiritual and sexual identities. *Professional Psychology: Research and Practice, 41*, 112–119. doi:10.1037/a0017471

Wagner, G., Serafini, J., Rabkin, J., Remien, R., & Williams, J. (1994). Integration of one's religion and homosexuality: A weapon against internalized homophobia? *Journal of Homosexuality, 24*, 91–110. doi:10.1300/J082v26n04_06

Whitehead, A. L. (2014). Politics, religion, attribution theory, and attitudes toward same-sex unions. *Social Science Quarterly, 95,* 701–718. doi:10.1111/ssqu.12085

Yarhouse, M., & Carrs, T. (2012). MTF transgender Christians' experiences: A qualitative study. *Journal of LGBTQ Issues in Counseling, 6,* 18–33. doi:10.1080/15538605.2012.649405

Yip, A. (2002). The persistence of faith among non-heterosexual Christians: Evidence for the neosecularization thesis of religious transformation. *Journal for the Scientific Study of Religion, 41,* 199–212. doi:10.1111/1468-5906.00111

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Health Issues

Cara Alexis Levine

Health is a broad construct that is determined by measurements of the material, physiological self and shaped by a constellation of social, economic, and structural factors. For LGBTQ young adults, health is deeply intersectional; race, socioeconomic class, regionality, gender presentation, body size/shape, religion/religious affiliation, disability/non-disabled identity/status, and access to resources determine both health and individual/systemic designations of healthiness.

Young adulthood is often but not always when many LGBTQ individuals begin publicly identifying (Strutz, Herring, & Halpern, 2015). Although there has been growing sociocultural acceptance of LGBTQ people in some communities across the United States over the last 10 years, progress is insecure within the shifting political climate. Access to health care, including mental health treatment, hormonal care, and basic dentistry and gynecological services, is an area of ongoing concern (Strutz, Herring, & Halpern, 2015). Meyer (2003) utilizes the Minority Stress Model to identify stressors that affect LGBTQ individuals: identity stress related to disclosure and/or concealment of identity and negative internalized identity; expectations/experiences of violence; and the threat of ongoing violence (including systemic violence, such as poverty). Minority stress is a resonant factor within the most significant barriers to LGBTQ young adult health; this includes homelessness, alienation and bias from the health care establishment, and lack of family and community support.

Developmental Considerations

There are community agencies and online forums and databases dedicated to identifying health care providers, including nurses, midwives, counselors, doctors, physician's assistants, and clinics who provide low income, affirmative health care services to LGBTQ young adults. These networks have been steadily growing to include the unique needs of LGBTQ youth who fear deportation or face threats to their immigration status when seeking health care. Social and political efforts to increase access to basic needs, such as the defeat of South Carolina Senate Bill 1203, are assisting in the creation of environments where LGBTQ spectrum young adults face decreased barriers to mental and physical health and wellness.

Systemically, a lack of inclusive efforts to gather data and conduct research that captures the experience of LGBTQ youth and young adults hinders progress in development at all levels (Rankin & Garvey, 2015). Counselors can engage in and advocate for research that attends to inclusive data collection that recognizes the intersectionality of identity. Identity salience is an important consideration in capturing sufficient information to understand a community. For LGBTQ individuals, it is essential to also consider and explore intersectional identity. Such exploration is essential to increased understanding of social groups and social structures to inform support, policy making, and response to incidents of bias or discrimination.

Growth and development takes place in context (Bronfenbrenner, 1992) within nested levels. This includes relationships and interpersonal interactions, as well as influence from systems and society. To focus support and counseling efforts only on individuals who identify as LGBTQ is not sufficient if there is not also attention to the additional layers of influence of friends, family, and allies as well as systemic influence on well-being (Luke & Goodrich, 2015).

Strengths and Challenges

Strengths

The health of an individual is always embedded within the health of the community, nation, and world. Communities of LGBTQ young adults have continually demonstrated remarkable strength and resiliency as community health advocates by exponentially expanding resources for education, community building, socializing, and access points through Internet networks, communities, and groups. Formal and informal networks of affirmative health care resources amongst gay men and transwomen, supported by lesbians and bisexuals, emerged at the advent of the AIDS crisis and continue to this day (Halkitis, 2014). Evidence supports the remarkable community and individual strengths of LGBTQ young adults. Higher levels of social support (Ueno, 2005), specifically family acceptance (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010), promote greater general health status and decrease rates of interpersonal violence as well as mental illness, substance abuse, and suicidal ideation and behaviors. Being "out" as LGBTQ has been shown to increase victimization but also lessen levels of depression and greatly increases resiliency (Kosciw, Palmer, & Kull, 2015). Although research demonstrates that many LGBTQ young adults face bullying and trauma in their youth (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016) and will encounter oppression throughout their lives, the resilience of the community is unquestionable. LGBTQ young adults have utilized and weaponized social media and visual culture (Craig, McInroy, McCready, & Alaggia, 2015) to organize, find community, and fight back against marginalization and violence (Scourfield, Roen, & McDermott, 2008), as well as establish health related supports (e.g., medical care, hormone treatments, safe housing).

Challenges

Homelessness and family support. LGBTQ young adults encounter unique systemic challenges to accessing and utilizing health

care. Over 40% of homeless young adults identity on the LGBTQ spectrum (McBride, 2012), which is overwhelmingly attributed to family rejection. Homelessness carries tremendous implications for health and wellness. The instability of homelessness can preclude access to health care and preventative services, including regular physicals, dental work, and mental health services (Institute of Medicine, 2011). Homelessness and poverty contribute to nutritional deficits and preclude access to preventative health care tests and screeners. There is also a heavily increased risk for violence, including rape, sexual assault, poverty, and police brutality (Rosario, Schrimshaw, & Hunter, 2012). Lack of education and resources around safer sex practices is a health issue for LGBTQ youth across the spectrum, with the most significant impact on young transwomen (Lombardi, Wilchins, Priesing, & Malouf, 2002).

The number one risk factor for homelessness amongst young adults is family rejection. Young adults with economic security and family support living in communities with affirmative clinicians and community resources are more likely to access health care services and face clinically significant lower risks of depression and homelessness, and they have higher levels of general health (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Family acceptance and community support are overwhelmingly associated with lower health risks (D'amico, Julien, Tremblay, & Chartrand, 2015; Snapp, Watson, Russell, Diaz, & Ryan, 2015). LGBTQ young adults with family support are healthier than any other young adult demographic (Dickenson & Huebner, 2016), a significant finding that dispels residual pathologization of gender and sexual diversity and demonstrates the impact of systemic support on mental health.

Health services and providers. Many LGBTQ young adults avoid seeking health care services or avoid disclosing health concerns due to past discrimination and trauma in medical settings. The threat of false attribution of gender/sexual identity to symptomology ("You're just a hysterical gay boy, calm down" or "Wanting hormones to look a certain way is not a medical emergency") can lead to avoidance of health care, regardless of whether the need is tangentially related to sexuality/gender. Transgender young adults report regularly encountering discrimination and traumatization, including misgendering and disruption of hormonal treatments (Cobos & Jones, 2009). Transgender youth who lack access and resources for medically supervised hormonal treatments face health risks from self-administration (Lombardi, Wilchins, Priesing, & Malouf, 2002). Recently, there has been notable attention to the training and practice standards of clinicians in medical (Jann, Edmiston, & Ehrenfeld, 2015; Wilson et al., 2014) and community mental health (Hellman & Drescher, 2004) working with LGBTQ spectrum individuals. Many providers report limited to no preparation for working with LGBTQ patients, and there are indications that many provide culturally insensitive care (Carabez et al., 2015).

Intersectionality

Disabled young adults often report gender and sexual erasure in health settings (Siebers, 2012). Many individuals with disabilities are assumed to be non-sexual or non-gendered and not asked about their sexual history or offered safer sex re-

sources; many report working with personal care aides who refuse to acknowledge their gender identities. LGBTQ young adults of color face compounding risks to mental and physical health from homophobia, transphobia, and racism across multiple settings (Sutter & Perrin, 2016).

Counseling Considerations

Counselors can play a pivotal role in the physical health and wellness of LGBTQ young adults. Normalizing and validating negative and alienating experiences in health care settings can help to establish trust within the therapeutic alliance. Counselors can help provide resources, including referrals and community and Internet networks of affirmative and culturally competent health care providers. The LGBTQ community has a long history of individual and community resilience in the face of catastrophic health crises and devastating homophobic and transphobic violence. Counselors can help educate their client on the ongoing progress and history of LGBTQ individuals and communities.

Counselors must advocate for their LGBTQ client's health care needs. Direct intervention, including working with medical social workers, nurses, doctors, and rehabilitation specialists, should be explored and negotiated with clients in crisis. Counselors can offer support, such as webinar and workshop trainings, consultation, and supervision, for community health care providers to work affirmatively with LGBTQ patients. Advocacy and psychoeducation can enhance or develop a supportive community, an important factor in the critical period of identity development among young adults, even more so those who identify LGBTQ.

Resources

Center of Excellence for Transgender Health: http://transhealth.ucsf.edu

CenterLink LGBT Community Center Member Directory: http://www.lgbtcenters.org/Centers/find-a-center.aspx

Gay and Lesbian Medical Association (GLMA): http://www.glma.org

GLMA Provider Directory: https://glmaimpak.networkats.com/members_online_new/members/dir_provider.asp

National Coalition for LGBT Health: http://www.healthhiv.org/sites-causes/national-coalition-for-lgbt-health/

World Professional Association for Transgender Health (WPATH): http://www.wpath.org/

References

Bronfenbrenner, U. (1992). Ecological systems theory. In R. Vasta (Ed.), *Annals of child development. Six theories of child development: Revised formulations and current issues* (pp. 187–249). London, UK: Jessica Kingsley.

Carabez, R., Pellegrini, M., Mankovitz, A., Eliason, M., Ciano, M., & Scott, M. (2015). "Never in all my years." Nurses' education about LGBT health. *Journal of Professional Nursing: Official Journal of the American Association of Colleges of Nursing, 31,* 323–329.

Cobos, D. G., & Jones, J. (2009). Moving forward: Transgender persons as change agents in health care access and human rights. *Journal of the Association of Nurses in AIDS Care*, *20*, 341–347.

Craig, S. L., McInroy, L., McCready, L. T., & Alaggia, R. (2015). Media: A catalyst for resilience in lesbian, gay, bisexual, transgender, and queer youth. *Journal of LGBT Youth, 12*, 254–275. doi:10.1080/19361653.2015.1040193

D'amico, E., Julien, D., Tremblay, N., & Chartrand, E. (2015). Gay, lesbian, and bisexual youths coming out to their parents: Parental reactions and youths' outcomes. *Journal of GLBT Family Studies*, *11*, 411–437.

Dickenson, J. A., & Huebner, D. M. (2016). The relationship between sexual activity and depressive symptoms in lesbian, gay, and bisexual youth: Effects of gender and family support. *Archives of Sexual Behavior, 45*, 671–681. doi:10.1007/s10508-015-0571-8

Halkitis, P. N. (2014). *The AIDS generation: Stories of survival and resilience*. New York, NY: Oxford University Press.

Hellman, R. E., & Drescher, J. (2004). *Handbook of LGBT issues in community mental health*. Binghamton, NY: Haworth Medical Press.

Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: National Academies Press.

Jann, J. T., Edmiston, E. K., & Ehrenfeld, J. M. (2015). Important considerations for addressing LGBT health care competency. *American Journal of Public Health, 105,* e8. doi:10.2105/AJPH.2015.302864

Kosciw, J. G., Greytak, E. A., Giga, N. M., Villenas, C., & Danischewski, D. J. (2016). *The 2015 National School Climate Survey: The experiences of lesbian, gay, bisexual, transgender, and queer youth in our nation's schools*. New York, NY: GLSEN.

Kosciw, J. G., Palmer, N. A., & Kull, R. M. (2015). Reflecting resiliency: Openness about sexual orientation and/or gender identity and its relationship to well-being and educational outcomes for LGBT students. *American Journal of Community Psychology, 55*, 167–178. doi:10.1007/s10464-014-9642-6

Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2002). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality, 42*, 89–101.

Luke, M., & Goodrich, K. M. (2015). Working with family, friends, and allies of lesbian, gay, bisexual, and transgender youth. *Journal for Social Action in Counseling and Psychology, 7*, 63–83.

McBride, D. L. (2012). Homelessness and health care disparities among lesbian, gay, bisexual, and transgender youth. *Journal of Pediatric Nursing, 27,* 177–179. doi:10.1016/j.pedn.2011.11.007

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*, 674–697.

Rankin, S., & Garvey, J. C. (2015). Identifying, quantifying, and operationalizing queer spectrum and trans-spectrum students: Assessment and research in student affairs. In D. Stewart, K. A. Renn, & G. B. Brazelton (Eds.), *Lesbian, gay, bisexual, trans*, and queer students in higher education: An appreciative inquiry* (New Directions for Student Services No. 152, pp. 73–84). San Francisco, CA: Jossey-Bass.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2012). Homelessness among lesbian, gay, and bisexual youth: Implications for subsequent internalizing and externalizing symptoms. *Journal of Youth and Adolescence, 41*, 544–560. doi:10.1007/s10964-011-9681-3

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*, 205–213. doi:10.1111/j.1744-6171.2010.00246.x

Scourfield, J., Roen, K., & McDermott, L. (2008). Lesbian, gay, bisexual and transgender young people's experiences of distress: Resilience, ambivalence and self-destructive behaviour. *Health & Social Care in the Community, 16,* 329–336. doi:10.1111/j.1365-2524.2008.00769.x

Siebers, T. (2012). A Sexual Culture for Disabled People. In R. McRuer & A. Mollow (Eds.), *Sex and disability* (pp. 37–54). Durham, NC: Duke University Press.

Snapp, S. D., Watson, R. J., Russell, S. T., Diaz, R. M., & Ryan, C. (2015). Social support networks for LGBT young adults: Low cost strategies for positive adjustment. *Family Relations, 64*, 420–430. doi:10.1111/fare.12124

Strutz, K. L., Herring, A. H., & Halpern, C. T. (2015). Health disparities among young adult sexual minorities in the U.S. *American Journal of Preventive Medicine, 48*, 76–88. doi:10.1016/j.amepre.2014.07.038

Sutter, M., & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *Journal of Counseling Psychology, 63*, 98–105. doi:10.1037/cou0000126

Ueno, K. (2005). Sexual orientation and psychological distress in adolescence: Examining interpersonal stressors and social support processes. *Social Psychology Quarterly, 68,* 258–277.

Wilson, C. K., West, L., Stepleman, L., Villarosa, M., Ange, B., Decker, M., & Waller, J. L. (2014). Attitudes toward LGBT patients among students in the health professions: Influence of demographics and discipline. *LGBT Health, 1*, 204–211.

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Family and Social Development

Quentin Hunter, Margaret O'Hara, and Colleen Logan

Young adults experience many changes in the social and family domains as they leave adolescence and begin to form adult relationships with others as part of the individuation process. This can include forming intimate relationships, creating families, forming social circles, and renegotiating relationships in their families of origin. LGBTQ individuals undergo these same family and social development milestones while also managing unique challenges.

Developmental Lens

When considering family issues and relationship issues experienced by LGBTQ young adult individuals through a developmental lens, there are frameworks and competencies counselors may reference. These include traditional theories of development, more recent theories of identity development derived from research, and competencies for working with LGBTQ persons from the Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGBTIC), a division of the American Counseling Association.

A traditional theoretical framework to understanding human development across the life span is Erikson's eight phases of self-development (Erikson, 1963). The growth process is defined by distinct developmental phases, each involving resolution of conflicts, with tasks that are psychosocial in nature. Success is determined by progress at previous stages. If managed well, a certain virtue or psychosocial strength is developed that affects future development.

The phase-specific task of young adulthood (18–30 years old) involves resolving the psychosocial conflict regarding intimacy versus isolation. People explore relationships toward longer-term commitments with someone other than a family member. The task is to achieve some degree of intimacy as opposed to remaining in isolation. In this stage, the adult becomes psychosexually mature and begins to establish significant intimate interpersonal relationships. The successful navigation of conflicts at this stage results in the psychosocial strength or virtue of love.

Love, in the context of Erikson's theory, means being able to put aside differences and antagonism through "mutuality of devotion" (Boeree, 2006, p. 10). It includes not only the love found in a good partnership or marriage but also the love between friends and the love of one's neighbor, co-worker, and compatriot as well.

In referencing Erikson's model, it is important to note that the phase-specific task of the prior stage, adolescence, is

> the consolidation of a stable identity . . . which is . . . of particular importance for LGBT individuals. It is the time when sexuality becomes realized and conflicts involving the physical self are brought to the fore. The challenges to completing the task of identity consolidation are many . . . and there . . . can be great variation in an adolescent's timelines for developing physical, cognitive, emotional, and social maturity. (Levounis et al., 2012, p. 282)

Young adulthood is a critical time for developing one's family of choice and procreation. For LGBTQ individuals, there are challenges and joys in terms of meeting other LGBTQ individuals, dating, partnering, being married, raising children, and divorcing.

For LGBTQ individuals, establishing and maintaining relationships may include unique complications or processes related to relationship milestones (e.g., initiating meetings, cohabitation, introduction to parents, having children), and counselors may need to consider the influences of individual development, gender identities, sexuality, and social and cultural environment on LGBT relationships (Macapagal, Greene, Rivera, & Mustanski, 2015).

Ethics and Competencies

When utilizing life span development theories, the ALGBTIC Competencies for Counseling Transgender Clients (ALGBTIC, 2009), specifically Standard A.5., reminds clinicians to "identify any gender-normative assumptions" of these theories and "address biases in assessment and counseling practices." Additionally, Standard A.9. calls upon counselors to "recognize that the normative developmental tasks of many transgender individuals may be complicated or compromised by one's self identity and/or sexuality confusion, anxiety and depression, suicidal ideation and behavior, non-suicidal self-injury, substance abuse, academic failure, homelessness, internalized transphobia, STD/HIV infection, addiction, and other mental health (issues)." The competencies identify similar complicating factors in Standard A.7. with the addition of "physical, sexual, and verbal abuse, homelessness, prostitution, and STD/HIV infection" (ALGBTIC, 2012).

There are other influences that affect development. Standard A.10. of the ALGBTIC competencies advises counselors to recognize the influence of other contextual factors and social determinants of health (i.e., race, education, ethnicity, religion and spirituality, socioeconomic status, role in the family, peer group, geographical region, age, size, gender identity/expression) on the course of development of LGBTQ identities (2012).

Similarly, both sets of competencies stress the importance of understanding "that biological, familial, cultural, socio-economic, and psychosocial factors influence the course of development of affectional orientations and gender identi-

ty/expressions" (ALGBTIC, 2009, 2012). Goodrich and Luke (2015), in their book, "Group Counseling with LGBTQI Persons," state that

> although there is overwhelming support for positive familial relationships within research, families may still struggle with accepting LGBTQI persons into the family system, and many families continue to reject and cast out family members who decide to be open about their gender identity and/or affectual orientation. (p. 115)

Regardless of the resiliency of the LGBTQ individual, Standard A.6. stresses that pressures to be heterosexual, stigma, prejudice and discrimination may still affect developmental decisions and milestones (ALGBTIC, 2012). Additionally, Standard A.18. gives consideration to the coming out process:

> Counselors, as noted earlier, must conceptualize coming out as an on-going and multi-layered process for LGBTQ individuals and that coming out/living out may not be the immediate goal for all individuals. While coming out may have positive results for a person's ability to integrate their identity into their lives thus relieving the stress of hiding, for many individuals coming out can have high personal and emotional costs (e.g., being rejected from one's family of origin, losing a job/career, losing one's support system). (ALGBTIC, 2012)

It is important to think beyond the traditional conceptualization of family when working with the LGBTQ population. Standard A.11. recommends that counselors "understand that LGBQQ individuals family structures may vary (e.g. multiple coupled parenting families, polyamorous families), and they may belong to more than one group they consider their family" (ALGBTIC, 2012). In the introduction to the transgender competencies, the authors stress:

> Due to the transprejudice, transphobia, and transnegativity evident in a cisgender-normative society that many transgender individuals experience, it is not uncommon for transgender people to be rejected from their families of origin; and, therefore, there may be conflict and/or separation from nuclear and extended families. Transgender individuals may therefore find and define family by those who perform the roles of family, despite biological or legal adoption with a family unit. This broader definition of family should be honored and integrated into the counseling process as the individual chooses. Within the transgender community, this may be referred to as "family of choice." It is essential for counselors to honor how individuals define and label family for themselves, asking respectful questions to affirmatively understand a family constellation and using the same terms as the client when referring to loved ones. (ALGBTIC, 2009)

Reinforcing this point, Standard A.12. relates to family and human growth and development (ALGBTIC, 2012). It empowers individuals to find and lean into supportive family and friends, including friends as family. It states:

> Understand that an LGBQQ individual's family of origin group and/or structure may change over time, especially as it relates to the family's acceptance/rejection of the LGBQQ member, and

acknowledge the impact that being rejected from one's family may have on the individual. If problems exist in the "family of origin," the individual may create a "family of choice," among supportive friends and relatives. (ALGBTIC, 2012)

Strengths and Challenges

Strengths

LGBTQ individuals and the LGBTQ community also have many strengths which can support individuals and their families throughout early adulthood. Strengths may include:

- The unique ability to build families of choice that may indeed manifest stronger and more sustainable bonds than are available to families of origin;
- LGBTQ organizations and family-focused groups for socialization and education;
- LGBTQ-affirming legislation or efforts with existing advocacy groups to create and champion such legislation;
- Social media to connect the community and share affirming stories of family and connection as well as to receive support (with caution, as it can also be a breeding ground for bullying and harassment); and
- LGBTQ-affirming health care providers and businesses serving families.

Challenges

LGBTQ young adults seek counseling for all the same reasons as their heterosexual counterparts (i.e., stressors related to work, communication, intimacy, financial concerns). What is different is that LGBTQ adults experience these normative stressors within a societal context that is laden with homoprejudice and cisgender assumptions. LGBTQ adults also seek counseling regarding legalizing their relationship, particularly after the right to legally marry became the law of the land; this newer possibility, for some, without the developmental context experienced in the heterosexual community may result in questions, misconceptions, and need for additional support and referrals. LGBTQ adults also seek help with creating families in terms of adoption, surrogacy, insemination, egg donation, using a known donor versus an unknown donor, deciding which partner will carry the child, how families will be integrated, and other issues. Dissolution of marriages or long-term partnerships, particularly those with children involved, is another area of need.

LGBTQ individuals encounter all the developmental milestones of early adulthood: individuation and identity achievement, career exploration and establishment, developing and maintaining intimate relationships, and others. LGBTQ individuals may face additional stressors related to these milestones.

Considerations

Coming out is a choice whether it is to oneself or to one's family of origin, friends, and colleagues. It is important to respect and value this choice given the real and perceived threat of the current sociopolitical climate.

Coming out is an iterative and continuous process. In LGBTQ families, each member may have a different trajectory for com-

ing out to which the counselor must be sensitive while also examining how these trajectories impact the family system.

Creating family and social connections after transition and reframing existing relationships after transition can be fraught with difficulty and stress. Clients will need affirmative support and guidance.

Navigating dating in the LGBTQ community can be challenging as it can be different from heterosexual dating practices given the ubiquitous impact of homoprejudice and transprejudice.

Discrimination can come from within the family and outside of family. How family/social supports respond to discrimination is critical to self-esteem and healthy adjustment. Discrimination and prejudice within the LGBTQ community also occurs and can be particularly painful when one is feeling disenfranchised and marginalized from one's family of origin. Internalized transphobia, biphobia, and homoprejudice must always be addressed and processed with clients.

Another challenge is feelings of isolation from family/social supports while also experiencing the message that forming a family is "sacred" and typically supported in heteronormative contexts; the disparity often becomes glaring and difficult to traverse.

Intersectionality

LGBTQ clients, like all clients, are not solely defined by one identity, even one as salient as gender and/or sexuality. Counselors should engage with LGBTQ clients' multi-faceted identities to better conceptualize the individual in context and effectively assist with presenting issues. To this end, counselors should become familiar with some of the basic tenets of intersectionality: groups are not homogenous, people are located within the structures of power and must be considered within those structures, and there are unique effects resulting from identifying with more than one group (Stewart & McDermott, 2004).

For example, an individual who identifies as a lesbian may be seen through a lens of intersectionality as a unique combination of identities including not only sexuality but also race, gender expression, age, ethnicity, nationality, and others. Often, identity dimensions garner individual privilege the closer they appear to the desired dimensions of the majority (McDowell & Hernández, 2010). For LGBTQ individuals, this can appear as privileging other identities in the LGBTQ community above others: white, able-bodied, cisgender, male, young, and upper socioeconomic status identities, to name a few. Counselors should make a point to explore the intersectionality of identities for each client and to view those identities as possible sources of oppression and resilience (Singh & Moss, 2016). Some examples include counseling interracial couples facing racism within the LGBTQ community, helping individuals concerned with the age differences in their relationship confront ageism in the LGBTQ community, or helping a multi-ethnic, LGBTQ-headed family find resources related to their multiple identities.

Counseling Considerations

Counselors should continually assess their biases and ensure they are working in the best interest of their LGBTQ clients, seeking supervision when biases may impact their

effectiveness in counseling. Developing competency is a prerequisite to effective counseling through avenues of consultation and supervision where deficits exist. Commit to adjustments that demonstrate inclusion (e.g., avoid binary "mother/father," "boy/girl" language when constructing a genogram).

Counselors should explore theories of couples and family therapy to see if they directly address LGBTQ relationships. Investigate if one's preferred family and couple counselor theory has literature that directly addresses LGBTQ individuals in therapy.

Counselors can also increase their personal exposure to LGBTQ couples and families. When permitted, visit support groups in person or online for LGBTQ couples or families. Seek biographies, documentaries, and, to a lesser extent, fictional accounts of young adult LGBTQ relationships. Increased exposure will promote an affirming disposition in therapy and enhance cultural competence.

Remember that LGBTQ families may consist of members of the client's family of origin (e.g., parents) and/or members of the client's family of choice (i.e., individuals identified by the client as family).

LGBTQ-affirming counselors should not quickly assume that presenting issues are directly related to gender identity or sexuality. However, counselors should feel confident to attend to these aspects of identity when they are related. Counselors should not shy away from frank discussions on transphobia, homophobia, and discrimination.

Counselors should routinely check their resources (e.g., family services, community organizations, protective institutions such as shelters, 12-step groups, health care providers) to ensure they are LGBTQ-affirming and able to provide adequate services.

Counselors should be able to identify quality resources to recommend to LGBTQ individuals and their families, including websites and literature developed by existing LGBTQ organizations and LGBTQ-affirming family organizations.

When working with LGBTQ clients, counselors should discuss additional identity dimensions as possible sources of privilege or marginalization and how these dimensions relate to those of significant others and family members. Counselors may wish to incorporate interventions where family members can list and discuss their identity dimensions and their salience using, for example, the ADDRESSING framework (Hays, 2001): Age, Disability, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender.

References

Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2009). *ALGBTIC competencies for counseling transgender clients*. Alexandria, VA: Author.

Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2012). *ALGBTIC competencies for counseling LGBQIQA*. Alexandria, VA: Author.

Boeree, C. G. (2006). *Personality theories: Erik Erikson.* Retrieved from http://webspace.ship.edu/cgboer/erikson.html

Erikson, E. (1963). *Childhood and society*. New York, NY: Norton.

Goodrich, K. M., & Luke, M. (2015). *Group counseling with LGBTQI persons*. Alexandria, VA: American Counseling Association.

Hays, P. A. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors.* Washington, DC: American Psychological Association.

Levounis, P., Drescher, J., & Barber, M. E. (2012). *The LGBT casebook*. Washington DC: American Psychiatric Publishing.

Macapagal, K., Greene, G. J., Rivera, Z., & Mustanski, B. (2015). "The best is always yet to come": Relationship stages and processes among young LGBT couples. *Journal of Family Psychology, 29,* 309–320.

McDowell, T., & Hernández, P. (2010). Decolonizing academia: Intersectionality, participation, and accountability in family therapy and counseling. *Journal of Feminist Family Therapy*, *22*, 93–111, doi:10.1080/08952831003787834

Singh, A. A., & Moss, L. (2016). Using relational-cultural theory in LGBTQQ counseling: Addressing heterosexism and enhancing relational competencies. *Journal of Counseling & Development*, *94*, 398–404.

Stewart, A. J., & McDermott, C. (2004). Gender in psychology. *Annual Review of Psychology*, *55*, 519–544. doi:10.1146/annurev.psych.55.090902.141537

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Bias and Discrimination

Amy Zavadil

As noted previously, LGBTQ young adults face all of the same tasks and challenges that all young adults do but they must do so through the lens of homoprejudice and transprejudice. Fortunately, society has advanced and there is greater appreciation for different orientations and identities. Unfortunately, homoprejudice is real and ubiquitous and LGBTQ young adults still face difficulty across many fronts including home, universities, and religious organizations as they strive to develop healthy and positive self-identities. In fact, with the recent sociopolitical changes seen in the 2016 election, these may become magnified, reflecting a pendulum swing back toward a darker period in the LGBTQ community's history. These challenges are particularly evident as young adults seek to come out and live out, when possible and when chosen, in their emerging homes, in their educational environments, in their occupations and in the community at large.

Over the past two decades, there have been rapidly changing rights for LGBTQ individuals afforded by local, state, and federal legislation (see Knauer, 2012) that may see a decline with the 2016 election. Bias, discrimination, perceived discrimination, and microaggressions can significantly impact an LGBTQ individual's well-being, career decision making, and other life adjustments. It has been estimated that two thirds of college students report experiencing or witnessing harassment or bias based upon sexual orientation or gender identity. Both the actual and perceived potential for harassment is a reality for LGBTQ individuals, in both school and workplace settings. There is an over-representation of LGBTQ youth, with the highest percentage being people of color, among the growing rate of homelessness and youth who are incarcerated; this is often attributed to homoprejudice, bias, and lack of acceptance by family or others (see the most recent report at http://www.lgbtmap.org/policy-and-issue-analysis/criminal-justice-youth). These experiences can certainly negatively impact the transition to young adulthood and individuation.

Counselors should explore with their LGBTQ clients what social support they see for themselves and emphasize the importance of such a network of support, even one that is nontraditional and fashioned by the clients themselves. A systems approach to identifying barriers and supports can assist in aiding clients, whether they are currently navigating experience of bias and discrimination or preparing for the potential experience. The Minority Stress Model (Meyer, 2003) emphasizes that the experience of bias, discrimination, or harassment creates excess conditions of the social environment and has a strong influence on well-being (Luke & Goodrich, 2015). It is also important to recognize that LGBTQ individuals may experience marginalization on multiple levels. In addition to a high prevalence of homoprejduce, individuals may also experience gender and/or racial and ethnic discrimination or harassment in combination associated with higher rates of substance use disorders (Center for American Progress, 2016; McCabe, Bostwick, Hughes, West, & Boyd, 2010). Seeking systems of support and utilizing those supportive networks is healthy and can empower LGBTQ individuals.

Coming forward to seek assistance or report incidents of harassment or discrimination can include increased barriers for LGBTQ identified individuals. In some cases it may be difficult to share this information to a counselor, but it is particularly difficult when seeking assistance in seeking to address experiences in community, school, and workplace settings. There may be a concern of being "outed" or being asked to disclose information that they may not be ready to disclose. In relationship violence, it may be that their partner has threatened outing an individual or indicated that to report would out the perpetrator. There are also concerns that those who are responsible for addressing complaints may not be properly trained to understand and respond sensitively to same sex violence, bullying, harassment, or discrimination.

Prevalence of Experience of Bias or Discrimination

More than one-third of LGBTQ college students indicate experience of harassment on campus. LGBTQ students typically report more hostile experiences of campus climate, and half of LGBTQ students indicate they conceal their sexual identity to reduce incidence of harassment or intimidation (Rankin, 2005).

Workplace policy and structure often do not support LGBTQ individuals. At least one quarter of LGBTQ workers report experience of harassment in the workplace; the number is likely greater (King & Cortina, 2010).

Outside/other settings present cultural and systemic bias, discrimination, and isolation. There are differences based upon location (e.g., urban/rural experiences). There is disparate impact with 20% of incarcerated youth identifying LGBTQ (compared to approximately 8% of LGBTQ among general population). Of those 20%, nearly half are LGBTQ youth of color. LGBTQ youth are at greater risk of homelessness, with more than half of LGBTQ homeless youth indicating that family rejection led to homelessness (Center for American Progress, 2016).

Developmental Lens

- Different stages of identity development can create resilience or barriers.
- LGBTQ youth who have the support of family (and other social networks) have a greater likelihood of developmentally appropriate transitions.

- LGBTQ youth who lack support and coping skills are likely to face barriers of more basic needs (e.g., housing, food) that may result in developmental delay.
- Youth who are supported in their own identity development demonstrate greater resilience when confronted with discriminatory or harassing experiences.

Strengths and Challenges

Strengths

- Increasingly, LGBTQ youth are connecting among communities of support as they learn how to seek out and create such community.
- Increasing affirmative community agencies (in some regions) provide greater opportunity for connection and advocacy.
- Youth are utilizing online resources that offer ready access to tools for self-advocacy (and advocacy for others).
- There is an increase in allyship, or those who are engaged in a process of supporting marginalized individuals and/or seeking to address the oppression. In some regions, young adults are experiencing greater support, and messages of support enhance resilience.
- Internal factors of empathy, self-efficacy, and coping skills can increase resilience.

Challenges

- LGBTQ youth often face concern or threats of being "outed" or disclosing information they are not ready to disclose.
- Victimization and marginalization experiences can lead to LGBTQ youth experiencing greater negative feelings toward themselves.
- LGBTQ youth may not have access to physical and mental health care.
- Experience of discrimination is correlated with negative health outcomes, negative academic impact, and social isolation for LGBTQ youth.
- Lack of family support can negatively impact coping and resilience for LGBTQ youth.

Intersectionality

The intersection of multiple identities can have a major influence on actual and perceived experience of discrimination and harassment. Multiple marginalized identities can shape experience in unique ways. Compounding instances of discrimination, such as homonegativity and experience of racial, religious, and/or gender bias, increases adverse impact on health and wellness. It is essential to listen to the individual to understand fully the experiences of LGBTQ youth and to recognize the influence of all aspects of their identity on their lived experience.

Counseling Considerations

Self-awareness and awareness of the needs of LGBTQ individuals are not sufficient; counselors must engage actively to reduce bias in policies and practices. Through a systems approach and a social justice perspective, it is important that counselors review assessment materials in use, discuss with clients their experience of school and/or work climate, and advocate for review of work and education practices to strive to identify and eliminate LGBTQ bias. It is necessary, also, to attend to the strength and resilience of LGBTQ population as well as the barriers and stressors that may be unique or compounded. Monitoring and contributing to continued research related to LGBTQ experiences of bias and discrimination, as well as identifying strengths, barriers, and coping mechanisms of LGBTQ and other diverse populations, can aid in supporting clients and shifting culture to enhance individual, academic, and career success.

Organizations like Lambda Legal, National Women's Rights Center, and the American Civil Liberties Union offer extensive resources regarding available legal protections for LGBTQ individuals. The Human Rights Campaign, GLAAD, PFLAG, the National Anti-Violence Project, and Campus Pride are among the organizations that offer prevention and support information.

Advice for counselors includes the following:

- Coming out is a choice but is it not always safe (e.g., coming out to nonsupportive parents who still provide financial support). It is not a linear process. One does not have to come out in order to be deemed healthy.
- How does one come out? When does one come out? How can we support young adults through the coming out process?
- What should a counselor know about the coming out/living out process? How can a counselor help? Consider strength-based coming out strategies.
- Explore your own internalized homoprejudice and bias related to gender identity.
- Educate yourself. There are a number of wonderful resources provided here. It is your responsibility to educate yourself about the issues facing LGBTQ youth.
- Be knowledgeable of LGBTQ affirmative environments and how to identify such environments (e.g., identifying company policies and non-discrimination protections).
- Allow for and expect ambiguity. Accept and affirm experimentation.
- Avoid over-sexualizing LGBTQ youth.
- Challenge negative and derogatory language. Model affirming behaviors and interventions that challenge bias.
- Respect confidentiality. If a LGBTQ youth trusts you with information about his or her orientation or identity, treat it as a gift because you are seen as trustworthy. You may be the first person he or she has shared this information with, and it is important to honor this information.
- Do not assume heterosexuality.
- Listen, take seriously reported experiences, and refer appropriately. Be prepared to serve as an advocate in order to help and protect.
- Take the experience of homoprejudice seriously. The risk of suicide in LGBTQ youth is 2 to 3 times higher than the risk for other adolescents. Feelings of self-hate and shame are not uncommon given the prevalence of homoprejudice. Actively listen without judgment.

Resources

Anti-Violence Project: http://www.avp.org/

American Civil Liberties Union: LGBT Rights: https://www.aclu.org/issues/lgbt-rights

Campus Pride: https://www.campuspride.org/topics/bias-and-hate-crime-prevention/

Center for American Progress: https://www.americanprogress.org/issues/lgbt/view/

GLAAD: http://www.glaad.org/resourcelist

GLSEN: http://www.glsen.org/policy

Guidance on Rights for Transgender and Gender Non-Conforming Students: https://www2.ed.gov/about/offices/list/ocr/lgbt.html

Human Rights Campaign: History of Federal Legislation: http://www.hrc.org/resources/a-history-of-federal-non-discrimination-legislation

Maps of State Laws and Policies: http://www.hrc.org/state_maps

Lambda Legal: Guide for Trans People and Their Advocatees: http://www.lambdalegal.org/know-your-rights/transgender

LGBT Teens and Young Adults: http://www.lambdalegal.org/know-your-rights/youth

The Law and LGBT Youth: http://www.lambdalegal.org/know-your-rights/the-law-and-lgbtq-youth/youth

Legal Advocates and Defenders for the LGBT Community (GLAD): http://www.glad.org/rights

National Center for Transgender Equality: http://www.transequality.org/know-your-rights

PFLAG: https://www.pflag.org/diverse-inclusive-world

Transgender Law Center: Map of Equality: http://transgenderlawcenter.org/equalitymap

United Nations Foundation: International LGBT Rights: http://www.unfoundation.org/features/lgbt-rights.html?gclid=CJnm-NzZ-vM8CFQpehgod3-4ATA

U.S. Department of Education, Office of Civil Rights: Index of guidance documents: https://www2.ed.gov/about/offices/list/ocr/frontpage/faq/rr/policyguidance/sex.html

U.S. Equal Employment Opportunity Commission Protections for LGBT Workers: https://www.eeoc.gov/eeoc/newsroom/wysk/enforcement_protections_lgbt_workers.cfm

References

Center for American Progress. (2016). *Unjust: How the broken criminal justice system fails LGBT people.* Retrieved from http://www.lgbtmap.org/file/lgbt-criminal-justice-unjust.pdf

King, E. B., & Cortina, J. M. (2010). The social and economic imperative of lesbian, gay, bisexual, and transgendered supportive organizational policies. *Industrial and Organizational Psychology*, *3*, 69–78.

Knauer, N. J. (2012). Legal consciousness and LGBT research: The role of the law in the everyday lives of LGBT individuals. *Journal of Homosexuality*, *59*, 748–756.

Luke, M., & Goodrich, K. M. (2015). Working with family, friends, and allies of LGBT youth. *Journal for Social Action in Counseling and Psychology*, *7*, 63.

McCabe, S. E., Bostwick, W. B., Hughes, T. L., West, B. T., & Boyd, C. J. (2010). The relationship between discrimination and substance use disorders among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*, *100*, 1946–1952.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129,* 674–697. doi:10.1037/0033-2909.129.5.674

Rankin, S. R. (2005). Campus climates for sexual minorities. *New Directions for Student Services*, *2005*, 17–23.

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Case Studies

Mary: Coming Out and Gay Identity Development

Mary is a Black female student-athlete on full scholarship at a large state institution, where she is majoring in engineering. She is an out-of-state student from a middle- to upper-class family where both parents were working professionals.

Mary comes to the counseling center in the spring semester of her sophomore year. She seems uncomfortable in the counseling milieu, squirming in her seat, smiling when uncomfortable, and unable to maintain direct eye-contact for extended periods of time. Mary reports feeling highly stressed and anxious regarding team performance, academic workload, and grades, as well having to adjust to a new coaching staff and uncertain role on the team.

Mary senses that she is perceived as someone who does not have any problems, is smart and does not have to work hard, is physically attractive, and has a "perfect life." She has developed into a highly independent young woman who never asks for help from others and always feels in control and emotionally stable—at least on the outside. Eventually Mary's feelings of inauthenticity and vulnerability to others' regard of her surfaced. She reports often feeling "disconnected."

Mary's greatest concern is her family of origin's sports-centered culture and how it has perhaps shaped her relationship dynamics and sexual identity. Mary recalls that her parents often rejected her wardrobe choices and those of her friends as she became an adolescent and joined teams with more "masculine-looking" girls. Her parents began controlling who she could hang around with due to their fears of her being gay, although at that time, Mary was not fully aware of to whom she was sexually attracted.

As her college tenure progressed, Mary began dating women and she solidified her sexual identity as a lesbian. Complicating her acceptance process, however, are mixed messages she has received from her teammates and coaches regarding what is and is not accepted on her team. Mary continues to struggle with coming out, most profoundly with her parents' unwillingness to have a relationship with her if there is any mention of her sexual identity, her partners, or her friends. She feels this is particularly sad and frustrating as she has embraced the most salient aspects of her identity as a smart, Black lesbian.

