View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by ScholarlyCommons@Penn

University of Pennsylvania
ScholarlyCommons

Doctorate in Social Work (DSW) Dissertations

School of Social Policy and Practice

Spring 5-16-2020

A TWO-PAPER EXPLORATION OF QUEER AFFIRMATIVE THERAPY

Luis M. Ramirez
University of Pennsylvania, lmrg@upenn.edu

Follow this and additional works at: https://repository.upenn.edu/edissertations_sp2

 Part of the Social Work Commons

Recommended Citation

Ramirez, Luis M., "A TWO-PAPER EXPLORATION OF QUEER AFFIRMATIVE THERAPY" (2020). *Doctorate in Social Work (DSW) Dissertations*. 143.
https://repository.upenn.edu/edissertations_sp2/143

This paper is posted at ScholarlyCommons. https://repository.upenn.edu/edissertations_sp2/143
For more information, please contact repository@pobox.upenn.edu.

A TWO-PAPER EXPLORATION OF QUEER AFFIRMATIVE THERAPY

Abstract

The following is a two-paper exploration of queer affirmative therapy. The first paper is a historical analysis of the pathological clinical discourses targeting queer clients. There has been a long history of pathological clinical frames in working with queer clients. Most notable have been the pathologizing of queer identities in the DSM and the practice of conversion therapy. Yet, these frames come from a broader socio-political history that precedes the development of the DSM and continues in our current time in a range of different ways. This paper traces these discourses of pathology across time. It pays particular attention to analyzing clinical papers from before and after the creation of the DSM. By bringing attention to this history and pointing to the ways that it continues to impact clinical frames in the present, this paper invites the readers to reflect on this history of oppression that the mental health field has reinforced as a point of entry for conceptualizing queer affirmative alternatives. The second paper is a qualitative study that explores queer affirmative approaches with queer-identified clinicians. According to the available literature there is a lack of queer affirmative training for clinicians. As a result, queer people struggle to find clinicians who are prepared to help them resist systemic marginalization and who address the reproduction of dominant discourses in the clinical room. Queer-identified clinicians' expertise is a significant and untapped resource to explore how to counteract frames of pathology and contribute to the fostering of a therapy that is responsive and affirming of the variety, fluidity and intersectional experiences of queer peoples' lives. This study examines the experiences of 8 queer-identified clinicians who have a range of experiences working with queer clients. The findings of this study are used to develop principles as a guide to provide queer affirmative therapy.

Degree Type

Dissertation

Degree Name

Doctor of Social Work (DSW)

First Advisor

Ezekiel Dixon-Roman

Second Advisor

Ed Brockenbrough

Keywords

LGBTQ, queer, pathology, queer affirmative therapy, intersectionality, heteronormativity

Subject Categories

Social and Behavioral Sciences | Social Work

This dissertation is available at ScholarlyCommons: https://repository.upenn.edu/edissertations_sp2/143

Spring 5-16-2020

A TWO-PAPER EXPLORATION OF QUEER AFFIRMATIVE THERAPY

Luis M. Ramirez, LCSW
University of Pennsylvania
lmrg@upenn.edu

COPYRIGHT

© Luis M Ramírez, 2020. All Rights Reserved

A TWO-PAPER EXPLORATION OF QUEER AFFIRMATIVE THERAPY

Abstract

The following is a two-paper exploration of queer affirmative therapy. The first paper is a historical analysis of the pathological clinical discourses targeting queer clients. There has been a long history of pathological clinical frames in working with queer clients. Most notable have been the pathologizing of queer identities in the DSM and the practice of conversion therapy. Yet, these frames come from a broader socio-political history that precedes the development of the DSM and continues in our current time in a range of different ways. This paper traces these discourses of pathology across time. It pays particular attention to analyzing clinical papers from before and after the creation of the DSM. By bringing attention to this history and pointing to the ways that it continues to impact clinical frames in the present, this paper invites the readers to reflect on this history of oppression that the mental health field has reinforced as a point of entry for conceptualizing queer affirmative alternatives. The second paper is a qualitative study that explores queer affirmative approaches with queer-identified clinicians. According to the available literature there is a lack of queer affirmative training for clinicians. As a result, queer people struggle to find clinicians who are prepared to help them resist systemic marginalization and who address the reproduction of dominant discourses in the clinical room. Queer-identified clinicians' expertise is a significant and untapped resource to explore how to counteract frames of pathology and contribute to the fostering of a therapy that is responsive and affirming of the variety, fluidity and intersectional experiences of queer peoples' lives. This study examines the experiences of 8 queer-identified clinicians who have a range of experiences working with queer clients. The findings of this study are used to develop principles as a guide to provide queer affirmative therapy.