Jason: Spirituality and Religion

Jason, a 22-year-old White community college student in rural Tennessee, presents as struggling with his coming out process. He is a "God loving young man" who finds it horrible that he knows in his heart that he is gay. While he doesn't fear death or Hell, as his grandmother has reminded him happens to those like him, Jason does fear some kind of retribution from God, classmates, teachers and neighbors. Jason seems certain that his church will abandon him, as will God, and he indicates he has considered suicide in the past. He reports that he "might be happier all around" if he hurts himself in some way, but that he also wants to live a gay lifestyle.

Jason would like to go on to a 4-year university to be a high school science teacher, although he's already been told that he can't be gay and a teacher, and no one would hire him. He thinks he might like to leave Tennessee and his rural environment, but fears losing his "link to God" and his basic religious roots. He expresses that God is "the anchor" to his life.

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Section 2:
Midlife LGBTQ Adults

Coming Out and Gay Identity Development

Leslie Kooyman

Coming out for LGBTQ individuals is a process of understanding one's sexual orientation and/or gender identity and openly disclosing these identities to others. According to Rust (2003), coming out is "the process by which individuals come to recognize that they have romantic or sexual feelings toward members of their own gender, adopt lesbian or gay (or bisexual) identities, and then share these identities with others" (p. 227). Rust (2003) asserts that the specific coming out/sexual identity development literature peaked in the 1970s and 1980s; however, the exploration of understanding the richness and varied intersectionality of LGBTQ identities and identity development has increased over the years. This section reviews "coming out" as a part of sexual identity development with a sociohistorical context of midlife populations. Strengths or benefits of coming out at midlife and challenges to coming out at midlife are discussed. Counseling implications based on these findings are suggested.

LGBTQ persons in midlife are a unique generation in that they consist primarily of the baby boomer generation and are the first cohort of LGBTQ persons to come out after the Stonewall riots and during or after the sexual revolution of the 1960s and gay liberation movement in the 1970s (Orel, 2014). This cohort has witnessed dramatic positive shifts in social attitudes and legal rights for LGBTQ populations (Herdt & de Vries, 2004; Hunter, 2007; Orel, 2014). LGBTQ persons in midlife have experienced the emergence of the gay pride movement, the removal of homosexuality as a mental illness, the AIDS crisis, the repeal of sodomy laws across the country, and the recent legalization of same-sex marriage. Coming out for this population is significantly different compared to older generations who faced extreme oppression, stigma, and harsh legal ramifications for being openly gay (Kimmel, Rose, Orel, & Greene, 2006). The LGBTQ midlife cohort grew up with oppression and yet witnessed the emergence of greater acceptance, which is also different from younger LGBTQ populations who are coming out earlier in life as a result of this greater acceptance (Savin-Williams, 2005).

In consideration of this LGBTQ baby boomer population, who have experienced oppression and greater social acceptance, counselors find greater variation in their level of "outness." In one of the first large scale studies of LGBTQ participants (*n* = 1,000) aged 40–61 years, 44% reported being "completely" out (work, family, social contexts), 31.7% reported being "mostly" out, 12.2% reported being "somewhat" out, 7.9% reported being a "little" out, and, 3.7% reported "not out at all" (MetLife, 2010). This variation in the level of outness among midlife LGBTQ persons may be reflective of the unique sociohistorical context this generation has experienced

and may also be understood through the development of sexual identity models.

This time period has also experienced a significant increase in research on LGBTQ populations, particularly with research focusing on sexual identity as a developmental process. In fact, most models of sexual identity development were framed with this particular cohort of midlife LGBT individuals. An understanding of sexual identity development and coming out is essential in understanding the complexity of coming out for midlife LGBTQ individuals.

Developmental Lens

Coming out is typically viewed as a process of sexual identity development that occurs over time. In this context, it is understood as an ongoing developmental process that occurs through the life span. Cass (1979) developed the first of these sexual identity development models which describes stages gay men or lesbians may go through in accepting their sexual orientation or gender identity. These stages are: identity confusion, identity tolerance, identity acceptance, identity pride, and identity synthesis. It became a "one size fits all" model lacking any other research on this topic. These broad sequential themes of the coming out experience are still well regarded in the research literature in understanding of sexual identity development. A midlife LGBTQ client in counseling in the 1980s and 1990s was probably understood by a counselor through Cass's model, and yet many midlife LGBTQ individuals may have struggled with fitting into this defined stage-sequential process.

More current research has enhanced this rudimentary understanding to address criticisms of the model. Criticisms of Cass's model include the lack of diversity of her sample (primarily gay white males), the linear description of the stages, the influence of human development and environment, the role interpersonal relations and romantic relationships play in this process, the applicability of this model to more current understandings of fluidity in sexual orientation and gender identity, and the intersectionality of various identities (D'Augelli, 1994; Lev, 2004; Manning, 2014; Rosario, Scrimshaw, Hunter, & Braun, 2006; Troiden, 1988, 1989). Coming out now is viewed through the context of gender, gender identity, human development, environment, sociohistorical events and age, intersectionality of other identities, and supportive relationships of others.

Some of the more prominent sexual identity models that have emerged address many of these contexts. Given that Cass's (1979) model was based on the experiences of gay men, McCarn and Fassinger (1996) proposed a model of sexual identity development for lesbians that uses a feminist approach focusing more on individual and group membership. For the first

time, gender was considered significant in influencing coming out and sexual identity development. Also, the influence of relationships and a sense of belonging became salient to the process. Women tend to come out later in life than gay men, and many are more involved in heterosexual relationships and may consider a bisexual identity prior to exploring same sex relations (Diamond, 1998, 2008; Floyd & Bakeman, 2006). Women also tend to be more fluid in their understanding of sexual orientation, and this may also account for their disclosing their lesbian identity later in life (Diamond, 2005). McCarn and Fassinger (1996) emphasize the importance of women coming out through meaningful relationships (heterosexual and homosexual) rather than immersing oneself into the external world of the gay community as gay men tend to do (Pew Research Center, 2013).

Adams (2011) and Manning (2014) assert that the external process of coming out to others may be variable and selective (e.g., coming out to select friends but not all friends, or coming out to coworkers but not family). This notion of "selective outness" is not fully discussed in previous models of sexual identity development, but their research supports the complexity that "coming out" may not be an "all or nothing" process and reflects the true experience of LGBTQ individuals. In the late 1980s in the United States, there was a push to "come out of the closet" in light of the AIDS epidemic. For many midlife LGBTQ individuals who, given the sociohistorical context, were not out to everyone in their life, they suddenly felt pressured to be fully out. Many of this age cohort retreated back into the closet during this turbulent time. The work of Adams (2011) and Manning (2014) indicate that communication and discernment of who to tell is valued and relevant to the process, and this may have some bearing on someone coming out as a teenager and someone coming out in midlife.

Lev (2004) developed a more recent model of transgender identity development that introduces the construct of gender identity and its influence on sexual orientation. Lev also distinguishes between sexual orientation and sexual identity. In addition, this model accounts for this variation of outness to others. This model reflects the current acceptance of gender fluidity and sexual orientation fluidity that did not exist as much in prior models where a binary or stigmatized understanding of gender and sexual identity were still the norm. Older LGBTQ individuals only understood the "stigmatizing" binary, and this may have created angst for bisexuals and others in midlife who did or do not solely identify as gay or lesbian. Clearly, an understanding of "coming out" in current times has shifted to more fully reflect the complexity of the LGBTQ person's life experience (D'Augelli, 1994; Lev, 2004; McCarn & Fassinger, 1996).

Weinberg, Williams, and Pryor (1994) developed a model of Bisexual Identity Development, and this model is similar to others but allows for greater ambiguity in acceptance of the bisexual identity with less of a focus on disclosure to others and an allowance for the uncertainty of full acceptance. Bisexual individuals are considered the largest population of the LGBTQ family, yet they are the least researched group (Pew Research Center, 2013). This population tends to come out later than others and disclose to fewer individuals. In a large-scale study comparing identity groups, 77% of gay men and 71% of les-

bians report that all or most of the people important to them know their sexual identity, whereas only 28% of bisexual individuals reported that most of the people who are important to them know about their sexual identity (Pew Research Center, 2013). Research studies have also shown that bisexual individuals do come out later in life and disclose to fewer friends and family, and this may shift as more young people are identifying as bisexual (Diamond, 2008; Rust, 2000).

D'Augelli (1994, 2012) provides a more holistic, comprehensive model that fully considers the developmental life span of LGBTQ individuals. His model allows for the influence of the environment, supportive relationships, societal shifting norms, and generational effects to influence the process of sexual identity development and coming out. His models include phases that a person may experience. The phases are: exiting a heterosexual identity (realization of not being heterosexual); developing a personal lesbian, gay, or bisexual (LGB) identity (identifying as LGB); developing a social LGB identity (disclosing to others in a supportive social network of your LGB identity); claiming an LGB offspring identity (coming out to family and relatives); developing an LGB intimacy status (entering into LGB relationships); and entering a LGB community (engaging in the LGB community as an LGB person). D'Augelli's model reflects a process that is internal and external and can be influenced by the responses or reactions of others. D'Augelli (2012) added to this model a multigenerational component that considers the influence of sociohistorical events and the shifts in societal norms. This addition to his model followed an important study by Parks (1999) who found that sociohistorical context has a significant influence on when and at what age a person understands his or her sexual identity and comes out.

Each of these discussed models reflect the current understanding of the complexity of LGBTQ persons' lives. The midlife LGBTQ person coming out today has many variables to consider and is not as restricted with regard to claiming an identity or sexual orientation or romantic attractions, in contrast to a person coming out in the 1980s or even the 1990s. The midlife individual coming out today may not want to be labeled into a binary of gay, lesbian, bisexual, or transgender.

Queer theory rejects the notion of labels and allows for fluidity in sexual orientation, sexual attraction, gender identity, gender expression, and romantic attractions. Queer theory does not assume, as these previous models do, that the identity is different from the heteronormative understanding of identity (Warner, 2004). In addition, today's researchers are calling for more emphasis on the relevance of fluidity and intersectionality that reflects many identities within the one individual. These can include race, ethnicity, socioeconomic status, ability/disability, sexual orientation, gender identity, religion/spirituality, family values, and geography (Few-Demo, 2014; Shields, 2008). This new understanding of "coming out" is now expanded, and this may feel more holistic and understandable for the midlife LGBT individual today, rather than the more restricted view the midlife LGBTQ person of the past may have experienced. This is why, in part, younger people are coming out earlier (Savin-Williams, 2005). However, as a midlife LGBTQ individual, there are still challenges and strengths to consider.

Counseling Considerations on Sexual Identity Development

In reviewing the development of these varying sexual identity models, counselors working with LGBTQ populations need to understand these models and how they vary depending on gender, sexual orientation, and gender identity. Also, counselors should understand that these models now advocate for a non-sequential ordering of experiences. So, counseling approaches can no longer follow a "one size fits all" linear process of coming out that happens in a year. Counselors now know it is an ongoing, lifelong process of understanding the differing developmental needs of gay men, lesbians, bisexual men and women and transgender individuals that varies with experiences, family reactions, societal norms, and varying degrees of outness. This understanding yields a more affirmative approach to counseling LGBTQ individuals. In addition, counselors need to consider fluidity of these identities and the intersection of race, ethnicity, ability/disability, socioeconomic status, and the role of spirituality or religion, if appropriate.

Counselors also need to keep in mind the role of intersectionality of varying identities. These models are based on primarily White individuals, so a person of color may not resonate with a counselor following these models. An understanding of how sexual identity may intersect with racial or ethnic identity development models (Cross, 1995; Helms, 1995; Phinney, 1993) is essential to a positive counseling approach for LGBTQ people of color, and the sexual identity development process will vary for LGBTQ individuals of color (Morales, 1989). Wilson, Okwu, and Mills (2011) discuss the role of intersectionality on various identities and implications for practice. For individuals coming out at midlife, each of the above considerations need to be understood including, most importantly, generational status.

Generational Status and Sociohistorical Context

In considering Erikson's (1959) stages of psychosocial development, midlife is a time when identity is shifting and people are seeking ways to be more creative and productive (generativity) and yet risk the feeling of stagnation in the life they have created as it may not be as accomplished or productive as they had hoped. The developmental milestones of LGBTQ individuals will vary from the heteronormative life span as understood by Erikson (Barret & Logan, 2002). LGBTQ individuals struggling with a differing sexual identity from the societal norm may delay the typical midlife individual life span development due to fear of being fully themselves in society (Cohler & Galatzer-Levy, 2000). For someone in midlife, contemplating coming out may reflect this struggle of not feeling fulfilled with a heterosexual identity and feeling stagnated while seeking change. For this cohort of midlife individuals, they probably knew they were different from an early age (Floyd & Bakeman 2006) but may have delayed (knowingly or unknowingly) exploring their sexual identity until later in life, given this generation's stigma and oppression associated with homosexuality (Dworkin & Pope, 2012).

Coming out for LGBTQ individuals in midlife also necessitates an understanding of the sociohistorical context that these individuals have lived through up until this point in their lives. As mentioned earlier, this cohort has experienced and grown up with a great deal of homophobia, stigma, the AIDS epidemic, and legal sanctions against being LGBTQ, and yet they have also witnessed tremendous strides in greater acceptance, repealing of sodomy laws, and legalization of same-sex marriage. This sociohistorical context is significant for the identity development of midlife individuals (Kerztner, 2001). While there has been great progress, the psychosocial scars or fears from the past in their youth and young adulthood do not simply fade away easily. Most LGBTQ persons recognized they were different from an early age (Floyd & Bakeman, 2006), and this recognition may not manifest into behavior or a sexual orientation until later in life.

The midlife individual who has lived a heterosexual or cisgender life and yet knows they are different from the heteronormative identity will struggle to adopt a gay, lesbian, bisexual, or transgender identity (Whitman, 2010). This identity shift does not occur entirely because of greater acceptance in the general population. This cohort of LGBTQ individuals may have grown up conforming to the heteronormative expectations of being married, having children, being cisgender, and to the external world present as heterosexual. They have carefully crafted this identity, and it can be challenging to divest from this identity to a gay, lesbian, bisexual, or transgender identity (Barret & Logan, 2002; Whitman, 2010). They have a different life course or identity development from LGBTQ individuals (Cohler & Galatzer-Levy, 2000; Kerztner, 2001), and this also can cause dissonance when first coming out.

In an older study, Bozett (1993) found that 33% of divorced gay men and more than 75% of divorced lesbians studied were unaware of their same sex-gender attractions at the time of their marriages. Men who have been married and followed a heteronormative life feel uncertain in social and relationship situations with gay men. This can appear as acting like an adolescent or "delayed adolescence" as they are navigating unchartered social interactions and relationships in the gay, bisexual, or transgender communities (Barret & Logan, 2002; Herdt, Beeler, & Rawls, 1997). Women coming out in midlife may experience fears of losing their traditional role including marital privilege, mother, social support, and being "cared for" by a man from their past (Kirkpatrick, 1989). These studies are older and reflect the pre-Stonewall cohort of midlife men and women who grew up with the traditional roles of husband/father and wife/mother. This cohort tends to remain closeted in many areas of their life such as school, work, neighborhood events, and so on (Schope, 2002).

In more recent studies, men and women who came out in midlife reported that as they got older, they didn't care so much what others thought of them, enjoyed exploring this new identity and relationships, valued women support networks, and found their families to be more accepting resulting in higher levels of well-being (Anderson & Holliday, 2005; Brown, Alley, Sarosy, Quarto, & Cook, 2001; Herek, 2004; Hunter, 2007; Jones & Nystrom, 2002). This new era of greater acceptance of LGBTQ persons has shifted the context of sexual identity development. Many LGBTQ individuals in midlife are rejecting stagnation and are seeking a more "genuine self" life (Johnston

& Jenkins, 2004). They have been coming out in greater numbers at midlife and navigating their new identities fairly well, recognizing there are gains and losses in the process (Hunter, 2007; Rickards & Wuest, 2006; Whitman, 2010).

Counseling Considerations With Generational Status

Today, counselors working with individuals coming out in midlife need to read and understand the history of the "gay movement" in the United States (D'Emilio, 1983, Marcus, 2009). The sociohistorical context is crucial to understanding how to approach and understand the decision making and lived experience of LGBTQ individuals during this remarkable span of history for this population.

Counselors will also need to be able to assist the person in negotiating family relationships and future relationships with this new LGBTQ identity. Midlife LGBTQ persons coming out fear the loss of relationships and the loss of their existing lifestyle with family and friends (Johnston & Jenkins, 2004). This can be challenging, but the exploration of relationships is essential to their growth and development (Barret & Logan, 2002; D'Augelli, 2012; Johnston & Jenkins, 2004).

Counselors may also want to explore the losses the LGBTQ person may be experiencing as a result of coming out in midlife. The LGBTQ person may also be experiencing the fear of these potential losses. These losses can include the loss of being married, marital privilege, heterosexual privilege, family relationships, children, and place in society, as well as financial and workplace losses. A certain amount of grief counseling may be the better approach early in the counseling process for this midlife cohort who are losing their known heterosexual identity. The exploration of fears is also critical during this time of transition.

With the knowledge gained from understanding sexual identity development and the sociohistorical context, the counselor can also help to normalize their transition process. Counselors can validate the individual's concerns and fears and help guide the individual to "try on" new identities and behaviors that may be more life affirming for the individual (e.g., women's groups, gay outings, reading LGBTQ materials, visiting an LGBTQ organization, volunteering, finding good supportive mentors, getting involved in community). Many authors have identified the importance of connecting LGBTQ populations with their respective communities as a positive influence in sexual identity development (Barret & Logan, 2002; Bieschke, Perez, & Debord, 2007; Dworkin & Pope, 2012; Hunter, 2007).

Strengths and Challenges

Strengths

The opportunity to live a life as who you are and be a genuine person (whatever orientation that takes) with meaning and purpose as an LGBTQ person seems to be worth the challenge of negotiating a new identity (Herek, 2004; Riggle, Whitman, Olson, Rotosky, & Strong, 2008). Researchers have found positive benefits of coming out, including a higher sense of well-being, higher self-esteem, less anxiety, and greater social support (Jordan & Deluty, 1998; Herek, 2004; Whitman, 2010).

Many times, this new identity is the result of a crisis or feeling stagnated (Gorman & Nelson, 2004; Kimmel, 2004; Rickards

& Wuest, 2006). The once held stereotype of an aging old gay man or woman living alone, depressed and anxious, has been debunked by research and reveals a more diverse, resilient aging LGBTQ population that is thriving well as a result of coming out (Fredriksen-Goldsen, et al., 2013; Herek, 2004; Kimmel, 2004).

Kimmel (1978) asserted that LGBTQ populations may be able to cope with changes in aging because of their experience in surviving and thriving as LGBTQ people in a homophobic, heterosexist society, and he called this "crisis competence." Friend (1991) contends that gay and lesbian individuals who have navigated successfully through the "coming out" process and established new identities are better able and equipped to navigate the aging process. Brown, Alley, Sarosy, Quarto, and Cook (2001) and other researchers have asserted that gay men and lesbians may be better able to manage the effects of aging more so than heterosexuals as a result of dealing with stress and stigmatization earlier in life. Gorman and Nelson (2004) and Isenee (2005) extend this "crisis competence" to gay men who have lived through the AIDS crisis dealing with early death, loss of body image, grief, and early aging with HIV to have better prepared this cohort for the aging process and making meaning of life and death.

Many midlife LGBTQ baby boomers feel that their experiences of coming out and being themselves has better prepared them for the aging process. In the Metlife survey (2010) of LGBTQ baby boomers, 38% reported that being LGBTQ has enabled them to develop more positive character traits, have greater resilience, and create better support networks. In this significant survey, greater numbers of Hispanics (51%) and African Americans (43%), in comparison to Whites, felt their LGBTQ identity better prepared them for facing midlife and older adulthood.

Over many years, research studies have validated the positive outcomes of coming out and disclosing one's LGBTQ identity to one's self and others. Herek (2004) found that disclosing one's gay identity yielded reductions in stress, greater feelings of being authentic, higher levels of psychological functioning, and higher levels of well-being. There is a greater sense of a positive identity (Coleman, 1982) and identity integration (Pope, 1995) from disclosing one's sexual identity.

While midlife LGBTQ populations may struggle with victimization, discrimination, health care disparities, social isolation, and a host of potential mental health issues, it seems that disclosure of sexual identity coupled with gaining greater social support and larger support networks may create greater resiliency for midlife LGBTQ individuals to live a healthy and productive life (Fredriksen-Goldsen, et al., 2013; Herek, 2004; Kimmel, 2004).

Riggle, Whitman, Olson, Rotosky, and Strong (2008) also found that disclosing sexuality identity may increase meaning-making and instill greater empathy and compassion for self and others. This is an important finding, particularly as LGBTQ individuals age and struggle to find meaning and purpose later in life. Greene, Britton, and Shepherd (2016) found a number of factors that predict mental health for midlife LGBTQ individuals: financial anxiety, physical health, self-compassion, alienation, self-transcendence, and body shame. These authors suggest counselors working with mid-

life LGBTQ clients focus their efforts on a strengths-based approach in developing greater self-compassion and self-transcendence. These two constructs of self-compassion and self-transcendence may buffer the negative effects and mental health issues of aging for midlife LGBTQ populations.

The positive aspects of coming out seem to be foundational to living a healthy, congruent, genuine life. Yet, the challenges in making a life transition with sexual identity are great and need to be considered in concordance with the person's worldview and personal development. In midlife, one is reviewing the past and beginning to realize that life is terminal. It may be one of the most opportune times to consider coming out based on the research presented in order to live with an authentic sense of self, with greater well-being, psychological functioning, empathy, and self-compassion.

Counseling considerations for strengths of coming out at midlife. Counselors will want to consider a strengths-based, LGBTQ affirmative counseling approach in working with midlife LGBTQ individuals, given the number of negative challenges these persons may have faced or may be facing as they age and come out. The strengths-based approach of affirmative LGBTQ counseling is illustrated well in two current books which counselors may want to consider for their library (Bieschke, Perez, & Debord, 2007; Dworkin & Pope, 2012). The LGBTQ affirmative approach to counseling needs to focus on the factors and identified themes of the literature that support a healthy, genuine life for the individual.

The midlife LGBTQ client who is coming out may need to explore and understand his or her sense of grief and loss of the relationships and life being left behind. However, these clients may also explore the possible integration of these relationships and activities into their new sexual or gender identity. Involved in this process may also be an understanding of internalized homophobia and stigma, negative stereotyping of LGBTQ individuals, and any issues of victimization, discrimination, social isolation, or trauma. For counselors, this will require careful exploration and balance of adjusting to the ongoing discussion of loss and negative experiences while also allowing the client to explore newfound excitement in integration of self. It is a haphazard journey, and flexibility and patience on the part of the counselor will be needed. Counselors also need to explore and encourage the process of meaning making, which this population may need to better understand who they were and who they are becoming as they age. This reflection may yield a greater sense of self, self-compassion, and empathy for others in the process (Greene, Britton, and Shepherd, 2016).

Counselors also need to be mindful of the significance of social support and community engagement that will be essential for this midlife LGBTQ population in buffering potential negative consequences (Fredriksen-Goldsen, Emlet, et al., 2013). This entails understanding what is available in terms of resources and activities in the LGBTQ communities in the area. It also involves an understanding of sexual or gender identity development to know when to refer the client to these activities. As counselors know from the sexual identity models, in general, when someone is past the first couple of phases developmentally, then they may be more open and ready to explore the LGBTQ community. Recommending this too early could be detrimental to the individual's coming out process. Knowing the developmental process of the LGBTQ individual, the research literature on this population and coming out, and how they understand their worldview is essential to successfully working with midlife coming out LGBTQ populations.

Challenges

Health, health care, and aging. The prevalence of more chronic conditions and less functionality in day-to-day living begins in midlife (National Academy on an Aging Society, 1999). The aging process, in general, for heterosexuals and LGBTQ populations may generate stressful negative impacts on health that can include financial stress, poorer health, greater social isolation, relocation due to work or health, loss of relationships, and caregiving burdens (Greene, Britton, Shepherd, 2016; Wight, Harig, Aneshensel, & Detels, 2016).

LGBTQ midlife individuals who are considering coming out are also wrestling with a number of other concerns and challenges. Due to age, they may be experiencing fears of victimization and stigma, discriminatory health care services, discrimination in employment, limited physical activity, trauma and grief due to the AIDS crisis, the feeling of being invisible and loss of attractiveness in a gay youth-oriented culture, the loss of family connections, body shame, identity confusion, and/or loss of identity as a productive and vibrant person in the community (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Greene et al., 2016; Whitman, 2010, Wight et al., 2016). LGBTQ adults who are middle-age and older experience significant health care disparities as a result of many of these negative experiences (Hatzenbuehler, 2009).

A 2010 study by Lamda Legal (2010) found that 55% of lesbian, gay, and bisexual respondents and 70% of transgender respondents had experienced discrimination by health care providers. This discrimination included refusal of care, biased assumptions about the patient, and overt derogatory statements (Lamda Legal, 2010). de Vries (2006) contends that earlier experiences of discrimination and harassment may be reignited as these older LGBTQ populations experience institutionalized heterosexism in seeking health care. This discrimination is more pronounced in African American communities (David & Knight, 2008) where color, rather than sexual identity, creates bias in receiving services. Harrison and Silenzio (1996) found that older gay men and lesbians sought out health care services less frequently than their heterosexual counterparts. These anticipated experiences and reliance on other institutions for health care may encourage LGBTQ individuals to remain in the closet or conceal their sexual identity. Meyer (2003) found that LGBTQ persons conceal their sexual orientation out of fear of stigmatization, being fired from a job, being refused services, experiencing shame, and physical harm.

HIV/AIDS. Gay men in the midlife years and older have been disproportionately affected by HIV/AIDS (Linsk, 2000). In the United States, 29% of people living with AIDS are currently aged 50 and over, and about 70% of people with HIV in the United States are at least 40 years of age (Centers for Disease Control and Prevention [CDC], 2014). Older gay men have shown to be a population increasing in HIV infection rates. Older gay and bisexual men are more likely than younger

people to be diagnosed with HIV infection late in the course of the infection, which can complicate treatment as the immune system may be more damaged. In addition, these new infections continue to disproportionately affect men of color (CDC, 2014). In a qualitative study, Emlet (2006) found that 68% of midlife to older gay and bisexual men experienced both ageism and HIV-associated stigma. Themes that emerged from the study included rejection, stereotyping, fear of contagion, breaches of confidentiality, and internalized ageism. For gay men and bisexual men in midlife who are contemplating coming out, the fear of rejection due to age and HIV infection are still real and of concern. The higher rates of alcohol and drug use for this population reflects the coping of these realities and raises the risk of HIV infection later in life.

Substance use. Rates of substance use and alcohol use are reportedly higher among older gay men and lesbians than among comparably aged heterosexuals (Cochran, Sullivan, & Mays, 2003; Gruskin, Hart, & Ackerson, 2001), and gay men have significantly higher levels of alcohol use and problem drinking than lesbians (Grossman, D'Augelli, & O'Connell, 2001). In addition, drinking rates among gay men and lesbians do not decline over the life span as rapidly as they appear to among heterosexual populations (Boehmer, Miao, Linkletter, & Clark, 2012). Drug use and alcohol use have always plagued the LGBTQ community and can be a result of many factors, including a reaction to and coping with internal and external homophobia, discrimination, and/or violence (Green & Feinstein, 2012; Ostrow & Stall, 2008). These experiences of discrimination, stigmatization, and homophobia, according to Meyer (2003), reflect "minority stress theory" and result in more LGBTQ individuals concealing their sexual identity and coping by the use of substances and increasing the risk of negative health outcomes.

Mental health. While the majority of LGBTQ individuals experience good mental health, studies do find that LGBTQ populations are susceptible to developing depression, anxiety disorders, mood disorders, bipolar disorder, and eating disorders (Cochran & Mays, 2008; Gilman, et al., 2001; Meyer, 2003). In comparison to members of the general population, older LGBTQ populations may be more susceptible to higher rates of depression as well as suicidal thoughts and beliefs (Paul et al., 2002).

Shippy, Cantor, and Brennan (2001) found in their large-scale study that because of anxiety and fear of discrimination, 75% of gay, lesbian, bisexual, and transgender older adults reported not being completely open about their sexual orientation to their medical providers. Transgender persons reported that only 28% of their medical providers are aware that they are transgender, and 14% report that they are not out to any of their doctors (Grant et al., 2011). In the Metlife Study (2010) with midlife LGBTQ populations, about 30% reported concerns of antigay bias as they age. When asked about their greatest concern with aging, 32% of gay men and 26% of lesbians reported discrimination due to their sexual orientation (Metlife, 2010). The anxiety of discrimination, harassment, and internalized stigma results in older LGBTQ populations concealing their sexual or gender identities, and this concealment of sexual or gender identity is one of the

primary reasons why LGBTQ individuals may experience greater isolation and greater mental health problems (Grossman, D'Augelli, & O'Connell, 2001; Herek, Gillis, & Cogan, 2009; Meyer, 2003).

One other concern affecting the mental health of midlife and older LGBTQ adults is social isolation and lack of family or community support. For midlife older adults, coming out to family and friends can result in potential rejection and stigma. In one of the most significant studies of transgender persons, Grant et al. (2011) found that 57% of transgender people reported experiencing family rejection. In relation to social isolation, Pappas (2011) found that 50% of gay and bisexual men in California live alone, compared with 13.4% of heterosexual men. In the same study, Pappas found that lesbians were more likely to live with a partner than gay men, but more than 25% of lesbians live alone as compared to 20% of straight women. Lack of social support among midlife and older LGBTQ individuals correlates strongly with increased depression, anxiety, and poorer mental health (Fredriksen-Goldsen et al., 2013). These realities certainly impact the coming out process for midlife LGBTQ individuals. Coming out with the additional stress of aging, discrimination and stigma intersects with the individual's mental health. Unfortunately, the LGBTQ person coming out at this stage in life may turn to alcohol or drugs to cope with these stressors (Cochran & Mays, 2008; Green & Feinstein, 2012).

Counseling Considerations for These Challenges

Counselors working with midlife LGBTQ persons who are coming out need to bear these findings in mind. In the counseling process, counselors want to encourage and support clients in exploring their sexual and gender identities. However, counselors need to recognize the potential negative consequences of coming out in midlife as described above. The "delayed adolescence" phenomena, developmentally, is normal development of sexual behavior for these populations, and this phase requires greater assessment and understanding of sexual behavior in the counseling relationship. Counselors with midlife clients need to do ongoing assessment in greater detail than perhaps with other clients, regarding fears of aging, health care treatment, and sexual practices. This means understanding the client's world in a deeper and richer relationship that allows for exploration of aging and sexuality.

In addition, greater assessment needs to occur in the counseling relationship regarding experiences with substances, discrimination, feeling stigmatized and isolation, and feeling "invisible" as a midlife LGBTQ person in a youth-oriented culture. These negative experiences can greatly impact the mental and physical health of midlife LGBTQ individuals and their coming out process (Fredriksen-Goldsen, et al., 2013; Grossman, D'Augelli, & O'Connell, 2001; Meyer, 2003). For many counselors, the exploration of these negative experiences, fears, and sexual behavior may feel foreign as much of counselors' training on this population, particularly midlife LGBTQ individuals, is limited. The counseling profession needs to provide more training opportunities for counselors regarding exploration of midlife experiences of gay men, lesbians, bisexual, and transgender individuals.

Intersectionality

Sexual identity development, sociohistorical context, and strengths and challenges of coming out in midlife all need to be considered when assisting midlife clients through the coming out process. In addition, the intersectionality of other identities can also impact each of these areas. Identities that can impact the sexual identity coming out process include race, ethnicity, socioeconomic status, and spirituality and religion. Intersectionality theory considers the ongoing and simultaneous identification with varying identities while coming out (Simien, 2007). These varying identities are occurring while individuals are also understanding their sexual and gender identity, and they and may experience conflicting oppressions within their identified communities such as the gay community, church community, family of origin, or neighborhood (Crenshaw, 1991).

LGBTQ men and women of color experience greater oppression and marginalization stress on many levels, and the varying acceptance of their marginalized identities may influence when they do come out and to what degree of "outness" they seek as they navigate through varying communities (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Ghabrial, 2017). Typically, LGBTQ men and women of color exercise "selective outness" that could involve being out with friends but not with family or their racially identified community. This "selective outness" can result in disconnecting from their racial or sexual orientation communities, yielding greater stress, anxiety, and poorer physical health and mental health, as they experience oppression within their gay and racial communities (Akerlund & Cheung, 2000; Frost, 2011; Ward, 2008). The navigation of these diverse identities involves learning to adjust and adapt one's identity to the norms of the community. This process of negotiating identity can result in greater resilience for LGBTQ individuals who may also be of lower socioeconomic status and/or racial and ethnic minority status (Meyer, 2010).

Conclusion

While there are significant issues to consider in coming out at midlife for LGBTQ populations, it seems the research on coming out indicates the positive outcomes are certainly worth the momentary and sometimes long-lasting negative effects of coming out. While the positive outcomes are worthwhile, coming out in midlife requires a great deal of self-reflection, careful review of consequences, identification of risk, and purposeful vision of moving forward to a greater sense of self that can be explored and achieved with a competent and caring counselor.

References

Adams, T. E. (2011). *Narrating the closet: An autoethnography of same-sex attraction*. Walnut Creek, CA: Left Coast.

Akerlund, M., & Cheung, M. (2000). Teaching beyond the deficit model. *Journal of Social Work Education, 36,* 279–292.

Anderson, S. C., & Holliday, M. (2005). Normative passing in the lesbian community: An exploratory study. *Journal of Gay & Lesbian Social Services, 17,* 25–38.

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT People of Color Microaggressions Scale. *Cultural Diversity & Ethnic Minority Psychology, 17,* 163–74.

Barret, R. L., & Logan, C. (2002). *Counseling gay men and lesbians: A practice primer*. Belmont, CA: Brooks/Cole.

Bieschke, K. J., Perez, R. M., & DeBord, K. A. (2007). *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients*. Washington, DC: American Psychological Association.

Boehmer, U., Miao, X., Linkletter, C., & Clark, M. A. (2012). Adult health behaviors over the life course by sexual orientation. *American Journal of Public Health, 102,* 292–300. doi:10.2105/AJPH.2011.300334

Bozett, F. W. (1993). Gay fathers: A review of the literature. In L.D. Garnets & D.C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences* (pp. 437–457). New York, NY: Columbia University Press.

Brown, L. B., Alley, G. R., Sarosy, S., Quarto, G., & Cook, T. (2001). Gay men: Aging well! *Journal of Gay & Lesbian Social Services, 13,* 41–54.

Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4,* 17.

Ceballos-Capitaine, A., Szapocznik, J., Blaney, N. T., Morgan, R. O., Millon, C., & Eisdorfer, C. (1990). Ethnicity, emotional distress, stress-related disruption, and coping among HIV seropositive gay males. *Hispanic Journal of Behavioral Sciences, 112,* 135–152.

Centers for Disease Control and Prevention. (2014). *HIV Surveillance Report*. Retrieved from https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf

Cochran, S. D., & Mays, V. M. (2008). Prevalence of primary mental health morbidity and suicide symptoms among gay and bisexual men. In R. J. Wolitski, R. Stall, & R. O. Valdiserri (Eds.), *Unequal opportunity: Health disparities affecting gay and bisexual men in the United States*. New York, NY: Oxford University Press.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71,* 53.

Cohler, B. J., & Galatzer-Levy, R. M. (2000). *The course of gay and lesbian lives: Social and psychoanalytic perspectives*. Chicago, IL: University of Chicago Press.

Coleman, E. (1982). Developmental stages of the coming out process. *Journal of Homosexuality, 7,* 31–43.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43,* 1241–1279.

Cross, W. E. (1995). The psychology of Nigrescence: Revising the Cross model. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 93–122). Thousand Oaks, CA: Sage.

D'Augelli, A. R. (1994). Identity development and sexual orientation: Toward a model of lesbian, gay, and bisexual development. In E. J. Trickett, R. J. Watts, & D. Birman (Eds.), *Human diversity: Perspectives on people in context* (pp. 312–333). San Francisco, CA: Jossey-Bass.

D'Augelli, A. R. (2012). Restoring lives: Developmental research on sexual orientation. *Human Development, 55,* 1–3.

D'Emilio, J. (1983). *Sexual politics, sexual communities: The making of a homosexual minority in the United States, 1940–1970.* Chicago, IL: University of Chicago.

David, S., & Knight, B. G. (2008). Stress and coping among gay men: Age and ethnic R differences. *Psychology and Aging, 23,* 62.

De Vries, B. (2006). Home at the end of the rainbow. *Generations, 29,* 64–69.

Diamond, L. M. (1998). Development of sexual orientation among adolescent and young adult women. *Developmental Psychology, 34,* 1085–1095.

Diamond, L. M. (2005). A new view of lesbian subtypes: Stable versus fluid identity trajectories over an 8-year period. *Psychology of Women Quarterly, 29,* 119–128.

Diamond, L. M. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology, 44,* 5.

Dworkin, S. H., & Pope, M. (Eds.). (2014). *Casebook for counseling lesbian, gay, bisexual, and transgender persons and their families.* Alexandria, VA: American Counseling Association.

Emlet, C. A. (2006). "You're awfully old to have *this* disease": Experiences of stigma and ageism in adults 50 years and older living with HIV/AIDS. *The Gerontologist, 46,* 781–790. doi:10.1093/geront/46.6.781

Erikson, E. H. (1959). Identity and the life cycle: Selected papers. *Psychological Issues, 1,* 1–171.

Few-Demo, A. L. (2014). Intersectionality as the "new" critical approach in feminist family studies: Evolving racial/ethnic feminisms and critical race theories. *Journal of Family Theory & Review, 6,* 169–183. doi:10.1111/jftr.12039

Floyd, F. J., & Bakeman, R. (2006). Coming-out across the life course: Implications of age and historical context. *Archives of Sexual Behavior, 35,* 287–296.

Fredriksen-Goldsen, K. I., Emlet, C. A., Kim, H., Muraco, A., Erosheva, E. A., Goldsen, J., & Hoy-Ellis, C. P. (2013). The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: The role of key health indicators and risk and protective factors. *The Gerontologist, 53,* 664–675. doi:10.1093/geront/gns123

Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health, 103,* 1802–1809.

Friend, R. A. (1991). Older lesbian and gay people: A theory of successful aging. *Journal of Homosexuality, 20,* 99–118.

Frost, D. M. (2011). Social stigma and its consequences for the socially stigmatized. *Social and Personality Psychology Compass, 5,* 824–839.

Ghabrial, M. A. (2017). "Trying to figure out where we belong": Narratives of racialized sexual minorities on community, identity, discrimination, and health. *Sexuality Research and Social Policy 14,* 42–55. doi:10.1007/s13178-016-0229-x

Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the national comorbidity survey. *American Journal of Public Health, 91,* 933–939.

Gorman, E. M., & Nelson, K. (2004). From a far place: Social and cultural considerations about HIV among midlife and older gay men. *Gay and Lesbian Aging: Research and Future Directions,* 73–93.

Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey.* Washington, DC: National Center for Transgender Equality.

Green, K. E., & Feinstein, B. A. (2012). Substance use in lesbian, gay, and bisexual populations: An update on empirical research and implications for treatment. *Psychology of Addictive Behaviors, 26,* 265–278. doi:10.1037/a0025424

Greene, D. C., Britton, P. J., & Shepherd, J. B. (2016). LGBTQ aging: Mental health at midlife and older adulthood. *Journal of LGBT Issues in Counseling, 10,* 180–196.

Grossman, A. H., D'Augelli, A. R., & O'Connell, T. S. (2001). Being lesbian, gay, bisexual, and 60 or older in North America. *Journal of Lesbian & Gay Social Services, 13,* 23–40. doi:10.1300/J041v13n04_05

Gruskin, E. P., Hart, S., & Ackerson, L. (2001). Patterns of cigarette smoking and alcohol use among lesbians and bisexual women enrolled in a large health maintenance organization. *American Journal of Public Health, 91,* 976–979. doi:10.2105/AJPH.91.6.976

Harrison, A. E., & Silenzio, V. M. (1996). Comprehensive care of lesbian and gay patients and families. *Primary Care: Clinics in Office Practice, 23,* 31–46.

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135,* 707.

Helms, J. E. (1995). An update of Helm's White and people of color racial identity models. In J. G. Ponterotto., J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 93–122). Thousand Oaks, CA: Sage.

Herdt, G., & de Vries, B. (2004). Introduction. In G. Herdt & B. de Vries (Eds.), *Gay and lesbian aging: Research and future directions* (pp. xi–xxii). New York, NY: Springer.

Herdt, G., Beeler, J., & Rawls, T. W. (1997). Life course diversity among older lesbians and gay men: A study in Chicago. *Journal of Gay, Lesbian, and Bisexual Identity, 2,* 231–246.

Herek, G. M. (2004). Beyond "homophobia:" Thinking about sexual stigma and prejudice in the twenty-first century. *Sexuality Research and Social Policy, 1,* 6–24.

Herek, G., Gillis, J., & Cogan, J. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology, 56,* 32–43. doi:10.1037/a0014672

Hunter, S. (2007). *Coming out and disclosures: LGBT persons across the life span.* Binghamton, NY: Haworth.

Isenee, R. (2005). *Are you ready? The gay man's guide to thriving at midlife.* Lincoln, NE: iUniverse, Inc.

Jones, T. C., & Nystrom, N. M. (2002). Looking back . . . looking forward: Addressing the lives of lesbians 55 and older. *Journal of Women & Aging, 14,* 59–76.

Johnston, L. B., & Jenkins, D. (2004). Coming out in mid-adulthood: Building a new identity. *Journal of Gay & Lesbian Social Services, 16,* 19–42.

Jordan, K. M., & Deluty, R. H. (1998). Coming out for lesbian women: Its relations to anxiety, positive affectivity, self-esteem, and social support. *Journal of Homosexuality, 35,* 41–63.

Kimmel, D. C. (1978). Adult development and aging: A gay perspective. *Journal of Social Issues, 34,* 113–130.

Kimmel, D. C., Rose, T., Orel, N., & Greene, B. (2006). Historical context for research on lesbian, gay, bisexual, and transgender aging. In D. Kimmel, T. Rose, & S. David (Eds.), *Research and clinical perspectives on lesbian, gay, bisexual, and transgender aging* (pp. 1–26). New York, NY: Columbia University Press.

Kimmel, M. S. (2004). Masculinity as homophobia: Fear, shame, and silence in the construction of gender identity. In P. S. Rothenberg (Ed.), *Race, class, and gender in the United States: An integrated study* (6th ed. pp. 81–93). New York, NY: Worth.

Kirkpatrick, M. (1989). Middle age and the lesbian experience. *Women's Studies Quarterly, 1–2,* 87–86.

Lambda Legal. (2010). *When health care isn't caring: Lambda Legal's survey of discrimination against LGBT people and people living with HIV.* Retrieved from www.lambdalegal.org/health-care-report

Lev, A. I. (2004). *Transgender emergence: Understanding diverse gender identities and expressions.* New York, NY: The Haworth Clinical Practice Press.

Linsk, N. L. (2000). HIV among older adults: age-specific issues in prevention and treatment. *The AIDS Reader, 10,* 430–440.

Manning, J. (2014). Coming out conversations and gay/bisexual men's sexual health: A constitutive model study. In V. L. Harvey & T. Housel (Eds.), *Left out: Health care issues facing LGBT people.* Lanham, MD: Lexington Books.

Marcus, E. (2009). *Making gay history: The half-century fight for lesbian and gay equal rights.* New York, NY: Harper Collins.

McCarn, S. R., & Fassinger, R. E. (1996). Revisioning sexual minority identity formation a new model of lesbian identity and its implications for counseling and research. *The Counseling Psychologist, 24*, 508–534.

MetLife. (2010). *Survey of American attitudes toward retirement: What's changed?* Westport, CT: MetLife Mature Market Institute.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674–697.

Meyer, I. H. (2010). Identity, stress, and resilience in lesbians, gay men, and bisexuals of color. *The Counseling Psychologist, 38*, 442–454.

Morales, E. S. (1989). Ethnic minority families and minority gays and lesbians. *Marriage & Family Review*, *14*, 217–239.

National Academy on an Aging Society. (1999). *Demography is not destiny*. Washington, DC: Author.

Orel, N. A. (2014). Investigating the needs and concerns of lesbian, gay, bisexual, and transgender older adults: The use of qualitative and quantitative methodology. *Journal of Homosexuality, 61*, 53–78. doi:10.1080/00918369.2013.835236

Ostrow, D. G., & Stall, R. (2008). Alcohol, tobacco, and drug use among gay and bisexual men. In R.J. Wolitski, R. Stall, & R. O. Valdiserri (Eds.), *Unequal opportunity: Health disparities affecting gay and bisexual men in the United States.* New York, NY: Oxford University Press.

Pappas, S. (2011, March 30). *Social isolation may hurt health of gay older adults.* Retrieved from http://www.livescience.com/13484-gay-older-adult-health.html

Parks, C. A. (1999). Lesbian identity development: an examination of differences across generations. *American Journal of Orthopsychiatry, 69*, 347.

Paul, J. P., Catania, J., Pollack, L., Moskowitz, J., Canchola, J., Mills, T., & Stall, R. (2002). Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents. *American Journal of Public Health*, *92*, 1338–1345.

Pew Research Center. (2013). *A survey of LGBT Americans: Attitudes, experiences and values in changing times.* Retrieved from http://www.pewsocialtrends.org/2013/06/13/a-survey-of-lgbt-americans/

Phinney, J. S. (1993). A three-stage model of ethnic identity development in adolescence. In M. E. Bernal & G. P. Knight (Eds.), *Ethnic identity: Formation and transmission among Hispanics and other minorities* (pp. 61–79). Albany, NY: SUNY Press.

Pope, M. (1995). The "salad bowl" is big enough for us all: An argument for the inclusion of lesbians and gay men in any definition of multiculturalism. *Journal of Counseling & Development, 73,* 301–304.

Rickards, T., & Wuest, J. (2006). The process of losing and regaining credibility when coming-out at midlife. *Health Care for Women International, 27*, 530–547. doi:10.1080/07399330600770254

Riggle, E. D., Whitman, J. S., Olson, A., Rostosky, S. S., & Strong, S. (2008). The positive aspects of being a lesbian or gay man. *Professional psychology: Research and practice*, *39*, 210.

Rosario, M., Schrimshaw, E. W., Hunter, J., & Braun, L. (2006). Sexual identity development among lesbian, gay, and bisexual youths: Consistency and change over time. *The Journal of Sex Research, 43*, 46–58.

Rust, P. C. (2000). *Bisexuality in the United States: A social science reader.* New York, NY: Columbia University Press.

Rust, P. R. (2003). Finding a sexual identity and community: Therapeutic implications and cultural assumptions in scientific models of coming out. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian, gay and bisexual experiences* (pp. 227–269). New York, NY: Columbia University Press.

Savin-Williams, R. (2005). The new gay teen: Shunning labels. *The Gay & Lesbian Review Worldwide, 12*, 16.

Schope, R. D. (2002). The decision to tell: Factors influencing the disclosure of sexual orientation by gay men. *Journal of Gay & Lesbian Social Services, 14*, 1–21.

Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*, 301–311. doi:10.1007/s11199-008-9501-8

Shippy, A., Cantor, M. & Brennan, M. (2001, November). *Patterns of support for lesbians and gays as they age.* Paper presented at the 54th Annual Scientific Meeting of the Gerontological Society of America, Chicago, IL.

Simien, E. M. (2007). Doing intersectionality research: from conceptual issues to practical examples. *Politics & Gender, 3*, 264–272.

Troiden, R. R. (1988). Homosexual identity development. *Journal of Adolescent Health Care, 9*, 105–113.

Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality, 17*, 43–73.

Ward, J. (2008). Dude-sex: White masculinities and "authentic" heterosexuality among dudes who have sex with dudes. *Sexualities*, *11*, 414–434.

Warner, D. N. (2004). Towards a queer research methodology. *Qualitative Research in Psychology, 1*, 321–337.

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction: Understanding bisexuality*. New York, NY: Oxford University Press.

Whitman, J. S. (2010). Lesbians and gay men at midlife. In M. H. Guindon (Ed.), *Self-esteem across the lifespan: Issues and interventions* (pp. 235–248). New York, NY: Routledge.

Wight, R. G., Harig, F., Aneshensel, C. S., & Detels, R. (2016). Depressive symptom trajectories, aging-related stress, and sexual minority stress among midlife and older gay men: linking past and present. *Research on Aging*, *38*, 427–452.

Wilson, B. D., Okwu, C., & Mills, S. A. (2011). Brief report: The relationship between multiple forms of oppression and subjective health among Black lesbian and bisexual women. *Journal of Lesbian Studies*, *15*, 15–24.

Career Development

Franco Dispenza and Nicole Pulliam

When considering the career development for any population, it is important to conceptualize this process using a development lens. The population in midlife (defined as 35–64 years of age for the purpose of this article) is considered to be at a more established career stage (Super, 1990). For example, Super (1990) described midlife adults to fall somewhere in between the *establishment* stage, marked by trial and stabilization through work experiences, and the *maintenance* stage, where individuals move through a process of continual adjustment to improve working positions and situations. Erickson (1959) described middle adulthood as a time when work in particular plays a significant role in one's psychosocial development. During this stage of adulthood, parenthood or the need to nurture things that will outlast them, along with level of success or failure, can determine one's development (Erickson, 1959).

While midlife LGBTQ individuals may face similar challenges to those in other life stages, many are unique to middle adulthood. As such, developmental contextualism is an additional lens that could be applied with this specific population. Developmental contextualism contends that maturation takes place within systemic and environmental contexts, and as such, these various processes cannot be separated from one another—particularly within the career development trajectory for LGBTQ persons (Dispenza, Brown, & Chastain, 2016; Vondracek & Reitzle, 1998). To that end, the information in the following sections will address each topic using a developmental lens.

Strengths and Challenges

Strengths

While it is important to remain aware of the career development barriers for LGBTQ populations, it is equally important to maintain a strengths-based approach to helping LGBTQ individuals along their career trajectory (Savage, Harley, & Nowak, 2005; Smith, 2006). Strengths-based approaches represent a shift in deficit-based perspectives primarily focused on barriers experienced by marginalized populations (Grothaus, McAuliffe, & Craigen, 2012; Myers & Sweeney, 2008). Considering the ages and stages of midlife LGBTQ populations, specific strengths for this population should be highlighted throughout the counseling process.

With respect to LGBTQ populations, it is essential that counselors use an affirmative counseling approach, defined as developing a counselor–client relationship in which the counselor engages in empowerment interventions with clients to explore the influence of internalized heterosexism on their mental health, coping, and overall well-being (American Counseling Association [ACA], 2010; Harper et al., 2013; Singh & Moss, 2016). From a theoretical perspective, one example that supports a LGBTQ-affirmative approach is relational-cultural theory, which emphasizes the importance of mutual empathy and empowerment through engagement as a means of facilitating growth-fostering relationships (Comstock et al., 2008; Singh & Moss, 2016). In general, relational-cultural theory is a comprehensive theory affirming that individuals innately seek connectedness throughout the life span and grow as a result of nurturing relationships (Duffey & Somody, 2011; Singh & Moss, 2016; Trepal, 2010). Thus, a counseling relationship built on mutual respect and understanding as it relates to the unique career development needs of midlife LGBTQ populations is critical.

Affirmation is a fundamental component to the counseling relationship when working with LGBTQ populations (Dispenza et al., 2016). It is especially important that counselors bear in mind the extent to which LGBTQ individuals have experienced oppression and discrimination at the individual and institutional levels; thus, these individuals are more attuned to signs of potential discrimination and bias from the counselor (Heck, Flentje, & Cochran, 2013). To provide competent and affirmative services to LGBTQ individuals, counselors must first expand their knowledge base as it relates to the ways by which individual and institutional stressors, such as minority stress and discrimination in the workplace, coming out concerns, and health and wellness issues related to workplace policies, affect this population (Heck et al., 2013). Some additional examples that can guide an affirmative approach to counseling LGBTQ individuals include examining personal biases toward LGBTQ individuals, use and adoption of affirmative language, modifying clinical paperwork to include inclusive and gender neutral language, and creating an affirmative counseling environment which communicates to the client a sense of respect and understanding without fear of judgment (Heck et al., 2013; Radkowsky & Siegel, 1997).

Challenges

LGBTQ persons may experience a variety of barriers as part of their career trajectory during the midlife stage of their life span. Dispenza et al. (2016) implicated minority stress as one significant barrier that interferes with the career trajectory of LGBTQ adults during midlife. Minority stress constitutes a host of unique stressors that include both distal and proximal stressors. Distal stressors include encounters of discrimination and societal prejudice, while proximal stressors include concealing one's LGBTQ identity and the expectation of stigma (Meyer, 2003).

Regarding distal stressors, LGBTQ persons encounter significant discrimination in workplace settings (Budge, Tebbe, & Howard, 2010; Chung, Williams, & Dispenza, 2009; Dispenza et al., 2016). According to the Human Rights Coalition (HRC; September 20, 2016), 32 states currently do not offer any legal protections for LGBTQ persons in the workforce. Furthermore, there are no federal statutes addressing employment-related discrimination practices based on sexual orientation or gender diversity, leaving LGBTQ persons vulnerable. LGBTQ persons have reported being terminated, harassed, turned down for promotions, and exposed to violent acts in the workplace as a result of having an LGBTQ identity (Chung et al., 2009). Perceptions of workplace heterosexist discrimination are also associated with lower ratings of job satisfaction among LGBTQ working persons (Velez, Moradi, & Brewster, 2013). Alternatively, when LGBTQ persons perceive their organizational work climate as being more affirmative and protective, they were more likely to be out about their identities to colleagues, supervisors, subordinates, and/or customers. The opposite could also be true (Brenner, Lyons, & Fassinger, 2010).

Transgender persons have specifically reported instances of being physically threatened, emotionally abused, and rejected by coworkers as a result of revealing a transgender identity (Budge et al., 2010; Dispenza, Watson, Chung, & Brack, 2012). Occupational related barriers for transgender persons have also included: name-calling, destruction of property, wrong pronoun use in the workplace, difficulty gaining employment as a result of not gender passing or not passing background checks, bathroom use discrimination policies, and workplace gender stereotypes (Budge et al., 2010). Furthermore, transmen have reported experiencing gender related microaggressions from employers, as well as stigma from members of the LGBTQ community as being particular barriers to their career development (Dispenza, Watson, Chung, & Brack, 2012).

Regarding proximal stressors, concealing one's sexual orientation and gender identity is a significant stressor that LGBTQ persons have to contend with in the context of their career. Disclosing sexual orientation or gender identity in the workplace is not necessarily associated with positive outcomes. In particular, fear of disclosure has been associated with negative career related outcomes, including lower evaluations of job satisfaction, commitment to the work organization, and self-esteem (Ragins, Singh, & Cornwell, 2007). Anticipating anxiety (or expectation of stigma) is associated with lower evaluations of career and job satisfaction among sexual minority persons (Dispenza, 2015; Velez et al., 2013).

It is also the case, especially among LGBTQ persons during the midlife stage of life span development, that while they are earning a living, they are also living an adult life (Niles & Harris-Bowlsbey, 2013). Known as the work-life interface, many LGBTQ persons are managing romantic partnerships, marriages, and children all while actively engaged in work and career (Dispenza, 2015). Most prevalent in the literature is the concept of dual-earner roles in the context of LGBTQ career development (Perrone, 2005). For instance, gay fathers in dual-earner, same-sex relationships report higher levels of anxiety than lesbian mothers in dual-earner, same-sex relationships. This could be the result of gender and sexual

orientation related stereotypes (Goldberg & Smith, 2013). Internalized homophobia, which is the internalization of homophobic stigma that manifests in self-loathing, is associated with decreased perceptions of dyadic adjustment among men in dual-earner, same-sex relationships (Dispenza, 2015). That is, men are more likely to report difficulty in the romantic relationship functioning as a result of internalized homophobia. Relatedly, internalized homophobia is associated with higher reports of relationship problems among sexual minority couples (Frost & Meyer, 2009).

Lastly, health and wellness are likely to be impacted in relation to the career development of LGBTQ persons in the midlife stage of their life span. For instance, fear of disclosing one's sexual orientation identity in the workplace is associated with higher ratings of somatic complaints, depression, anxiety, and emotional irritation (Ragins et al., 2007). Furthermore, perceptions of workplace heterosexist discrimination are associated with increased rates of psychological distress among LGBTQ working persons (Velez et al., 2013).

Intersectionality

Intersectionality suggests that no one identity can be appreciated without examining its interactions with other identities. Deep-rooted in intersectionality is an understanding that intersections exist within structures of inequality, while creating both privilege and oppression (Bowleg, 2008; Crenshaw, 1989). When working with LGBTQ populations, it is imperative that counselors understand their lived experiences in relation to other intersecting identities, including but not limited to gender, race and ethnicity, social class, and ability status (Parent, DeBlaere, & Moradi, 2013). When considering career barriers such as workplace discrimination, counselors should acknowledge possible multiple minority stressors impacting lived experiences of LGBTQ individuals. For example, workplace discrimination for a Black lesbian might differ significantly than that of her White lesbian counterpart (Crenshaw, 1989). Again, competent counselors need to understand the unique lived experiences of their LGBTQ clients based on their social identities at the convergence of multiple social identities (Bowleg, 2008; Crenshaw, 1989).

Counseling Considerations

Career-related issues faced by midlife LGBTQ individuals have numerous implications for counselors. First, counselors may find it helpful to conceptualize client experiences from an affirmative development perspective. Counselors should recognize that LGBTQ individuals are not a homogenous group; rather, their lived experiences can vary greatly depending upon many factors. Counseling approaches that support and foster relationships grounded in empathy and affirmation can guide clients successfully throughout their career trajectories. Dispenza et al. (2016) specifically advocates for the use of an affirmative developmental contextualist approach when providing career-related interventions with sexual minority persons. For instance, counselors may find it helpful to provide career-based interventions by utilizing couples and family counseling modalities, since career development is likely to occur within family and relational systems. While some barriers

cut across ages and stages, a clear understanding of life span concerns directly related to career and workplace settings is imperative (Erickson, 1959; Super, 1990).

Minority stress is a significant contextual factor that influences the career development trajectory of LGBTQ persons (Dispenza, 2015; Velez et al., 2013). According to Dispenza et al. (2016), counselors should appraise the extent to which distal and proximal minority stressors impact career development factors for middle aged adults (e.g., career transition, career skill development, career advancement) and interpersonal relationship functioning. Consistent with the minority stress framework (Hatzenbuehler, 2009; Meyer, 2003), counselors should also appraise and provide relevant counseling interventions that address emotional regulation processes, cognitive schematic systems (e.g., self-esteem, self-worth), and social and interpersonal relationship functioning—all for the purposes of enhancing factors related to one's career development trajectory.

Next, counselors should acquire a firm knowledge base of multicultural competence. In addition, affirmative approaches to counseling LGBTQ individuals to empower and promote advocacy for the LGBTQ population in the workplace are paramount (ACA, 2010; Singh & Moss, 2016). Furthermore, counselors should understand the role that intersectionality plays in the lived experiences of LGBTQ clients, especially for clients who come from multiple minority backgrounds, as they are more prone to numerous levels of oppression and discrimination (Bowleg, 2008; Crenshaw, 1989). For instance, counselors could help clients identify a variety of engaging coping strategies to address potential stressors in the workplace that may be the result of having a sexual minority identity (Chung, Williams, & Dispenza, 2009). Relatedly, counselors may also have to help their diverse LGBTQ clients identify and address stressors that may also be related to gender, race/ethnicity, ability status, and other diverse identities.

References

American Counseling Association. (2010). American Counseling Association competencies for counseling with transgender clients. *Journal of LGBT Issues in Counseling, 4*, 135–159. doi:10.1080/15538605.2010.524839

Bowleg, L. (2008). When Black + lesbian + woman does not equal Black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles, 59*, 312–325.

Brenner, B. R., Lyons, H. Z., & Fassinger, R. E. (2010). Can heterosexism harm organizations? Predicting the perceived organizational citizenship behaviors of gay and lesbian employees. *The Career Development Quarterly, 58,* 218–331.

Budge, S. L., Tebbe, E. N., & Howard, K. S. (2010). The work experiences of transgender individuals: Negotiating the transition and career decision-making processes. *Journal of Counseling Psychology, 57,* 377–393. doi:10.1037/a0020472

Chung, Y. B., Williams, W., & Dispenza, F. (2009). Validating work discrimination and coping strategy models for sexual minorities. *The Career Development Quarterly*, *58*, 162–170. doi:10.1002/j.2161-0045.2009.tb00053.x

Comstock, D. L., Hammer, T. R., Strentzsch, J., Cannon, K., Parsons, J. & Salazar, G., II. (2008). Relational-cultural theory: A framework for bridging relational, multicultural and social justice competencies. *Journal of Counseling & Development, 86*, 279–287. doi:10.1002/j.1556-6678.2008. tb00510.x

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *The University of Chicago Legal Forum, 140,* 139–167.

Dispenza, F. (2015). An exploratory model of proximal minority stress and the work–life interface for men in same-sex, dual-earner relationships. *Journal of Counseling & Development*, *93*, 321–332. doi:10.1002/jcad.12030

Dispenza, F., Brown, C., & Chastain, T. E. (2016). Minority stress across the career-lifespan trajectory. *Journal of Career Development*, *43*, 103–115. doi:10.1177/0894845315580643

Dispenza, F., Watson, L. B., Chung, Y. B., & Brack, G. (2012). Experience of career-related discrimination for female-to-male transgender persons: A qualitative study. *The Career Development Quarterly*, *60*, 65–81. doi:10.1002/j.2161-0045.2012.00006.x

Duffey, T., & Somody, C. (2011). The role of relational-cultural theory within mental health counseling practice. *Journal of Mental Health Counseling, 33,* 223–242. doi:10.17744/mehc.33.3.c10410226u275647

Erikson, E. H. (1959). *Identity and the life cycle: Selected papers, with a historical introduction by David Rapaport.* New York, NY: International University Press.

Frost, D. M., & Meyer, I. H. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology, 56,* 97–109. doi:10.1037/a0012844

Goldberg, A. E., & Smith, J. Z. (2013). Work conditions and mental health in lesbian and gay dual-earner parents. *Family Relations, 62,* 727–740. doi:10.1111/fare.12042

Grothaus, T., McAuliffe, G., & Craigen, L. (2012). Infusing cultural competence and advocacy into strength-based counseling. *The Journal of Humanistic Counseling, 51*, 51–65. doi:10.1002/j.2161-1939.2012.00005.x

Harper, A., Finnerty, P., Martinez, M., Brace, A., Crethar, H. C., Loos, B., . . . Hammer, T. R. (2013). Association for lesbian, gay, bisexual, and transgender issues in counseling competencies for counseling with lesbian, gay, bisexual, queer, questioning, intersex, and ally individuals. *Journal of LGBT Issues in Counseling, 7*, 2–43. doi:10.1080/15538605.2013.755444

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135,* 707–730. doi:10.1037/a0016441

Heck, N. C., Flentje, A., & Cochran, B. N. (2013). Intake interviewing with lesbian, gay, bisexual, and transgender clients: Starting from a place of affirmation. *Journal of Contemporary Psychotherapy, 43*, 23–32. doi:10.1007/s10879-012-9220-x

Human Rights Campaign. (2016). *U.S. Federal Government Employment Policies.* Retrieved from: http://www.hrc.org/resources/u.s.-federal-government-employment-policies

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674–697. doi:10.1037/033-2909

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling & Development, 86*, 482–493. doi:10.1002/j.1556-6678.2008.tb00536.x.

Niles, S. G., & Harris-Bowlsbey, J. (2013). *Career development interventions in the 21st century* (3rd ed.). Upper Saddle River, NJ: Pearson Education.

Parent, M. C., DeBlare, C., & Moradi, B. (2013). Approaches to research on intersectionality: Perspectives on gender, LGBT, and racial/ethnic identities. *Sex Roles, 68*, 639–645. doi:10.1007/s111-99-013-0283-2

Perrone, K. M. (2005). Work–family interface for same-sex, dual-earner couples: Implications for counselors. *The Career Development Quarterly, 53*, 317–324. doi:10.1002/j.2161-0045.2005.tb00662.x

Radkowsky, M., & Siegel, L. J. (1997). The gay adolescent: Stressors, adaptations, and psychosocial interventions. *Clinical Psychology Review, 17,* 191–216. doi:10.1016/S0272-7358(97)00007-X

Ragins, B. R., Singh, R., & Cornwell, J. M. (2007). Making the invisible visible: Fear and disclosure of sexual orientation at work. *Journal of Applied Psychology, 92,* 1103–1118. doi:10.1037/0021-9010.92.4.1103

Savage, T. A., Harley, D. A., & Nowak, T. M. (2005). Applying social empowerment strategies as tools for self-advocacy in counseling lesbian and gay male clients. *Journal of Counseling & Development, 83,* 131–137. doi:10.1002/j.1556-6678.2005.tb00589.x

Singh, A. A., & Moss, L. (2016). Using relational-cultural theory in LGBTQQ counseling: Addressing heterosexism and enhancing relational competencies. *Journal of Counseling & Development, 94,* 398–404. doi:10.1002/jcad.12098

Smith, E. J. (2006). The strength-based counseling model: A paradigm shift in psychology. *Counseling Psychologist, 34,* 134–144.

Super, D. E. (1990). A life-span, life-space approach to career development. In D. Brown and L. Brooks (Eds.), *Career choice and development* (pp. 167–261). San Francisco, CA: Jossey-Bass.

Trepal, H. (2010). Exploring self-injury through a relational-cultural lens. *Journal of Counseling & Development, 88,* 494–499.

Velez, B. L., Moradi, B., & Brewster, M. E. (2013). Testing the tenets of minority stress theory in workplace contexts. *Journal of Counseling Psychology, 60,* 532–542. doi:10.1037/a0033346

Vondracek, F. W., & Reitzle, M. (1998). The viability of career maturity theory: A developmental-contextual perspective. *The Career Development Quarterly, 47,* 6–15.

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Religion and Spirituality

Verna Oliva and Rufus Tony Spann

It is important to first define and differentiate spirituality and religion. *Religion*, or institutionally-based beliefs and rituals, and *spirituality*, a more personal experience of connection or transcendence beyond the self, are important in the lives of many individuals (Pargament, Mahoney, Shafranske, Exline, & Jones, 2013), including people who identify as LGBTQ. This spiritual tendency can move individuals toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. While spirituality is usually expressed through culture, it both precedes and transcends culture. Religion can be thought of as the organization of belief that is common to a culture or subculture.

A distinction between the two concepts is important to consider for LGBTQ midlife adults, because for many individuals different feelings and experiences will be associated with both terms. Helping clients distinguish religion, church and spirituality may help (Beagan & Hattie, 2015). Each individual should be given the room to express his or her own sense of spirituality and religion. If those terms do not accurately describe inner feelings and beliefs, the client should be encouraged to reframe using words that are familiar and more personal.

Developmental Lens

During the midlife adult stage, individuals have the nearly uninhibited opportunity to explore needs, wants, and desires that can be healthy as well as unhealthy (Corrigan, Kosyluk, & Rusch, 2013). For many LGBTQ individuals, the time of middle age typically offers more complete independence with the most knowledge and wisdom as possible thus far in life. The stage can open a gateway to exploration that may have been shielded by religion or familial ideas as a younger person (Theron & Theron, 2013). Thus, individuals' attitudes, believes, ideals, and schemas may change due to personal self-exploration which may have been hindered by societal norms and standards. As noted by Willoughby, Malik, and Lindahl (2006), research demonstrates how imperative it is to have family cohesion and aware parents and family who are supportive of an individual's coming-out process, especially if it occurs in midlife.

Strengths and Challenges

Strengths

Although negative experiences with religion and religious communities have been the focus of conversation as well as numerous studies, there is also evidence that inclusion of religion and/or spirituality may contribute to the health and well-being of all people, including LGBTQ individuals. LGBTQ adults report that their beliefs in an accepting, loving higher power are a source of support and strength (Fowler, 1981; Rosenkrantz, Rostosky, Riggle, & Cook, 2016). Religion and/or spirituality can help people cope with discrimination and negative life experiences, especially midlife adults who identify as LGBTQ and who are experiencing the level of responsibility that typically occurs during the midlife years. Religious or spiritual belief can offer a source of strength that clients can rely on as coping skills, as well as assist in the development of the positive relationship between the client and the counselor. There are many positive aspects of discussing the belief system of the client as long as the client comes forward with an agenda that would include such discussion.

Challenges

Although there appear to be many strengths around incorporating and solidifying the religious and spiritual beliefs presented by LGBTQ clients and families seeking counseling, there are also challenges that can present many questions and require further knowledge on the counselor's part. Qualitative studies suggest that religion may be associated with negative feelings and experiences in LGBTQ-identified individuals. For instance, religion may be the source of negative feelings such as shame, guilt, inadequacy, depression, low self-esteem, isolation, trauma, hypervigilance, and even suicidality. Past research suggests that LGBTQ-identified individuals may cope with negative experiences by compartmentalizing their identities, rejecting their faith tradition, or attempting to reconcile conflicts in ways that do not support positive identity development, such as trying to change their sexual or gender identities (e.g., Hattie & Beagan, 2013; Sherry, Adelman, Whilde, & Quick, 2010). Religion-based conflict has been associated with higher levels of generalized anxiety in lesbian and gay individuals (Hamblin & Gross, 2013) and sexual orientation conflict, depression, and low self-esteem for LGBTQ young adults (Dahl & Galliher, 2010). Counselors should be aware of any emotional or mental health concerns new clients or families have as part of the past.

Intersectionality: Culture and Spirituality

The important aspect of intersectionality to a clinician is to gain understanding of the individual's experience and to share in the person's narrative to better understand how to address the individual within multiple systems. Using a lens of intersectionality helps to better develop the therapeutic relationship while discussing several identities within the LGBTQ individual, specifically their spirituality.

As the LGBTQ individual emerges into mid-life, having a sense of spirituality could be a protective factor while navigat-

ing multiple systems of oppression and discrimination. While engaging in therapy, counselors should be open to explore the individual's narrative, self-efficacy, views of themselves, and empowerment to succeed over potential negative circumstances. Furthermore, the clinician should have awareness of potential challenges that are faced by LGBTQ individuals and how these placate the spirituality of the individual. Last, counselors should also be open to their own personal experience of spirituality and how this may intersect for them. This personal exploration of spirituality may aid in assisting clients to complete their own personal exploration. Further research into spirituality as a part of LGBTQ identity will assist professionals to support spirituality as a salient identity in within the LGBTQ individual in the most ethical manner (Francis & Dugger 2014).

Counseling Considerations

As individuals develop strategies and coping skills in order to maintain a healthy emotional and physical well-being, spirituality is often an integral aspect. Often individuals consider their spiritual or religious community their support system. When their support system is compromised, it is difficult to maintain a well-balanced lifestyle, often leading to emotional instability. Many individuals in the LGBTQ community who identify as needing a spiritual or religious system struggle with their religious or spiritual beliefs at some point in either the coming out process or at important developmental milestones.

There are many different stances held by various religious communities. Some are supportive of the LGBTQ community and welcome LGBTQ midlife adults without reservation into their churches, temples, other house of worships, or communities, while other religious do not or have stipulations. If individuals who feel that their spirituality or religion is an integral part of their support system have negative experiences or feel rejection from their spiritual community, then their support system is not only compromised but harmful (Baker & Beagen, 2014). Allowing and being empathically open to discussion of spirituality and religion in the counseling process may develop coping skills that clients can utilize on their own, outside the counseling session. Religion and spirituality may be an integral part of the presenting concern, and if the counselor does not allow space for this subject to be brought up, then this presenting problem may be overlooked and not addressed. Clients who otherwise may simply put their spiritual needs aside may, through open and safe in session discussion, find that they can indeed continue their spiritual and religious identity through finding LGBTQ-affirming communities or by developing their own personal spirituality.

There are ways in which counselors can safely and ethically incorporate spirituality and religion into the counseling session. It is important for counselors to respectfully assess the impact that their race and culture has had on the client's well-being and how it relates to their definition of spirituality. To understand a client in depth, it is important to allow safe discussions on how the client views spirituality (Barnett & Johnson, 2011).

Counselors should carefully assess any connection between the presenting problem and religious or spiritual beliefs and commitments with their clients. Even though ethical codes require counselors to respect all faiths and religions, codes do not state counselors are to be complacent with destructive beliefs that result in significant physical or mental harm. Therefore, it may be appropriate for counselors to explore and question their own beliefs and their own competence, and, when necessary, seek assistance from experts and through trainings and consultation. If a counselor believes that a client's spiritual beliefs are pervasive in the client's life, then the counselor must decide if an explicitly faith-integrative approach will be necessary or preferred by the client (Barnett & Johnson, 2011).

As counselors prepare to include spirituality or religion into the counseling session, they must nonjudgmentally consider any countertransference to the client's religiousness or previous experience. In addition, counselors should assess their own reactions to a client's religious beliefs and values. Counselors should foster discussions in which clients explore their feelings toward their client's sexuality or gender identification and how they perceive that this may or may not have an impact on the religious beliefs. After sufficient discussion, counselors could then evaluate the efficacy of several spiritually relevant treatment goals that may be developed to reach the clients counseling needs. Counselors should then decide whether consultation is necessary. It may be helpful for counselors to establish connections with LGBTQ-affirming faith groups to provide these clients with safe spaces to explore religion and spirituality if the client feels it would be helpful to reach treatment goals. It is then crucial for counselors to consistently monitor the outcomes of the treatment plan and its impact on the client, the significant others in the client's life, and the relationships between the client and their spiritual/religious community (Barnett & Johnson, 2011).

There are many aspects inherent in counseling LGBTQ midlife adults, and the significance of spiritual belief or religious dedication is a most important aspect. Although at times hidden, that bond is more than worth exploring.

References

Baker, K., & Beagen, B. (2014). Making assumptions, making space: An anthropological critique of cultural competence and its relevance for queer patients. *Medical Anthropology Quarterly, 28,* 578–598.

Barnett, J. E., & Johnson, W. B. (2011). Integrating spirituality and religion into psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision-making process. *Ethics & Behavior, 21,* 147–164. doi:10.1080/10508422.2011.551471

Beagan, B. L., & Hattie, B. (2015). Religion, spirituality, and LGBTQ identity integration. *Journal of LGBT Issues in Counseling, 9,* 92–117. doi:10.1080/15538605.2015.1029204

Corrigun, P. W., Kosyluk, K. A., & Rüsch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health, 103,* 794–800. doi:10.2105/AJPH.2012.301037

Dahl, A., & Galliher, R. V. (2010). Sexual minority young adult religiosity, sexual orientation conflict, self-esteem and depressive symptoms. *Journal of Gay & Lesbian Mental Health, 14,* 271–290.

Fowler, J. (1981). *Stages of faith: The psychology of human development and the quest for meaning.* New York, NY: Harper & Row.

Francis, P. C., & Dugger, S. M. (2014). Professionalism, ethics, and value-based conflicts in counseling: An introduction to the special section. *Journal of Counseling & Development, 92*, 131–134. doi:10.1002/j.1556-6676.2014.00138.x

Hamblin, R., & Gross, A. M. (2013). Role of religious attendance and identity conflict in psychological well-being. *Journal of Religion and Health, 52,* 817–827.

Hattie, B., & Beagan, B. L. (2013). Reconfiguring spirituality and sexual/gender identity: "It's a feeling of connection to something bigger, it's part of a wholeness". *Journal of Religion & Spirituality in Social Work: Social Thought, 32,* 244–268.

Pargament, K. I., Mahoney, A. E., Shafranske, E. P., Exline, J. J., & Jones, J. W. (2013). *From research to practice: Toward an applied psychology of religion and spirituality*. Washington, DC: American Psychological Association.

Rosenkrantz, E., Rostosky, S., Riggle, D., & Cook, R. (2016). The positive aspects of intersecting religious/spiritual and LGBTQ identities. *Spirituality in Clinical Practice, 3,* 127–138.

Sherry, A., Adelman, A., Whilde, M. R., & Quick, D. (2010). Competing selves: Negotiating the intersection of spiritual and sexual identities. *Professional Psychology: Research and Practice, 41,* 112–119.

Theron, L., & Theron, A. (2013). Positive adjustment to poverty: how family communities encourage resilience in traditional African contexts. *Culture & Psychology*, *19,* 391–413.

Willoughby, B., Malik, N. & Lindahl, K. (2006). Parental reactions to their sons' sexual orientation and disclosures: The roles of family cohesion, adaptability, and parenting style. *Psychology of Men & Masculinity, 7,* 14–26.

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Health Issues

Stacy Speedlin

The experiences and health needs of LGBTQ middle-aged persons have traditionally remained invisible throughout mainstream health care systems and policies. This is primarily the result of LGBTQ health being historically understood through a heteronormative framework (Bauer et al., 2009; Colpitts & Gahagan, 2016; Mulé et al., 2009). Current studies recognize a disparity in the physical and mental health needs of LGBTQ persons compared to their heterosexual and cisgender counterparts. In response to these needs, the U.S. Department of Health elevated sexual orientation from disparity status in their objectives to a targeted group worthy of primary concern (as cited in Wheeler & Dodd, 2011).

Despite efforts to bridge the gap, the trend for greater affirmation offers a mixed review in serving LGBTQ clients and their needs (Shelton & Delgado-Romero, 2011). Research demonstrates a trend that LGBTQ persons are still reporting considerable hostility and discrimination when receiving health care (Bowers, Plummer, and Minichiello, 2005; Greene, 2007; Shelton & Delgado-Romero, 2011). Existing research further demonstrates this may also affect uptake rates of preventative health screening programs and health care services (Johnson et al., 2014; Makadon, 2011; National Institute of Health, 2011), which is pertinent for individuals of this age group. Further, several variables that reduce LGBTQ persons seeking help in mainstream settings results from lack of understanding and knowledge from health care providers.

A multitude of gaps still exist within the context of research and culturally sensitive assessment instruments for studies conducted on the LGBTQ population at the midlife stage. This is noteworthy because LGBTQ health research plays an important role in shifting how LGBTQ health is understood and measured, directly affecting health promotion strategies aimed at keeping LGBTQ populations healthy across the life span (Colpitts & Gahagan, 2016). For better provisions of services offered to LGBTQ persons, research must inform these practices. Therefore, adequate research practices are needed to strengthen the understanding of the health needs of LGBTQ persons.

Developmental Lens

LGBTQ midlife adults are in the working stage of their life. They are in the workforce and the academic settings with hopes and dreams to create a successful life for themselves and their families. Yet despite their goals, LGBTQ middle-age persons are not immune to the problems similar of any other age group. Recent research indicates that LGBTQ middle-age individuals have higher levels of psychological distress compared to their midlife heterosexual counterparts (Fredricksen-Goldsen et al., 2013c; Wallace et al., 2011). Dissimilar to middle-aged heterosexual men, middle-aged gay and bisexual men are less likely to have children and are more likely to live alone (Fredicksen-Goldsen et al., 2013c; Wallace et al., 2011). Living alone increases the risk of social isolation and loneliness, which are significant predictors of depression for midlife adults (Cacioppo et al., 2006).

LGBTQ people suffer disproportionately and are at disproportionate risk for various health conditions, including obesity, depression, anxiety, substance use disorders, tobacco use, HIV, some cancers, and inadequate health screenings (Hussey, 2006; Mayer et al., 2008; Millett, Flores, Peterson, & Bakeman, 2007). These health risks tend to emerge during midlife for most persons, and LGBTQ persons are not the exception. While heterosexual and cisgender persons experience these same issues, the compounding effect on LGBTQ persons is relatively higher and requires adequate and appropriate intervention. When physical issues are coupled with mental health issues, the prognosis can be poor. Hoy-Ellis, Ator, Kerr, and Milford (2016) write, "Achieving mental and physical health equity among LGBTQ middle-age adults requires recognizing and addressing multidimensional, multi-level barriers and strengths and resiliency factors that inhibit and promote health" (p. 56).

Health issues are prevalent within this age group, but there are discrepancies between the needs and the services accessed. This may be the result of poor healthcare services being provided to LGBTQ persons. Negative variables—including bias and ignorance—are present throughout therapeutic and research processes, which directly affect understanding of needs, policies, and service provisions (Shelton & Delgado-Romero, 2011). The negative variables may also affect accessibility and funding of preventative health screening programs and health care services (Johnson, Singh, & Gonzalez., 2014; Makadon, 2011; National Institute of Health, 2011).

Lack of knowledge regarding the realities of LGBTQ midlife adults contributes to the perception among health providers that "they treat everyone equally and do not discriminate" against this population (Hoy-Ellis et al., 2016, p. 57). While these providers are often well meaning, this stance can become a barrier, as it is assumed that "everyone stands on equal ground, having equal representation and access" (Hoy-Ellis et al., 2016, p. 57). Experiences of discrimination and informational misunderstanding can affect the ways in which LGBTQ populations choose to access or avoid health care systems (Dean et al., 2000; Mulé et al., 2009; Ryan & Chervin, 2000). Worse yet, they may decline preventative health care measures or even avoid well-needed health care interventions to cope with chronic issues. As a result, many LGBTQ adults "remain distrustful and are reluctant to interact" with mainstream health care professionals and agencies (Hoy-Ellis et al., 2016, p. 57).

The still serious consequences (hate crimes, loss of employment, loss of social supports) for LGBTQ individuals who are "out" regarding their sexual identity or orientation remain significant and threaten the well-being of this population (Singh, 2010). Counselors, although well-intentioned are not immune to the frequent stigmatization of LGBTQ individuals within the therapeutic alliance (Singh & Shelton, 2011).

Strengths and Challenges

Strengths

Midlife LGBTQ persons have a multitude of strengths that become protective factors for their health and overall well-being. The following are a few:

- Resiliency as the basis for overcoming times when LGBTQ persons had fewer rights and less tolerance from heterosexuals and cisgender persons;
- High utilization of counseling, which is effective when counselors are trained and competent in the needs of this population;
- Connections and relationships with other LGBTQ persons, which increase overall wellness;
- Social media and other accessible domains for finding more LGBTQ-friendly health care and counseling agencies; and
- Mentorship for LGBTQ persons who are in the workforce.