Degree Type
Dissertation

Degree Name
Doctor of Social Work (DSW)

First Advisor
Ezekiel Dixon-Román, PhD

Second Advisor
Ed Brockenbrough, PhD

Keywords
LGBTQ, queer, pathology, clinical frames, queer affirmative therapy, queer theory, intersectionality, pathology, heteronormativity

Subject Categories
Social and Behavioral Sciences | Social Work

A Two-Paper Exploration of Queer Affirmative Therapy

Luis M Ramirez

A DISSERTATION
In
Social Work

Presented to the Faculties of the University of Pennsylvania

In

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

2020

Ezekiel Dixon-Román, PhD
Dissertation Chair

Sara S. Bachman, PhD
Dean, School of Social Policy and Practice

Ed Brockenbrough, PhD
Dissertation Committee

DEDICATION

For all my family (queer and non-queer). First, to el amor de mi vida, my husband Nelson, my rock and the center of my life. I am a better person because of you. You are my secure attachment. Para mi mamá Raquel, quien siempre me motivó a aprender y a luchar por mis sueños. Gracias por todo lo que me has dado en la vida mami. To my dad Donald, who taught me how to thrive, I am alive because of you. You were gone too soon. Para mi hermana Gloria (Melis) y mis hermanos Uriel y Angel quienes llenan mi vida de amor, risas y locuras. Lxs amo mucho. To Malena, who taught me how to survive in NYC and how to be compassionate with others. To Cristina for sharing your love, wisdom and nurturing my knowledge. You are a guerrera Christina. To David, who inspires me to overcome adversities and do not give up on myself. Your friendship taught me how to live.

Thanks to all of you.

ACKNOWLEDGEMENTS

I would like to first thank my committee, Ezekiel Dixon-Roman and Ed Brockenbrough for their support throughout this process. I would also like to thank all my colleagues and friends in the field who inspired me to create new knowledge and joined me in my journey to explore new clinical territories. Shana Williams, my right hand, your love for the profession and compassion to your clients taught me that I need to be humble in my learning journey and to raise my voice when injustices happen. To all my clinical interns who expanded my thinking about the field, who trusted me and engaged in mutual learning. You are the legacy that we need in this field, keep thinking outside of the box. I am endlessly grateful to all my mentors from the beginning of my profession, those who supervised my clinical work, who invested their knowledge in my future, who believed in me, who pushed my critical thinking, who were willing to learn with me, who advocated for me, who shared their privilege to open access for me in this field. I have all of you in my mind when I am supervising new generation of students. Finally, thank you to those queer clinicians who keep resisting and creating new ways to resist oppression for them and their clients. Our stories will not be erased, and we will continue resisting.

A TWO-PAPER EXPLORATION OF QUEER AFFIRMATIVE THERAPY

Luis Ramírez, LCSW

Ezekiel Dixon-Román, PhD

Abstract

The following is a two-paper exploration of queer affirmative therapy. The first paper is a historical analysis of the pathological clinical discourses targeting queer clients. There has been a long history of pathological clinical frames in working with queer clients. Most notable have been the pathologizing of queer identities in the DSM and the practice of conversion therapy. Yet, these frames come from a broader socio-political history that precedes the development of the DSM and continues in our current time in a range of different ways. This paper traces these discourses of pathology across time. It pays particular attention to analyzing clinical papers from before and after the creation of the DSM. By bringing attention to this history and pointing to the ways that it continues to impact clinical frames in the present, this paper invites the readers to reflect on this history of oppression that the mental health field has reinforced as a point of entry for conceptualizing queer affirmative alternatives. The second paper is a qualitative study that explores queer affirmative approaches with queer-identified clinicians. According to the available literature there is a lack of queer affirmative training for clinicians. As a result, queer people struggle to find clinicians who are prepared to help them resist systemic marginalization and who address the reproduction of dominant discourses in the clinical room. Queer-identified clinicians' expertise is a significant and untapped resource to explore how to counteract frames of pathology and contribute to the fostering of a therapy that is responsive and affirming of the variety, fluidity and intersectional experiences of queer peoples' lives. This study examines the experiences of 8 queer-identified clinicians who have a range of experiences working with queer clients. The findings of this study are used to develop principles as a guide to provide queer affirmative therapy.

Key words: LGBTQ, queer, pathology, clinical frames, queer affirmative therapy, queer theory, intersectionality, pathology, heteronormativity

Table of Contents

Dedication……v
Acknowledgements.....vi
Abstract.....vii
Table of Contents.....viii
Introduction.....1

Paper One: Historical analysis of the pathological clinical discourses targeting queer clients

Introduction…….....5
Theoretical frame.....9
Era 1: Pre DSM-I to the creation of the DSM-I (1952) 11
    Describing queer clients
    Assessing and treating queer clients
Era 2: Post DSM-I (1953) to the removal of homosexuality diagnosis from DSM (1973) 17
    Describing queer clients
    Assessing and treating queer clients
Era 3: Tracing discourses of pathology into the present 27
Conclusion.....31
References.....32

Paper Two: Exploration of queer affirmative approaches with queer identified clinicians: A qualitative study