Challenges

Heterosexism is a multidimensional, institutionalized manifestation of sexual stigma that functions by "denying, denigrating, and/ or segregating any non-heterosexual form of behavior, identity, relationship, or community" (Walls, 2008, p. 27). In health care settings and counseling agencies where heterosexism still exists, this population encounters issues that impede their willingness to seek help, particularly with midlife LGBTQ individuals who may have come out when homosexuality was still considered a psychiatric disorder, immoral, or illegal behavior (Colpitts & Gahagan, 2016). These individuals may be more attuned to the overt or covert discriminatory language used by providers or counselors. The result is higher attrition rates in treatment settings that fail to recognize the role of heterosexism in the decay of adequate service provisions.

Similarly, ageism remains a significant issue in LGBTQ communities. LGBTQ persons of middle age are often the less championed group, with funding going primarily to programming for youth-centered agencies (Hoy-Ellis et al., 2016). The expectation is that this age group is less vulnerable and has fewer needs compared to older or younger LGBTQ adults; the assumption is that they are of working and educational age and therefore can access resources more readily.

However, resources are limited for a group that experiences such high discrimination rates in the context of the workforce. The coupling of the denial of health insurance and employment in the United States has a negative impact on their access to health insurance. Lack of recognition of LGBTQ families means that even when available to workers, health benefits may not be extended to same-sex partners or their children. These discriminatory patterns and their impact hold true for transgender or gender-nonconforming individuals (Wheeler & Dodd, 2011).

While this group has a larger risk of health issues, these individuals are often unable to attain adequate health care or are anxious about seeking health care for fear of disclosing their sexual or gender orientation to mainstream providers. The same can be stated of counseling agencies where LGBTQ persons recognize nonaffirming environments and where a limited knowledge of heterosexual and cisgender privilege exists.

Intersectionality

The LBGTQ community is not exclusive to any race, ethnicity, age, socioeconomic status, or region (Quinn et al., 2015). However, based on certain combining demographic variables, LGBTQ persons will experience different perceptions and outcomes in their health care treatment. LGBTQ individuals of color, for example, will experience double-bind marginalization when seeking adequate health care. Studies (Grant et al., 2011; Quinn et al., 2015) show that LGBTQ persons of color experience negative determinants of health such as homelessness, social exclusion, and poverty at higher rates than their age-matched White peers. Racial and gender LGBTQ minorities will also encounter greater bias and discrimination, resulting in further confusion and distrust with health care professionals.

Education is a limited protective factor for LGBTQ and transgender individuals. Despite being more educated than the general population, transgender people experience higher rates of homelessness and unemployment, as well as lower incomes (Grant et. al., 2011). This is also demonstrated within the LGBTQ population, which exhibits higher rates of education yet lower income and employment retention rates. Therefore, it cannot be assumed that education guarantees immunity from structural and systemic issues.

Current U.S. law plays a role in the gaps experienced between education and healthcare access. While the U.S. attempts to change certain policies to improve the rights of LGBTQ individuals, they lack credibility to meet major health care needs. For example, LGBTQ persons only recently secured federal legal protections to visit their loved ones in the hospital (Wahlert & Fiester, 2012). Despite efforts to change accessibility to equal rights, little was done to affect the surrogate decision making powers of LGBTQ couples when they do not have legally honored documentation for the advanced directive, health care proxy, or durable power of attorney in place- standards which many heterosexuals are not required to possess (Walhert & Fiester, 2012). Transgender people are still not protected by law from discrimination and are not guaranteed healthcare in several states (Pega & Veale, 2015).

Counseling Considerations

Research conducted on this population should require demographic information related to sexual orientation and gender identity (Wheeler & Dodd, 2011). Data on this group is typically unavailable in mainstream research and as a result cannot be used to inform LGBTQ-specific health initiatives (Gates, 2011; Silvestre, 2003).

Counselors can advocate to increase Safe Zone trainings and culturally competent trainings within health care settings. Also, within clinical settings, the appropriate use of language and symbols is essential for working with the LGBTQ population (Quinn et al., 2015).

Counselors should advocate by promoting policies that end workplace discrimination and lack of access to insurance, since access to health insurance is largely employer driven (Wheeler and Dodd, 2011). Further, advocacy should be exercised to "promote policies that support same-sex partner access to health insurance for all and removal of the tax burden for those who take advantage of the health benefits" (Wheeler & Dodd, 2011, p. 309). This can strongly benefit midlife LGBTQ persons who are in professional careers.

State licensure boards should offer (or require) continuing education units on working with LGBTQ clients in this age group. Medical academic institutions can also infuse cultural competence in the education curriculum for health care professionals (Wheeler & Dodd, 2011).

The federal government can also support funding research that examines health disparities within LGBTQ populations and the LGBTQ cultural competence during midlife to better understand both the needs of the population and the specific training needs (Wheeler & Dodd, 2011). This would also mean that researchers should apply for these funds to conduct research and measure outcomes of interventions specific to this age group.

References

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I don't think this is theoretical; this is our lives": How erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care*, *20,* 348–361.

Bowers, R., Plummer, D., & Minichiello, V. (2005). Homophobia in counselling practice. *International Journal for the Advancement of Counselling*, *27*, 471–489.

Cacioppo, J. T., Hughes, M. E., Waite, L. J., Hawkley, L. C., & Thisted, R. A. (2006). Loneliness as a specific risk factor for depressive symptoms: Cross-sectional and longitudinal analyses. *Psychology and Aging, 21,* 140–151.

Colpitts, E., & Gahagan, J. (2016). The utility of resilience as a conceptual framework for understanding and measuring LGBTQ health. *International Journal for Equity in Health*, *15.* doi:10.1186/s12939-016-0349-1

Dean, L., Meyer, I. H., Robinson, K., Sell, R. L., Sember, R., Silenzio, V. M., . . . Dunn, P. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association, 4,* 102–151.

Fredriksen-Goldsen, K. I., Kim, H.-J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay male and bisexual older adults: Results from a population-based study. *American Journal of Public Health, 103,* 1802–1809.

Gates, G. J. (2011). *How many people are lesbian, gay, bisexual and transgender?* Retrieved from The Williams Institute website https://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf

Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J. & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington DC: National Center for Transgender Equality.

Greene, B. (2007). Delivering ethical psychological services to lesbian, gay, and bisexual clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 181–199). Washington, DC: American Psychological Association.

Hoy-Ellis, C. P., Ator, M., Kerr, C., & Milford, J. (2016). Innovative approaches Address aging and mental health needs in LGBTQ communities. *Generations*, *40,* 56–62.

Hussey, W. (2006). Slivers of the journey: The use of Photovoice and storytelling to examine female to male transsexuals' experience of health care access. *Journal of Homosexuality*, *51,* 129–158.

Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.* Washington, DC: National Academies Press.

Johnson, C. W., Singh, A. A., & Gonzalez, M. (2014). "It's complicated": Collective memories of transgender, queer, and questioning youth in high school. *Journal of Homosexuality*, *61,* 419–434.

Kitts, R. L. (2010). Barriers to optimal care between physicians and lesbian, gay, bisexual, transgender, and questioning adolescent patients. *Journal of Homosexuality*, *57,* 730–747.

Makadon, H. J. (2011). Ending LGBT invisibility in health care: the first step in ensuring equitable care. *Cleveland Clinic Journal of Medicine*, *78,* 220–224.

Mayer, K. H., Bradford, J. B., Makadon, H. J., Stall, R., Goldhammer, H., & Landers, S. (2008). Sexual and gender minority health: What we know and what needs to be done. *American Journal of Public Health*, *98,* 989–995.

Millett, G. A., Flores, S. A., Peterson, J. L., & Bakeman, R. (2007). Explaining disparities in HIV infection among black and white men who have sex with men: A meta-analysis of HIV risk behaviors. *AIDS*, *21,* 2083–2091.

Mulé, N. J., Ross, L. E., Deeprose, B., Jackson, B. E., Daley, A., Travers, A., & Moore, D. (2009). Promoting LGBT health and wellbeing through inclusive policy development. *International Journal for Equity in Health*, *8.* doi:10.1186/1475-9276-8-18

National Institutes of Health. (2011). *The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding.* Washington, DC: National Academies Press.

Pega, F., & Veale, J. F. (2015). The case for the World Health Organization's Commission on Social Determinants of Health to address gender identity. *American Journal of Public Health*, *105,* e58–e62.

Quinn, G. P., Sanchez, J. A., Sutton, S. K., Vadaparampil, S. T., Nguyen, G. T., Green, B. L., Kanetsky, P. A. & Schabath, M. B. (2015). Cancer and lesbian, gay, bisexual, transgender/transsexual, and queer/questioning (LGBTQ) populations. *CA: A Cancer Journal for Clinicians, 65,* 384–400.

Ryan, B., & Chervin, M. (2000). *Framing gay men's health in a population health discourse: A discussion paper*. Ottawa, ON: Canadian HIV/AIDS Clearinghouse.

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology, 58,* 210–221.

Silvestre, A. J. (2003). Ending health disparities among vulnerable LGBT people. A commentary. *Clinical Research and Regulatory Affairs, 20,* ix–xii.

Wahlert, L., & Fiester, A. (2012). Mediation and surrogate decision-making for LGBTQ families in the absence of an advance directive. *Journal of Bioethical Inquiry*, *9,* 365–367.

Wallace, S. P., Cochran, S. D., Durazo, E. M., Ford, C. L. (2011). *The health of aging lesbian, gay and bisexual adults in California.* Los Angeles, CA: UCLA Center for Health Policy Research.

Walls, N. E. (2008). Toward a multidimensional understanding of heterosexism: The changing nature of prejudice. *Journal of Homosexuality*, *55,* 20–70.

Wheeler, D. P., & Dodd, S. J. (2011). LGBTQ capacity building in health care systems: A social work imperative. *Health & Social Work*, *36,* 307.

Family and Social Development

Melanie Iarussi

Midlife (ages 30 to 60) is generally a time in which partnership, children, and aging parents are of focus. Many individuals enter into partnerships, including those formally recognized through marriage or civil unions, in their 20s, and continue this developmental task in their 30s, 40s, and 50s. In 2014, the average age for a woman to have her first child was 26 (Mathews & Hamilton, 2016), resulting in midlife being largely focused on raising children. Finally, when individuals are in midlife, their parents are older adults who may be experiencing declining health and functioning, often requiring support from adult children. For people who identify as LGBTQ, each of these developmental tasks require unique considerations, including specific challenges and strengths.

In this article, common developmental tasks of midlife related to family and social factors will be detailed, followed by information about the possible challenges encountered as LGBTQ persons pursue these milestones. Possible strengths possessed by members of these communities as related to midlife developmental tasks are also described. Intersectionality is then discussed in regard to members of LGBTQ communities and family issues. Finally, considerations for counseling will be described.

Developmental Lens

Partnership, raising children, and caring for aging loved ones are all typical developmental tasks that may be initiated in middle adulthood or may begin in early adulthood and continue into midlife. Erikson's idea of generativity involved influencing the next generation, not only through childbearing and rearing but also through extending into the greater community and social world (Berk, 2007). In this section, how these developmental tasks apply to family issues among LGBTQ individuals will be examined.

Partnership

On June 26, 2015, the United States Supreme Court voted in favor of nationwide marriage equality (*Obergefell et al. v. Hodges et al.,* 2015). This landmark decision granted same-sex couples the right to marry, a human right that was previously denied to these groups in many states. According to the U.S. Census Bureau (2016a), the average age for marriage in the United States in 2016 was approximately 29.5 years for men and 27.5 years for women, and an estimated 85% of people will eventually marry in the United States (Popenoe, 2007). However, in order to understand partnerships among same-sex couples, counselors must examine statistics specific to these groups. In 2014, there were an estimated 783,000 same-sex couple households in the United States (405,000 male couples and 378,000 female couples; U.S. Census Bureau, 2014). Because marriage equality occurred so recently, the U.S. Census Bureau statistics are not able to differentiate between married and non-married same-sex couples.

Other noteworthy characteristics of same-sex couples include education level, employment status, and the presence of children in the household. In regard to education level, in more than 30% of same-sex couples, both partners have earned at least a bachelor's degree, exceeding married and unmarried opposite sex couples (23.7% and 12.5%, respectively). The majority of same-sex couples involve both partners working (59.5% of couples), which is comparable to opposite-sex unmarried partners (59.4%) but higher than opposite-sex married partners (47.8%).

Parenting

Parenting is a common way for individuals in middle adulthood to develop generativity, or the perception of providing something for the next generation (Erikson, 1968; Santrock, 2009). Attitudes of the general population have shifted in favor of gay men and lesbian women gaining adoption rights, as recent estimates reported 74.8% of women and 67.5% of men in the United States were in favor, both representing significant increases from 55.4% and 46.9%, respectively, in 2002 (Daugherty & Copen, 2016). Of course, LGBTQ persons are less likely to become parents the same way cisgender or heterosexual parents do. Therefore, LGBTQ persons are not only faced with the question, "Do I want to be a parent?" but, if the answer is affirmative, then they are left to contend with, "How do I become a parent?"

Moore and Stambolis-Ruhstorfer (2013) described four primary ways through which LGBTQ persons become parents: (a) a previous relationship with a person of the opposite sex that led to the birth of a child; (b) adoption; (c) using assistive reproductive methods (e.g., donor insemination, in vitro fertilization, surrogacy); or (d) becoming a partner to someone who has had a child by one of the preceding options. Compared to opposite-sex parents, same-sex couples who raise children are four times more likely raise an adopted child and six times more likely raise foster children (Moore & Stambolis-Ruhstorfer, 2013).

Caring for Aging Loved Ones

Developing generativity in middle adulthood can also extend to caring for other family members (e.g., parents, aunts, uncles, siblings) and loved ones who need assistance (Berk, 2007). An estimated 30% of the adult population in the United States provides care to another adult, and 64% of these caregivers are ages

30–64 (Fox & Brenner, 2012). Thus, caring for aging parents or other family members is a common reality for individuals in middle adulthood. Being a member of an LGBTQ community can have a significant impact on these relationships, which can ultimately lead to unique challenges in this developmental task, including discrimination on individual and interpersonal levels as well as within the systems involved to provide care to loved ones (Coon, 2007).

Strengths and Challenges

Strengths

People who identify as LGBTQ exercise specific strengths to seek and maintain the family relationships they desire. In this section, specific strengths are identified.

Partnership. In regard to partnerships, the strengths that are inherent in partner relationships will also extend to same-sex relationships, including having the support and human connection of an intimate partner and a sense of belonging. Beyond these generic strengths, LGBTQ persons have long fought for their civil rights to engage their intimate relationships publicly, including through legally recognized marriages. Intense determination and resiliency are required for pursuing such social and legislative changes. After decades of advocating for equal rights, in June 2015, the United States Supreme Court finally established the right to marry nationwide (*Obergefell et al. v. Hodges et al.,* 2015). Such accomplishments can strengthen pride in one's LGBTQ identity. Further, with this legislative progress, LGBTQ persons are contributing to the advancement of society, including equal rights being inherent for same-sex couples to come after them. Such actions and accomplishments are well-aligned with cultural generativity, or the progression of a culture that survives beyond the individual (Santrock, 2009).

Parenting. In regard to parenting, research has consistently supported that same sex parenting does not negatively impact children's development (Manning, Fettro, & Lamidi, 2014; Paige, 2007; Patterson, 2005). Same-sex parenting has been rigorously scrutinized in research, resulting in consistent outcomes in support of same-sex parents. For example, Farr (2016) conducted a longitudinal study investigating differences between children who were adopted by same-sex couples and those who were adopted by opposite-sex couples. Farr found that the children were equally well-adjusted across developmental milestones from preschool to middle childhood.

In an effort to diminish discrimination against LGBTQ parents, the Human Rights Campaign (HRC, 2016b) summarized the official statements of several professional organizations that explicitly stated their support of same-sex parenting. Such professional organizations included the American Academy of Pediatrics, the American Medical Association, the American Academy of Family Physicians, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, Child Welfare League of America, National Adoption Agency, and Voice for Adoption. The close examination of same-sex parenting has become a strength of this parenting group, because there is now strong and consistent empirical evidence supporting same-sex and LGBTQ parents.

Beyond empirical research and professional organizations, such scrutiny and hurdles are also evident in the process for same-sex couples to become parents through adoption, in vitro fertilization, or surrogacy. Of course, strategic efforts are needed for the empirical research to impact the day-to-day practices of adoption and social service workers. The resiliency and determination needed to become a parent, including having to "prove" more so than opposite-sex couples that they are fit to be parents, may result in LGBTQ persons being more intentional, motivated, and child-centered parents. Programs such as HRC's All Children–All Families promote understanding of and effective services to LGBTQ persons by providing resources, training, support, and LGBTQ cultural competency assessments for child welfare agencies. Accompanying the social services and legislative progress, there are increasing literature and resources for the public to normalize and assist same-sex couples in raising children. For example, children's books such as *Heather Has Two Mommies* by Lesléa Newman and *The Trouble With Babies* by Martha Freeman and websites such as thenextfamily.com provide normalizing stories and information for families with same-sex parents.

Caring for aging loved ones. Generativity in middle adulthood often includes parenting, but it can also extend to other family relationships (Berk, 2007). Caring for aging parents and positively contributing to the lives of other family members can help provide individuals with a sense of generativity. Further, providing this care may facilitate stronger relationships with the person's parents and/or family of origin, which may also increase the likelihood of LGBTQ parents establishing strong bonds with their children.

Challenges

Partnership. Due to the denial of the right to enter legally acknowledged marriages before June 2015, a variety of statuses and terms have been historically used to describe same-sex partnerships. For instance, a *domestic partnership* describes a relationship between two adults who are not biologically related, live together, are not in a civil union or marriage with anyone else, and are in an intimate and committed relationship in which the partners are fiscally and legally responsible for one another (HRC, 2016a). A *civil union* is used to describe a legal contract between partners that confers similar rights as those granted by marriage but with many limitations. Whereas marriage is federally recognized, and therefore respected and honored across states, civil unions are state-specific. For example, if a couple celebrated a civil union in Vermont, their partnership would not be legally recognized in Alabama.

Further, because civil unions lack federal acknowledgment, the benefits inherent in marriages are often not afforded in civil unions, including being able to take leave from work to care for a partner who is ill or injured or receiving survivor benefits after the death of a partner. Marriages also provide a process from which partners can exit: divorce. Civil unions can only be terminated by states that acknowledge them, thus limiting partners' abilities to legally terminate their partnership. The fact that same-sex couples are not offered the same status acknowledgements and legal benefits as opposite-sex partners illustrates the oppression by inequality of the LGBTQ population (Gay & Lesbian Advocates & Defenders, 2014).

Finding an intimate partner is typically a task of young adulthood; however, this process can extend into middle adulthood and can be more challenging among the LGBTQ community due to oppressing stigmas, having to come out in order to partner, and having limited opportunities to meet suitable partners. Once adults enter their 30s, they experience increased pressure to "settle down and get married" (Santrock, 2009, p. 454). Benefits found in happy marriages, including living longer, healthier lives (Karasu, 2007), may therefore be more difficult for LGBTQ persons to incur. Even once LGBTQ individuals are in a partnership, they are often in a position to have to negotiate their relationship within their families of origin and peer groups (Oswald, 2002).

Further, substance use is frequently used as a means to connect LGBTQ individuals (e.g., gay bars), and the LGBQT community in general has higher rates of substance use (Kelly, Izienicki, Bimbi, & Parsons, 2011). Minority stress, including factors such as discrimination, can also lead to higher substance use rates among LGBTQ couples (Mason, Lewis, Gargurevich, & Kelley, 2016). Unfortunately, substance use is a common factor in violence in partner relationships.

Due to reporting and research sampling concerns, accurate statistics related to LGBTQ relationships are difficult to ascertain; however, the existing research suggests that intimate partner violence (IPV) occurs within LGBTQ relationships at comparable or higher rates when compared to opposite-sex partners (Walters, Chen, & Breidig, 2013), and women are more likely to be victims than men (Goldberg & Meyer, 2013). An estimated one out of five gay and lesbian individuals will experience IPV in their lifetime (Langenderfer-Magrudeer, Whitfield, Walls, Kattari, & Ramos, 2014). Studies that were successful in including individuals who identify as transgender found significantly higher rates of IPV inflicted on this group compared to people who are cisgender (Langenderfer-Magrudeer et al., 2014), including transgender individuals being twice as likely and people who identified as queer being three times as likely to experience sexual violence (National Coalition of Anti-Violence Programs, 2012). Only about 25% of those experiencing IPV report the incident (Langenderfer-Magrudeer et al., 2014), raising concerns about barriers for seeking help. Specific barriers to LGBTQ persons seeking and receiving help include stigma and fear of discrimination, the justice system failing survivors, and potential helpers having a limited understanding of LGBTQ IPV (Calton, Cattaneo, & Gebhard, 2016). Individuals who experience IPV will often experience physical and mental health problems (Houston & McKirnan, 2007), and therefore reducing the barriers to assistance is essential.

In regard to exiting a partnership, research has suggested that specific social influences, such as legally recognized partnership status, children, and interdependent finances, decrease the likelihood of relationship termination. On the other hand, social stressors, financial difficulties, and discrimination increase the likelihood of relationship termination. These factors contribute to same-sex couples who are living together terminating their relationships at higher rates compared to opposite-sex couples who are married (Moore & Stambolis-Ruhstorfer, 2013). Regardless, divorce is common among opposite-sex couples, and it serves as a legally recognized termination to the partnership. As noted previously, before same-sex marriage was legalized, divorce was not an option for same-sex couples. Not only does this have legal implications for each partner of the disbanded couple, but social issues may exist as well if the individuals are not able to openly grieve the end of the relationship and receive the support necessary. If children are involved, they also require unique considerations after the end of the partnership of their parents.

Parenting. Only 17.3% of same-sex couples have children in the home, compared to around 40% of opposite-sex couples (U.S. Census Bureau, 2014). Myths such as, "Children need a mother and a father to have proper male and female role models," and "Gays and lesbians don't have stable relationships and don't know how to be good parents," still need to be dispelled among the general population (American Civil Liberties Union [ACLU], 2015, p. 3). These statistics and myths highlight the challenges of same-sex couples and LGBTQ individuals becoming parents as compared with opposite-sex couples. As mentioned previously, there are four main ways for LGBTQ persons to become parents. The most common pathway to parenthood for LGBTQ persons historically was through an opposite-sex relationship prior to identifying as or coming out as LGBTQ (Telingator & Patterson, 2008). With increasing social acceptance and practice of surrogacy, donor insemination, and adoption by LGBTQ individuals and couples, these routes to parenthood are increasing for LGBTQ people (Moore & Stambolis-Ruhstorfer, 2013). It is easier for lesbian women to become parents by donor insemination as compared with gay men by surrogacy, although both routes can be costly (Moore & Stambolis-Ruhstorfer, 2013).

Despite an overwhelming amount of research that supports LGBTQ parenting and adoption, sexual orientation and gender identity continues to be used to deny custody, adoption, visitation, and foster care rights to people who identify as LGBTQ. For example, transgender parents have had their parental rights removed from their biological children if the other parent makes the case that the transitioning parent poses a "social harm" to the child (GLAAD, 2016. p. 3). In addition, Florida and New Hampshire have laws that explicitly ban gay men and lesbian women from adopting children (ACLU, 2015). Although most states and social services agencies now make decisions about adoption and parenting issues in the best interest of the child, LGBTQ individuals and couples who wish to adopt are still largely at the mercy of these institutions. Concerning couples in which one partner has a biological child, the other partner must formally adopt the child in order to be a legally recognized parent. According to the National Center for Lesbian Rights (2016):

> The most common means by which LGBT non-biological parents establish a legal relationship with their children is through what is generally referred to as a "second parent adoption." A second parent adoption is the legal procedure by which a co-parent adopts his or her partner's child without terminating the partner's parental rights, regardless of marital status. As a result of the adoption, the child has two legal parents, and both partners have equal legal status in terms of their relationship to the child. (p. 2)

Second-parent adoption typically creates a more legally secure family environment and is more likely to result in both parents having parental rights should the partnership end. However, this is largely left up to the judicial system (Moore & Stambolis-Ruhstorfer, 2013).

Once an LGBTQ person becomes a parent, raising a child in an environment that is heteronormative and cisgender presents significant challenges, including stigma, discrimination, and maltreatment (e.g., bullying). To contend with these challenges, parents who are LGBTQ often communicate closely with their children, including teaching them how to talk with others about their family and creating supportive social networks that include other LGBTQ families (Moore & Stambolis-Ruhstorfer, 2013). In addition to parents' efforts, children develop their own strategies to mitigate these challenges, including not disclosing about LGBTQ parents, confronting negative comments with corrections, and seeking support groups (Leddy, Gartrell, & Bos, 2012).

Caring for aging loved ones. Being a caregiver for an aging parent or for other family members is a stressful task for any individual, as it can be emotionally, physically, spiritually, and financially draining. Unfortunately, LGBTQ caregivers can encounter additional challenges, including those at individual and interpersonal levels as well as systemic and organizational levels (Coon, 2007). Such challenges can include discrimination based on sexual identity, forced coming out, and even ageism among the LGBTQ community (Coon, 2007). Attention has been paid in general to the support necessary for caregivers, including access to social support among people with similar experiences, especially in online formats (Fox & Brenner, 2012), which can also be helpful for LGBTQ caregivers.

In addition to the typical stressors of caregiving, LGBTQ individuals may be faced with situations in which a family member is in need of care despite his or her lack of acceptance of the individual's LGBTQ status. Another possibility is that the individual is isolated from family due to LGBTQ status, and despite an aging person needing assistance, he or she declines to receive it from the individual who identifies as LGBTQ. Further, LGBTQ individuals who are parents may encounter a lack of acceptance among older adults compared to younger generations. If an LGBTQ person's own parents are not supportive of them becoming parents themselves, this can severely impact the children's relationships with their grandparents, and the LGBTQ parents may have limited support from extended family in their parenting efforts. Finally, unresolved conflicts with parents due to the individual's LGBTQ status upon death of parents can be more likely to lead into complicated grief (Kraybill-Greggo, Kraybill-Greggo, & Collins, 2005). For example, if a gay man has not spoken to his father since his father rejected him upon coming out, and the man's father has died, he may be at a higher risk to get "stuck" in his grief. Assessment and interventions for complicated grief may be warranted in such situations.

Intersectionality

Accurate research is difficult to ascertain with LGBTQ groups, and this task becomes even more challenging when considering intersectionality. For example, many studies are not able to report on transgender or queer persons in partnerships due to too small sample sizes. Thus, getting a sufficient sample to report meaningful information for persons who are both racial and sexual minorities can be a challenge. The U.S. Census Bureau has worked diligently to adjust their surveying methods to safeguard accurate reporting on LGBTQ partnerships (U.S. Census Bureau, 2016b). In 2014, they found that 83.6% of couples who reported being same-sex were White, and 75.7% identified as non-Hispanic White. Approximately 7% identified as African-American or Black, 3 % as Asian, and almost 12% as Hispanic ethnicity and of any race other than White (U.S. Census Bureau, 2014). These statistics should signal counselors to attend to the intersectionality of race with sexual and gender identity. Individuals who represent "double minority" groups, such as a racial or ethnic minority as well as a minority in sexual orientation or gender identity, will have additional cultural and social implications, including minority stress, as compared with White LGBTQ persons.

Beyond race, considering the challenges noted above related to marriage equality, socioeconomic status can have large implications. If a partner is of lower socioeconomic status and denied health insurance coverage offered by his or her partner's employer or denied benefits after the death of a partner, these situations can easily tailspin into issues of poverty. Finally, sex and gender are significant factors to consider related to intersectionality. As noted above, LGBTQ persons have various options to become parents, but those options differ contingent upon the person's sex (e.g., lesbian women can use donor insemination and gay men can use a surrogate if they wish to have a biological child). Further, gender roles within LGBTQ partnerships, with and without parental responsibilities, are typically intentional and meaningful.

Counseling Considerations

When considering family issues of LGBTQ clients who are in midlife, counselors must pay special attention to strive for multicultural competence. This includes being aware of the counselor's own values and biases and not placing them on the client, being knowledgeable about the specific culture of the client, and being skilled in interventions that are appropriate for the client. Each of these tasks should be considered seriously and with intentionality, especially when examining the intersections of sexual orientation or gender identity with the client's other culture identities.

In regard to family counseling with LGBTQ clients, interventions intended to increase the family's adaptability and cohesion can help improve the family's overall functioning, including closer connections with the LGBTQ individual(s) within the family (Reeves et al., 2010). However, the family's environmental context, including experiences of discrimination, systemic oppression, and the political/social climate, must be acknowledged when working with LGBTQ families and couples because these factors will impact the clients and their relationships (Adams, Jaques, & May, 2004). It might be helpful for counselors to apply tenets of critical race theory (CRT; Delgado & Stefencic, 2001) to provide a framework for counselors to acknowledge societal practices that oppress LGBTQ individuals and to understand their inter-

secting identities and related oppression (Cerezo & Bergfeld, 2013). For instance, the CRT tenet of permanence and intersectionality can be applied to LGBTQ clients, as well as the tenet that emphasizes that discrimination and oppression still exist despite progress such as the legalization of same-sex marriage. These tenets can help shape the counselor's understanding and awareness of contextual factors that are impacting the LGBTQ family, and they invite the client to acknowledge these factors as well. When used with LGBTQ clients, the tenet of counter-storytelling could be powerful, because this process invites clients to describe their reality which may conflict with the dominant culture's discourse related to the oppressed population. To illustrate, consider two men who are a same-sex couple who served as foster parents to two children and are now in the process of adopting them. The men experienced discrimination in becoming parents due to their sexual orientation as well as being both men, despite the fact that they are legally married. They persisted through the challenges and are pursing adoption of the children whom they love. The couple provides a loving, caring home for the children who are thriving in their care. The couple's story of being parents to two children who needed a family contradicts the dominant discourse of same-sex parents causing harm to children or not representing the ideal family structure.

Further, counselors should be aware of specific resources in their area for LGBTQ clients who wish to partner, become parents, or need support in the process of caring for a loved one. Such resources should include legal referrals as needed to support LGBTQ clients in advocating for their rights and overcoming oppression related to family issues and concerns.

References

Adams, J. L., Jaques, J. D., & May, K. M. (2004). Counseling gay and lesbian families: Theoretical considerations. *The Family Journal*, *12*, 40–42. doi:10.1177/1066480703258693

American Civil Liberties Union. (2015). *Overview of lesbian and gay parenting, adoption and foster care.* Retrieved from https://www. aclu.org/fact-sheet/overview-lesbian-and-gay-parenting-adoption-and-foster-care

Berk, L. E. (2007). *Development through the lifespan* (4th ed.)*.* Boston, MA: Pearson.

Calton, J. M., Cattaneo, L. B., & Gebhard, K. T. (2016). Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. *Trauma, Violence, & Abuse, 17*, 585–600. doi:10.1177/1524838015585318

Cerezo, A., & Bergfeld, J. (2013). Meaningful LGBTQ inclusion in schools: The importance of diversity representation and counterspaces. *Journal of LGBT Issues in Counseling, 7*, 355–371. doi:10.1080/15538605.2013.839341

Coon, D. W. (2007). Exploring interventions for LGBT caregivers. *Journal of Gay & Lesbian Social Services, 18*, 109–128. doi:10.1300/J041v18n03_07

Daugherty, J., & Copen C. (2016). *Trends in attitudes about marriage, childbearing, and sexual behavior: United States, 2002, 2006–2010, and 2011–2013* (National Health Statistics Report No. 92). Hyattsville, MD: National Center for Health Statistics.

Delgado, R., & Stefancic, J. (2001). *Critical race theory: An introduction.* New York, NY: University Press.

Erikson, E. (1968). *Identity: Youth and crisis.* New York, NY: W. W. Norton.

Farr, R. H. (2016). Does parental sexual orientation matter? A longitudinal follow-up of adoptive families with school-age children. *Developmental Psychology, 53*, 252–264. doi:10.1037/dev0000228

Fox, S., & Brenner, J. (2012). *Family caregivers online*. Retrieved from http://www.pewinternet.org/files/old-media//Files/Reports/2012/PIP_Family_Caregivers_Online.pdf

Gay & Lesbian Advocates & Defenders. (2014). *Civil marriage v. civil unions: What's the difference?* Retrieved from https://silc.ku.edu/sites/silc.drupal.ku.edu/files/docs/LBGT/PDF%20Documents/cu_vs_marriage.pdf

GLAAD. (2016). *In focus: LGBT parenting.* Retrieved from http://www.glaad.org/reference/lgbt-parenting

Goldberg, N. G., & Meyer, I. H. (2013). Sexual orientation disparities in history of intimate partner violence: Results from the California health interview survey. *Journal of Interpersonal Violence, 28*, 1109–1118. doi:10.1177/0886260512459384

Houston, E., & McKirnan, D. J. (2007). Intimate partner abuse among gay and bisexual men: Risk correlates and health outcomes. *Journal of Urban Health, 84*, 681–690. doi:10.1007/s11524-007-9188-0

Human Rights Campaign. (2016a). *Domestic partner benefit eligibility: Defining domestic partners and dependents.* Retrieved from http://www.hrc.org/resources/domestic-partner-benefit-eligibility-defining-domestic-partners-and-depende

Human Rights Campaign. (2016b). *Professional organizations on LGBTQ parenting.* Retrieved from http://www.hrc.org/resources/professional-organizations-on-lgbt-parenting

Karasu, S. R. (2007). The institution of marriage: Terminable or interminable? *American Journal of Psychotherapy*, *61*, 1–16.

Kelly, B. C., Izienicki, H., Bimbi, D. S., & Parsons, J. T. (2011). The intersection of mutual partner violence and substance use among urban gays, lesbians, and bisexuals. *Deviant Behavior, 32*, 379–404. doi:10.1080/01639621003800158

Kraybill-Greggo, J. W., Kraybill-Greggo, M. J., & Collins, T. (2005). The crisis of death. In B. G. Collins & T. M. Collins (Eds.), *Crisis and trauma: Developmental-ecological intervention* (pp. 319–361). Boston, MA: Houghton Mifflin Company.

Langenderfer-Magruder, L., Whitfield, D. L., Walls, N. E., Kattari, S. K., & Ramos, D. (2014). Experiences of intimate partner violence and subsequent police reporting among lesbian, gay, bisexual, transgender, and queer adults in Colorado: Comparing rates of cisgender and transgender victimization. *Journal of Interpersonal Violence, 31,* 855–871. doi:10.1177/0886260514556767

Leddy, A., Gartrell, N., & Bos, H. (2012). Growing up in a lesbian family: The life experiences of the adult daughters and sons of lesbian mothers. *Journal of GLBT Family Studies, 8*, 243–257. doi:10.1080/1550428X.2012.677233

Manning, W. D., Fettro, M. N., & Lamidi, E. (2014). Child well-being in same-sex parent families: Review of research prepared for American Sociological Association Amicus Brief. *Population Research and Policy Review, 33,* 485–502. doi:10.1007/s11113-014-9329-6

Mason, T. B., Lewis, R. J., Gargurevich, M., & Kelley, M. L. (2016). Minority stress and intimate partner violence perpetration among lesbians: Negative affect, hazardous drinking, and intrusiveness as mediators. *Psychology of Sexual Orientation and Gender Diversity, 3*, 236–246. doi:10.1037/sgd0000165

Mathews, T. J., & Hamilton, B. E. (2016). *Mean age of mothers is on the rise: United States, 2000–2014* (NCHS Data Brief No. 232). Hyattsville, MD: National Center for Health Statistics.

Moore, M. R., & Stambolis-Ruhstorfer, M. (2013). LGBT sexuality and families at the start of the twenty-first century. *Annual Review of Sociology, 39*, 491–507. doi:10.1146/annurev-soc-071312-145643

National Center for Lesbian Rights. (2016). *Legal recognition of LGBT families.* Retrieved from http://www.nclrights.org/wp-content/uploads/2013/07/Legal_Recognition_of_LGBT_Families.pdf

National Coalition of Anti-Violence Programs. (2012). *Lesbian, gay, bisexual, transgender, queer and HIV-affected intimate partner violence 2011.* New York, NY: New York City Gay & Lesbian Anti-Violence Project, Inc.

Obergefell et al. v. Hodges et al., 575 U.S. 14-556 (2015).

Oswald, R. F. (2002). Resilience within the family networks of lesbians and gay men: Intentionality and redefinition. *Journal of Marriage & Family*, 64, 374–383.

Paige, R. U. (2007). Proceedings of the American Psychological Association for the legislative year 2006: Minutes of the Annual Meeting of the Council of Representatives, February 17-19, 2006, Washington, DC; and August 17 and 21, 2006, New Orleans, LA; and minutes of the February, June, August, and December 2006 meetings of the Board of Directors. *American Psychologist, 62,* 400–490. doi:10.1037/0003-066X.62.5.400

Patterson, C. J. (2005). Lesbian and gay parents and their children: Summary of research findings. In *Lesbian & Gay Parenting* (pp. 5–22). Washington, DC: American Psychological Association.

Popenoe, D. (2007). What is happening to the family in developed nations? In A. S. Loveless & T. B. Holman (Eds.), *The family in the new millennium: World voices supporting the 'natural' clan, Vol 1: The place of family in human society* (pp. 186–190). Westport, CT: Praeger Publishers.

Reeves, T., Horne, S. G., Rostosky, S. S., Riggle, E. B., Baggett, L. R., & Aycock, R. A. (2010). Family members' support for GLBT issues: The role of family adaptability and cohesion. *Journal of GLBT Family Studies*, 6, 80–97. doi:10.1080/15504280903472857

Santrock, J. W. (2009). *Life-span development* (12th ed.). New York, NY: McGraw-Hill.

Telingator, C. J., & Patterson, C. (2008). Children and adolescents of lesbian and gay parents. *Journal of The American Academy of Child & Adolescent Psychiatry, 47,* 1364–1368. doi:10.1097/CHI.0b013e31818960bc

U.S. Census Bureau. (2014). *American Community Survey 1-year data file.* Retrieved from https://www.census.gov/hhes/samesex/files/ssex-tables-2014.xlsx

U.S. Census Bureau. (2016a). *Decennial censuses, 1890 to 1940, and current population survey, annual social and economic supplements, 1947 to 2016.* Retrieved from https://www.census.gov/hhes/families/files/graphics/MS-2.pdf

U.S. Census Bureau (2016b). *Measuring same-sex couples, sexual orientation, and gender identity on census bureau and federal surveys* (Webinar for the National LGBTQ Task Force). Retrieved from https://www.census.gov/hhes/samesex/files/FinalPresentation.pdf

Walters, M. L., Chen J., & Breiding, M. J. (2013). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 findings on victimization by sexual orientation.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

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Bias and Discrimination

Christian Chan

Discrimination has surfaced as an extremely salient issue within the counseling profession in response to the rising number of current events detailed by violence, oppression, and barriers impacting the LGBTQ community. As discrimination has become a significantly widespread issue across many systemic levels outside the counseling progression (e.g., government, legislation, policy), important facets of discrimination extend to an intimate understanding of its effects on marginalized and oppressed communities while noting its longstanding impact historically on marginalized and oppressed individuals and communities. Observing the numerous issues attached to discrimination, an increased need exists for identifying key problems and solutions that occur across multiple systemic levels. Most visibly for victims of discrimination, the issues remain multifaceted, which requires attention to microlevel interactions harmful to the well-being of individual members of the LGBTQ community in addition to macrolevel structures (e.g., policies) perpetuating barriers for the LGBTQ community.

The major struggle with bias appears explicitly at the microlevel. While issues of bias targeting the LGBTQ community persist largely in everyday interactions, bias is also recursively apparent on both explicit and subtle levels within the counseling profession. It is one of many reasons the counseling profession has paradigmatically shifted to a deeper focus on multiculturalism and social justice as integral values of counselor professional identity (Ratts, 2011; Ratts & Pedersen, 2014; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Guidelines for implementation have also risen in visibility with the advent of multiple revisions and emergence of guiding documents, beginning with the American Counseling Association *Code of Ethics* (2014), and including the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals (Harper et al., 2012) and the ALGBTIC Competencies for Counseling Transgender Clients (2009). These guiding documents reflect the spectrum of diversity and identify the intersections associated with unique lived experiences that represent the LGBTQ community.

Bias is significantly predicated on lack of knowledge, training, and implicit bias associated with values and prejudice. Although an individual can perpetuate bias based on deficits in knowledge and awareness (Sue & Sue, 2016), the deleterious effects remain substantial, especially in the counseling profession's effort to advocate for wellness, growth, and development for marginalized communities. Bias also serves to exact prejudicial belief systems damaging to historically marginalized communities and stratification based on power differentials (Dworkin & Yi, 2003). Both issues are problematic, particularly within the context of counseling since biased perspectives often lead to misunderstanding clients and consumers, inappropriate interventions, and an overall decrease in the effectiveness of services (Pope, 2012). Preparation, training, and best practices for working with the LGBTQ community continue to subsist as a staunch developing effort with widespread attention (Heck, Flentje, & Cochran, 2013; Nadal, Escobar, David, Prado, & Haynes, 2012; Smith, Shin, & Officer, 2012; Troutman & Packer-Williams, 2014) as a means to mitigate bias against the LGBTQ community within counseling practices.