Introduction.....38
Toward queer affirmative therapy.....41
    Queer theory
    Trans studies
    Queer of color critique
    Putting them together
Methodology.....47
Research design.....47
Researcher Positionality.....50
Findings.....52
    Queering the clinical setting: What queer-identified clinicians currently do
    Queer affirmative intake
    Queer Affirmative diagnosis
    The elephant in the room: systemic privilege and oppression
    Self-disclosure and use of self: Experiences of queer clinicians
    Advance trainings in Queer Affirmative Therapy
Discussion and implications 83
References.....86
Appendix.....90

INTRODUCTION

Removing the diagnosis of homosexuality as a psychological disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973 (Krajeski, 1996) was an important milestone in changing how the mental health field approaches sexual orientation. The depathologizing of homosexuality has since led to the development of affirmative research, trainings, and direct clinical practice for Lesbian, Gay and Bisexual people (Grzanka & Miles, 2016). Despite these efforts, there is still a need to continue addressing the stigma and oppression that therapists often enact in clinical settings when working with LGB people (Grzanka & Miles, 2016; McGeorge & Stone Carlson, 2011).

Researchers have documented the continued lack of competency and training that many therapists show when working with Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) people (Corturillo, McGeorge & Carlson, 2016, Bernstein, 2000; Godfrey et al, 2006; Green, 1996; Long & Serovich, 2003). These issues highlight the need for continued training of therapists in a queer affirmative approach that entails engaging with LGBTQ clients in an affirming and inclusive way (Corturillo, McGeorge & Stone Carlson, 2016). Yet, due to the lack of clarity around what queer affirming therapy entails when dealing with sexual orientation and/or gender identity, therapy often fails to be queer affirmative (Grzanka & Miles, 2016). The need for queer affirmative therapy is especially urgent in light of the many mental health challenges that confront LGBTQ individuals. LGBTQ youth and adults are at risk of physical and mental health challenges due to the experiences of victimization and negative peer relationships (Ryan et al, 2010).

This dissertation formatted in a two conceptually linked article length papers focuses first on exploring the clinical discourses in the mental health field generated about queer people, taking as a timeline the period of time before and after the creation of the DSM. The first paper is an analysis of clinical documents to examine the history of pathology and oppression that has characterized clinical approaches focused on queer clients. This paper will contribute to the learning that clinicians need to have when working with queer populations. It is an ethical obligation for any clinician to learn about the legacy of oppression that clinical approaches hold before using it with clients. Secondly, this dissertation intends to collect knowledge from unheard voices in the mental health field, by focusing on the experiences of queer-identified clinicians. The second paper will describe a qualitative study focused on understanding how current queer identified clinicians work with queer clients. This paper will inform the creation of principles that will guide clinicians into practicing queer affirmative therapy.

PAPER ONE:

HISTORICAL ANALYSIS

OF THE

PATHOLOGICAL CLINICAL DISCOURSES TARGETING QUEER CLIENTS

Luis Ramírez, LCSW

University of Pennsylvania

Paper One:
Historical analysis of the pathological clinical discourses targeting queer clients

Abstract

There has been a long history of pathological clinical frames in working with queer clients. Most notable have been the pathologizing of queer identities in the DSM and the practice of conversion therapy. Yet, these frames come from a broader socio-political history that precedes the development of the DSM and continues in our current time in a range of different ways. This paper traces these discourses of pathology across time. It pays particular attention to analyzing clinical papers from before and after the creation of the DSM. By bringing attention to this history and pointing to the ways that it continues to impact clinical frames in the present, this paper invites the readers to reflect on this history of oppression that the mental health field has reinforced as a point of entry for conceptualizing queer affirmative alternatives.

Key words: LGBTQ, queer, pathology, clinical frames

Historical analysis of the pathological clinical discourses targeting queer clients

2019 marked the 50th anniversary of the Stonewall riots. As part of commemorating this historic moment, I was asked to participate in a few events talking about the challenges that the queer community continues to confront in accessing queer affirmative mental health services. As I was gathering my ideas for these presentations, I realized that I needed to look back to history to understand the development of these challenges and compare them with the ones that we currently confront. As I explored this history, I began to see that while the mental health field has made many advances toward queer affirmative therapy, new ways to reinforce oppression continue to be enacted. Certainly, things have changed in the past 50 years in the mental health field. Yet, how much have things really changed for queer people? Who has benefit from these changes and who hasn't? How are we repeating the same pathological frames?

Based on my nine years of experience working in the mental health field with queer clients, I continue to see these pathological frames being reproduced on a daily basis.
For example, I remember having a conversation with some mental health colleagues who accused me of not being objective and of pushing an ideological agenda in my direct practice when talking about privilege and oppression. Though at first, I was uncertain how to reply to such accusations, I came to realize that the assumption behind those comments is that the mental health field is neutral and there is not a possibility of bias in our profession. This assumption stands in stark contrast to the neglect and pathology that has characterized the history of our field and continues to shape dominant approaches to supporting queer people.