Developmental Lens

There are numerous issues underscoring the experience of the LGBTQ community during the midlife stage of the human life span. Although emerging and young adults often experience discrimination developmentally, it can also culminate in numerous experiences of oppression and discrimination during midlife (Greene, Britton, & Shepherd, 2016). It is these life tasks that distinguish the possibilities, opportunities, challenges, and salience of midlife LGBTQ individuals. Considerably, members of the LGBTQ community in midlife are exposed to even more contexts that affect satisfaction, wellness, outness, and congruency to identity, especially LGBTQ identity. Primarily, individuals in the LGBTQ community experience these contexts potentially with discrimination that alters their safety. Identity salience and consolidation as part of self-construals (i.e., self-definitions) are features of the midlife in that individuals often build on the clarity, confidence, and meaning associated with their expression and identification with beliefs, worldviews, and cultural aspects.

Other issues include the prominence of the workplace, career, and higher education, specifically as individuals organize their vocational identities and trajectories. Considerations also exist for access to health care as declining health (e.g., physical, mental, emotional) is more apparent in later stages of the life span. The other developmental aspects of midlife are the renegotiation of family; understanding reconfigurations of family, friends, intimate relationships; and social relationships (Hash & Mankowski, 2017).

Effects of Discrimination

Contextualizing LGBTQ discrimination in the community throughout the midlife stage of the adult life span negotiates specific issues relevant to the stage while attending to discriminatory events and effects impacting the community. It is clear that the LGBTQ community continues to suffer immensely at alarming rates of discrimination that commonly result in lower outcomes of mental health and wellness (Dworkin & Yi, 2003; Meyer, 2013, 2014, 2016; Szymanski, Kashubeck-West, & Meyer,

2008) in addition to increased rates of suicidality and trauma (Alessi, Martin, Gyamerah, & Meyer, 2013). More alarming indices also garner attention for advocacy, mental health, and wellness outcomes for the transgender community (Frost, Lehavot, & Meyer, 2015), given the complexity of visibility and invisibility of transgender individuals in the overarching LGBTQ community. The alarming concern for the transgender community has also increased as a result of historical changes in advocacy, especially with respect to differentiating gender identity in comparison to sexual and affectional identity.

The midlife stage of the adult life span surfaces with many concerns, ranging from marriage and intimate relationships to career transitions. While midlife is arguably the cornerstone of identity consolidation, it is also the representation of instability and crisis. Discrimination and bias both have a multidirectional relationship within midlife, which often exacerbate the recurring instability affecting decisions in midlife. Discrimination and bias change perceptions of family, intimate relationships, health, coming out, and spirituality frequently as a result of the nature of affirming environments, barriers, and access to resources.

Examples of Discrimination and Bias

Many forms of discrimination within the LGBTQ community expand across the domains of family, marriage, intimate relationships, career, and spirituality.

Micro. At the microlevel, members of the LGBTQ community face numerous possibilities of discriminatory actions. Examples include microaggressions, which invalidate the experiences of the community. For example, someone could easily refer to a transgender individual with the wrong pronouns or misidentify an individual's sexual or affectional identity. Microaggressions also include everyday slights that create blatant assumptions, such as assuming any person identifying as gay must like musicals or fashion. Other more explicit issues of discrimination in personal experiences also manifest in derogatory name-calling and terminology that have historically painful associations. Other examples are much subtler, such as overlooking an individual for a job interview, job promotion, or housing. These forms of discrimination on a covert level continue to persist across midlife, given the variability of contexts in contact with this developmental stage and the LGBTQ community.

Meso. Mesosystemic forms of discrimination are often targeted at relations between systems. For example, groups and communities can deny each other rights to thrive in a given context. Within the LGBTQ community in midlife, courts of law could strike down a decision to allow a couple to legally adopt children or create extensive difficulty for legally validating a marriage license. Other examples involve interactions between groups, where a venue (e.g., hotel, restaurant) might not allow a LGBTQ group to host a career networking event for members of their community.

Macro. Macrosystemic forms of discrimination are generally woven into the fabric of social structures, impacting development, growth, and wellness in the midlife stage. A blatant example is that only approximately 19 jurisdictions within the United States of America currently have nondiscrimination laws for protection in the workplace. The language often used

in jurisdictions defines the protections of nondiscrimination under sexual orientation. In a large majority of the United States, many states do not have nondiscrimination laws that include sexual identity and gender identity, which allow for many workplaces and organizations to fire their employees. While macrosystemic issues also relate to policy, they are also representative in the culture of organizations. For example, larger systems of culture, such as neighborhood communities and workplaces, may reduce the visibility and safety of LGBTQ individuals. Examples include the resources for finding affirmative-practicing health professionals (e.g., medical doctors, counselors) that are well-versed in understanding implications of gender identity, sexual identity, and affectional identity. This issue is also related to health insurance companies that would fail to cover necessary funding for practices within the scope needed for LGBTQ persons.

Strengths and Challenges

Strengths

Multiple strengths emerge as a result of moving into the stage of midlife. People within this stage negotiate resources within their communities and social relationships. Despite the issues of discrimination pervasive for the LGBTQ community across the life span, it is notable that resilience, acceptance, and life satisfaction can become a reality (Degges-White & Myers, 2006; Greene & Britton, 2015; Hash & Rogers, 2013; Jarnagin & Woodside, 2012). Across the life span, acceptance from communities can act as a buffer to discriminatory events and effects. Constructing and gaining access to communities of support collectively builds resilience, not only within the LGBTQ community but also connections and relationships from affirming and accepting heterosexual networks outside of the community. It is the access to these communities currently in the midlife stage and the scaffolding of communities across the life span that organize strengths to act collectively against discrimination and protect safety, wellness, and expression for marginalized LGBTQ individuals.

Additionally, members of the LGBTQ community continue to grow and build on knowledge of resources in the community and at-large that increase over the life span. While these resources may not be readily available for young adults, persons in midlife sometimes have access to additional resources and to organizations (e.g., Lambda Legal, American Civil Liberties Union, Human Rights Campaign) through their experiences. Consequently, they might be more cognizant of methods in which society and systemic issues affect their lives negatively through having already experienced multiple discriminations (Moane, 2008).

Challenges

Discrimination and oppression result in significant challenges and barriers associated with midlife and the LGBTQ community. For example, the community could experience discrimination in the workplace, career development, higher education, and families. It is this juncture of the life span that carries immense meaning, as individuals located in the midlife are frequently at transitions and are subject to pressure from career and work identity congruence. A concept that significant-

ly captures this idea is the meaning of "the dream" by Levinson, Darrow, Klein, Levinson, and McKee (1979), which describes the congruence and meaning of personal identity with goals and other developmental tasks (e.g., marriage, intimate relationships, parenting, work and career).

In midlife, individuals uniquely negotiate resources from community and family, as cultural expectations from families and society influence pressures and ideas about developmental tasks (Havigshurst, 1972). The issue most critical to Havigshurst's contributions and most relevant to discrimination and bias for the LGBTQ community in midlife is the persistent influence of societal and cultural expectations regarding developmental life tasks. In this context, discrimination can play a major role in barriers to establishing many of the developmental tasks described by Havigshurst (1972), such as health adjustments and priorities, economic standard of living, family restructuring between parents and parenting children, and engagement with community.

For the LGBTQ community, applying many of Havigshurst's (1972) developmental tasks is ultimately determined by heteronormative viewpoints. Many of society's current aspects regarding these developmental tasks lead to many resources within the community, dissemination of helpful information, and access to care that are significantly representative of heterosexual and cisgender norms. As a result, this pervasive issue exacerbates difficulties in response to health adjustments and access to appropriate care affirming for LGBTQ individuals. Another significant barrier coincides with the economic standard of living, as heterosexist and genderist environments do not extend safety to the LGBTQ community within the workplace. Similarly, access to economic opportunities, where LGBTQ individuals are well-represented, is much more challenging to find. Engagement with the community at-large in civic and social spaces becomes much more complex since violence and discrimination against the LGBTQ community reduces welcoming and affirming environments for members of the community.

Placing the context of "the dream" (Levinson et al., 1979) in understanding discrimination and bias for LGBTQ persons remains important due to discriminatory effects on personal identity salience and congruence. Because the midlife time period can be an intense transition point in the life span, heteronormative, homophobic, and heterosexist pressures from society can elicit fear by threatening safety and survival. There are two major effects through how discrimination and bias specifically affect personal identity. One issue is consequential on personal identity as a result of discrimination events that serve as barriers for individuals within the LGBTQ community to live authentically and openly with their identities in multiple contexts (e.g., workplace, home, community, family). The other issue based on discrimination and bias is representation. Histories of policies, knowledge, and environments (e.g., workplace) frequently take heteronormative accounts as the norm. Consequently, members of the LGBTQ community are omitted from representations in protections and policies. Additionally, the number of LGBTQ persons within a community or context can be minimal, which affects the idea of safety and social connection. Barriers to realization of "the dream" can add to dissatisfaction (Levinson, 1996; Levinson et al., 1979;

Minter & Samuels, 1998). Since midlife generates pressure from subsisting economically, members of the LGBTQ community are required to consider their own fears of self-disclosure in the workplace and safety among family and community. They are likely to renegotiate relationships and satisfaction with social and intimate relationships. Discrimination, for instance, alters these possibilities by influencing laws which attack the rights necessary for marriage and legality in intimate relationships. Within social relationships, salient issues include building friendships. The problem for LGBTQ individuals resides in the possibilities of alienation and loneliness (Greene et al., 2016), especially if a community is not affirming of a LGBTQ person's identities.

The other issue resulting from discriminatory events on the LGBTQ community is the continued increase of victimization and internalized stigma over time (Bennett & Douglass, 2013; Greene et al., 2016). If a member of the community experiences multiple discriminations over time, this issue can remain detrimental as a barrier to growth, development, wellness, and health. Internalized transphobia and homophobia over time can negatively alter self-identity and, subsequently, change perspectives on love, intimate relationships (Bennett & Douglass, 2013). Additionally, barriers instituted for legal rights may not offer individuals the rights to legally adopt children or participate in meaningful child-rearing experiences (Bennett & Douglass, 2013).

Intersectionality

Scholarship and research on intersectionality has exponentially amassed as a multidisciplinary force redefining the methods through which disciplines critically examine social identity, cultural identity, and social justice (Bowleg, 2012, 2013; Carasthatis, 2016; Carbado, Crenshaw, Tomlinson, & Mays, 2013; Cho, 2013; Cole, 2008, 2009; Collins & Bilge, 2016; Corlett & Mavin, 2014; May, 2014; McCall, 2005). The underlying principles of intersectionality theory form a significant connection in application as a tool of critical analysis that seeks to excavate problematic issues of social structures often hidden in the margins between multiple intersecting marginalized identities. Given this innate emphasis on social justice, the constructs of intersectionality hold to the contextual, political, temporal, and historical factors impacting marginalized communities.

Arguably, the promise of intersectionality as a viable tool for counteracting systemic forces of discrimination asserts its utility in the counseling profession uniquely with its claims as a developmental force. Considering the applicability of intersectionality, the framework employs an overarching understanding of utilizing personal experiences among the confluence of multiple identities, especially multiple marginalization, to mirror the matrix of power relations giving root to discriminatory practices, events, and incidents. Its multidimensional nature operates under the functions of a social justice agenda that creates opportunities, solutions, and critiques on the basis of microlevel experiences to enact social change with social structures.

Defining intersectionality also presents an anti-essentialist framework by expanding identity categories through demonstrating heterogeneity within identities. The expansion of social and cultural identity unifies multiple identity categories, including

but not limited to race, ethnicity, gender identity, sexual identity, affectional identity, spirituality, age, ability status, social class, and regional identity. Intersectionality considers these aspects of identity both as multiple identities as well as a method to explore particular intersections overlooked in research and practice (e.g., LGBTQ older adults, LGBTQ people of color). The intention of intersectionality is to improve efforts associated with personal experiences of injustice and discrimination through changing systemic policies and systemic marginalization.

Counseling Considerations

Discrimination and bias continue to be pervasive issues for the LGBTQ community through the midlife stage of the life span. To consider the relationship between counseling and discrimination, counselors must consider their own worldviews and value systems, particularly if those value systems might remain harmful to the LGBTQ community. Because changes often occur to bolster best practices, it is incumbent upon counselors to update their knowledge with updated research and training. It should be an iterative process that requires counselors to continually reconsider enhancing their practices. Avenues to address counselor development within the context of the LGBTQ community refer to continued supervision, consultation, training, and research associated with a professional and ethical responsibility outlined for counselors. Participating heavily in these efforts also enhances development for affirmative practices while reducing biases and assumptions. This participation also generally utilizes opportunities for gaining knowledge on a newer language in referring to members within the LGBTQ community.

Given the midlife stage, it would be significant to learn about resources, such as support groups, community groups, and community centers, focused on LGBTQ issues (e.g., Human Rights Campaign; It Gets Better Project; Intersex Initiative; The DC Center for the LGBT Community; Los Angeles Gay and Lesbian Center; San Francisco LGBT Community Center; Pride Center; Center on Halsted). Similarly, there is a plethora of community groups and community centers focused on the LGBTQ community and its intersections with other identities (e.g., Shades of Yellow; National Queer Asian Pacific Islander Alliance; The Visibility Project; The Audre Lorde Project; Services and Advocacy for LGBT Elders; Griot Circle). It would be helpful to also consider other professionals (e.g., lawyers) vital to support for advocacy and consultation in order to take action against discriminatory violations. Larger organizations, such as the American Civil Liberties Union and Lambda Legal, exist as forms of legal assistance for LGBTQ communities.

Counselors can attend to building upon culturally responsive interventions by considering heteronormativity, heterosexism, and genderism in contexts. Many policies and cultures stem from individuals and communities that were not representative of the LGBTQ community. Additionally, many systems only consider the normative experiences of heterosexuality and cisgender individuals, where policies and cultures often derive these assumptions. They also develop problematic norms that exclude the voices and representation of LGBTQ individuals.

To mitigate the effects of bias and discrimination, counselors can utilize critical consciousness by alerting clients served about the contexts affecting their health and wellness. Clients and communities served within the LGBTQ community may not necessarily fully understand the influence of discrimination in their own wellness, which would warrant a transparent conversation between counselors and clients about discriminatory issues. This discussion would also help clients consider the contextual issues barring them from access to necessary resources. Counselors can work with clients to dialogue about problems associated with the contexts surrounding the clients, such as policies prohibiting access to care or subtle acts of discrimination.

To further consider discrimination with respect to LGBTQ midlife adults in relationship to counseling practice, it is necessary to consider which areas and contexts influence the development of members of the LGBTQ community. For example, the midlife stage can include contact with the workforce, workplace issues, family and intimate relationship decisions, and education. As counselors expand critical thinking to attend to the variation of issues within the midlife stage, they must consider multiple forms of discrimination appearing in these contexts on both an explicit and subtle level. Some forms of discrimination are much subtler, yet substantially contribute to barriers and silence subverting rights for members of the community. Explicit forms of discrimination can include slang and verbal insults associated with homophobia, heterosexism, and genderism. Perpetrators of discrimination can be explicit in their derogatory and offensive language toward members of the LGBTQ community. Other forms of discrimination can include failure to recognize a marriage certificate, firing someone from the workplace, or refusing to serve clients in a restaurant, hotel, hospital, or office.

As outlined by the ACA *Code of Ethics* (2014), counselors can also take an active stance in reducing discrimination and bias on a larger systemic level by producing training in communities and participating in sociopolitical advocacy and change. Counselors can search for opportunities to learn about governmental policies affecting the LGBTQ community, especially with issues salient in the midlife. Contacting or visiting with legislators provides them with informative viewpoints to contextualize the experiences of the LGBTQ community. In addition, counselors with substantial knowledge can formulate trainings within the community to educate other counselors about salient issues in the midlife of discrimination for the LGBTQ community. Counselors who also practice as supervisors have access to a different role to provide training for supervisees about discrimination for the LGBTQ community.

References

Alessi, E. J., Martin, J. I., Gyamerah, A., & Meyer, I. H. (2013). Prejudice-related events and traumatic stress among heterosexuals and lesbians, gay men and bisexuals. *Journal of Aggression, Maltreatment & Trauma, 22,* 510–526.

American Counseling Association (2014*). ACA code of ethics.* Alexandria, VA: Author.

Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2009). *Competencies for counseling with transgender clients.* Alexandria, VA: Author.

Bennett, J. L., & Douglass, K. E. (2013). Growing pains: An Eriksonian view of the arc of presenting concerns in an LGBT community mental health center. *Clinical Social Work Journal, 41,* 277–287. doi:10.1007/s10615-013-0442-5

Bowleg, L. (2012). The problem with the phrase *women and minorities:* Intersectionality—an important theoretical framework for public health. *American Journal of Public Health*, *102,* 1267–1273. doi:10.2105/AJPH.2012.300750

Bowleg, L. (2013). "Once you've blended the cake, you can't take the parts back to the main ingredients": Black gay and bisexual men's descriptions and experiences of intersectionality. *Sex Roles, 68*, 754–767. doi:10.1007/s11199-012-0152-4

Carastathis, A. (2016). *Intersectionality: Origins, contestations, horizons*. Lincoln, NE: University of Nebraska Press.

Carbado, D. W., Crenshaw, K. W., Mays, V. M., & Tomlinson, B. (2013). Intersectionality. *Du Bois Review, 10,* 303–312. doi:10.1017/S1742058X13000349

Cho, S. (2013). Post-intersectionality: The curious reception of intersectionality in legal scholarship. *Du Bois Review, 10,* 385–404. doi:10.1017/S1742058X13000362

Cole, E. R. (2008). Coalitions as a model for intersectionality: From practice to theory. *Sex Roles, 59,* 443–453. doi:10.1007/s11199-008-9419-1

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, *64,* 170–180. doi:10.1037/a0014564

Collins, P. H., & Bilge, S. (2016). *Intersectionality*. Malden, MA: Polity Press.

Corlett, S., & Mavin, S. (2014). Intersectionality, identity and identity work. *Gender in Management, 29,* 258–276. doi:10.1108/GM-12-2013-0138

Degges-White, S., & Myers, J. E. (2006). Transitions, subjective age, wellness, and life satisfaction. *Journal of LGBT Issues in Counseling, 1,* 21–43. doi:10.1300/J462v01n02_03

Dworkin, S. H., & Yi, H. (2003). LGBT identity, violence, and social justice: The psychological is political. *International Journal for the Advancement of Counselling, 25*, 269–279. doi:10.1023/B:ADCO.0000005526.87218.9f

Frost, D. M., Lehavot, K., & Meyer, I. H. (2015). Minority stress and physical health among sexual minority individuals. *Journal of Behavioral Medicine, 38,* 1–8. doi:10.1007/s10865-013-9523-8

Greene, D. C., & Britton, P. J. (2015). Predicting adult LGBTQ happiness: Impact of childhood affirmation, self-compassion, and personal mastery. *Journal of LGBT Issues in Counseling, 9,* 158–179, doi:10.1080/15538605.2015.1068143

Greene, D. C., Britton, P. J., & Shepherd, J. B. (2016). LGBTQ aging: Mental health at midlife and older adulthood. *Journal of LGBT Issues in Counseling, 10,* 180–196. doi:10.1080/15538605.2016.1233839

Harper, A., Finnerty, P., Martinez, M., Brace, A., Crethar, H., Loos, B. . . . Lambert, S. (2012). *Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) Competencies for counseling with lesbian, gay, bisexual, queer, questioning, intersex and ally individuals*. Retrieved from http://www.counseling.org/docs/ethics/algbtic-2012-07

Hash, K. M., & Mankowski, M. (2017). Caregiving in the LGBT community. *Annual Review of Gerontology & Geriatrics, 37*, 77–87. doi:10.1891/0198-8794.37.77

Hash, K. M., & Rogers, A. (2013). Clinical practice with older LGBT clients: Overcoming lifelong stigma through strength and resilience. *Clinical Social Work Journal, 41*, 249–257. doi:10.1007/s10615-013-0437-2

Havigshurst, R. J. (1972). *Developmental tasks and education*. New York, NY: David McKay Company.

Heck, N. C., Flentje, A., & Cochran, B. N. (2013). Intake interviewing with lesbian, gay, bisexual, and transgender clients: Starting from a place of affirmation. *Journal of Contemporary Psychotherapy, 43,* 23–32. doi:10.1007/s10879-012-9220-x

Jarnagin, W. L., & Woodside, M. (2012). Life lived well: A description of wellness across the lifespan of a senior woman. *The Qualitative Report, 17,* 1–22.

Levinson, D. J. (1996). *The seasons of a woman's life*. New York, NY: Alfred A. Knopf.

Levinson, D. J., Darrow, C. N., Klein, E. B., Levinson, M. H., & McKee, B. (1979). *The seasons of a man's life*. New York, NY: Alfred A. Knopf.

May, V. M. (2014). "Speaking into the void"? intersectionality critiques and epistemic backlash. *Hypatia, 29,* 94–112. doi:10.1111/hypa.12060

McCall, L. (2005). The complexity of intersectionality. *Signs, 30,* 1771–1800. doi:10.1086/426800

Meyer, I. H. (2013). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychology of Sexual Orientation and Gender Diversity, 1*, 3–26. doi:10.1037/2329-0382.1.S.3

Meyer, I. H. (2014). Minority stress and positive psychology: Convergences and divergences to understanding LGBT health. *Psychology of Sexual Orientation and Gender Diversity, 1,* 348–349. doi:10.1037/sgd0000070

Meyer, I. H. (2016). The elusive promise of LGBT equality. *American Journal of Public Health, 106,* 1356–1358. doi:10.2105/AJPH.2016.303221

Minter, L. E., & Samuels, C. A. (1998). The impact of 'the dream' on women's experience of the midlife transition. *Journal of Adult Development, 5,* 31–43. doi:10.1023/A:1023017029910

Moane, G. (2008). Building strength through challenging homophobia: Liberation workshops with younger and midlife Irish lesbians. *Journal of Gay & Lesbian Social Services, 20,* 129–145. doi:10.1080/10538720802179096

Nadal, K. L., Escobar, K. M. V., David, E. J. R., Prado, G. T., & Haynes, K. (2012). Racial microaggressions and the Filipino American experience: Recommendations for counseling and development. *Journal of Multicultural Counseling and Development, 40,* 156–173. doi:10.1002/j.2161-1912.2012.00015.x

Pope, M. (2012). Embracing and harnessing diversity in the US workforce: What have we learned? *International Journal for Educational and Vocational Guidance, 12,* 17–30. doi:10.1007/s10775-012-9215-x

Ratts, M. J. (2011). Multiculturalism and social justice: Two sides of the same coin. *Journal of Multicultural Counseling and Development, 39,* 24–37.

Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice: Integration, theory, and application* (4th ed.). Alexandria, VA: American Counseling Association.

Smith, L. C., Shin, R. Q., & Officer, L. M. (2012). Moving counseling forward on LGB and transgender issues: Speaking queerly on discourses and microaggressions. *The Counseling Psychologist, 40,* 385–408. doi:10.1177/0011000011403165

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice* (7th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008). Internalized heterosexism: A historical and theoretical overview. *The Counseling Psychologist, 36,* 510–524. doi:10.1177/0011000007309488

Troutman, O., & Packer-Williams, C. (2014). Moving beyond CACREP standards: Training counselors to work competently with LGBT clients. *Journal of Counselor Preparation and Supervision, 6,* 1–19. doi:10.7729/51.1088

Case Studies

Tess: Family and Social Development

Tess is a 38 year-old White, cisgender female seeking counseling for depression, anxiety, and feelings of hopelessness. She identifies as a lesbian and has been "out" since her early twenties, and reports that she has struggled with depression and anxiety since adolescence. Although Tess co-parents two daughters, ages 2 and 6, her partner Carol recently dissolved the relationship, saying she was no longer in love with Tess. Tess reported feeling completely "turned upside down, confused, desperate, and totally devastated." Tess moved out of the family home and now resides in a two-bedroom apartment. They have agreed to share physical custody of the children. Although both Tess and Carol have complied with this agreement, Tess reported that it's a "struggle" and that her ex-partner makes it difficult to agree on consistent terms of their agreement, which, according to Tess, adds to the "despair" she already feels.

Tess and Carol had been in a committed relationship for 13 years. During their first few years as a couple, they planned their future together which included having children. Both children were conceived through artificial insemination from two different anonymous donors. Carol is the biological mother and also gave birth to both children. Tess has legally adopted the oldest child while the adoption of youngest child is still pending.

It was decided before the birth of the children that Tess would work from home so she could care for the children and not depend on outside childcare. Tess was able to carve out a small part-time graphic design business with no benefits; benefits such as health care would be provided by Carol. During this time, Tess started taking college classes with the hope of completing a graduate degree. At the time of the separation, Tess was five classes short of a graduate degree and currently taking a hiatus to get her life "in order."

Tess reported a close relationship with her partner's biological family but has heard very little from them since the relationship ended. Since Tess's parents are deceased and she has no siblings, she had considered ex-partner's family her own for many years. Tess feels completely alone.

Tess and Carol never sought couple's counseling, but Tess has now made an appointment for individual counseling. She reports that she has "been meaning to start" counseling for a long time. She has feelings of betrayal, anger, confusion, and underlying hopelessness. Her "family" as she knew it no longer exists; she felt for 13 years that she had a family of her own again, but now all dynamics are different. Carol's family is in Tess's life because of the children, but how will that manifest in the future? Tess also has questions about the legal adoption of the second child, and where that would leave the child as well as Tess regarding her parenting rights.

Rosa: Discrimination and Bias

Rosa, a 46-year-old Latina and a midlevel executive in the Northeast, recently decided to move closer to friends and family in the Midwest. She is self-identified as a lesbian but never came out to her colleagues at work out of fear of discrimination and bias. Rosa has been very active in a few local and regional LGBTQ advocacy organizations and decided it was important for her to list her involvement on her resume. Rosa has applied for over 45 jobs in the past three months, and for many of these positions, she exceeded minimum qualifications. Although Rosa has made the conscious decision not to come out at work or to many of her family members, she has reached a point in her life where she is "ready to embrace her true self," so it was meaningful for her to list her involvement in such activities.

After three months of no interview offers, Rosa began to question whether she was being discriminated against based on her work with LGBTQ advocacy organizations. At the same time, Rosa wondered if she was being discriminated against based on assumptions about her ethnicity, as her last name, Suarez, might sound "typical." Although she was unable to test her assumptions about ethnicity, she did decide to remove her involvement with LGBTQ advocacy organizations from her resume. Rosa applied to a few more positions and received three calls inviting her for interviews. At those interviews, Rosa sensed that her ethnicity might actually have helped her gain invitations. However, on two separate occasions, Rosa felt judged about her clothing and physical presentation, about not being a "girly-girl" and wearing clothes not considered to be feminine, even though they were professional.

Rosa now has concerns about not being able to be her "true self" and is unsure if she would feel "safe" coming out at a new place of work, despite her interest in doing so. Rosa has begun to think that her personhood will continue to keep her at a certain professional level, and she feels anger and confusion.

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Section 3:
Older LGBTQ Adults

Coming Out and Gay Identity Development

Michael Chaney and Joy Whitman

Coming out is the process of acknowledging one's own sexual and gender identity and/or disclosing that identity to others. Grov, Bimbi, Nanin, and Parsons (2006) described the process of coming out as accepting one's sexual identity, disclosing it to others, and connecting with other LGBTQ individuals. Although the average age at which most LGBTQ individuals realize they are LGBTQ is 17 years, and the average age of first disclosure to others is 20 years (Pew Research Center, 2013), there are many LGBTQ persons who come out in later adulthood.

What is known about coming out trends among LGBTQ older adults is extremely limited. The majority of epidemiological studies focused on coming out have focused on younger LGBTQ individuals. The few studies focused on older LGBTQ adults' coming out experiences reported a common theme that as age increases, there is less likelihood of coming out. For example, a MetLife study of LGBTQ baby boomers (2010) found that among LGBTQ adults 45 to 64 years old, transgender and bisexual individuals were less likely to report being out as compared to lesbians and gay men. Further, only 30% of lesbians, 38% of gay men, 28% of transgender individuals, and 12% of bisexuals reported being open to anyone about their identities. Another study focused on men who have sex with men (MSM) aged 50 to 85 years found that almost 5% of men had never disclosed their sexual orientations to anyone, and the proportion of men who had disclosed significantly decreased as the age of participants increased (Rawls, 2004).

There are several reasons why older LGBTQ adults may decide to disclose their sexual orientations and/or gender identities in later life:

- The benefits of self-disclosure outweigh the stressors associated with concealment, such as anxiety, depression, isolation, and stress.
- A desire to make meaningful social and intimate connections with other LGBTQ individuals, to decrease isolation, and increase social support.
- Fear associated with expected rejections from family and friends has decreased due to greater self-acceptance or change in relationships with family members and friends (e.g., divorce, death, children have moved out of the home).
- Existential issues such as the realization that they are in later stages of life and want to live out their later years in a meaningful, authentic fashion.
- Changes in societal attitudes and institutional policy changes destigmatize the coming out process and LGBTQ identities.

Developmental Lens

It is important to understand the different experiences between older adults (69-79 years) and those who are 80 and older in regard to the gay liberation movement and the integration of a stigma identity (Cronin & King, 2010; Rosenfeld, 2002). Older LGBTQ adults may have internalized the messages the counseling profession and society communicated through decades of discrimination and pre-Stonewall/gay liberation movement events, and coming out with those internalized messages can lead to shame and result in discomfort with coming out to self and others. Both groups witnessed immense changes in the civil rights of LGBTQ people and a declassification of same-sex attractions as mental illness. There has also been a shift in perspectives of transgender identity as a mental illness. The impact on living through these transitions is significant and must be explored with clients.

Other factors counselors must consider are:

- External support systems surrounding the LGBTQ individual, such as family, friends, coworkers, volunteer connections, and spiritual and faith communities. Depending on the affirming nature of these social connections, LGBTQ older adults may or may not choose to come out to others even though they are out to themselves.
- Where LGBTQ adults live also has importance on their coming out and the challenges presented. Geographic areas of the United States that are affirming and contain laws that protect against discrimination for health care, housing, and employment create communities that are safer and more welcoming of LGBTQ people. Coming out in those geographic locations may be easier than in those locations where discrimination and fear prevail.
- Differences between cisgender female and male coming out experiences must be understood. Though not an exhaustive list of differences, consider the following for cisgender women when coming out:
  - Concern about job loss (Jacobs, Rasmussen, & Hohman, 1999).
  - Reliance on family of origin as a major support system (Frost, Meyer, & Schwartz, 2016).
  - Following a heterosexual relationship, raising children, and creating an identity as a wife and mother, finding and participating in lesbian communities may be difficult (Cronin, 2004).
  - Moving to a new community to find support and potential partners given the above concerns can be a challenge, as can initiating intimate contact with other women as a result of gender role socialization.
  - Economic support and financial security when coming out of a heterosexual marriage (Sang, Warshow, & Smith, 1991).

- For cisgender males, consider these factors:
  - Anxiety about sexuality, sexual behavior, and sexual health. These may include fearing the risk of sexually transmitted infections (STIs) and HIV infection through sexual activity.
  - Because substance use, especially alcohol, smoking, methamphetamine, ecstasy, and cocaine, is a cultural norm in gay clubs and at gay events, counselors should assess a client's susceptibility to engaging in such use (Chaney & Brubaker, 2016; Choi & Meyer, 2016).
  - MSM are conditioned to be particularly focused on body image, and older MSM whose aging bodies may be transforming may experience adjustment issues associated with coming out in this type of image-conscious environment (Clark, 2010).

Professional counseling literature that has addressed transgender individuals is limited, and published literature centered on aging issues among transgender individuals is nearly invisible. In many ways, issues affecting the aging transgender communities are similar to concerns faced by older cisgender adults. However, aging among transgender persons is complicated by their transgender identities. Witten and Eyler (2012) reviewed aging-related concerns of older transgender individuals, including:

- concerns around affirming medical procedures;
- transitioning in later life;
- discrimination;
- relationships and social support;
- education and career; and
- end-of-life issues.

Other aging-related concerns described by older transgender individuals include becoming incapable of taking care of oneself, being alone, developing cognitive impairment (i.e., confusion or dementia), and discrimination related to a transgender identity (Witten, 2016).

Another potential concern for aging transgender individuals may be related to coming out. The coming out process for transgender and gender-nonconforming individuals may involve not only disclosing gender identity but also sexual orientation. Disclosure of gender identity and/or sexual orientation for older transgender people can be impacted by several factors. Financial and workplace climate can influence whether transgender individuals come out in the workplace. A recent survey found that almost 50% of older transgender individuals reported moderate to extreme financial strain, and more than 60% reported not being able to meet basic needs due to financial constraints (Witten, 2016). Taking this into consideration, for individuals who are part of the workforce, disclosure of gender identity and/or sexual orientation can lead to workplace discrimination that results in unemployment, which exacerbates financial strain. It is not uncommon for older transgender persons to come out after retirement to avoid workplace discrimination (Siverskog, 2014). Furthermore, transgender individuals may come out in older adulthood because they have had time to contemplate how they want to live their lives.

Strengths and Challenges

Strengths

As a result of living through societal changes, witnessing various injustices, and negotiating their own personal challenges, older LGBTQ adults coming out after age 65 can utilize coping strategies and demonstrate the resilience they have developed through the years. Many older LGBTQ adults have existing coping strategies that have been used to deal with histories of adversity involving discrimination, violence, rejection, and oppression, and affirming counselors should assist older clients to apply previous effective coping skills and individual resilience to stressors associated with the coming out process (Hillman & Hinrichsen, 2014). Muraco and Fredriksen-Goldsen (2016) recommended exploring turning points which "reflect the individuals' own definitions of the significant experiences that define their lives within a shifting socio-historical context" (p. 2). For older adults, this process may facilitate counselors' exploration of resilience.

Challenges

Concealing one's sexual and gender minority status can have a negative impact on the physical and mental health of LGBTQ people (Rawls, 2004). However, there are many reasons LGBTQ individuals decide not to come out to others, and for the older adult, these reasons must be considered. Many LGBTQ older adults rely on families of choice for care and connection (Choi & Meyer, 2016). Those who come out later in life have not created those families of choice with other LGBTQ people, and coming out at this stage of life not only can compromise the friendship circles they have created prior to coming out but can also leave them without a support network of other LGBTQ older adults to help them come out. They may develop those families of choice as they reach out for support, but prior to doing so, they may feel isolated and without the resource of community support (Choi & Meyer, 2016; Zians, 2011).

LGBTQ older adults face the potential loss of support from adult children who can provide social, emotional, and physical assistance through this transition. However, the growing body of literature on this topic indicates that adult children of gay parents are accepting of their parents' sexual identities (Barrett & Tasker, 2001; Tasker, Barrett, & De Simone, 2010). Nevertheless, older adults may decide to conceal their sexual and gender identities because they fear rejection (LGBT Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders, 2010). In a study looking at older LGBTQ adults, Orel (2014) found that the decision of whether to come out to family was based on LGBTQ persons' perceptions of the level of sexism and heterosexism within the familial context.

Older LGBTQ individuals experience ageism in the LGBTQ communities and society as a whole (Blando, 2001; Hash & Rogers, 2013). They often are invisible and discriminated against within LGBTQ organizations and communities (LGBT Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders, 2010) and within the health care system wherein their health needs are

ignored (Brotman, Ryan, & Cormier, 2003; Knochel, Croghan, Moone, & Quam, 2010). This presents a challenge to coming out and receiving the support needed from their community.

Older adults may choose not to come out because they fear they may be discriminated against when accessing health care services, social services, and government assistance (Brotman, et al., 2003; Czaja et al., 2015; Johnson, Jackson, Arnette, & Koffman, 2005; Stein, Beckerman, & Sherman, 2010). This is consistent with a recent report by Neville, Kushner, and Adams (2015), who found that older gay men experience a great deal of apprehension associated with coming out to physicians and social service providers for fear of discrimination. Further, as a result of this fear, some older MSM may conceal not only their sexual identities but also refrain from sharing accurate sexual and medical histories. Older LGBTQ individuals also have concerns about moving to a residential care facility or nursing home for long-term care and may delay coming out because they fear care will be compromised and they will be discriminated against because of their sexual and gender identities (Choi & Meyer, 2016). If they did come out, they may return to concealing their identities because they fear the reactions of other residents and neglect from health care providers (Brotman et al., 2003; Stein et al., 2010).

Health issues can also influence the coming out experiences of aging transgender people. A recent study found that 31.3% of older transgender respondents had a chronic illness, 33.3% had a disability, and 21.1% had a chronic illness and a disability (Witten, 2016). For some individuals, it may be that managing medical conditions is more of a priority than coming out. In addition, because some health care providers may lack knowledge of how to competently treat transgender individuals or may engage in discriminatory practices, these variables can inhibit transgender people from disclosing their identities to providers. This is consistent with a recent study that explored reasons why older transgender clients may not disclose their identities to mental health care providers (Elder, 2016). These factors included:

- Providers lacked knowledge about transgender issues.
- Providers engaged in harmful behaviors (i.e., professional boundary crossing, sexual advances).
- Older transgender clients experienced heterosexist and transphobic events with therapists.
- Mental health professionals refused to treat or write letters for affirming medical procedures for older transgender clients.
- Fear of being mandated into mental health hospitals and fear of being over-medicated.

There are many other challenges facing older LGBTQ adults who come out at this life stage. These can include:

- Fear of discrimination in the workplace, which may forestall coming out or create stress for the LGBTQ older adult who has internalized the stigma of being a sexual and gender minority (Choi & Meyer, 2016).
- Integration of a sexual or gender identity that is ostracized by their religious community.
- Intersectionality of a sexual or gender identity rejected by their culture and ethnic community. Many older LGBTQ individuals of color report racism as an ever-present construct in their lives and perceive it as more detrimental than ageism and heterosexism (Woody, 2014).

- If coming out as bisexual, indivisibility within their community and the LGBTQ community is common.
- Due to physical changes associated with aging, coming out in older adulthood as transgender might mean that gender affirming surgery is no longer an option (Siverskog, 2014).

Intersectionality

The preceding sections have underscored that counselors need to pay attention to how LGBTQ older clients' multiple identities come together to influence the coming out process. Intersectionality has been defined as acknowledging the interconnected identities of individuals based on power and privilege that influence facets of identity (Shields, 2008). Applied to older LGBTQ individuals who are navigating the coming out process, competent counselors must recognize that race, gender, social location, age, spirituality, and sexual orientation converge together to influence the coming out process.

Contemporary research has demonstrated that multiple oppressed identities can influence disclosure of sexual orientation. Aranda et al. (2015) found that among a sample of lesbians (18 to 83 years old), African American lesbians were less likely than White lesbians to come out to non-family members, and Latina lesbians were less likely than White lesbians to come out to family members. Dunlap (2016), who investigated coming out milestones across multiple age-based cohorts, reported that women in the oldest cohort (60 years or older) generally disclosed their sexual orientations to others at significantly later ages and achieved other sexual orientation related milestones (i.e., first awareness of same-sex attractions, first relationships) at significantly later ages compared to lesbians and gay men in younger cohorts; this highlights the potential influence of gender-role expectations and age on coming out. Although counseling literature that specifically addresses intersectionality and coming out among older LGBTQ individuals is limited, based on the aforementioned findings, affirming counselors would serve their older LGBTQ clients well by assessing how one or more aspects of a client's identity effects disclosure of sexual orientation.

Counseling Considerations

For counselors who work with older LGBTQ adults who are navigating the coming out process, a primary goal is to assist clients to develop adequate coping skills to effectively deal with the stressors associated with decisions around disclosure or concealment. In a study of older adult LGBTQ individuals, Fredrickson-Goldsen et al (2001) found that over 80% of their sample engaged in wellness activities and approximately 40% relied on religion and spiritual practices. In addition to facilitating the development of coping strategies, counselors should also encourage older LGBTQ clients to expand social support networks, particularly during the coming out process. Support groups focused on LGBTQ and aging issues may help promote personal empowerment and adaptability. Directing older LGBTQ adults to online resources may not only foster resilience, but it may also provide clients with a sense of autonomy and responsibility. The National Resource

Center on LGBT Aging (www.lgbtagingcenter.org) is a comprehensive resource that not only links individuals to local resources but also provides competency trainings for service providers.

The following recommendations to enhance coping skills for older LGBTQ adults throughout all stages of the coming out process are adapted from the work of Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, and Hooyman (2014), who developed general competencies for health and human service providers who work with older LGBTQ adults.

- Help aging LGBTQ clients understand how culture, religion, media, and the mental health care system impact the coming out process.
- Teach aging LGBTQ clients how historical and social systems over their life span have influenced their coming out experiences.
- Work with aging LGBTQ clients to develop coping strategies that take into consideration the norms and values of the respective LGBTQ sub-communities and explore with clients their level of connection to the LGBTQ community as a collective group. Foster clients' recognition of the coming out process as an individual, ongoing process.
- Engage older LGBTQ clients in critical discourse related to age, gender, and sexual orientation, and help them put meaning to their experiences with ageism, heterosexism, racism, and transphobia in relation to the coming out process. Assist clients in externalizing these forms of oppression through all stages of coming out.

In a report on LGBTQ aging, Choi and Meyers (2106) also recommend the following:

- Help LGBTQ older adults create a family of choice. As noted previously, helping them connect to social networks will reduce isolation and provide them with communities of support to negotiate coming out.
- Connect clients to LGBTQ community centers. There are services specific to older LGBTQ people and their unique needs.
- Help clients explore religious networks if appropriate. This is particularly important for communities of color who value faith traditions.
- Support and guide aging LGBTQ adults as they renegotiate their identities throughout the coming out process.