To start this conversation, I wanted to share two cases that I encountered in my clinical work, the cases of Manny and Lorena. I will use these names as pseudonyms to protect the

confidentiality of these clients. At the time I met Manny, he was a 12 years old Black cis male who was in 7th grade. Because his biological parents struggled with addiction problems, he had been in foster care since he was 8 years old. Manny had a crush on Ricky, one of his school friends who was also a cis male. He decided to create a love letter to Ricky to express his feelings. On a piece of paper, he wrote "I like you; would you like to go out with me?" He sent the letter to him. Somehow the other kids in his school found out that Manny sent this letter to Ricky. Everybody began making fun of both of them. They were both very embarrassed and Ricky also became very upset with Manny. The situation escalated even more when a teacher found out about the letter and decided to tell the school counselor and the principal about the behavior that Manny was displaying. While the school was trying to understand how to manage the situation, Ricky went home to tell his mom about the fact that he was getting teased by the other students about the letter. The mother was upset about the way that her son was being treated and she decided to go to school to complain. The school's principal, counselor, teacher and Ricky's mother decided to talk to Manny about his sexual behavior and the possibility that he had committed sexual harassment towards Ricky with that letter. Based on the treatment he received by his peers and school staff, Manny stopped attending school regularly and the social worker assigned to his case decided to send him to an inpatient program when he began experiencing suicidal ideation. There he was diagnosed as having bipolar disorder and was prescribed different psychotropics. He was then assigned to a lower level of care to continue his treatment and address his truancy. It was also decided that he would wear a GPS ankle monitoring device to make sure that he wouldn't run away. Manny, a 12 years old black gay boy arrived in my office with a GPS device attached to his feet to start his outpatient mandated care.

Manny was blamed for expressing his romantic feelings, something that is a normal process for children his age. He was policed and treated as "deviant" for expressing something out of what everybody around him considered normal, especially when a cisgender heterosexual boy's well-being is compromised in the process. Different institutions were involved in Manny's case, the school, foster care, mental health field and the police to help him adjust to what was considered a healthy and normal sexual development. Allegedly, these institutions worked together to ensure his "well-being." However, the efforts that all of them invested in Manny's case only caused him to feel stressed and ashamed while also criminalizing his behavior.

Lorena is a 26 years old transwoman who emigrated from Honduras to the United States. She fled Honduras looking for freedom to be fully herself. She travelled all the way up to Guatemala and then to Mexico. She crossed different borders following another group of immigrants who identified as being LGBT. They all came together to protect themselves from the homophobia and transphobia that they might face on their journey. She was successfully able to arrive to New York City where she found support coming from the Trans Latinas community. Lorena knew that returning to Honduras would put her life in danger. She decided to apply for political asylum. She met with an immigration lawyer who requested paperwork to support her asylum case. One thing the lawyer requested was an affidavit coming from a therapist who would assess her experiences with trauma and persecution based on gender identity. In the process of the creation of this paperwork, the therapist was expected to gather information about Lorena's experience of persecution and the impact this has had on her mental health. In addition, the therapist was expected to provide a diagnosis to validate in the immigration court that Lorena is truly a transgender woman. Lorena arrived to my office describing these requirements and asked if I could help her. Since arriving in the United States, Lorena has had to navigate both the

immigration and mental health systems with the immigration system demanding that she get the stamp of approval from "a reliable source" who can determine whether she is "truly transgender" to ensure that she was not trying to "taking advantage" of the system. The only way to do this was for her to describe her history of trauma in a short period of time and be assigned a mental health diagnosis, such as gender identity disorder, which would not only help her immigration case but also allow her to get access to gender affirmative therapy that she desperately wanted.

Together, these cases show that discourses of pathology are alive and well in how the system continues to frame queer clients. In this paper, I trace the roots of the discourses of pathology that continue to inform mainstream clinical approaches to working with queer clients. I pay particular attention to the historical development of the way that clinicians talked about their queer clients with a particular focus on how they diagnosed and assessed them alongside the kind of treatments that they suggested. I organized this history around the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM) that has historically and continues to play an important role in informing clinical practice. While it is typically framed as a neutral tool that is based in science and creates categories to inform assessment and the most beneficial treatment for clients, I will show the ways that it has been complicit in the pathologizing of queer clients. Using the DSM as my primary point of entry, I have divided the analysis into three eras. The first era is pre-1952 when the DSM-I was created. The second era is from 1953 when the DSM-I was published until 1973 when the diagnosis of homosexuality was removed from the DSM. The last era focuses on tracing the discourses of pathology that permeated the DSM into the present to illustrate the enduring nature of these discourse in clinical approaches to working with queer clients as illustrated in the above two case studies.

Theoretical Frame

I will use queer theory and trans studies as a point of entry for identifying the hegemonic, dominant and pathological discourses emerging from the selected clinical documents across the three eras. These theories are essential in identifying pathological frames and deconstructing the normative narratives that clinicians have relied on when working with queer clients. In addition, these two theories will support this paper to challenge the claims of objectivity in the mental health field that led to the creation of the DSM and its diagnoses.

Queer theory has its origins in the work of Michel Foucault. Foucault (1978) argued that sexuality has been read in history through what he called the repressive hypothesis, that suggested that society constrains people from enacting their true sexual desires. According to this hypothesis, any sexuality outside to normative frames is prohibited and thus is repressed. In contrast, Foucault suggested that discourses surrounding discussions of sexuality were productive rather than repressive in that they created the sexual desires and identities that they were working to regulate. He was specifically interested in exploring how and why sexuality became an object of scientific discussion in Europe in the 18th and 19th centuries. He was interested in examining who was speaking around sexuality in what context and to what effect. Foucault stated that knowledge is power and believed that whoever determines what can be talked about in relation to sexuality determines what can be known about it. Through this paper I will explore about what voices were given authority and priority when providing services to queer clients and how much the voices of queer people were included in the process. In the same vain, it will be important to reflect about the voices who were excluded and how that process happened.

Queer theorists have built on Foucault's insights to denaturalize binary framings of gender and the presumption of heterosexuality illustrating the ways that dominant discourses of gender and sexuality erase the fluid and dynamic ways that many people experience and express the gender and sexual identities (Jagose, 1996). Some queer theorists have pushed these frameworks even further by centering the experiences of trans individuals through the creation of Trans studies. Trans studies complements queer theory by deconstructing transmisogynist discourses and static and linear models of gender identity (Getsy, 2014). Likewise, trans studies brings more explicit attention to discourses of disability because of the ways that trans bodies continue to be framed as disabled and in need of normalization using overtly pathologizing and stigmatizing frameworks (Puar, 2014). Together these two theories provide a coherent framework for deconstructing institutional frameworks of gender and sexual normativity that impose labels on people in ways that naturalize their oppression.

I will be further extending on queer theory and trans studies by bringing attention to the models that the mental health field has historically and continues to rely on to work with queer people and the ways that clinicians relate to those models when making assessments, generating diagnosis and describing queer clients while claiming to be interested in their the well-being. I will trace the discourses generated by the clinical documents in relation to sexual orientation and gender identity. I am interested in understanding what the clinicians were saying at the time, how they were framing their clinical assessment and how they were using the knowledge they found. In addition, I am interested in understanding the history of the clinical frames that are currently used by clinicians and see if these discourses are still relevant and still used in the present time.

As a caveat, this paper focuses exclusively on the history of pathology generated in the mental health field as an effort to raise attention to that oppressive legacy. So often mental health

professionals position ourselves as part of the solution and don't critically reflect on the ways that our field and the frameworks that we use reproduce an oppressive legacy. As a mental health provider who is invested in developing queer affirmative approaches to mental health, it is especially important for me to critically examine the history of pathology in the field and reflect on if and how it is shaping my work with clients and other clinicians. This is not intended to suggest that counternarratives that resist problematic clinical frames have not existed historically or in the present. There is much that we can learn from those who resisted and continue resisting the use of these pathological frames when providing services to the queer community. That said, it is equally important to recognize that these counternarratives have always been the exception to the rule in a field that by and large as adopted pathological frames. It is this dominant history that I seek to examine and challenge in this paper as a first step in developing a counternarrative in the present.

Era 1: Pre DSM-I to the creation of the DSM-I (1952)

Before the 1900s mental illness was treated primarily with superstitions and brutality. One of the people who influenced the start of mental health reform in the United States was Clifford Beers, who spent 3 years institutionalized in mental health facilities and then exposed their poor conditions after his release (Fahey, 1952). The book that he wrote which documented these experiences (Beers, 1908) attracted attention from influential people and led to the creation of the National Committee for Mental Hygiene in 1909. This organization took a leading role in reforming the care and treatment of the mentally ill in the US. With the outbreak of World War I the mental hygiene movement began to shift its focus to finding people mentally fit to engage in combat with many of its proponents identifying that many soldiers struggled with what was called "war neurosis" (Fahey, 1952). In the process of screening soldiers, they created a standard

for candidates and a concept of deficiency for those who were unable to meet the requirements to fight in war. Under that category were suspected homosexuals, who were identified and offered treatment with the intention of getting them to disavow their homosexuality and make them "fit" into the requirements for a capable soldier.