As counselors consider how to help older adults come out, reflect on what training might be useful and consider the following scenarios when working with older adult clients:

- How do you help an older adult prepare for coming out?
- How might you review with them the challenges and benefits in coming out?
- How can you explore the resilience and coping strategies they already possess to manage their coming out?
- How do you explore with them losses they have experienced in their past and how to use those strengths to face any potential loss they may face in coming out now?
- How can you help clients find resources and communities that will support them when coming out?
- How do you discuss with them sexual and romantic relationships and finding partners?

References

Aranda, F., Matthews, A. K., Hughes, T. L., Muramatsu, N., Wilsnack, S. C., Johnson, T. P., & Riley, B. B. (2015). Coming out in color: Racial/ethnic differences in the relationship between level of sexual identity disclosure and depression among lesbians. *Cultural Diversity and Ethnic Minority Psychology, 21*, 247–257. doi:10.1037/a0037644

Barrett, H., & Tasker, F. (2001). Growing up with a gay parent: Views of 101 gay fathers on their sons' and daughters' experiences. *Educational and Child Psychology*, *18,* 62–77. doi:10.1111/j.1365-2524.2008.00774.x

Blando, J. (2001). Twice hidden: Older gay and lesbian couples, friends, and intimacy. *Generations*, *25,* 87–89.

Brotman, S., Ryan, B., & Cormier, R. (2003). The health and social service needs of gay and lesbian elders and their families in Canada. *The Gerontologist*, *43*, 192–202. doi:10.1093/geront/43.2.192

Chaney, M. P., & Brubaker, M. D. (2016). Substance abuse and LGBTQ people. In A. Goldberg (Ed.), *The SAGE encyclopedia of LGBTQ studies* (pp. 1140–1143). Thousand Oaks, CA: SAGE Publications.

Choi, S. K., & Meyer, I. H. (2016). *LGBT aging: A review of research findings, needs, and policy implications.* Los Angeles, CA: The Williams Institute.

Clark, J. M. (2010). HIV/AIDS, aging, and diminishing abilities: Reconfiguring gay masculinity in literature and theology. *The Journal of Men's Studies, 18,* 137–144.

Cronin, A. (2004). Sexuality in gerontology: a heteronormative presence, a queer absence. In S. O. Daatland and S. Biggs (Eds.), *Ageing and diversity: Multiple pathways and cultural migrations* (pp. 107–122). Bristol: Policy Press, Bristol.

Cronin, A., & King, A. (2014). Only connect? Older lesbian, gay and bisexual (LGB) adults and social capital. *Ageing and Society, 34,* 258–279. doi:10.1017/S0144686X12000955

Czaja, S.J., Sabbag, S., Lee, C.C., Schulz, R., Lang, S., Vlahovic, T., . . . Thurston, C. (2015). Concerns about aging and caregiving among middle-aged and older lesbian and gay adults. *Aging & Mental Health, 20,* 1107–1118. doi:10.1080/13607863.2015.1072795

Dunlap, A. (2016). Changes in coming out milestones across five age cohorts. *Journal of Gay & Lesbian Social Services, 28,* 20–38. doi:10.1080/10538720.2016.1124351

Elder, A. B. (2016). Experiences of older transgender and gender nonconforming adults in psychotherapy: A qualitative study. *Psychology of Sexual Orientation and Gender Diversity, 3,* 180–186. doi:10.1037/sgd0000154

Fredriksen-Goldsen, K. I., Hoy-Ellis, C. P., Goldsen, J., Emlet, C. A., & Hooyman, N. R. (2014). Creating a vision for the future: Key competencies and strategies for culturally competent practice with lesbian, gay, bisexual, and transgender (LGBT) older adults in the health and human services. *Journal of Gerontological Social Work, 57,* 80–107. doi:10.1080/01634372.2014.890690

Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C., . . . Petry, H. (2011). *The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults.* Seattle, WA: Institute for Multigenerational Health.

Frost, D. M., Meyer, I. H., & Schwartz, S. (2016). Social support networks among diverse sexual minority populations. *American Journal of Orthopsychiatry, 86*, 91–102. doi:10.1037/ort0000117

Grov, C., Bimbi, D. S., Nanin, J. E., and Parsons, J. T. (2006). Race, ethnicity, gender, and generational factors associated with the coming out process among gay, lesbian, and bisexual individuals. *Journal of Sex Research, 43,* 115–121.

Hash, K. M., & Rogers, A. (2013). Clinical practice with older LGBT clients: Overcoming lifelong stigma through strength and resilience. *Clinical Social Work Journal*, *41,* 249–257. doi:10.1007/s10615-013-0437-2

Hillman, J., & Hinrichsen, G. A. (2014). Promoting an affirming, competent practice with older lesbian and gay adults. *Professional Psychology: Research and Practice*, *45,* 269–277. doi:10.1037/a0037172

Jacobs, R. J., Rasmussen, L. A., & Hohman, M. M. (1999). The social support needs of older lesbians, gay men, and bisexuals. *Journal of Gay & Lesbian Social Services*, *9,* 1–30. doi:10.1300/J041v09n01_01

Johnson, M., Jackson, N., Arnette, J., & Koffman, S. (2005). Gay and lesbian perceptions of discrimination in retirement care facilities. *Journal of Homosexuality. 49*, 83–102. doi:10.1300/J082v49n02_05

Knochel, K. A., Croghan, C. F., Moone, R. P., & Quam, J. K. (2010). *Ready to serve? The aging network and LGB and T older adults*. Washington, DC: National Association of Area Agencies on Aging.

LGBT Movement Advancement Project & Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders. (2010). *Improving the lives of LGBT older adults*. Retrieved from http://www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf

MetLife. (2010). *Still out, still aging: The MetLife study of lesbian, gay, bisexual, and transgender baby boomers.* Westport, CT: MetLife Mature Market Institute.

Meyer, I., & Northridge, M. (2007). *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations*. New York, NY: Springer.

Muraco, A., & Fredriksen-Goldsen, K. I. (2016). Turning points in the lives of lesbian and gay adults age 50 and over. *Advances in Life Course Research*, *30*, 124–132.

Neville, S., Kushner, B., & Adams, J. (2015). Coming out narratives of older gay men living in New Zealand. *Australasian Journal on Ageing, 34,* 29–33. doi:10.1111/ajag.12277

Orel, N. A. (2014). Investigating the needs and concerns of lesbian, gay, bisexual, and transgender older adults: The use of qualitative and quantitative methodology. *Journal of Homosexuality, 61,* 53–78. doi:10.1080/00918369.2013.835236

Pew Research Center. (2013, June 13). *A survey of LGBT Americans.* Retrieved from http://www.pewsocialtrends.org/2013/06/13/a-survey-of-lgbt-americans/

Rawls, T. W. (2004). Disclosure and depression among older gay and homosexual men: Findings from the Urban Men's Health Study. In G. Herdt & B. De Vries (Eds.), *Gay and lesbian aging: Research and future directions* (pp. 117–141). New York, NY: Springer.

Rosenfeld, D. (2002). Identity careers of older gay men and lesbians. In F. Gubrium and J. Holstein (Eds.), *Ways of aging* (pp. 160–181). Oxford, UK: Blackwell Publishers.

Sang, B., Warshow, J., & Smith, A. (Eds.). (1991). *Lesbians at midlife: The creative transition, an anthology*. Midway, FL: Spinsters Ink.

Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*, 301–311. doi:10.1007/s11199-008-9501-8

Siverskog, A. (2014). "They just don't have a clue": Transgender aging and implications for social work. *Journal of Gerontological Social Work, 57,* 386–406. doi:10.1080/01634372.2014.895472

Stein, G. L., Beckerman, N. L., & Sherman, P. A. (2010). Lesbian and gay elders and long-term care: identifying the unique psychosocial perspectives and challenges. *Journal of Gerontology of Social Work, 53,* 421–435. doi:10.1080/01634372.2010.496478

Tasker, F., Barrett, H., & De Simone, F. (2010). 'Coming Out Tales': adult sons and daughters' feelings about their gay father's sexual identity. *Australian and New Zealand Journal of Family Therapy*, *31,* 326–337. doi:10.1375/anft.31.4.326

Witten, T. M. (2016). Aging and transgender bisexuals: Exploring the intersection of age, bisexual sexual identity, and transgender identity. *Journal of Bisexuality, 16,* 58–80. doi:10.1080/15299716.2015.1025939

Witten, T. M., & Eyler, A. E. (2012). *Gay, lesbian, bisexual, ad transgender aging: Challenges in research, practice, and policy.* Baltimore, MD: John Hopkins University Press.

Woody, I. (2014). Aging out: A qualitative exploration of ageism and heterosexism among African American lesbians and gay men. *Journal of Homosexuality, 61*, 145–165. doi:10.1080/00918369.2013.835603

Zians, J. (2011). *LGBT San Diego's trailblazing generation: Housing and related needs of LGBT seniors*. San Diego, CA: The San Diego Lesbian, Gay, Bisexual & Transgender Community Center.

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Career Development

Larry D. Burlew and Suzy Wise

The terms *career, work,* and *career development* are often used interchangeably, but the nuances of each should be considered carefully. When examining the concepts in this article, try filtering them through the lifelong work experiences of an LGBTQ older adult: How might those experiences have impacted an older LGBTQ adult's career and sexual identity development?

Career is a broad term involving all activities, experiences, and opportunities/chances contributing to where an individual is in his or her work life. Not all Americans think in terms of a "career." Intersectionality of identities (e.g., cultural variables such as race, gender, and socioeconomic status, and the interaction of those variables in the contexts of one's life) can affect this thinking. A career is a luxury for Americans who have opportunities and choices, perhaps leading to self-fulfillment.

Work is often thought of by Americans as employment, something one must do to survive, and is related to job skills, knowledge, and supporting self and family.

Career development is the process that occurs over the life span during which a person learns about the world of work and self-awareness, contributing to the person's occupational self-concept and work/career decisions.

None of these concepts has been studied extensively in the older adult age group, much less with older LGBTQ adults.

Career Development and the World of Work Before Stonewall

According to Choi and Meyer (2016), an estimated 2 to 4 million LGBTQ adults over the age of 60 years live in America. As early as 1930 and as late as 1960 (given an old-old adult may be 100 years or older, born in 1916), older LGBTQ adults reached Super's (1990) exploration stage of development. They entered adolescence and young adulthood in a volatile and psychologically, spiritually, and physically intolerant time for race, gender, and sexual minorities. They developed their identities before the Stonewall riots and gay pride (or only soon after), a time when sexual minorities were labeled immoral or pathological and their love was illegal. Occupational and sexual identities were both formed during an extremely oppressive and explosive climate in America (Muraco & Fredriksen-Goldsen, 2016).

Therefore, when working with LGBTQ older adults and their process of career development, career counselors must understand the experiences older adults likely had in the workplace as they managed oppressive environments and beliefs about their sexual and worker identities (see earlier articles on career development for an in-depth description).

House (2004) wrote that counselors need to "integrate sexual orientation as a biographical variable in Super's (1990) Archway Model and life-span, life-space perspective" (p. 253). Indeed, other such variables must be considered as an addition to the Archway Model when counseling LGBTQ older adults. These variables include societal contexts like the Eisenhower era, during which homosexuals were fired from jobs because of their sexual identity and when nondiscrimination laws for LGBTQ workers were never considered; and the need for personal coping strategies such as using supportive opposite-sex friends as "beards" for work functions or marrying someone of the opposite sex, perhaps allowing for greater potential for workplace advancement.

The impact of these formative years on an LGBTQ adult's career development later in life probably depends on later work experiences, stages of coming out, and the ability to move beyond internalized shame or fear of being an openly LGBTQ employee. House's (2004) "biographical variable" concept is critical because changes have occurred in the United States and the world of work with respect to sexual minorities. However, the biographies of LGBTQ older adult workers remain the same and necessarily inform their behaviors, beliefs, and feelings about the world of work. Their actions may not mirror the current cultural climate shared by younger LGBTQ individuals, but it is important to respect the actions and decisions made by LGBTQ older adult retirees/workers when they seek career counseling.

Developmental Lens

While no career theories or models explicitly address cultural variables and career development with LGBTQ older adults, some theories can be helpful in examining the career development experiences (i.e., milestones) of older LGBTQ adults. Some aspects of each theory reviewed can provide greater insight into the changes occurring in older adulthood, specifically as they relate to the career development of LGBTQ clients.

According to Super (1990), older adults work toward achieving the developmental tasks of deceleration, disengagement from full-time work, and retirement. If decelerating but remaining in the workforce, they may experience ageism. For LGBTQ adults in a gay affirmative environment, this may bring up old feelings of persecution; if in a homophobic work environment, this can cause additional psychological distress. If disengaging and retiring, they lose the full-time worker identity. For some, this can be a "freeing" experience, as they no longer have to worry about heterosexism in the workplace. However, if the worker identity was a major source of pride, adjusting to a leisure identity and finding gay affirmative leisure environments can be a challenge.

Bronfenbrenner (1979) emphasizes the importance of the person/environment interaction in human development. This interaction involves historical contexts and sociocultural factors that may cause internal struggles in response to environmental changes. Changes in the microsystem (individual environmental encounters) can cause challenges. For example, LGBTQ older adults remaining in the workforce may frequently encounter newly hired employees with homoprejudice. For those retiring, finding gay affirming retirement communities or leisure activities may be a challenge. At the macrosystem level (societal changes/interactions), LGBTQ older adults will have to deal with legislative changes like employment non-discrimination acts and religious freedom bills. For some older LGBTQ adults, such changes may give them a sense of empowerment, where others may be wary of the benefits of such acts, and younger LGBTQ adults may be dismissive of those concerns.

As LGBTQ older adults experience changes in their ecological systems with respect to career development, they construct their own sense of reality and perhaps re-shape (i.e., make meaning of) their perceptions of their core life roles (Savickas, 2002). This meaning making process includes internal and external client factors, such as family and social support, social identities, intersectionality of identities, the level of collegiality in the workplace, financial stability, and post-retirement plans. This process can be empowering to older LGBTQ employees who remain in the workforce and advocate for equal treatment of LGBTQ workers in an organization. Conversely, the process can be distressing if, for example, an LGBTQ retiree feels isolated and is fearful of making new social connections (perhaps due to internalized homophobia or fear of repeated persecution).

At the foundation of an LGBTQ older adult's later career development is Dawis and Lofquist's (1984) concepts related to the Theory of Work Adjustment. Whether remaining in the workforce or retiring, internal and external changes will occur as discussed. Their theory takes into account the person–environment fit during one's career journey, in that workers consistently evaluate their happiness, satisfaction, relationships, and safety within the working (and community) environment, and make adjustments as necessary to continue to feel life satisfaction and self-fulfillment.

Strengths and Challenges

Strengths

Older LGBTQ clients may not realize the strengths that they have garnered over the years through their work, personal, and societal history that contributed to their success and survival in the world of work. Clients may need help in identifying the strengths they have accumulated through a lifetime of working in a heterosexist world. Strengths in multiple areas could be addressed; several major ones can be directly related to their career development:

- Dealing with multiple "isms" in the workplace honed coping skills that can be used when confronted with "isms" either while establishing leisure activities in retirement or if returning to work once retired.
- Having experienced discrimination and oppression in the world of work, older adult workers can use that expe-

rience to mentor younger LGBTQ workers and/or provide guidance in how to deal with such issues.
- When reflecting on their behaviors and actions taken to confront "isms," older LGBTQ individuals can use those same skills when ageism is evident, perhaps uncovering a sense of self-efficacy not previously identified.
- If LGBTQ older workers came out during their working years, they can use those skills to come out either in new leisure experiences with heterosexual individuals or, if returning to work, coming out would be easier if already experienced.
- LGBTQ older workers had to develop the skill of creativity in order to successfully cope in oppressive work environments; they can use this same skill to successfully transition to leisure activities (or to new work environments).
- Older LGBTQ workers are "survivors" during extremely oppressive years in the United States and certainly in the workplace. They can use this resilience to encounter new oppressive experiences, like ageism from their own LGBTQ community of younger individuals or in the workplace.

Challenges

Given that current LGBTQ older adults grew up in a social system that required them to silence their identities, they had to make career choices for safety, practicality, and, sometimes, invisibility. Though the workplace climate has become more accepting in many ways, older LGBTQ adults who become laid off or those who retire but choose to continue working in a new environment must review their options and therefore re-adjust their personal constructs related to work. In addition to their complex sexual identities, older LGBTQ adults contend with significant ageism and the ramifications of an economy in repair, sometimes causing perpetual unemployment or underemployment with the threat of poverty at higher rates than the general population.

If they are disengaging or retiring from full-time work, developing leisure activities may be a challenge for some LGBTQ older adults. Very little is written about leisure and older LGBTQ adults in the gerontological literature, yet some existing challenges include:

- Finding new friendships and social networks not related to work. If an individual is tied to his or her LGBTQ community, then confronting ageism from within that community arises as the person tries to continue socializing or attending functions and gatherings with younger people.
- Relating to predominately heterosexual peers and staff in senior communities and deciding whether to come out.
- Finding enjoyable activities without concerns for being mistreated or discriminated against (e.g., asking a senior center to occasionally show a gay-themed movie on film night).
- Dating if single or widowed. For older men in particular, going to bars may be problematic as they might be viewed as "dirty old men," and learning to use the internet to date may feel foreign to them.
- Finding leisure events catering to older LGBTQ adults and being involved with one's own age cohort.

Additionally, a longer life span potentially means more years spent in the workforce and thus more implications for safety and openness. While there is not much research about older adults who identify as transgender or nonbinary, those in the process of medically based gender transition at older ages encounter the worrisome impact of changing insurance costs and structures. For sexual minorities who avoided health care during their "healthy" years because of the threat of medical discrimination, they might now need to confront that fear due to increasing physical and mental health issues. If workplace-sanctioned insurance companies and medical facilities are not gender and sexual minority-affirming, older adults may see detrimental health effects. Additionally, clients aged 85 or older are less likely to seek helpful services for fear of discrimination rooted in their past.

Intersectionality

Little is written about the career development of LGBTQ older adults or about retirement issues (Muraco & Fredriksen-Goldsen, 2016), possibly due to the fact that adult development theorists did not plan for life after retirement or disengagement, not understanding what is now known about adults' capacity for continued development. Many of the published stage models utilized current life span projections and did not make adjustments for future medical technology and health innovations that increased longevity.

However, Super (1990) built some flexibility into his model and labeled the fifth stage of career development as the decline stage involving three developmental tasks: deceleration, disengagement, and retirement. When these tasks are accomplished depends on one's intersectionality of identities and how well an LGBTQ individual is able to prepare (or not) for the eventual deceleration and disengagement from the full-time worker role. For example, the intersectionality of sex, race, partner status, and socioeconomic status (e.g., lesbian, Black, single, lower socioeconomic status) may delay the achievement of the career developmental tasks until later in life (if at all) due to financial and other constraints. Like many of the stage models, Super's (1990) model aligns nicely with those who are able to develop a financially rewarding career, but for those people who work just to survive, actual disengagement may not be possible until they are physically unable to work any longer.

LGBTQ individuals struggle with similar challenges facing heterosexual workers who engage in deceleration and disengagement; however, if disengaging, they have several of their own unique challenges:

- Giving up a strong worker identity may cause distress, particularly if a lot of pride was placed on success in the workplace with less focus on personal life.
- If out and open at work, giving up a supportive collegial network may cause issues; if not out, then isolation may occur if a gay affirmative social network was not established.
- Finding a retirement community that does not exhibit ageism, homophobia, transphobia, sexism, and racism may be a challenge.
- Being involved in activities away from work may require coming out again, which is less stressful, perhaps, for those who already came out at work.

- Attempting to identify with a gay community with no or less fear of being outed at work (if closeted) may have challenges such as ageism for older gay men in a youth-oriented culture; for people of color, racism in the LGBTQ community; and potential homophobia issues within their own cultures.

Other challenges exist in the career development process for LGBTQ older adults. For example, in these economically unstable times, older LGBTQ adults may financially need to continue working full-time. However, the threat of downsizing may evoke renewed fears of being fired or laid off due to previously experienced "isms" with the added concern of ageism. If an older LGBTQ adult is able to disengage and retire, then other financial concerns may arise. If the individual is single, will social security and retirement plans be enough to survive? If the individual is partnered/married with one partner still working, will his or her benefits cover them both? In either situation, how will an increase in medical costs as the individual's age be affordable? Finally, if an older LGBTQ adult must return to work part-time, then concerns about workplace homophobia, ageism, and transphobia may hinder the job search due to renewed fears about society's treatment of sexual minorities and older adult workers. Transgender older adults may experience more distress if continuing to work or returning to the workforce due to multiple forms of discrimination (e.g., microaggressions, horizontal oppressions, discrimination by health care systems) that have already significantly impacted their work lives and career development.

Exploring the client's intersectional identities and their situated contexts will give voice to the struggles, strengths, and resiliencies that the client brings to their career development work. Facilitating client reflection on the turning points in their lives will assist them to more powerfully move into the next phase of their working life. Turning points, as defined by Muraco and Fredricksen-Goldsen (2016), are "events that have unfolded within specific social and historical contexts that are central to understanding one's life course" (p. 1). As clients consider the salient turning points in their lives, informed by their multiple lived identities, future moves may be taken with keen intentionality.

The 21st Century Workplace Landscape for LGBTQ Older Adults

Efforts to pass laws for gay, lesbian, and female (not including transgender individuals) equality began with 1974's *Equality Act*. This act and similar versions continue to fail in the legislature due to the strong opposition of well-funded and well-organized conservative groups. The *Employment Non-Discrimination Act* (ENDA) evolved 20 years later from this early equality effort and is focused solely on protections for gay, lesbian, and bisexual people in the workplace (again, transgender individuals were not initially included and would not be until 2007). Passage of *ENDA*, too, has failed time and again, most recently in November 2014. *ENDA* would protect workers through legal means in all workplace environments from employment discrimination, and the lack of it leaves workers vulnerable to violence and prejudice because of their perceived sexual and gender

identities. As it stands, companies can take action in their employment policies to protect diverse workers, and states can pass legislation to protect diverse citizens, but there is no federal protection for LGBTQ people nationwide and none on the horizon. The new presidential administration brings with it severe implications for LGBTQ rights overall, specifically the potential to set back worker and consumer protections.

As mentioned previously, financial concerns may supersede other issues for LGBT older adults as they retire or transition careers. One major win for the LGBTQ community occurred in 2015, when the Supreme Court decision *Obergefell v Hodges* instituted marriage equality nationwide (Obergefell et al. v. Hodges et al., 2015). One of the many positive effects of this landmark event occurred in the workplace with regard to tax parity for same-sex spousal benefits. This law potentially returns more money to workers during tax season, saves the business owner money on benefits administration given the simpler methods for processing spousal versus partner benefits, and has spurred record numbers of benefits enrollments for LGBTQ married couples. However, in a recent study, 50% of LGBTQ workers reported that their employers had not yet informed them of the implications for the new law (Lincoln Financial Group, 2016). As older workers marry their same gender partners, additional workplace implications of this law will surface for study.

Other financial issues that older LGBTQ adults may experience with greater uncertainty than their younger adult counterparts include:

- dwindling retirement plans and benefits;
- increased reliance on social security and public assistance;
- lay-offs/unemployment/underemployment;
- poverty/reduced economic security;
- ageism in a workforce that is more and more demanding of cutting-edge technology, immediate responses, agility, and quick thinking;
- changing contexts of work;
- frequent workplace transition (forced and voluntary);
- somewhat unstable or uncertain economy; and
- a strong need to update and adapt skills to fit new workforce.

Due to the possible sexual or gender identity discrimination that individuals might face in career transition, LGBTQ workers must contend with an ambiguity about their role at work and how close they can get to their co-workers and superiors. A re-closeting process may occur as a form of self-protection, no matter in what other spaces they may be out or whether they have a same-gender partner at home.

Counseling Considerations

Various career development theories and related models exist that can be used in career counseling with older LGBTQ adults. Counselors should choose approaches and models that they think are most appropriate for their particular older LGBTQ adult population; that is, consider the intersectionality of identities that client brings and the modifications needed to make to these theories work best for the older LGBTQ adult population being served.

What career theory(ies) and model(s) do counselors feel would work best with the issues that older LGBTQ adults are encountering?

Savickas's (2002) career constructivist approach focuses on the meaning one makes along one's career development path, and this process necessarily includes internal and external client factors such as family and social support, social identities, intersectionality of identities, the level of collegiality in the workplace, financial stability, and post-retirement plans. Helping older LGBTQ adult clients explore the meaning of their career journey could be integrated into any approach that counselors decide to use. Counselors can better understand their clients' personal constructs (thus, the meaning) related to their interactions with both the micro- and macrosystem and the world of work. This exploration of clients' personal constructs can help the clients identify strengths, ongoing deficits to their career development, and open awareness to paths yet to be achieved.

How would a counselor help an older LGBTQ adult client identify personal constructs?

If counselors consider the career development milestones addressed earlier, they may question how accomplishing these milestones would enhance an older LGBTQ adult's career development. For example, how would a career counselor help an older LGBTQ client transition from a full-time worker role to a relatively new full-time leisure role (i.e., if disengaging and retiring), particularly with facing issues like finding gay affirming leisure environments and/or addressing homophobia in retirement communities?

Pearson (1998) found a positive relationship between leisure satisfaction and psychological health, so helping older LGBTQ clients face the challenges to finding leisure satisfaction seems important. Counselors could apply Bloland and Edwards's (in Pearson, 1998) model of leisure counseling with some modification; determine client needs, identify leisure activities (excluding the originally suggested combination with work activities) to meet needs, then encourage clients to engage in the activities. Similarly, Brott's (2001, 2005) constructivist storied approach encourages the counselor and client to collaborate on the storytelling process about leisure activities throughout the client's life. The counselor and client unveil through co-construction (uncovering of the life story) the client's leisure history; next, they de-construct the story opening up to different viewpoints; and finally they construct how the new leisure role as a retiree can create challenging and exciting new stories/chapter for the client.

Finally, Brown's research (2002) on work and cultural values will help clients focus on what matters most to them as they transition in their personal and worker roles. Values are inherent to the meaning an individual makes in life, and exploring current as well as historical values throughout a person's career and home life can be very beneficial in shaping what comes in the future.

If counselors return to the career development milestones, what approaches and/or strategies can be determined through research (or approaches/strategies already in use) that would allow counselors to address various elements of the milestones?

Career and other counselors must use essential skills in working with LGBTQ older adults, such as empathy, open-

ness, nonjudgment, and a strong awareness of the needs of older adults and the LGBTQ community. This may require additional training on the part of the counselor to understand the unique pressures facing older adults in addition to inquiring about their own specific inner values around aging that are necessary for effective work with older clients, such as:

- respect for older adults;
- honoring the lives of older adults;
- awareness of one's own aging and resultant implications; and
- experience with LGBTQ identity development models, career theories, and developmental aging models so that they inform one another and intersect.

What are the counselor's own beliefs and values with respect to aging and LGBTQ older adults?

It is imperative that professional counselors advocate for their clients, especially for those most marginalized in society. LGBTQ older adults face daily stigma and discrimination, especially with additional intersectional identities such as race and low socioeconomic status. Therefore, it will be important for counselors to be prepared with the following:

- A humanistic approach that supports the client in exploration of personally significant issues and concerns.
- A prepared list of trusted community-based resources and referrals for concerns of daily living, such as medical professionals, financial advisors, real estate services, retirement and end-of-life consultants, and others.
- Open and accessible office space, which includes physical accommodations for disabled clients and signs of the counselor's LGBTQ-affirmative professional stance, such as inclusive language on intake and other documentation, posted signs, and marketing materials.
- Available career, social, and personal support groups, whether in the counselor's own practice or nearby, that are appropriate for the client's needs.

In these ways, counselors will be better positioned to help LGBTQ older adult clients through the various decision-making processes in which they need to engage to afford them a satisfying and fulfilling life. In addition to exploring clients' values, occupational experiences, and future planning, counselors must broach the subject of clients' cultural identities and how clients navigate their multiple social and career environments through those identities. It is important to discover whether a client struggles with finances, enjoys a rich social life, encounters daily discrimination, feels fulfilled at work or in retirement, strives to remain healthy, or finds comfort in spirituality. A client's quality of life in these spaces will all play a role in how the client fosters and maintains resilience in his or her later years.

References

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

Brott, P. E. (2001). The storied approach: A postmodern approach to career counseling. *The Career Development Quarterly, 49*, 304–313.

Brott, P. E. (2005). A constructivist look at life roles. *The Career Development Quarterly*, *54*, 138–149.

Brown, D. (2002). The role of work and cultural values in occupational choice, satisfaction, and success: A theoretical statement. *Journal of Counseling and Development, 80,* 48–56.

Choi, S. K., & Meyer, I. H. (2016). *LGBT aging: A review of the research findings, needs, and policy implications*. The Williams Institute. Retrieved from http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Aging-A-Review.pdf

Dawis, R. V., & Lofquist L.H. (1984). *A psychological theory of work adjustment: An individual differences model and its application*. Minneapolis, MN: University of Minnesota.

House, C. J. (2004). Integrating barriers to Caucasian lesbians and Super's life-span, life-space approach. *The Career Development Quarterly, 52*, 246–255.

Lincoln Financial Group. (2016). *Special Report: M.O.O.D. of America on employee benefits.* Retrieved from http://newsroom.lfg.com/mood-of-america-special-report

Muraco, A., & Fredriksen-Goldsen, K. I. (2016). Turning points in the lives of lesbian and gay adults age 50 and over. *Advances in Life Course Research*, *188*, 1–9.

Obergefell et al. v. Hodges et al., 575 U.S. 14-556 (2015).

Pearson, Q. (1998). Job satisfaction, leisure satisfaction, and psychological health. *The Career Development Quarterly*, *46,* 416–426.

Savickas, M. L. (2002). Career construction: A developmental theory. In D. Brown & Associates (Eds.), *Career choice and development* (4th ed., pp. 149–206). San Francisco, CA: Jossey-Bass.

Super, D. E. (1990). A life-span, life-space approach to career development. In D. Brown & Associates (Eds.), *Career choice and development: Applying contemporary theories to practice* (2nd ed., pp. 197–261). San Francisco, CA: Jossey-Bass.

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Religion and Spirituality

Bret Hendricks and Tonya Hammer

When working with older LGBTQ adults, it is vital for counselors to consider and work with the role that religion and/or spirituality has played and continues to play in their lives. According to Fowler (1981), religion often has a vital role in people's identity development. Religion and/or spirituality can play a positive or negative role in the lives of older LGBTQ individuals, and it is important that mental health professionals do not disregard or avoid the discussion of these issues. Further, it is important that counselors understand the constructs of religion and spirituality.

An article by Halkitis et al. (2009) provided a definition constructed by the community and that proves effective in the discussion for the purposes of this topic. Halkitis et al. (2009) identified that LGBTQ individuals define religion in terms of communal worship and in terms of its negative influences in the lives of individuals and communities. In comparison, spirituality was defined in relational terms, such as the relationship with one's self, God, and others.

Counselors must also be aware of their own understanding of the roles of spirituality and religion when working with older LGBTQ clients. In that light, and in compliance with the competencies developed by Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC), in this article the developmental milestones related to spiritual and/or religion and identity development, including barriers encountered by older LGBTQ adults and areas of strength and coping that relate to this populations' own spiritual and/or religious identity, are examined.

Developmental Lens

Historically, religious institutions have rejected LGBTQ identities as many view same-sex sexual behavior as immoral (Buchanan, Dzelme, Harris, & Hecker, 2001; Sherkat, 2002). Individuals who are part of religious groups that are not gay affirming may face severe psychological health disparities (Rodriguez & Ouellette, 2000). These attitudes often require LGBTQ individuals to negotiate their religious identities and their sexual identities. Cass' (1979) theory of homosexual identity development describes a series of stages in which individuals understand and make sense of their own same-sex attractions within a context of society that considers heterosexuality as "normal." Cass proposed that the development of sexual identity is the result of trying to escape the cognitive dissonance one feels as a result of the difference in social expectations, which could include those defined by the religion of their upbringing, and their internal experiences. In more recent work, Wood and Conley (2014) found that these negotiations typically take four forms: (a) identity integration; (b) compartmentalization; (c) rejection

of sexual identity; and (d) rejection of religious identity. Three of these negotiations (compartmentalization, rejection of sexuality, and rejection of religion) result in individuals not being able to live authentically.

According to Hattie and Beagan (2013), individuals experienced transition regarding spiritual or religious occupations after acknowledging identities as LGBTQ. For some, their transition in regard to incorporating their sexual identity with their spiritual or religious occupations occurs in later adulthood. Some participants remained in the faith traditions of their upbringings; others adopted new faith traditions; many created personal relationships to spirituality; and a few abandoned anything spiritual. For those who remained in faith traditions either of their upbringing or a new version, the connections created provided a support for them throughout adulthood and other transitions in their life. Those who left religions often lost faith, rituals, community, family connections, and specific religious occupational roles. No matter the outcome, the struggles brought on by rejection, discrimination, and religious struggles often cause psychological distress.

Strengths and Challenges

Strengths

Where negative religious experiences have presented challenges for LGBTQ individuals throughout their life span, it is also important to acknowledge that gay affirming churches and/or religions have provided strength and resilience to members of the community, and the number of religious institutions in this area seems to be growing (Rodriguez & Ouellette, 2000). Examples of this growing acceptance include recent changes in stances on homosexuality in some mainline Protestant churches, the establishment of the Gay Christian Network, celebration of LGBTQ identities found in the Unitarian Universalist Church, and acceptance in Reform and Reconstructionist Jewish faith groups. If individuals join LGBTQ-affirming religious communities, then they are more likely to integrate their faith and sexuality (Lease, Horne, & Noffsinger-Frazier, 2005). They are also more like to integrate their faith into their personal relationships as well as decisions around family and children.

Challenges

According to Super and Jacobsen (2011), religion is often the place an LGBTQ individual may turn to in order to understand and navigate their sexual orientation identity development. However, religious abuse may occur when a religious group or leader, whether intentionally or unintentionally, uses coercion, threats, rejection, condemnation, or manipulation

to force the individual into submission of the religious views about sexuality. The abuse may result in great harm to the victim by causing low self-esteem, guilt, shame, spirituality loss, substance abuse, or thoughts of suicide. Counselors need to be aware of religious abuse to help clients navigate any spiritual divide between religious beliefs and sexuality. Wood and Conley (2014) further explain that LGBTQ individuals are at risk of having negative experiences with religion because of mainstream religions' non-LGBTQ-affirming stance. Negative religious experiences can lead to religious or spiritual struggles and loss of religious or spiritual identity in favor of maintaining sexual identity. The authors describe religious or spiritual abuse and struggle and how these experiences can result in loss of religious or spiritual identity in LGBTQ individuals.

Another complication for older adults who may have experienced religious discrimination, abuse, oppression, or internal conflict due to their own belief system is the difficulty in finding an affirming therapist to help them cope. According to Sherry, Adelman, Whilde, and Quick (2010), psychotherapy itself has sometimes been seen as incongruent with religion and spirituality. This fact is even more pronounced when counseling LGBTQ clients, who feel as if their sexual orientation places them at odds with religious doctrine that is experienced as anti-gay. Postmodern theory provides a context for understanding socially constructed identities that may be in conflict with one another and may also provide some insight into how therapists may approach religious issues with LGBTQ clients. Results of some research have indicated that conservative religious beliefs were related to higher levels of shame, guilt, and internalized homophobia.

Unfortunately, as evidenced by recent consciousness clauses, there is relevant fear of religious conservativism impacting the counseling relationship (Bidell, 2014). Bidell (2014) found that there is a relationship between religious conservatism and LGBTQ-affirmative counselor competence. Bidell discusses that degrees of religious conservatism may be viewed as a continuum that ranges from liberal or non-religious to fundamental or conservative. Results of the study indicate that as religious conservatism increases, LGBTQ competency significantly decreases. Thus, there is evidence that stigmatization of LGBTQ persons results in negative treatment outcomes.

Intersectionality

When examining the strengths and/or challenges faced by LGBTQ individuals with regard to religion and/or spirituality, intersection of identities such as ethnicity, race, and gender also needs to be examined. Religion and/or spirituality play different roles and levels of importance within varying ethnicities, and for some LGBTQ individuals, abandoning their faith is to reject not only their religious identity but perhaps also their ethnicity and family because of the role it plays in their community.

Counseling Considerations

There is a complex relationship between older LGBTQ people and spirituality and religion. This relationship is complicated by the rise in extreme fundamentalism and anti-gay rhetoric (Koepke, 2016). Counselors must understand that religion

and spirituality are personal constructs; therefore, individual treatment planning which integrates each client's unique experiences and perspectives should be used as counselors address spiritual and religious issues in older LGBTQ clients.

How can counselors assist older LGBTQ clients as they define and resolve their religious and sexual identity conflicts?

Many older LGBTQ clients are ambivalent regarding the role of organized religion in their lives. While they agree that organized religion may not be affirming of their sexual identity, they are hesitant to leave their religious affiliation. Thus, they continue to use religion to cope with some life issues despite the mixed messages they receive regarding their own sexual identity. According to Schuck and Liddle (2001), some counselors believe that LGBTQ clients must leave organized religion altogether in favor of pursuing spirituality that is apart from religious institutions before they can resolve their inner conflicts between religious identity and sexual identity.

Tan and Yarhouse (2010) propose a more moderate approach, as they recommend that LGBTQ clients seek gay-affirming religious institutions without completely abandoning organized religion. Further, Tan and Yarhouse (2010) suggest that counselors use mindfulness techniques as they work with individuals who are questioning whether to leave organized religion. As clients determine whether to stay or leave their organized religious affiliation, they should explore their beliefs, feelings, and values without judgment. Thus, counselors must assist clients as they navigate these questions by providing nonjudgmental therapy that is without unduly heightened emotionality. In other words, counselors should use a counseling approach that is framed as gay-affirmative therapy committed to principles that support and affirm the LGBTQ individual. Tan and Yarhouse (2010) do not recommend a therapeutic approach that employs "cookie-cutter" protocols for all clients. Instead, they propose a person-centered approach in which counselors assist clients to develop a cognitive framework that destigmatizes sexual minority status and encourages positive views of individual sexual identity development.

Finally, counselors should help clients understand that they have choices regarding faith communities with which they choose to affiliate. Many clients have simply never known anything about gay-affirming churches which actively advocate for their LGBTQ members. Thus, clients should be encouraged to explore community alternatives which are more positive and inclusive of sexual minorities.

Many older LGBTQ clients have experienced religious abuse. How can counselors effectively work with these clients to explore the potentially positive influence of spirituality?

First, clients must understand and differentiate the definitions of "religion" and "spirituality." As clients begin to understand that religion is communal worship and spirituality pertains to relational aspects of self-awareness, self-understanding, and self-acceptance (Halkitis et al., 2009), they will hopefully begin to gain insight into their understanding of how they can achieve spiritual fulfillment. Kocet, Sanabria, and Smith (2011) encourage counselors to facilitate spiritual exploration with LGBTQ clients so they can find the spirit within themselves.

Similarly, Yarhouse and Tan (2010) encourage counselors to assist clients' spiritual self-exploration by helping them identify negative automatic thoughts that reflect dogmatic schemas related to their sexual identity. After identifying the negative thoughts, the client can continue to define feelings and behaviors associated with these thoughts and replace the negative thoughts with positive reframes. Additionally, Tan and Yarhouse (2010) recommend that clients use all five senses to ground their emotional reactions rather than simply being emotionally reactive to their negative thoughts. Thus, clients might examine a recurring automatic thought related to religious condemnation of sexual minorities. After identifying their automatic thought, they can use their five senses to "ground" themselves in the here and now and use strategies that insert cognitive rationality to calm themselves, perhaps substituting negative messages from their former religious affiliations to positive messages of gay affirming faith communities and integration of the spirit within (Kocet et al., 2011.)

Reverend Daniel Hooper, a retired pastor who is an activist and theologian for LGBTQ inclusivity, states that many persons who have experienced religious abuse may not wish to connect with religion at all (Koepke, 2016). He states that faith communities must begin to earn the trust of LGBTQ people by standing with LGBTQ persons in a public way. They must adopt official statements that make their LGBTQ advocacy publicly known and they must espouse their support of life events of LGBTQ people in non-apologetic language. Further, the faith community must be honest in admitting historic institutionalized homophobia. Thus, counselors should encourage clients to seek religious institutions that publicly teach LGBTQ inclusion and do not shame, reject, or despise anyone, including LGBTQ people.

Counselors must advocate for their clients. If counselors are to advocate for older LGBTQ clients and their healthy religious and spiritual development, counselors must be prepared with the following:

- Seek community resources of faith communities which affirm LGBTQ people community-wide.
- Advocate that the faith community be honest in admitting past discrimination and bias toward LGBTQ persons and clearly communicate that they now teach inclusivity and affirmation of LGBTQ persons in their life endeavors. They should clearly endorse LGBTQ persons as they struggle with family, legal, career, and other situations in which they encounter bias and discrimination.
- Advocate that affirming faith communities actively engage in LGBTQ community activities as a visible supporter of LGBTQ persons, seeking information about LGBTQ experiences in their neighborhoods and communities (Koepke, 2016).
- Encourage faith communities to address the needs of older LGBTQ persons by developing assisted-living arrangements that are inclusive and do not overtly or co-

vertly require older LGBTQ persons to "go back into the closet" in order to have appropriate housing and care.
- Advocate that faith communities begin older LGBTQ adult ministries that provide social activities and spiritual bonding for members.

References

Bidell, M.P. (2014). Personal and professional discord: Examining religious conservatism and lesbian-, gay-, and bisexual-affirmative counselor competence. *Journal of Counseling & Development, 92,* 170–179.

Buchanan, M., Dzelme, K., Harris, D., & Hecker, L. (2001). Challenges of being simultaneously gay or lesbian and spiritual and/or religious: A narrative perspective. *The American Journal of Family Therapy, 29,* 435–449. doi:10.1080/01926180127629

Cass, V. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4,* 219–235.

Fowler, J. W. (1981). *Stages of faith.* San Francisco, CA: Harper & Row.

Halkitis, P. N., Mattis, J. S., Sahadath, J. K., Massie, D., Ladyzhenskaya, L., Pitrelli, K., . . . Cowie, S. E., (2009). The meanings and manifestations of religion and spirituality among lesbian, gay, bisexual, and transgender adults. *Journal of Adult Development, 16,* 250–262.

Hattie, B., & Beagan, B. (2013). Reconfiguring spirituality and sexual/gender identity: It's a feeling of connection to something bigger, it's part of a wholeness. *Journal of Religion & Spirituality in Social Work: Social Thought 32,* 244–268.

Kocet, M. M., Sanabria, S., & Smith, S. (2011). Finding the spirit within: Religion, spirituality, and faith development in lesbian, gay, and bisexual individuals. *Journal of Lesbian, Gay, Bisexual Issues in Counseling, 5,* 163–179.

Koepke, D. (2016). Opportunities for ministering to LGBT elders: A conversation with Rev. Daniel Hooper. *Journal of the American Society on Aging, 40.* 26–30.

Lease, S. H., Horne, S. G., & Noffsinger-Frazier, N. (2005). Affirming faith experiences and psychological health for Caucasian lesbian, gay, and bisexual individuals. *Journal of Counseling Psychology, 52,* 378–388. doi:10.1037/0022-0167.52.3.378

Rodriguez, E. M., & Ouellette, S. C. (2000). Gay and lesbian Christians: Homosexual and religious identity integration in the members and participants of a gay-positive church. *Journal for the Scientific Study of Religion, 39,* 333–347. doi:10.1111/0021-8294.00028

Schuck, K. D., & Liddle, B. J. (2001). Religious conflicts experienced by lesbian, gay and bisexual individuals. *Journal of Gay and Lesbian Psychotherapy, 5,* 63–82.

Sherkat, D. E. (2002). Sexuality and religious commitment in the United States: An empirical examination. *Journal for the Scientific Study of Religion, 41,* 313–323. doi:10.1111/1468-5906.00119

Sherry, A., Adelman, A., Whilde, M. R., & Quick, D. (2010). Competing selves: Negotiating the intersection of spiritual and sexual identities. *Professional Psychology Research and Practice, 41,* 112–119.

Super, J. T., and Jacobson, L. (2011). Religious abuse: Implications for counseling lesbian, gay, bisexual, and transgender individuals. *Journal of LGBT Issues in Counseling, 5,* 180–196.

Tan, S. N., & Yarhouse, M. A. (2010). Facilitating congruence between religious beliefs and sexual identity with mindfulness. *Psychotherapy Theory, Research, Practice, Training, 47,* 500–511.

Wood, A. W., & Conley, A. H. (2014). Loss of religious or spiritual identities among the LGBT population. *Counseling and Values, 59,* 95–111. doi:10.1002/j.2161-007X.2014.00044.x

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Health Issues

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Along with the normative health changes for older adults, older LGBTQ adults might experience unique needs. Life events such as the loss of a spouse or family member can impact older adults' engagement with life and may result in isolation (Morrow-Howell, Hong, & Tang, 2009). In terms of social isolation, older LGBTQ adults might be considered "the most invisible of an already invisible minority" (Blando, 2001, p. 87) and "the most invisible of all Americans" (Cahill, Ellen, & Tobias, 2003, p. 2). Discrimination and internalized homophobia may often stop older LGBTQ adults from disclosing sexual orientation and other potential challenges they might be facing (Rogers, Rebbe, Gardella, Worlein, & Chamberlin, 2013). Some older LGBTQ individuals might share their issues, but the majority may still be fearful of accessing health and other support services due to previously experienced discrimination and victimization (Fredriksen-Goldsen & Emlet, 2012).

The older adult population is increasing, and the health concerns are changing to include a broader reporting of issues:

- In the 1980s, LGBTQ public health research focused on sexually transmitted diseases (Davis, 2012).
- By 2020, 70 percent of people with HIV in the United Stated will be aged 50 and older (Diverse Elders Coalition, 2014).
- The number of dually diagnosed older adults with HIV and AIDS is on the rise likely due to not being screened early enough to prevent more severe health consequences (Fredriksen-Goldsen & Espinoza, 2015).
- More recently, the focus for LGBTQ health issues has expanded to include mental health challenges, lifestyle issues, support networks, disability, chronic illness, discrimination in long-term care, and body-related challenges (Mayer et al., 2008).

Developmental Lens

Older adulthood is a time in life when people experience many gains and losses, and aging looks different for various older adults, especially those who identify as LGBTQ. These changes require transition and adaptation, and many times such transitions are associated with experiences of isolation, anxiety, depression, and overall lack of life satisfaction (Hagedoorn et al., 2006). Development in older adulthood is complex. Two theories of aging are worth considering to understand this complexity: (a) continuity theory (Atchley, 1989), and (b) selective optimization and compensation theory (SOC; Baltes & Baltes, 1990).

Continuity theory is a wish to continue participating in familiar activities, which is the primary adaptive strategy for addressing normal aging as well as negative life events. It argues that continued involvement in familiar leisure activities and significant relationships can restore meaning and direction after negative life events (Atchley, 1989).

SOC theory postulates the importance in achieving a balance between gains and losses in the aging process. In this theory, clients apply resources to selected goals to optimize performance and compensate for deficiencies interfering with achieving these goals (Baltes & Baltes, 1990). They modify activities to fit physical needs; for example, older adults might choose to jog or walk instead of running, or they might take the elevator instead of taking the stairs.

Strengths and Challenges

Strengths

Despite the fact that many older LGBTQ adults are facing multiple challenges, there are great gains associated with older adulthood as well. For the older LGBTQ population, gains might be even greater due to special circumstances LGBTQ adults experienced throughout their lives. For example, they might have advanced knowledge and skills, and their experience can be rich. Besides advancements in crystallized intelligence, emotions are more enhanced, stable, and complex. LGBTQ older adults tend to cope well with overall challenges. Some aspects of well-being such as positive relationship and self-acceptance are great in such advanced age. Due to discrimination, LGBTQ older adults might be more independent, determined, and resilient. When interacting with others, they might be more supportive and understanding of others. Such gains and strengths need to be considered when working with LGBTQ older adults in counseling settings.

Challenges

Older LGBTQ adults might experience a plethora of challenges associated with aging and their sexual minority status. In addition to changes in physical functioning, such as hearing and vision impairment, decreased mobility, and increasing probability of arthritis, hypertension, heart disease, diabetes, and osteoporosis, some older LGBTQ adults could be suffering from sexually transmitted diseases such as HIV. If so, the physical and psychological well-being of older LGBTQ adults might be severely challenged. These unique challenges are linked to sexual engagement, sexual performance, and medication compliance. Further, if using a variety of medications to address multiple issues, side effects are always a concern for older LGBTQ adults. Although the LGBTQ older adult community has largely remained in the shadows, these challenges are sufficient enough that this population can be considered an at-risk one (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2014).

Health disparities. Older LGBTQ adults may find themselves alone and not willing or able to seek help, particularly if they have not developed a strong social support and network of friends. Therefore, at the time of diagnosis, their illnesses might be in more advanced stages where only little help is possible. As a consequence, older LGBTQ adults may be put on multiple medications that might have an adverse effect on their health and performance (e.g., less mobility, less verbal expression). Additionally, the physical changes that can occur due to disease and medication use may cause some older adults to feel less vital and less attractive. Fredriksen-Goldsen, Simoni et al. (2014) claim that across the United States, individuals from marginalized populations are at increased risk for health concerns, disability, and premature death. They define health disparities as "adverse health outcomes for communities that have, as a result of social, economic and environmental disadvantage, systematically experienced greater obstacles to health" (Fredriksen-Goldsen, Simoni et al., 2014, p. 653).

Significantly, from an intersectionality perspective, LGBTQ older adults of color as a subpopulation are absent from "frameworks . . . research and public policy initiatives" (Kim, Acey, Guess, Jen, & Fredriksen, 2016, p. 49). Notably in 2011, the Institute of Medicine and the Centers for Disease Control and Prevention stated that not only did health disparities exist but also the LGBTQ population is underserved, and these agencies highlighted that "the lack of attention to sexual and gender identity [are] critical gaps efforts to reduce overall health disparities" (Fredriksen-Goldsen, Simoni et al., 2014, p.653). According to Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, and Hooyman (2014), health disparities are evident in both mental and physical health compared to heterosexual individuals:

- Lesbian, gay, and bisexual older adults have higher rates of poor mental health and disability.
- Cardiovascular disease and obesity is higher among older lesbians and bisexual women;.
- Older gay and bisexual men are more likely than heterosexual men of similar age to have poor general health.
- Transgender older adults have higher rates of disability, stress, and poor mental and physical health (p. 2).

Other health challenges/concerns exist for older LGBTQ adults and are varied. These include an elevated risk of some cancers and cardiovascular disease. Transgender individuals may have more mental health issues (Fredriksen-Goldsen, 2014). Older LGBTQ adults may engage in risky health behaviors such as smoking, alcohol abuse, and risky sexual behaviors (Choi & Meyer, 2016); they may underutilize health screenings and preventative health measures often of fear of discrimination or the inability to afford the health care costs; and they may seek treatment and health services for cancer at later stages than heterosexuals with several cancers more prevalent in the LGBTQ community, such as Hodgkin's and non-Hodgkin's lymphoma, Kaposi sarcoma, and anal, cervical, breast, lung, and liver cancers (Arthur, 2015).

HIV and older LGBTQ adults. Despite many advances in understanding HIV and its treatment, HIV remains a major concern for LGBTQ communities, and it disproportionately affects gay and bisexual men and male-to-female transgender individuals (Davis, 2012). According to the Centers for Disease Control and Prevention (CDC, 2014), from 2005 to 2014, HIV diagnoses decreased in the United States by 19% overall but increased by 6% in gay and bisexual men, driven by the increases among Black and Hispanic/Latino gay and bisexual men. In 2014, people aged 50 and over accounted for 17% of those diagnosed with HIV in the United States.

Another population affected by HIV is older men, but the older LGBTQ population may still be understudied with respect to HIV. Even though the screening methods have improved, HIV remains a big challenge in at-risk populations; therefore, health care professionals and practitioners should know the various ways HIV can present, such as flu-like symptoms, fever and rash, and, at times, psychiatric symptoms and cognitive disturbance.

Discrimination preventing use of health care services. Older adults living with HIV infection are more likely to live alone and be socially isolated than their younger peers (Emlet, 2016). Also, LGBTQ older adults with HIV infection are more likely to experience discrimination and marginalization, limited social support, and higher rates of depression, anxiety, and suicidality (Fredriksen-Goldsen & Emlet, 2012). As a result, other LGBTQ individuals and couples are often reluctant to seek home health care, or they may refuse services altogether (Arthur, 2015). Seniors are often fearful of having strangers in their homes who may discover that they are LGBQT and thus hide their identity for fear of how the provider may react. Routine personal possessions, such as partner and family photos, become items that rouse fear. Thus, health care workers need to be culturally competent and anticipate LGBTQ clientele even if patients do not openly self-identify because seniors are skilled at "passing" in an effort to feel safe and avoid either real or perceived discrimination (Arthur, 2015).

Informal health care. The majority of long-term care for older adults in the United States with chronic illnesses is not provided by formal care organizations, such as nursing homes, but rather provided informally (Stone, 2000). Immediate and extended family members and friends provide 70% to 80% of the informal care for older adults with chronic illnesses (National Alliance for Family Caregiving and AARP, 2004). Nearly 30% of older adults will require assistance by the year 2030, and almost 20% of older adults will have rather severe limitations with high caregiving needs (Stone, 2000). As with most people, LGBTQ older adults prefer to live independently and age well. However, living independently often requires support and informal caregiving, especially when dealing with declining health and increased frailty. Because of concerns about discrimination and victimization of LGBTQ older adults, it is not surprising that many LGBTQ older adults prefer to live independently and avoid any type of formal care (Stone, 2000). For these older LGBTQ adults, the issue then becomes how connected they are to family members and/or social networks within the community who might provide informal health care while respecting their sexual minority status.

Needs of caregivers. LGBTQ older adults and their caregivers face many obstacles in receiving and providing care due to discrimination in health and human services agencies, lack of supportive services, and lack of legal protection for their loved

ones (Cahill, Ellen, & Tobias, 2003). According to Meyer and Northridge (2007), the lack of access and discrimination have adverse effects and present as additional risk factors for the acceleration of chronic illness and decline in mental health. For example, Fredriksen-Goldsen, Kim, Muraco, and Mincer (2009) found two particularly stressful effects due to caregiving: caregivers experiencing discrimination based on orientation and an increase in the clinical levels of depression noted in both caregivers and care receivers. Thus, there is an increased reliance on informal networks for caregiving. The majority of gay men, lesbians, and bisexuals ages 50 years and older reported that they first ask their partners for caregiving help, and among those without partners, the majority ask for help from their friends (Cahill, Ellen, & Tobias, 2003).

Most federal and state laws and policies, such as the federal Family and Medical Leave Act of 1993, are designed to support families except for those with same-sex relationships. These policies often are biased against caregivers and care recipients in same-sex relationships. Many LGBTQ care recipients and caregivers are not legally protected against discrimination. A majority of LGBTQ individuals do not have the power of attorney to protect themselves (Fredriksen-Goldsen et al., 2009). Many laws that provide legal protection for caregiving couples, such as Social Security benefits, Medicaid, and state-sanctioned marriage statutes, exclude those in same-sex relationships.

Society also needs to more broadly define caregivers and those with chronic illnesses in order to recognize and support the needs of LGBTQ population and their caregivers within diverse communities.

Long-term care (LTC) facilities and older LGBTQ adults. Despite well-established caregiving systems in some communities, without traditional support systems in place, many LGBTQ elders end up relying on nursing homes or other institutions to provide LTC. Most often, LTC facilities and skilled nursing centers and hospitals base their care on gender-normative practices. According to a 2010 survey by the National Senior Citizens Law Center (NSCLC), few LGBTQ individuals feel safe enough to either be open to staff and doctors or to come out while in the facility if they are not identified as LGBTQ upon admission (Arthur, 2015). Today's older LGBTQ individuals grew up in a time of greater intolerance, and many have lived long portions of their lives closeted and invisible to avoid discrimination. Thus, entering into a facility where so much of their care may be directed by others who either are not sensitive or are unaware of their identity presents a frightening prospect to LGBTQ individuals (Farmer & Yancu, 2015). However, culturally sensitive practices to ensure safe, humane, and dignified care are more likely if the following concerns are reviewed: fear of being out and vulnerable; verbal or physical harassment by residents; verbal or physical harassment by staff; staff refusal to accept medical power of attorney (health care proxy); restriction of visitors; staff refusal to refer or use preferred name or pronoun; staff refusal to provide basic services or care; failure to provide proper medical care; and abrupt or attempted discharge and refusal to admit or readmit (National Senior Citizens Law Center, 2011).

Palliative and end-of-life care. As older LGBTQ individuals, partners, spouses, and family members approach the end of life, the fear and apprehension of discriminatory care does not disappear when one enters hospice or facilities that offer palliative care. In fact, many organizations and institutions that offer palliative and hospice care are either run by religious groups or have religious affiliations (Arthur, 2015). The belief systems and practices of these organizations and the individuals who offer care can express well-intended yet discriminatory and hurtful sentiments to LGBTQ patients, such as imploring them to repent their sexual orientation. Moreover, some institutions may either formally or informally prohibit physical and sexual intimacy for LGBTQ patients (Arthur, 2015). Therefore, pre-entry inquiry about the belief systems, practices, and policies to assess a facility's level of inclusivity of LGBTQ needs and openness is essential (Arthur, 2015).

Intersectionality

When considering various social identities of LGBTQ older adults, attention to intersecting and overlapping identities is imperative. Age and sexual orientation are just two social identities of LGBTQ older adults that are significant enough to relate to the system of oppression and discrimination. Further, race, gender, and socioeconomic status greatly contribute to intersectionality, creating even greater possibilities for marginalization. Counselors must possess cultural competence to sensitively and empathically address issues stemming from and/or related to intersectionality that may exacerbate typical issues related to older adulthood. Counselor advocacy is necessary in order to seek legal protection and improve treatment of LGBTQ older adults.

Counseling Considerations

Many contemporary and postmodern developmental and counseling theories exist that explain development in later life, which might serve as a framework while working with older LGBTQ adults. It is imperative to select an approach that is sensitive to variations in human development and intersectionality of identities and that offers adaptive perspectives as well. A counselor must first be aware of the need to introduce discussions about health challenges occurring in an older LGBTQ client's life and how those challenges are impacting the client's lifestyle and psychological perspective.

What counseling or developmental theories would be appropriate to help an older LGBTQ client discuss, for example, health issues that are interfering with sexual performance?

In his continuity theory, Atchley (1989) posits that people have a tendency to participate in the same activities they have enjoyed during their life. Continuity may also serve as an adaptive coping strategy when facing negative or challenging life events in older age. Continuity does not mean a person has to do the same activity in the same way to which the individual is accustomed. Adaptation may be necessary to still be able to participate in the activity, or another familiar activity may substitute for the time spent in the activity in which one can no longer engage.

In counseling the older LGBTQ client described previously, how would a counselor apply Atchley's theory to help the client address the issue?

Health challenges do occur where a client can no longer engage in a familiar activity due to a physical limitation. In that case, Baltes and Baltes' (1990) SOC theory can complement continuity theory, because it suggests that older adults can

navigate through various challenges, such as loss of mobility or isolation. An older LGBTQ client can select familiar activities that will not compromise his or her health further; the client can optimize his or her performance by applying resources to those chosen activities, while compensating for any deficiencies at the same time.

In revisiting the developmental health challenges (i.e., milestones), which counseling theories or strategies can be identified through research (or are already in use) that would allow counselors to help older LGBTQ clients address various elements in the health challenges?

Various counseling theories and models can be used to help older LGBTQ adults with successful aging while also addressing developmental challenges that may occur for them. For example, cognitive behavioral therapy may help older LGBTQ clients with long-developed fears of and hesitancy in seeking proper medical care and/or being admitted to a long term care facility. Creative problem solving as suggested by Kampfe (2015) can be used help clients choose appropriate facilities and medical personnel. Reminiscence therapy can help clients focus on the use of memories of life events. This therapy can assist older LGBTQ adults in understanding and making meaning of life experiences and remind them how they survived intense discrimination and intolerance, thus giving them an understanding of their place in the world and their resilience in dealing with that world.

Regardless of the theories or strategies counselors decide to use with older LGBTQ adults and health challenges, counselors must:

- be familiar with major developmental milestones in later life, including major presentations of physical decline;
- be knowledgeable about specific health issues related to racial minority older adults;
- have detailed knowledge from completing a biopsychosocial assessment;
- have a variety of resources prepared that are LGBTQ friendly;
- be familiar with the community of older LGBTQ client and be knowledgeable about neighboring LGBTQ communities;
- be familiar with potential health risks and intimacy issues pertaining to the older LGBTQ population;
- be knowledgeable about legislative work pertaining to minorities; and
- be informed about the end-of-life issues specific to LGBTQ population.

Deteriorating health can be an obstacle in daily life for older adults and an even greater challenge for older LGBTQ adults due to their marginalized status. Therefore, as one nears the end of life, advanced planning or consideration of advance directives is essential. Arthur (2015) suggests that LGBTQ adults and their families discuss and determine the following:

- power of attorney;
- health proxy;
- permanency planning;
- final arrangements;
- hospital visitation directive;
- life sustaining or resuscitative treatments;

- drafting a will;
- indicating beneficiaries to include 401(k) retirement plans and individual retirement accounts;
- provisions for children's health insurance (e.g., determine options based on biological or adoptive child); and
- disposition of remains.

Many older LGBTQ adults may be isolated and not involved in necessary treatment or preventive work. Therefore, counselors must engage in psychoeducation that focuses on preventive work that includes informing midlife LGBTQ adults about potential challenges pertaining to later life development and the unique health and health care access challenges associated with it. That way, midlife LGBTQ adults can prevent potential future adversities and/or be prepared and equipped with the skills and resources to handle adversities in later life. Further, advocacy for older LGBTQ adults, particularly those with intersecting minority identifies, would include more direct actions on behalf of clients. For example, clients may need assistance evaluating long-term facilities or palliative care with respect to finding gay-affirming environments. Further, it is essential to have LGBTQ friendly resources ready to help connect older LGBTQ clients with individuals and community resources of their choice. Advanced advocacy might include educating the majority population about the unique health challenges of older LGBTQ clients, and forcing legislators to adopt policies and laws that respect minorities and reduce discrimination in daily life.

What are some questions counselors should develop to aid an older transgender client with little to no social support evaluate long-term care facilities?

When evaluating and selecting a long-term care facility, consider some of the following questions to discuss with the client: How important is it for the client to select a long-term care facility with a large LGBTQ population? How far would the client like to be from his or her present residence? Are there any financial restrains when it comes to selecting a long-term care facility? How important it is for the client to maintain as much independence as possible in a long term care facility? Do visitation hours in such facilities matter?

Cultural Competence Needs of Health Care Professionals

Many kinds of health care professionals exist who at some point will assist LGBTQ older adults. Considering the many challenges the LGBTQ population faces on a daily basis, such as discrimination, limited access to services, preferred informal long term care, it is imperative for any health care professional to have knowledge and skills in order to help LGBTQ individuals effectively.

To address institutional needs, *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health, Second Edition*, highlights the Healthcare Equality Index (HEI), which was developed by the Human Rights Campaign and is designed for health care institutions and organizations to determine if their level of care meets the set criteria to be LGBTQ inclusive (Makadon, Mayer, Potter, & Goldhammer, 2016). The HEI is not designed for specific institutions; rather, it is a broad, overarching index that allows upper level management to assess

the degree to which health equity is a reality in their institution. For example, the report notes that engagement in the HEI can help managers determine the degree to which all staff are aware of policies that directly impact LGBTQ individuals. To achieve this leadership status, the institutions or organizations must demonstrate that they meet four core metrics:

- patient non-discrimination;
- equal visitation policies;
- employee non-discrimination policies; and
- training in LGBTQ patient-centered care (Makadon, Mayer, Potter, & Goldhammer, 2016, pp. 13–14).

How can counselors evaluate their agency/organization for inclusive policies and procedures with respect to older LGBTQ client services?

First, it is important to determine the actual percentage of LGBTQ population served by an agency/organization. Second, it is crucial to evaluate the quality of service to LGBTQ population by interviewing LGBTQ population and their relatives or friends about their satisfaction with services provided. Also, it is important to review the way policies and procedures are written to ensure that inclusive and non-discriminatory language is included. If the reviews reflect non-discriminatory language and the interviews reflect satisfaction of those being served, then a given agency/organization might be providing inclusive services to LGBTQ clients.

Conclusion

Fredriksen-Goldsen (2014) stated that despite the discussed health disparities, most LGBTQ elders are aging well. She notes qualities and strengths exemplified by this population, such as resilience, social engagement, and connectedness to community. Unfortunately, when health declines, LGBTQ individuals, partners, spouses, and families can face significant challenges in accessing and receiving culturally sensitive health care. LGBTQ older adults face the challenges of caregiving at higher rates than their heterosexual peers as traditional supports are often not available, and inclusive long-term health facilities and end-of-life-care may be difficult to find. Thus, culturally competent health care workers, facilities, and systems are needed and should be supported by training and policies to ensure that older LGBTQ individuals, partners, spouses, and families receive inclusive health care. To accomplish this requires changes in public policy that is both comprehensive in content and systemic in nature.

References

Arthur, D. P. (2015). Social work practice with LGBT elders at end of life: Developing practice evaluation and clinical skills through a cultural perspective. *Journal of Social Work in End-of-Life and Palliative Care, 11*, 178–201.

Atchley, R. (1989). The continuity theory of normal aging. *The Gerontologist, 29*, 183–190.

Baltes, P. B. & Baltes, M. M. (1990). *Successful aging: Perspectives from behavioral sciences*. Cambridge, MA: Cambridge University Press.

Blando, J. (2001). Twice hidden: Older gay and lesbian couples, friends, and intimacy. *Generations, 25*, 87–90.

Cahill, S., Ellen, M., & Tobias, S. (2003, January 22). *Family policy: Issues affecting gay, lesbian, bisexual, and transgender families* [Report]. New York, NY: National Gay and Lesbian Task Force Policy Institute.

Centers for Disease Control and Prevention. (2014). *The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention social determinants of health*. Retrieved from www.cdc.gov/nchhstp/socialdeterminants/definitions.html

Choi, S. K. & Meyer, I. H. (2016). *LGBT aging: A review of research findings, needs, and policy implications*. Los Angeles, CA: The Williams Institute.

Davis, J. A. (2012). HIV and the LGBT community: A medical update. *Journal of Gay and Lesbian Mental Health, 17,* 64–79.

Diverse Elders Coalition. (2014). Eight *Policy recommendations for improving the health and wellness of older adults with HIV*. New York, NY: Diverse Elders Coalition.

Emlet, C. A. (2016). Social, Economic and health disparities among LGBT older adults. *Journal of the American Society on Aging, 40,* 16–22.

Farmer, D. F., & Yancu, C. N. (2015). Hospice and palliative care for older lesbian, gay, bisexual and transgender adults: The effects of history, discrimination, health disparities and legal issues on addressing service needs. *Palliative Medicine and Hospice Care Open Journal, 1*, 36–43.

Fredriksen-Goldsen, K. I. (2014). Despite disparities most LGBT elders are aging well. *Aging Today, 35,* 1–3.

Fredriksen-Goldsen, K. I., & Emlet, C. A. (2012). "Research Note: Health Disparities Among LGBT Older Adults Living with HIV." *Aging Today Online.* Retrieved from www.asaging.org/blog/research-note-healthdisparities-among-lgbt-olderadults-living-hiv

Fredriksen-Goldsen, K. I., & Espinoza, R. (2015). Time for transformation: Public policy must change to achieve health equity for LGBT older adults. *The Journal of American Society on Aging, 38,* 97–106.

Fredriksen-Goldsen, K. I., Hoy-Ellis, C., Goldsen, J., Emlet, C. A., & Hooyman, N. R. (2014). Creating a vision for the future: Key competencies and strategies for culturally competent practices with lesbian, gay, bisexual, and transgender (LGBT) older adults in the health and human services. *Journal of Gerontological Social Work*, 1–28. doi:10.1080/01634372.2014.890690

Fredriksen-Goldsen, K. I., Kim, H.-J., Muraco, A., & Mincer, S. (2009). Chronically ill midlife and older lesbians, gay men, and bisexuals and their informal caregivers: The impact of the social context. *Sexuality Research & Social Policy, 6,* 52–64.

Fredriksen-Goldsen, K. I., Kim, H.-J., Shiu, C., Goldsen, J., & Emlet, C A. (2014). Successful aging among LGBT older adults: Physical and mental health-related quality of life by age group. *The Gerontological Society of America, 55,* 154–168.

Fredriksen-Goldsen, K. I., Simoni, J. M., Kim, H.-J., Lehavot, K., Walters, K. L., Yang, J., . . . Muraco, A. (2014). The health equity promotion model: Reconceptualization of lesbian, gay, bisexual, and transgender (LGBT) health disparities. *American Journal of Orthopsychiatry, 84,* 653–663.

Hagedoorn, M., van Yperen, N. W., Coyne, J. C., van Jaarsveld, C. H., Ranchor, A. V., van Sonderen, E., & Sanderman, R. (2006). Does marriage protect older people from distress? The role of equity and recovery of bereavement. *Psychology and Aging. 21,* 611–620.

Kampfe, C. M. (2015). *Counseling older people: opportunities and challenges*. Alexandria, VA: American Counseling Association.

Kim, H.-J., Acey, K., Guess, A., Jen, S., & Fredriksen-Goldsen, K. I. (2016). A collaboration for health and wellness: GRIOT circle and caring and aging with pride. *Generations, 40*, 49–55.

Makadon, H. J., Mayer, K. H., Potter, J., & Goldhammer, H. (2016). *The Fenway guide to lesbian, gay, bisexual and transgender health* (2nd ed.). Philadelphia, PA: American College of Physicians.

Mayer, K. H., Bradford, J. B., Makadon, H. J., Stall, R., Goldhammer, H., Landers, S. (2008). Sexual and gender minority health: what we know and what needs to be done. A*merican Journal of Public Health, 98,* 989–995.

Meyer, I. H., & Northridge, M. E. (2007). *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations*. New York, NY: Springer.

Morrow-Howell, N., Hong, S.-I., & Tang, F. (2009). Who benefits from volunteering? Variations in perceived benefits. *The Gerentologist*, *49,* 91–102.

National Alliance for Family Caregiving & AARP. (2004). *Caregiving in the United States*. Washington, DC: AARP Public Policy Institute.

National Senior Citizens Law Center, Lambda Legal, National Center for Lesbian Rights, National Center for Transgender Equality, National Gay and Lesbian Task Force and Services & Advocacy for GLBT Elders. (2011). *LGBT older adults in long-term care facilities: Stories from the field*. Washington, DC: National Senior Citizens Law Center.

Rogers, A., Rebbe R., Gardella, C., Worlein M., & Chamberlin, M. (2013). Older LGBT adult training panels: An opportunity to educate about issues faced by the older LGBT community. *Journal of Gerontological Social Work, 56,* 580–595.

Stone, R. I. (2000). *Long-term care for the elderly with disabilities: Current policy, emerging trends, and implications for the twenty-first century*. New York, NY: Milbank Memorial Fund.

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Family and Social Development

Sandra I. Lopez-Baez and Laura Wheat

The "positive role of close relationships with friends and family" (Santrock, 2014, p. 625) is one of the three themes that Erik Erikson delineates as relevant to older adults leading an emotionally fulfilling life. A support network that nourishes and sustains individuals as they go through their daily tasks is important in maintaining a healthy emotional balance. The support of family and friends contributes to positive mental health and emotional balance.

Developmental Lens

Erikson's stages of psychosocial development (Santrock, 2014) place the individual at the "integrity versus despair" juncture in which the individual reflects on the past and determines whether his or her life was well spent, resulting in either satisfaction (integrity) or a negative view of life's worth (despair). The ultimate resolution of this stage is a sense of integrity strong enough to withstand physical "disintegration" as the end of life approaches. The process of life review generates a mix of regret and satisfaction in some individuals as they ponder: "Have I led a full life? Did my choices in the past lead me to a positive place? Or are there things I wish I'd done/not done?" Reminiscing is common in this age group; it serves to help individuals make meaning of their lives and also revisit unfinished business. This process may bring up grief, both new and old, as they think about losses they've experienced and how they've dealt with them (Bristowe, Marshall, & Harding, 2016). Older individuals have had to cope with losses that include people (friends, family, and significant others, whether through death or separation) and status in society, some dulling of their senses such as vision and hearing, decline of general health and wellness, and the onset of chronic conditions. Spirituality also becomes a salient matter as people contemplate the end of their life and what their legacy or contribution to society has been. Life review can trigger revelation of unknown characteristics and experiences that can facilitate integration leading to greater satisfaction with the life they have led (MacKinlay, 2006).

For LGBTQ individuals, these typical developmental tasks come with added complexities. The cohort effect means that LGBTQ older adults were old enough to have experienced life before the Stonewall Inn riot as well as after it; the civil rights movement; the AIDS epidemic; Don't Ask, Don't Tell; and the fight for marriage equality as well as the ensuing backlash, including religious freedom bills and "bathroom bills" in numerous states (Kimmel, 2015). Living through these historical events at varying stages of being "out" necessarily colors LGBTQ older adults' experience of life review and the types of unfinished business they may be dealing with. This could be difficult to integrate and incorporate into their identity since

there is no "single identity" but multiple identities related to culture, ethnicity, gender, socioeconomic status and more, with common denominators that include oppression and prejudice. Some older LGBTQ individuals survived adversity by hiding and denying aspects of the self. This survival mechanism may have delayed "synthesis" (Cass, 1979), which leads to full acceptance of LGBTQ identity and synthesizes into the person's total sense of self as an individual that has integrated multiple aspects of the self in order to fully function in a healthy way.

"Sexual minority" status can shape adult experience and the ongoing review of personal identity as well as life narrative. Both of these intersect with diverse factors such as gender, race, ethnicity, class, historical age cohort, and the experience of coping with stigmatization. These factors become "grist for the mill" in the evolution of adult and elders' identity and the information of a personal narrative (Kertzner, 2001). The reciprocal influences on self-representation of aging and multiple "minority" identities has not been addressed by the literature in the depth and breadth necessary to fully understand the increasing numbers of LGBTQ baby boomers attaining senior status. Multiple factors must be considered in understanding how identity is enacted by this population. For example, consider the importance of when the individual self-identified as LGBQT; if it occurred during adulthood or at midlife, their life trajectory may have included heterosexual marriage and parenthood. Their entry into the LGBTQ social sphere would be different had it happened in late adolescence or early adulthood. Thus, exploring the individual's self-narrative as they consolidate multiple identities with past experiences is of importance in generating a life story that includes their awareness, transition, and implementation of the different elements leading to their current identity.

When counseling clients in this cohort, consider the following questions: At what stage of their life did these individuals first realize they were "different"? When did they come out to themselves? To others? How did the realization that they were gay/lesbian/bisexual impact their life narrative/story?

Family Issues

According to McGoldrick, Carter, and Garcia-Prieto, (2011), the family life cycle has "become a classic over 35 years". It describes the stages that individuals pass through from childhood to later life as a member of a family. Each stage provides milestones that ease the transition to the next stage. This section focuses on the elder LGBTQ individual; thus, only the "retirement or senior stage" will be discussed. During this phase, many changes occur, such as welcoming new members into the family and seeing members leave the family as children marry,

divorce, or produce grandchildren. Caring for elderly parents or frail partners, retirement, and coping with physical changes all require coping skills and support from caring individuals.

LGBTQ families are varied since there is no "typical" LGBTQ family nor family "model". For diverse racial/ethnic minority LGBTQ individuals, cultural norms dictate additional family interactions. LGBTQ "elders," like the general population, may get support from a number of sources that include the family of origin as well as a family of choice. *Family of origin* (FOO)refers to the biological or adoptive family an individual was either raised with or born into, and it includes the instances in which parents have separated and now live with new partners. Many individuals have a history of strained relationships with their FOO, which can add stressors to aging related concerns. Support, conflict, and ambivalence can add tension with FOO members.

Family of choice (FOC) includes persons or a group of people an individual sees as significant in his or her life (Weston, 1991). It may include none, all, or some members of the individual's FOO. In addition, it may include individuals such as significant others, domestic partners, friends, and coworkers, as well as "kin folk." If the FOO rejects the individual due to their "lifestyle," a FOC group provides the nurturing bond that becomes their community (Grossman, D'Augelli, & Hershberger, 2000). These individuals have an influential role in their lives and are not blood relatives. For many ethnic/racial minority individuals, a system of kin may already exist which is imbedded into their FOO. This poses a challenge in that it extends their FOO but it also provides a possible alternative to finding allies who accept them among the kin folk. The FOC offers acceptance and support to the individual by integrating him or her and the partner for holiday celebrations and events, and the FOC lends emotional support and affirmation regardless of sexual orientation.

The importance of friendships that lend social and emotional support to LGBTQ individuals cannot be emphasized enough. Many older LGBTQ persons, in fact, consider friendships to be their most important relationships (Heaphy, 2009), thus fulfilling needs that family and siblings may not. Social support wards off isolation and loneliness that can occur as a result of aging, possible declining health, loss of a partner, and children growing and forming their own families. For single LGBTQ individuals, the closeness and support that friendship bonds provide sustains, nourishes, and gives them companionship and affirming acceptance of being valued (Hooyman & Kiyak, 2008). Many LGBTQ individuals expand their social network as they age to include younger individuals who may not share their sexual orientation or gender identity/expression but who are nevertheless open and understanding of LGBTQ issues. Older adults become more selective about their social networks, valuing emotional satisfaction over "fitting in".

Aging brings forth assets such as experience, life knowledge, and wisdom, as well as negatives such as a degree of physical decline that can result in greater dependence on others as well as social services. Western society values independence and self-sufficiency over dependence and even interdependence. The reliance on others for help and support in performing tasks that were formerly possible can bring forth self-esteem

issues and depression. Individuals may withdraw and attempt to isolate and insulate themselves to avoid becoming a burden. Social isolation impacts many LGBTQ elders as they cope with stigma and discrimination related to ageism, heterosexism, and underrepresented status. This "triple whammy" is a primary risk factor for social isolation, impacting LGBTQ elders in unique and disproportionate ways (Kimmel, 2015). A primary risk factor is living alone. LGBTQ elders are twice as likely to live alone, twice as likely to be single, and 3 to 4 times less likely to have children; many are estranged from their biological families. Providing these individuals access to a supportive and nurturing community and providing a gathering place for those who are mobile and transportation for those who are not mobile can foster a healthy mental balance that serves to inoculate against stress and depression.

Concerns for this population include anxieties about aging, financial matters, health issues, companionship, and the stereotypes surrounding ageism that result in discriminatory attitudes by others (Mabey, 2011). These issues are not unique to LGBTQ elders, but the synergy of those issues when combined with underrepresented statuses can become a complex issue for counselors to address with their clients. These issues grow again in complexity when the LGBTQ elder is also a person of color (Otis & Harley, 2016).

In light of this diverse intersectionality, counselors should consider how different ethnicities and cultural backgrounds can impact their clients' relations with their FOO or FOC. For example: In what ways might cultural expectations impact an African American bisexual man's access to FOO or FOC differently from a White gay man? A Latina lesbian? A second generation immigrant who identifies as transgender? Also, counselors can reflect on the greatest supports in their lives in order to relate more easily to clients who may be struggling with their own support system. Counselors may ask themselves, "If something happened and I couldn't take care of myself, who would I lean on? What would I do if I couldn't depend on someone in my family of origin?"

Strengths and Challenges

Strengths

Though there is a long list of potential challenges for LGBTQ older adults in addition to those facing more enfranchised populations of aging people, these individuals are not without hope, as many have developed a strong inner resilience and self-sufficiency. Living for decades as an LGBTQ person, through varying degrees of "outness" and facing varying degrees of oppression due to intersecting identities, some older LGBTQ adults use their past experiences to help them make meaning of their current strengths and give them purpose (Unger, 2000). Enduring oppression and discrimination, witnessing some progress in the movement towards acceptance and assimilation into the population as a contributing member of society, and celebrating the recognition of basic human rights in marriage equality all serve to affirm the valid contribution of the LGBTQ community to greater society. The strength and resilience developed by these individuals has been attained through great sacrifices. Thus, helping profes-

sionals who work with LGBTQ older individuals must procure training and information that sets them as affirming, supportive and knowledgeable allies. This is a social justice issue that permeates professional competence.

Considerations related to these issues include: How would the counselor work with a dying LGBTQ elder who is thinking about end of life? How can counselors help to balance sadness and regret with a search for strengths? What needs are vital for younger LGBTQ adults to address so that they enter older adulthood with resilience and purpose?

Challenges

LGBTQ older adults may have come out later in life due to many factors and circumstances consonant with the time period when they were developing adolescents and young adults. Lack of information, geographic isolation, family cultural and religious beliefs, and fear of losing social connections could all be considered contributing factors to the person's inhibition for questioning their sexual orientation or gender identity (Scherrer & Fedor, 2015). Some may have had previous relationships or marriages with a different sex partner or, in the case of transgender individuals, they may have tried to live in those relationships as the sex they were assigned (Barker, Herdt, & de Vries, 2006). Because of this, they may struggle with developing new romantic or friendship relationships within the LGBTQ community and suffer isolation as a result (Fullmer, 2006). They may also mourn a separation from heterosexual and cisgender couples they previously connected with through their own relationships. The identity transition from "perceived heterosexual/cisgender person" to "acknowledged LGBTQ person" requires support and affirmation in the face of oppression and fear of rejection. Many efforts to attain integration are accompanied by a sense of loss until gains are acknowledged.

LGBTQ individuals who lose partners, spouses, or members of their FOC to death often suffer *disenfranchised grief,* which is defined as grief resulting from a loss that is not socially sanctioned in the wider society, or grief that is unrecognized (Doka, 2002). This may be particularly true for folks losing loved ones to AIDS or HIV-related illnesses. Because the stigma associated with AIDS has been pervasive across time, older LGBTQ adults may have carried unmourned losses for decades without recognition or support. If they have mourned and were lucky enough to find support among other LGBTQ adults, they still may feel slighted by the wider society who ignores (at best) or persecutes (at worst) them or their deceased loved ones. In addition, there are few resources available in most areas that are specifically tailored to helping bereaved LGBTQ folks. Finally, even for those who live in areas with a concentrated LGBTQ population, there may be barriers to accessing support depending on cultural expectations. For example, a bisexual Black man may not feel comfortable reaching out for assistance even if he lives in a city with a relatively significant LGBTQ population and resources because of rampant stigma and stereotypes within Black culture surrounding men who have sex with men (Quinn, Dickson-Gomez, & Young, 2016).