In 1946, building on this mental hygiene movement, the government passed the National Mental Health Act for the purpose of improving the mental health of the US population. Section 2 of the Act had the purpose of encouraging research in public and private spaces, experiments, demonstrations related to the cause, diagnosis and treatment of psychiatric disorders, training personnel in mental health challenges, and supporting states in the use of effective methods of prevention, diagnosis and treatment of psychiatric disorders. In line with previous screening tools that had been developed, homosexuality was included as one of those psychiatric disorders. Clinics that were developed as part of this reform sought to diagnose homosexuality and provide treatment to cure it. This mental hygiene perspective of homosexuality was taken up in different fields, such as education, public health, general medicine, industry, criminology, penology and social work (Fahey, 1952).

Describing queer clients

The language used by clinicians in this era when talking about queer individuals primarily described them as homosexuals. Homosexuality was connected to both mental and biological deficiencies. Connected to this discourse was the idea that homosexuality was an example of maladapting or maladjustment to a productive, heteronormative and cisgender society. Together these discourses produced the image of a homosexual as a deficient individual (or even a criminal individual) in need of support to adapt and adjust.

The connection of homosexuality with mental deficiencies can be seen in discourse surrounding men deemed ineligible for enrollment in the army. In addition to a list of factors such as mental retardation, epilepsy and brain tumors were a list of "conduct disorders and special difficulties" such as drug addiction, homosexuality and stammering (Arrington & Grossmann, 1942). Likewise, homosexuals were described as individuals who were engaged in extreme types of anti-social behaviors, emotional instability, impulsivity and poor judgement. They were also categorized as belonging to the same deviant group as the tramp, the chronic alcoholic, the drug addict and members of families with social problems (Howarth, 1949). This deviancy was connected to a range of biological defects including congenital defects, hereditary contamination, endocrinological imbalance and a slow down growth process which made them adopt characteristics of the opposite sex. In the case of homosexual men these biological defects were said to lead to psychological effeminacy that was connected to supposedly feminine ways of carrying one's arm, a feminine boy formation, long legs, narrow hips, lack of hair on face, chest and back, a high pitch voice, a feminine distribution of pubic hair, a small penis and testicles and excess fat on the shoulders, buttocks and abdomen (Ploscowe, 1951). In addition, some boys referred to be treated for homosexuality were described by a clinician as follows: depressed looking boys, effeminate when walking, talking, antisocial, aggressive, very active sexually, with pathological sexualities, confused, lonely, neglected, mentally defective and having emotionally unstable families (Fahey, 1952).

A related discourse was the description of homosexuals as maladapted or maladjusted to society. For example, Fahey (1952) described the opening of clinics in the US with the primary function of the diagnosis and treatment of people with characteristics of maladjustment or abnormality within their social relationships, and mental or emotional lives. These clinics were

invested in the prevention of future mental illness, juvenile delinquency and social disorder with homosexuality being a key behavior that they were working to modify. Queer clients often took on this discourse of maladjustment and accepted that they had a problem and expressed a desire to change their condition. Such is the example described by Henry (1948) who conducted a study with the support of physicians, nurses, social workers, and lawyers where he interviewed homosexual participants who saw themselves as "maladapted" and who were willing to participate in his study in the hopes of being cured. At the same time, the team wanted to circulate the findings of the research, knowing also that the public believed that punishing cases of "sex crime" for being homosexual was not sufficient and that participants in the study, who were considered sex offenders, needed to be studied to understand their maladjustment and how to cure it. As will be examined below, the development of this discourse also brought new ways to think about assessing these individuals and their homosexual activity. Some suggestions around treatment to help these individuals started to emerge.

Assessing and treating queer clients

A key aspect in curing homosexuality was to develop a clear definition of homosexuality that would allow clinicians to assess whether somebody was a homosexual and develop a treatment plan for curing them. A key debate in defining homosexuality was determining its origins. Fahey (1952) identified two major perspectives on this question. He noted that some scholars believed that homosexuality was caused by physiological disturbances. They believed that homosexuals were born that way and there was nothing that could be done to change them. In contrast other authors believed that environmental influences were key factors, as well as glandular failure, endocrine functioning or incompletion in the personality development. In addition, some discourses described homosexuality as the result of a situation or the context

where individuals socialized or lived**.** Ploscowe (1951) mentioned that whenever men or woman were segregated from each other, homosexual behavior was inevitable, such as the case of the homosexual behavior displayed in armed services, boarding schools, camps, prisons, etc. Clinicians called this "Faute de mieux"(for a want of a better alternative). In addition, other discourses of homosexual behavior included excessive drinking and sex experimentation during adolescence, especially in places were boys and girls were separated from one another (Ploscowe, 1951). Aligned with this idea of the origins of homosexuality was the idea that homosexual behavior is also an activity that could be introduced by older men. For example, Ploscowe (1951) mentioned a study about sexual development with boys where most of the advances were made by strangers, or those who had a position of trust in relation to the boys such as teacher, pastors or camp counselors. In addition, there was a belief that homosexuality came from excessive masturbation. He mentioned that those studying homosexuality believed that biology and other factors influence in the development of homosexuality.

Related to discussions of determining the origins of homosexuality was a discussion of how to define it, diagnose it and treat it. Among the variety of tools developed to assess "true" homosexuality was the psychometric testing of clients to understand their level of intelligence. For example, many clients identified as homosexuals received an IQ test, such as Stanford-Binet Intelligent test or Wechsler- Bellevue intelligent test and some of them received the Szondi and the Rorschach tests to determine personality traits and homosexual tendencies (Fahey, 1952).

The primary method of treatment during this time period revolved around reforming homosexuality through adjusting to heterosexuality. One of the functions of therapy was the reorganization of the behaviors of clients. Cuber (1945) described that therapist can support clients to change homosexual behavior by helping them understand that it is wrong (Cuber,

1945). This can be seen in the case of a 17-year-old girl who was seen as having a close relationship with her female friend. She received recommendations to engage in relationships with men as a way to cure her. In addition, she was told that homosexuality was an "immature and futile practice." In the case of a 13-year-old girl, her treatment was to be separated from her primary family and she was sent to a foster home while meeting with a psychiatrist regularly to monitor her behavior (Fahey, 1952). In other cases, individuals suspected of engaging in homosexual behavior were placed on probation for a few years to track their recovery or were institutionalized to change the behaviors. Some of them received individual and group therapy and left their treatment with several diagnoses such as psychopathic personality and psychopathic sexuality (Fahey, 1952). Additionally, a series of scalp treatments were offered to generate a recovery from homosexual behavior, such as in the case of a young boy who received a course of scalp treatments and was described as slowly recovering from his disorder (Arrington & Grossmann, 1942).

These perspectives of describing, diagnosing and treating homosexual clients were circulating in the mental health field before the creation of the first DSM in 1952. This manual is the main source that clinicians use for the assessment and categorization of all mental disorders in the United States, Europe and Asia. The first edition included 102 diagnostic categories and was subdivided into two groups of mental disorders: (1) those conditions caused by organic brain dysfunctions and (2) conditions that resulted from socio-environmental stressors on the biology of individuals to adapt to some pressures (Kawa & Giordano, 2012). The first edition classified homosexuality as a "sociopathic personality disturbance" (Baughey-Gill, 2011; Drescher, 2015). It is important to explore the impact of this first official diagnosis of homosexuality and how it

influenced the clinical practice in the mental health field and the way that clinicians provided treatment.

Era 2: Post DSM-I (1953) to the removal of homosexuality diagnosis from DSM (1973)

After the first edition of the DMS-I was published, clinicians finally had a reference to go to when thinking about providing treatment to their clients. However, clinicians identified a couple of inadequacies in the manual that lead to some amendments. Kawa & Giordano (2012) described that the two major changes were as follows. The first one was a broader definition of mental illness that was more inclusive of milder conditions in the general population. The second was the multiple subdivisions of former disorder categories, for example the addition of eight new alcoholic brain syndromes. These amendments led to the creation of the DSM II in 1968. However, the DSM II had in its description a new diagnosis called Sexual Orientation Disturbance (SOD) where homosexuality was described as an "illness if an individual with same-sex attractions found them distressing and wanted to change."(Drescher, 2015; Baughey-Gill, 2011) This description provided legitimacy to the practice of conversation therapy and insurance reimbursement for these services. Using this context of the creation of the DSM I and the development of the DSM II, I reviewed articles and critical reports within this period of time and I found themes that emerged from this data in the ways clinicians described queer clients and the ways that they thought about assessment and treatment.

Describing queer clients

In this era, queer clients continued to primarily be described as homosexuals with a new emerging discourse also describing transsexuals and tranvestites. All three of these categories were described as deviant behaviors associated with a lack of social adjustment (Prince, 1957;

Northrup 1959). Homosexuals were described as wanting contact with people of the same sex, acting in feminine ways, adopting feminine style or clothing and having an over dominating mother (Northrup, 1959; Prince, 1957; Ullman, 1960). In the specific case of female homosexuals Socarides (1962) described them as experiencing fear of castration (aphanisis), struggling adapting, displaying frequent suicidal attempts and turning aggression towards themselves. In the case of transvestism, clinicians connected these behaviors to "defense against psychosis by projecting sexual delusional material onto others" that make others around them "act as if he were a women", for example, men holding the door for her, treating and talking to her as "if he were a women" (Northrup 1959).

This era had little emphasis on differentiating homosexuality from transsexuality. The few cases that described transsexuality relied on similar pathological frames with one clinician describing them as patients who had feelings of inferiority due to a non-masculine appearance in their childhood and that they needed to find a way to compensate for those feelings (Gutheil, 1954). Some authors noted that these clients wanted to blame their surroundings for their experiences while the clinicians believed their problem to be internal. For example, Worden & Marsh (1955) stated that their clients tended to externalize their problems, believing that their problems were attached to a sick culture that didn't provide them with acceptance of being a woman and they rejected the idea that they had an internal disorder. The authors rejected these claims and suggested that the issue was in fact, internal to the clients and needed to be cured. Transsexualism was also connected to promiscuity and sex work with Northrup (1959) suggesting that one cause of transsexualism was the desire for social advancement. Aligned with these pathological frames, some clinicians attempted to describe symptoms to understand more about homosexual and transsexual experiences. Northrup (1959) stated that confusion of sexual

identity could be seen as a cardinal sign of schizophrenia. In the same way, Druss (1967) connected homosexuality with other behaviors seen as socially deviant and argued that being intoxicated brought gender identity confusion for people and led them to commit deviant sexual acts.