Older LGBTQ adults who are bereaved may also experience differing levels of support depending on how "out" each part-

ner or spouse was to their FOO and others. If the surviving partner was more out, their grief would be unrecognized by the FOO of the deceased, and therefore they may face limitations regarding support from that network as well as the potential not to be included in memorial arrangements. If either of them were out to some but not all the people in their lives, the survivor will likely undergo pain and confusion regarding who knows what about their relationship and what it means to the survivor (Whipple, 2005). This makes working with grief issues more difficult and may require the help of a trained professional who can offer a safe, confidential forum for processing the pain of grief (Worden, 2009).

Varying degrees of connection to FOO impact caregiving issues for LGBTQ older adults (Scherrer & Fedor, 2015). They may have a caregiver who is not a member of their FOO, or they may be providing caregiving to someone who is not a member of their FOO (MetLife, 2010). Systemic bias may affect the quality of health care these individuals receive, thus also affecting their resilience and self-sufficiency. Many older LGBTQ adults rely only on their FOC for health care and dependent support. They may not feel comfortable coming out to health care professionals for fear of discrimination (Kertzner, Meyer, Frost, & Stirratt, 2009). Their wariness is justified, because many health care professionals may not be LGBTQ affirming or knowledgeable of LGBTQ health issues. On top of this, an LGBTQ person of color, immigrant, or refugee may face additional discrimination or lack of access to appropriate health care (Fredriksen-Goldsen et al., 2011). This issue brings forth the consideration that the divulging of a person's sexual orientation or gender identity to others is a lifelong process that does not stop when family and friends are told for the first time. This can be a constant stressor that further exhausts the individual.

Entering into assisted living and giving up independence causes some older LGBTQ adults to "reenter the closet." Many older LGBTQ adults avoid or delay this action, or they conceal their sexual orientation or gender identity from health providers and social service professionals for fear of discrimination (Johnson, Jackson, Arnette, & Koffman, 2005). This could be because of the lack of recognition of the needs of LGBTQ folks within these facilities as well as the reintroduction of stigma based on sexual orientation and/or gender identity/expression. Unmarried partners may be separated due to misunderstanding of their relationship. Many institutions opt to cite legal stipulations to bypass the rights of partners to have access to their loved ones once their loved ones are institutionalized.

Older transgender adults may face additional challenges (Cook-Daniels, 2015). Although the current LGBTQ rights movement began with primarily transgender women of color standing up against oppression at the Stonewall Inn, the movement has largely privileged gay men and lesbians and issues of sexual orientation. Transgender individuals often find themselves disenfranchised even within the LGBTQ community and, as a result, feel less connection to it. This may be even truer for older transgender individuals, who do not experience the current surge in support for transgender adolescents and young adults. This population may be effectively invisible, leading to disenfranchisement and loneliness.

Finally, ageism itself presents yet another challenge to LGBTQ older adults. Wider American society favors the young, considering them to be more beautiful and more valuable (Orel & Fruhauf, 2015). In addition to the discrimination, disenfranchisement, and/or invisibility LGBTQ older adults already face because of their sexual orientation or gender identity/expression, they may feel devalued as a result of their age. This may be especially true for women and feminine identifying individuals, for whom society's standard of beauty offers a harsh yardstick. This, complicated by differing cultural ideas of aging persons as well as disability status, may serve to further isolate LGBTQ older adults.

Some questions for counselors to reflect on include: What are some of the challenges shared by LGBTQ individuals who are trying to consolidate multiple identities? How can counselors work to address these challenges?

Intersectionality

LGBTQ older adults' experience of life review and the types of unfinished business with which they may be dealing could be difficult to integrate and incorporate into their identity since there is no "single identity" but multiple identities related to culture, ethnicity, gender, socioeconomic status, and more, with common denominators that include oppression and prejudice. Even for those who live in areas with a concentrated LGBTQ population, there may be barriers to accessing support depending on cultural expectations.

The convergence of being a sexual minority with gender, race, ethnicity, socioeconomic status, and age necessitates integration and assimilation to form a unique identity. Of particular importance is the meaning of "family" to some cultural groups that define family as encompassing a broader circle than the nuclear "couple and children," thus exploring how LGBTQ elders identify what they consider family, how they define it, and the role it plays in their life related to their identity is very important to the synthesis of the individual as "whole." There are varying degrees of acceptance of sexual identity in different cultures, such as the "two spirited" construct that some Native American tribes hold. Exploring the meaning of sexual identity and couple formation within the ethnic LGBTQ community is useful and necessary.

Questions for counselors to consider are: How would the counselor describe him- or herself in context of the groups that share a similar identity? How does the counselor describe his or her family composition as it relates to his or her culture and ethnic heritage?

Counseling Considerations

Gendron, Pendleton, and White (2016) provide recommendations for counselor-specific competencies in working with LGBTQ older adults. They emphasize that counselors must possess an "understanding of the sexual minority experience and the effects that such experience along with the aging experience have had on the life of the LGBT elder" (Gendron et al., 2016, p. 463). Counselors must understand how growing up LGBTQ impacts psychological development differently from heterosexual and cisgender individuals. Understanding and acknowledging the synergy of multiple minority statuses is imperative for counselors' ability to help this population that

has received negative messages from society. Sensitivity to the following issues is a necessity in order to provide competent services to LGBTQ elders (Mabey, 2011):

- the social and historical context presented by the client;
- the language utilized by the client specific to his or her historical context;
- ageism, fear of aging, homophobia (internalized or societal);
- empathy and compassion regarding the LGBTQ/minority experiences;
- understanding the intersectionality between LGBTQ issues, race, ethnicity, and aging; and
- how to foster and provide an inclusive environment.

As has been discussed throughout this article, older LGBTQ adults face many complex issues related to family, whether FOO or FOC. Counselors therefore should remain curious about individual clients' experiences with the concept of "family," investigating who a given client means when using that term rather than making assumptions. The meaning of this term may have changed several times over the years as well, shifting with coming out; finding a community; making lifelong friends, companions, lovers, partners, and spouses; raising children; and experiencing changes in federal and state laws. Counselors should explore these issues with older LGBTQ clients in connection with their presenting issues. Ultimately, the counselor's willingness to build a positive, accepting working relationship with an older LGBTQ client, one that values and respects their personhood, will be most beneficial for the counseling process particularly with this population (Mabey, 2011).

As changes continue to be made to existing laws and statutes, the rights of older LGBTQ clients with respect to the various members of their families may change as well (Mabey, 2011). Laws may affect visitation rights in a hospital setting, custody of minors, wills and living wills, and other issues. Counselors working with this population should be vigilant about staying abreast of these changes as they impact who can have power of attorney should the client become incapacitated (i.e., limited to a blood relative, anyone the client has chosen). Counselors should also consider whether clients have made plans for crises that occur as a result of aging, both health- and non-health related, and whether any FOO or FOC members know about these plans (Heaphy, Yip, & Thompson, 2003).

As with any other population, having a list of resources handy helps enhance the work of counseling. For LGBTQ elders and their families, this may become crucial. Counselors should investigate what family services might be available in clients' home areas; what legal resources exist; and what national organizations might be able to help. An example of a national resource might be Services & Advocacy for GLBT Elders (SAGE; www.sageusa.org). In particular, their "SAGENet" affiliates provide useful resources and connections throughout the United States. SAGE also includes a pre-marriage program called "Talk Before You Walk" tailored to the needs and concerns of older LGBTQ individuals who are considering marriage.

Conclusion

As the number of older adults increases because of expanding longevity, the demand for competent services for this popu-

lation will also increase. Cahill and South (2002) suggest that approximately one to four million Americans aged 65 and older identify as LGBTQ. With the aging baby boomer population and the increasing visibility of the LGBTQ population, these numbers could double by 2030. Rendering competent, high quality gerontological counseling services is an increasing need that must be addressed by the profession.

Counselors must understand how growing up LGBTQ impacts psychological development differently from heterosexual individuals. Understanding and acknowledging the synergy of multiple minority statuses is imperative for counselors' ability to help this population that has received negative messages from society.

References

Barker, J. C., Herdt, G., & de Vries, B. (2006). Social support in the lives of lesbians and gay men midlife and later. *Sexuality Research & Social Policy, 3,* 1–23. doi:10.1525/srsp.2006.3.2.1

Bristowe, K., Marshall, S., & Harding, R. (2016). The bereavement experiences of lesbian, gay, and/or trans* people who have lost a partner: A systematic review, thematic synthesis and modelling of the literature. *Palliative Medicine, 30,* 730–744. doi:10.1177/0269216316634601

Cahill, S., & South, K. (2002). Policy issues affecting lesbian, gay, bisexual, and transgendered people in retirement. *Generation, 26,* 49–54.

Cass, V. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4,* 219–235.

Cook-Daniels, L. (2015). Transgender aging: What practitioners should know. In N. A. Orel & C. A. Fruhauf (Eds.), *The lives of LGBT older adults: Understanding challenges and resilience* (pp. 193–215). Washington, DC: American Psychological Association. doi:10.1037/14436-009

Doka, K. J. (Ed.) (2002). *Disenfranchised grief: New directions, challenges, and strategies for practice*. Champaign, IL: Research Press.

Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., . . . Petry, H. (2011). *The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults*. Seattle, WA: Institute for Multigenerational Health.

Fullmer, E. M. (2006). Lesbian, gay, bisexual, and transgender aging. In D. M. Morrow & L. Messinger (Eds.), *Sexual orientation & gender expression in social work practice: Working with gay, lesbian, bisexual and transgender people* (pp. 284–303). New York, NY: Columbia University Press.

Gendron, T. L., Pendleton, T., White, J. T. (2016). Mental health counseling of LGBT elders. In D. A. Harley & P. B. Terster (Eds.), *Handbook of LGBT elders: An interdisciplinary approach to principles, practices, and policies* (pp. 455–472). Cham, Switzerland: Springer International Publishing.

Grossman, A. H., D'Augelli, A. R., & Hershberger, S. L. (2000). Social support networks of lesbian, gay, and bisexual adults 60 years of age and older. *Journal of Gerontology: Psychological Sciences, 55B*, 171–179. doi:10.1093/geronb/55.3.P171

Heaphy, B. (2009). Choice and its limits in older lesbian and gay narratives of relational life. *Journal of GLBT Family Studies, 5,* 119–138. doi:10.1080/15504280802595451

Heaphy, B., Yip, A. K. T., & Thompson, D. (2003). The social and policy implications of non-heterosexual ageing—selective findings. *Quality in Ageing–Policy, Practice and Research, 4,* 30–35.

Hooyman, N., & Kiyak, H. (2008). *Social gerontology: A multidisciplinary perspective* (8th ed.). Boston, MA: Pearson.

Johnson, M. J., Jackson, M. C., Arnette, J. K., & Koffman, S. D. (2005). Gay and lesbian perceptions of discrimination in retirement care facilities. *Journal of Homosexuality, 49,* 83–102. doi:10.1300/J082v49n02_05

Kertzner, R. (2001). Developmental issues in lesbian and gay adulthood. In I. Meyer & M. Northridge (Eds.), *The Health of Sexual Minorities* (pp. 48–64). New York, NY: Springer.

Kertzner, R., M., Meyer, I. H., Frost, D. M., & Stirratt, M. J. (2009). Social and psychological well-being in lesbians, gay men, and bisexuals: The effects of race, gender, age, and sexual identity. *American Journal of Orthopsychiatry, 79,* 500–510. doi:10.1037/a0016848

Kimmel, D. C. (2015). Theories of aging applied to LGBT older adults and their families. In N. A. Orel & C. A. Fruhauf (Eds.), *The Lives of LGBT Older Adults: Understanding Challenges and Resilience* (pp. 73–90). Washington, DC: American Psychological Association. doi:10.1037/14436-004

Mabey, J. (2011). Counseling older adults in LGBT communities. *The Professional Counselor, 1*, 57–62. doi:10.15241/jem.1.1.57

MacKinlay, E. (2006). Spiritual care: Recognizing spiritual needs for older adults. In E. MacKinlay (Ed.), *Aging, spirituality and palliative care* (pp. 59–71). New York, NY: Haworth Pastoral Press.

McGoldrick, M., Carter, B., & Garcia-Prieto, N. (2011). *The expanded family life-cycle* (4th ed.). New York, NY: Pearson.

MetLife. (2010). *Still out, still aging: The MetLife study of lesbian, gay, bisexual, and transgender baby boomers*. Westport, CT: MetLife Mature Market Institute.

Orel, N. A., & Fruhauf, C. A. (2015). The intersection of culture, family, and individual aspects: A guiding model for LGBT older adults. In N. A. Orel & C. A. Fruhauf (Eds.), *The lives of LGBT older adults: Understanding challenges and resilience* (pp. 3–24). Washington, DC: American Psychological Association. doi:10.1037/14436-001

Otis, M. D., & Harley, D. A. (2016). The intersection of identities of LGBT elders: Race, age, sexuality, and care network. In D. A. Harley & P. B. Terster (Eds.), *Handbook of LGBT elders: An interdisciplinary approach to principles, practices, and policies* (pp. 83–101). Cham, Switzerland: Springer International Publishing.

Quinn, K., Dickson-Gomez, J., & Young, S. (2016). The influence of pastors' ideologies of homosexuality on HIV prevention in the Black church. *Journal of Religion and Health, 55,* 1700–1716. doi:10.1007/s10943-016-0243-6

Santrock, J. W. (2014). *Life-span development* (15th ed.). New York, NY: McGraw-Hill.

Scherrer, K. S., & Fedor, J. P. (2015). Family issues for LGBT older adults. In N. A. Orel & C. A. Fruhauf (Eds.), *The lives of LGBT older adults: Understanding challenges and resilience* (pp. 171–192). Washington, DC: American Psychological Association. doi:10.1037/14436-008

Unger, R. K. (2000). Outsiders inside: Positive marginality and social change. *Journal of Social Issues, 56,* 163–179. doi:10.1111/0022-4537.00158

Weston, K. (1991). *Families we choose: Lesbians, gays, kinship*. New York, NY: Columbia University Press.

Whipple, V. (2005). Addressing the needs of lesbian widows. *Journal of LGBT Issues in Counseling, 1,* 61–74. doi:10.1300/J462v01n01_05

Worden, J. W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed.). New York, NY: Springer.

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Bias and Discrimination

John Nance

Describing discrimination within the LGBTQ community holds unique complexities based upon minority status as well as multiple intersectionalities. The group experiences inimitable discrimination based on imposed societal norming and pressures. As the LGBTQ community ages into older adulthood, life course events and compounded discrimination along with losses, create unique considerations for treatment.

Current legislative trends across American society exemplify sweeping discriminatory policies within state governments and local municipalities. The largest mass shooting in recent American history took place June 11, 2016, in an Orlando, Florida, gay nightclub which sent shockwaves through the LGBTQ community throughout the nation. Disproportionate numbers of deaths due to fatal violence against transgender women of color have been reported throughout the United States. Although these events and expressions may not directly impact individuals, the ongoing message clearly demonstrates marginalization taking place in the lives of LGBTQ individuals who are reminded daily of their status as they observe from a distance.

Many negative societal dynamics impact vulnerable LGBTQ older adults. Because of nontraditional self-identification or the lack of identification, challenges exist for the older LGBTQ population resulting from their own or their peers' past negative experiences. The complexity of intersectionalities with each marginalized individual in combination with normative discrimination (e.g., ageism, genderism) can create an atmosphere of disparity for the older adult population. Normal developmental milestones for the general aging population contribute to the complex intersectionality and the need for inquiry into the perception of the older LGBTQ client.

There are numerous questions counselors must address when they begin working with an LGBTQ client. Have they come out and to what degree? How is their health care, and are they transparent with their providers? What is their relationship status and how supportive are individuals in their life? Are they considering retirement or have they retired? What communities are available to them? Is spirituality an important factor as they make meaning of their lives?

All of these questions pose considerations as clients describe life events and complex histories as LGBTQ older adults. The unique history of each individual will reveal the potential impact of discrimination as the answers to these questions unfold. The exploration of LGBTQ older clients might begin to highlight the possible discriminatory experiences within their own minority group. For example, an older gay male seeking to date and posting personal information on social/dating media sites might illicit negative, harmful comments based upon his physical attributes and age.

Life Course Perspective

Later life involves maintaining well-being in the face of loss and compounded life difficulties. Building on a life course perspective of development, practitioners are able to consider the unique needs of aging LGBTQ adults based upon the cohort effects of their generation. Life experiences and generations of discrimination differentiate this group from their younger counterparts (Institute of Medicine, 2011). According to Elder (1994, 1998), interplay of historical times, the timing of social roles and events, the linked and interdependent nature of life, and human agency are all central to understanding impacts on each aging LGBTQ individual.

The impact of experiences throughout life and the compounded minority stress brought on by a lifetime of discrimination on the health of LGBTQ adults is well documented. LGBTQ individuals report high rates of prejudice and discrimination across the life span, with one survey reporting up to one quarter of LGBTQ identified adults experiencing victimization related to sexual orientation (Herek, 2000; Herek, Gillis, & Cogan, 1999).

Concepts of Minority Stress

Aging LGBTQ adults live in discord between the dominant society and their personal culture, needs, and experiences, creating social stress and unpredictability (Meyer, 1995). This describes minority stress and has become a widely-accepted framework for understanding such disparities in mental health outcomes among gay men and other sexual and gender minority populations (Meyer, 2003). Several studies quantify stressors including victimization, discrimination, stigmatization, expectations of rejection, and vigilance (Fredriksen-Goldsen, Kim, Barkan, Balsam, & Mincer, 2010; Mays & Cochran, 2001; Meyer, 1995, 2007). Based upon discriminatory experiences and expectations the development of internalized self-hatred or internalized homophobia can lead to greater mental duress.

Developmental Lens

Has the client come out and to what degree?

Older LGBTQ adults remain on a continuum of those who have come out identifying as a sexual minority and those who have never come out. The process for subgroups and individuals may vary across the life span. Some individuals discover their unique identities much later than others. Many have disclosed to select individuals or groups and may not reveal their orientation in all areas of life. Practitioners have an obligation to seek the levels of disclosure with each client. As individuals

reveal orientation to family who are more likely to reject them, they tend to express resiliency by finding connections in sexual minority communities (D'Augelli, Grossman, & Gershberger, 2001). Zimmerman, Darnell, Rhew, Lee, and Kaysen (2015) described these findings with sexual minority women. The study found that concealment of orientation in highly rejecting families, leading to lower collective self-esteem.

Counselors should consider the following when engaging with LGBTQ clients about their experiences coming out: What might the counselor want to know? What might clients believe is important? What is that timeline in their life? Who all did it impact, what relationships were strained, and who demonstrated alliance?

How might discrimination affect elder LGBTQ clients seeking medical care?

As LGBTQ adults age, declines in physical health occur which impacts any older adults' abilities, capabilities, and feelings of well-being. Additionally, the need to interact more frequently with medical personnel and facilities requires special attention to how an older LGBTQ adult feels about the medical treatment being provided and how medical personnel and facilities understand the needs of this special population.

Medical/health care providers. Many sexual minorities describe difficult interactions with health care providers who might shame or avoid normalized discussion regarding the orientation of their clients. Therefore, often LGBTQ adults must decide whether to disclose their orientation or different relationships to providers.

Overt discrimination from health care providers. Health care providers demonstrate a wide range of negative reactions toward all ages of LGBTQ patients, including rejection of the patient or exhibition of hostility, harassment, excessive curiosity, pity, condescension, ostracism, refusal of treatment, avoidance of physical contact, and breach of confidentiality (Brotman, Ryan, & Cormier, 2003; Coon, 2007; Kauth, Hartwig, & Kalichman, 2000; Meezan & Martin, 2009). Particular to the older LGBTQ population, discrimination in health care is evident (Cahill, South, & Spade, 2000; Concannon, 2009; D'Augelli & Grossman, 2001). LGBTQ adults may provide subtle hints to a provider to see if they understand the language and situations (MacBride-Stewart, 2001).

The risk of medical providers outing the client is a reality. Medical providers may neglectfully out clients when they may not have disclosed their identity with close relatives and friends. Additionally, providers might disclose to other professionals who might not be as engaging with clients and their orientation.

Access and equity in the design and delivery of health services can be an issue if medical service providers are unaware of the needs of older LGBTQ adults, if they omit special considerations for LGBTQ older client needs (omission bias), or if as a result of heterosexist attitudes these providers treat LGBTQ clients with unfair or unjust practices. Discrimination also occurs in the form of silence and therefore neglect. Health care institutions and providers neglect to inquire about the LGBTQ experience and fail to incorporate inclusive consideration into assessments and accommodations.

Complexity of health care needs within the community create more of a need to address older LGBTQ issues because more will be seeking treatment for various physical/emotional needs they will experience. The needs are complex and varied and include illnesses such as HIV and cancer, substance abuse treatment considerations, evaluating and choosing assisted living facilities, making end of life decisions, and transitioning to hospice care.

How will discrimination impact the narrowing of the social network for aging LGBTQ clients?

Family of origin. LGBTQ individuals are often rejected by family members as they come out. The rejection requires individuals to use their resiliency in establishing new relationships and community. LGBTQ people begin to develop "families of choice" rather than "families of origin" (Price, 2005). Medical treatment and procedure can limit or ignore the created families because of laws and policies of disclosure and limits of confidentiality. In medical health care facilities, these families of choice experience insufficient recognition for visiting, decision making and caring for their friend or partner (Swartz, Bunting, Fruhauf, & Orel, 2015; Turner & Catania, 1997). LGBTQ people benefit from informed health care providers who explore family dynamics and work with the individuals important to the client, so it is crucial to determine who clients consider their family members.

Caring for elderly parents or siblings. Discrimination might be demonstrated through families who believe that LGBTQ individuals are more able to care for aging family members because of the negative perception of relationships (Price, 2011).

Relationships. Explore the client's language and description of relationships and relationship status. Each client may present with different terms for a long-term relationship. Reflect on how clients describe their relationship status. Each client may present with differing forms of relationships including same-sex relationship, open relationships, triangulated relationships, and so on. Also consider the level of outness the client describes. How can the counselor explore the client's comfort in being out and to whom? What are the costs and benefits to coming out to different individuals in their lives? Some family members that may need to be considered include a spouse, children, and grandchildren.

Dating. Sexuality of older LGBTQ people must be addressed as it is often overlooked and even deemed as a problem to be managed or treated (Price, 2005). Because of this, aging LGBTQ clients might experience their sexuality as needing to be hidden (Blando, 2001). When addressing this issue with clients, consider the following:

- The possibilities of discrimination within group. How do clients explore dating and in what venues?
- Does the dating scene create stress and duress from the discrimination within group dynamics? Do clients experience body image concerns as a result of dating?
- Sexual performance in men might be an issue of concern and potential within group discrimination.

Meaning and Wisdom

Continuing tension exists within the greater culture of the United States as small groups press to pass religious freedoms

legislation targeting the LGBTQ community. Religion is often perceived as a source of trauma and discrimination for many in the LGBTQ cohort. Many have been shunned by their families of origin with shaming and laying guilt on them, casting belief that their orientation is truly a part of them. One of the suggested coping strategies for the general aging population is to connect with a spirituality which aids in development of resilience. Within the LGBTQ aging cohort, this is a question that might need to be processed at depth, especially when individuals are approaching the end of life and wondering about the meaning of their lives.

Discrimination and/or bias can occur with respect to several issues:

- Role of spirituality/faith.
- Influence of discrimination on the processing and pursuit.
- End-of-life meaning while trying to deal with stressful service providers and/or organizations.
- Careful selection of faith communities to avoid potential discrimination.

The loss of one's spouse is hard enough for any older adult. However, older LGBTQ adults may feel hesitant to identify their relationship after the death of a spouse to personnel planning the funeral. Additionally, the older LGBTQ surviving spouse may not receive the consideration, respect, and sympathy that a heterosexual survivor might, creating even more stress. Older adults may also feel, to a lesser degree, a similar sense of loss and hardship over the loss of pets.

Strengths and Challenges

Strengths

Compared to their heterosexual counterparts, older LGBTQ adults are more likely to experience poor health, disability, and mental distress (Fredriksen-Goldsen et al., 2013). However, growing evidence demonstrates a need for exploration of the subjective experiences of LGBTQ individuals which might contribute to successful aging (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2015). The narrative of each individual illustrates a depth of resilience useful in highlighting character strengths and coping abilities. For example, investigation into the story and history of the aging LGBTQ client has the potential to uncover aspects of strength relative to sexual identity development experienced over time. The client might also describe previous coping through physical and leisure activities contributing to emotional well-being. Indicators highlighting resilient expression assist the practitioner with interventions described by their clients.

Counselors should keep in mind the following when working with older LGBTQ clients:

- Consider the life-long narrative the client describes.
- How can the counselor explore the client's perspective of discrimination throughout the narrative?
- What in the client's story indicates resilient features and characteristics?
- How can the counselor focus on aspects of resiliency without dismissing the client's experiences of discrimination throughout his or her life?

Challenges

LGBTQ older adults have experienced lifelong minority stress. This distress comes from identity intersectionality related to race, gender, ability status, nationality, socioeconomic status, and sexual orientation. With the possibility of multiple lifelong experiences with discrimination from various cultural identities, older LGBTQ adults may now face discrimination and bias both from within their cultures and from heterosexual cultures based on age. Being an older adult is a newer identity (only experienced as one does age into older adulthood) that adds to the potential for discrimination and/or bias (i.e., ageism).

Butler (as cited in Aosved & Long, 2006) defined ageism as "institutionalized and individual prejudice against the elderly, stereotyping, myth making, distaste, and/or avoidance" (p. 482). While "elders" are respected and revered in some cultures, other cultures pay less respect to or neglect older adults and either fail to recognize ageist actions or allow ageism to thrive. In response to ageism, older LGBTQ adults may actually have developed adaptive coping strategies because of their lifelong experiences living in a homophobic world (Woolf, 2002). However, because of the multiple layers of potential discrimination (e.g., sexism, racism, classism), older LGBTQ adults face a more complex adaptation process when ageism interacts with homoprejudice.

Each milestone described holds unique complexities with the LGBTQ community. For older LGBTQ adults, age causes an additional identity issue, making the milestones even more complex. Some questions counselors might want to consider about milestone include addressing lifelong family of origin issues with respect to coming out (or not). How might age (as in older adulthood) create different needs for the older LGBTQ adult with respect to family of origin? For the family of origin?

A unique challenge for older LGBTQ adults is the belief that the LGBTQ community is youth-oriented. As older LGBTQ adults lose a partner/friends (via death) or perhaps have remained single but seek companionship, they may feel isolated from and discriminated by younger LGBTQ adults. While they may have learned to live with homophobia and discrimination from the heterosexual world, now they might also have to deal with ageist attitudes and beliefs from younger LGBTQ individuals. In some ways, this may be more painful and unbearable causing isolating behaviors and/or a new form of minority stress.

In assisting clients in processing this sort of discrimination, try the following exercise: Imagine going into a gay/lesbian bar and having people avoid you, or maybe you overhear people making fun of you, saying things like, "You're a dirty old man/woman" for being in the bar. How would you feel? If you had an older LGBTQ client with this experience, how would you begin to address the issue with the client?

Intersectionality

Within the greater society, normal aging processes hold important milestones which create vulnerability for aging individuals. Considering the intersectionality of identity along with marginalization and discrimination, elder LGBTQ individuals develop self-identities similar to their heterosex-

ual counterparts based upon multifaceted components of culture, race, gender, age, socioeconomic status, and social relationships. However, considering the intersectionality of identity along with marginalization, each of these facets has the potential for compounded discriminatory expression by others. Compared to their younger LGBTQ counterparts, coming out and being out might be negatively impacted by aging and necessary approach to enlisting a health care agency or helping individual. Considerations for these complexities is necessary.

Aging persons are faced with the potential for forced retirement based on age alone. As workplace discrimination and hiring discrimination remains a reality for LGBTQ-identified individuals, the impact for ageism and deepening of marginalization and discrimination greatly increases.

Some considerations for counselors include:
- If an older LGBTQ working client describes his or her fears relative to being "out" and approaching the age of retirement, what questions need to be pursued?
- How is the client addressing retirement and/or future employment?
- How has the client's employment history impacted his or her current retirement decisions?

Counseling Considerations

Evidence exists for the belief that the repertoire of coping strategies increases with age. Woolf (2002) addresses this idea in reporting that "successful adaptation to—and coping with—life in a homophobic culture provides useful psychological and interpersonal skills to use in later life" (p. 17). The two theories Woolf reviews with respect to successful adaptation to older adulthood for LGBTQ adults relate to many behaviors and psychological responses that were developed throughout their adult years. The concept of "mastery of crisis" or "crisis competence" relates to older LGBTQ as they lived successful lives in a homophobic world. Additionally, the experience of coming out (or the choice not to) develops self-confidence and a sense of accomplishment to survive, factors which are helpful in dealing with later life issues.

The second theory is Lee's (cited in Woolf, 2002) belief that "successful adaptation in life and aging is not grounded in learning how to cope with crisis or stress but rather in knowing how to side-step crisis or stressors" (p. 17). Older LGBTQ adults learned how to "avoid" potentially oppressive or dangerous situations; for example, they could determine when it was safe to "come out" to someone or an organization and when was it not. The belief then is that older LGBTQ clients can use this "side-stepping" when necessary to avoid discriminatory or difficult situations that arise in older adulthood.

A panacea of counseling and/or coping strategies for all the oppressive and discriminatory situations an older LGBTQ adult may experience does not exist. However, counselors can draw on any number of counseling strategies or models to address discrimination. For example, Chung's (2001) model for dealing with workplace discrimination can be modified to help an older LGBTQ client address some type of discriminatory situation. If counselors consider a medical/health care provider who the client believes is discriminating against him

or her, then simply substitute health care provider choice for vocational choice: health care tracking (i.e., researching medical care providers who are gay-affirming) or risk taking (i.e., choose another health care provider without knowledge of how gay-affirming the provider is).

Other helpful counseling considerations might be:
- Exploring evidence of resilience with respect to a strengths-based counseling approach.
- Exploring wisdom as a tool to address aging issues.
- Using storytelling and narrative therapy to help uncover the ego strength and coping strategies developed through living in a homophobic world.
- Conducting motivational interviewing: What has worked for the client in the past with discrimination and stigma?
- Introducing the idea of community building. Seek access to organizations like The Gay and Lesbian Outreach to Elders, which is located in San Francisco. If such an organization does not exist, then advocate to start one (particularly in rural areas). Involvement in an LGBTQ community may help some older LGBTQ adults address consequences like feelings of isolation due to stigma.
- Processing perspectives on faith and spirituality may provide a different lens for addressing ageism and discrimination.
- Following are some additional considerations counselors should keep in mind:
- Is the discrimination of older LGBTQ adults similar to the discrimination experienced by younger LGBTQ adults?

Some questions counselors may want to consider before working with older LGBTQ clients include:
- How might counselors approach an older client reporting with discriminatory behavior from younger LGBTQ adults?
- What are counselors' beliefs and feelings about older LGBTQ adults who go to bars and/or who seek younger partners?
- What Internet resources might help older LGBTQ adults find companionship?
- How might counselors find gay-affirming health care providers or assisted living facilities for older LGBTQ adult clients?

Conclusion

Older LGBTQ adults have experienced discrimination, stigma, alienation, and early persecution throughout their adult lives. Therefore, a greater chance exists that they now have the wisdom, ego strength, and coping strategies to deal with age-related minority stress. However, older clients will still report to counseling with developmental stress (e.g., health problems that impact sexual functioning) and with life experiences/milestones that they have not yet encountered. These experiences were also not likely to happen during younger adult years.

Counselors must be prepared to understand the historical climate for older LGBTQ clients to better assess the coping strategies (e.g., side-stepping, avoidance) that they may need

help in implementing in new situations (e.g., ageist actions). Younger LGBTQ therapists should be willing to allow older clients to use coping strategies that feel best for them, rather than focusing on strategies that they themselves would use in a discriminatory experience.

References

Aosved, A. C., & Long, P. J. (2006). Co-occurrence of rape myth acceptance, sexism, racism, homophobia, ageism, classism, and religious intolerance. *Sex Role, 55*, 481–492.

Blando, J. A. (2001). Twice hidden: Older gay and lesbian couples, friends, and intimacy. *Generations, 25,* 87–89.

Brotman, S., Ryan, B., & Cormier, R. (2003). The health and social service needs of gay and lesbian elders and their families in Canada. *The Gerontologist, 43,* 192–202.

Cahill, S. R., South, K., & Spade, J. (2000). *Outing age: Public policy issues affecting gay, lesbian, bisexual, and transgender elders.* Washington, DC: Policy Institute, National Gay and Lesbian Task Force.

Chung, Y. B. (2001). Work discrimination and coping strategies: Conceptual frameworks for counseling lesbian, gay, and bisexual clients. *The Career Development Quarterly, 50,* 33–44. doi:10.1002/j.2161-0045.2001.tb00887.x

Concannon, L. (2009). Developing inclusive health and social care policies for older LGBT citizens. *British Journal of Social Work, 39*, 403–417.

Coon, D. (2007). Exploring interventions for LGBT caregivers: Issues and examples. *Journal of Gay & Lesbian Social Services, 18*, 109–128.

D'Augelli, A. R., & Grossman, A. H. (2001). Disclosure of sexual orientation, victimization, and mental health among lesbian, gay, and bisexual older adults. *Journal of Interpersonal Violence, 16,* 1008–1027.

D'Augelli, A. R., Grossman, A., & Hershberger, S. (2001). Social support networks of lesbian, gay, and bisexual adults 60 years of age and older. *Journal of Gerontology: Psychological Sciences, 55B*, 171–179.

Elder, G. H. (1994). Time, human agency, and social change perspectives on the life-course. *Social Psychology Quarterly, 57*, 4–15.

Elder, G. H. (1998). The life course as developmental theory. *Child Development, 69,* 1–12.

Fredriksen-Goldsen, K. I., Emlet, C. A., Kim, H. J., Muraco, A., Erosheva, E. A., Goldsen, J., & Hoy-Ellis, C. P. (2013). The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: The role of key health indicators and risk and protective factors. *The Gerontologist, 53,* 664–675. doi:10.1093/geront/gns123

Fredriksen-Goldsen, K. I., Kim, H. J., Shiu, C., Goldsen, J., & Emlet, C. A. (2015). Successful aging among LGBT older adults: Physical and mental health-related quality of life by age group. *The Gerontologist, 55,* 154–168. doi:10.1093/geront/gnu081

Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Balsam, K. F. & Mincer, S. L. (2010). Disparities in health-related quality of life: A comparison of lesbians and bisexual women. *American Journal of Public Health, 100,* 2255–2261. doi:10.2105/AJPH.2009.177329

Herek, G. (2000). The psychology of sexual prejudice. *Current Directions in Psychological Science, 9,* 19–22.

Herek, G. M., Gillis, J. R., & Cogan, J. C. (1999). Psychological sequelae of hate-crime victimization among lesbian, gay, bisexual and transgender adults. *Journal of Consulting and Clinical Psychology, 67,* 945–951.

Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.* Washington, DC: National Academies Press.

Kauth, M. R., Hartwig, M. J., & Kalichman, S. C. (2000). Health behavior relevant to psychotherapy with lesbian, gay, and bisexual clients. In R. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 435–456). Washington, DC: American Psychological Association.

MacBride-Stewart, S. (2001). *Health "in queer street": Constituting sickness, sexualities and bodies in the spaces of lesbian health* (unpublished doctoral dissertation). Retrieved from http://www.uncc.worldcat.org

Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 91,* 1869–1878.

Meezan, W., & Martin, J. I. (2009). *Handbook of research with lesbian, gay, bisexual, and transgender population.* New York, NY: Routledge.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36,* 38–56.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674–697.

Meyer, I. H. (2007). Prejudice and discrimination as social stressors. In I. H. Meyer and M. E. Northridge (Eds.), *The health of sexual minorities.* New York, NY: Springer.

Price, E. (2005). All but invisible: Older gay men and lesbians. *Nursing Older People, 17,* 16–18.

Price, E. (2011). Caring for mum and dad: Lesbian women negotiating family and navigating care. *British Journal of Social Work, 41*, 1288–1303: doi:10.1093/bjsw/bcr015

Turner, H. A., & Catania, J. A. (1997). Informal caregiving to persons with AIDS in the United States: Caregiver burden among central cities residents eighteen to forty-nine years old. *American Journal of Community Psychology, 25,* 35–59.

Woolf, L. M. (2002). Gay and lesbian aging. *SIECUS Report, 30,* 16–21.

Zimmerman, L., Darnell, D. A., Rhew, I. C., Lee, C. M., & Kaysen, D. (2015). Resilience in community: A social ecological development model for young adult sexual minority women. *American Journal of Community Psychology, 55,* 179–190. doi:10.1007/s10464-015-9702-6

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Case Studies

Ruth: Religion and Spirituality

Ruth is a 74-year-old Black lesbian who lives in Manhattan. Until she graduated from high school, she lived in the South, growing up in a strict fundamentalist household. Her father was a preacher and her mother was the church secretary. She had "crushes" on other girls and in junior high school realized what her attraction to these girls meant. As an active member of her father's church, she felt ashamed of her feelings and did her best to conform to the church's belief that homosexuality was a mortal sin.

At the end of her senior year, Ruth became good friends with another girl from the church, Beth Ann. They had sleepovers and talked about their dreams, and they discovered they both had the same attraction to women. During a sleepover, her mother "caught them" in bed, "freaked out," dragged Ruth out, and started beating her with a belt. Ruth's parents told Beth Ann's parents. Both girls were sent to a church camp for "troubled teens."

The camp was a terrible and violent experience for both women, and they were indoctrinated to view themselves as evil, wicked, and undeserving of being with God until they changed their ways. Ruth began to hate everything about religion, and she couldn't stop feeling that somehow God was punishing her. In the end, Ruth and Beth Ann ran away together to Manhattan, where they stayed with a young gay male friend for the first year.

Ruth struggled throughout her adult years with depression, anxiety, and guilt. When her beloved Beth Ann was killed in a car accident, she blamed God for her problems and the church for rejecting her. At the worst times, she abused alcohol to make herself feel better, but she always realized that that was not going to save her.

Ruth retired two years ago from a bank where she worked for many years as a senior loan officer. She learned that her mother had recently passed away and nobody in the family informed her. If an old high school friend hadn't found her and told her, she would not have known her mother she died. This lack of communication from her family brought back her angry memories about religion and God. She called her father and said she wanted to visit her mother's grave; her father asked her if she had "changed her ways," and she honestly responded, "No, Dad, I am still a lesbian." He called her the "devil incarnate" and told her he didn't have a daughter.

Ruth's first instinct was harm herself in some way, but she realized it would not help. She started thinking about the Goddess that she often turned to, wondering how she could gain acceptance from her father. Then, she wondered if the Goddess would even think it necessary for her to convince her religious father of anything. Ruth is confused again; she wants to connect with her family of origin, but she doesn't see how that is going to be possible. Instead of love for her parents, she begins to feel the "hate" that she used to feel for her father and the church. This frightens her because she has a strong inner core of religious/spiritual values (perhaps partially left over from her childhood), and she feels it is wrong to hate anyone as strongly as she does for her father.

Allen: Health Issues

Allen is an 82-year-old White man who has identified as bisexual his entire life. He has been married for more than 55 years to the same woman, Patty. When the AIDS epidemic hit in the 1980s, he told Patty about his attraction to men. While they decided not to divorce for the sake of the children (two sons), they started sleeping in separate bedrooms. Although Allen has had the same physician for many years, he is reluctant to share some of his more "personal" medical issues with him. When Allen shared even the basics about having sex with men and women in the past, the doctor told Allen his behavior put his wife at risk, which made Allen feel ashamed about his behavior.

In the past eight years, Allen lived with Patty but has had a committed sexual relationship with Tim, a 69-year-old Black man. Recently, Patty was admitted to a long-term care facility due to a stroke that left her paralyzed and unable to communicate well. Allen also has medical problems. He has had severe arthritis and high blood pressure for several years now. About a year ago, Allen started having rectal bleeding. He waited for more than 6 months before going to the LGBTQ community clinic again. The doctor there suggested that he go to his own doctor for further testing. Although embarrassed to do so, he went to his own doctor and after testing found out that he had anal cancer. By that time, the disease had progressed and Allen went through surgery as well as chemotherapy. Now he needs more, help and his doctor wants him to go into a long-term care facility.

The doctor recommends that he go into the same facility as his wife and then they could share a room. Tim wants Allen to move in with him because Tim wants to take care of him. Allen does not want to share a room with his wife in that facility. The few times that Tim went with Allen to visit his wife, he noticed the lack of diversity at the nursing home and that the staff talked with him but avoided talking with Tim. However, if he moves in with Tim, Allen fears his sons would think that was "weird" and would want to know why he does not want to be with Patty; neither of them had ever disclosed Allen's sexual orientation to their sons. Allen feels more and more hopeless every day; he doesn't want to lose Tim if he chooses to go to a nursing home, and he has not yet discussed his options with anyone.

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