While there was some discussion of how these deviant behaviors differed in children versus adults, the descriptions of the two groups were quite similar with the major difference being a more explicit focus on human development in discussions of children. For example, Socarides (1962) mentioned that adolescents often experienced conflict related to their sexual behaviors due to puberty and the increase of the libido. He argued that adolescents engaged in activities that were considered prohibited since they wanted to rebel against authority. In addition, he argued that this was the time when adolescents looked for an identity and tried to connect to someone from their same sex and age which could lead to homosexual behaviors. There was a preoccupation that this behavior at this age could turn into irreversible homosexuality.

Similar frames were used to connect childhood with gender identity in ways that often conflated homosexuality and transsexualism. Gershman (1968) provided a binary definition of gender identity, which he described as the capacity to experience oneself as a man or a woman in society and in sexual encounters. He stated that "a mature gender identity indicates a heterosexual relationship that has care and tenderness." He noted that gender identity was established by the age of 3 but that it kept maturing as a person gets older. He described "pervert individuals" as suffering from homosexuality or transsexualism because of trauma they experienced at a young age related to their gender identity that led them to experience doubt in

their assigned sexual role. For him having ambiguous gender identity meant a lack of caring and tender feelings, “sex is used for reassurance against self-doubts and for neurotic needs.”

In line with this focus on childhood, many researchers investigated the relationship between homosexuality, transsexualism and parenting. Researchers believed that parents played an important factor in the creation of deviant behaviors at an early age. For example, they believed overprotection, rejection, domination and overindulgence from parents produced deviant behaviors in children. The basic argument was that in an effort for parents to provide protection, they fell into pathological behaviors that created in their children dependency and the inability to navigate life (Ullman, 1960). Stoller (1973) mentioned that parents were the main source that taught their children behaviors and transmit to their children what they considered masculinity or femininity. Aligned with this idea, researchers described in detail the interaction between parents and their children that created pathological behaviors. For example, tendencies around maternal overparticipation and paternal underparticipation in training kids around behavior “influences abnormal sexual behaviors, such as the lack of mature heterosexuality” (Ullman, 1960). Stoller (1973) placed the bulk of responsibility on the mother who he argued created all of the deviant behavior associated with homosexuality and transsexualism. In a similar vein, Ullman (1960) stated that male homosexuality was produced by the domination of the mother and the identification of the male homosexual with her. In the case of female homosexuality, Socarides (1962) mentioned that there was a hostility towards the mother from the female, which led to identification with the father that because of the incest taboo often led to overt female homosexuality. However, other clinicians argued that “homosexuality is never caused by the attitude of one parent but by the strong constellation of the parent child triangle” (Gershman, 1968).

All of these discourses came together in the discussion of the case of a 14-year-old boy in a treatment center exhibiting homosexual behavior. Clinicians associated these homosexual behaviors with their perception of him as immature, antisocial, aggressive, angry, frightened and doing bad in school (Wasserman, 1960). The clinical team in charge of the treatment believed that they needed to help the client to develop a concept of self and separate from his parents, especially his mother. His symptoms of homosexuality were framed as a defiant act to get attention and love that stemmed from his anxiety about being castrated and taking a more masculine role. He was aggressive because he identified with the aggressor in his family (his mother). He was framed as angry at his father because he was passive and unable to give him protection and because he allowed his mother to be aggressive. In short, in this case, as in many others during this era, homosexual behavior was connected with generalized pathological social traits that were produced through deviant parenting styles.

In summary, clinicians described female and male homosexuals, as well as transsexuals as perverse people, who suffered from a confusion of sexual and gender identity. In this era, these individuals were described as having suffered disturbances in an early age coming from their families, specifically their parents. The role of the mother was specifically targeted by patriarchal frames that put the burden on her, asking her to be submissive in the parenting dynamic. Fathers were expected to be the center of the parenting process and enact hypermasculinity in this process. The efforts to understand and name the source of all these experiences were present in the literature, as well as the efforts to find a cure and provide treatment to help, which will be discussed below.

Assessing and treating queer clients

Within the context of the emergence of an official diagnosis for both homosexuality and transsexualism in the DSM-I and DSM II were increasing concerns about identifying who the "true" homosexual, transvestites and transsexuals were. In order to identify the true homosexual, there was a need to describe who would fit that profile and what behavior they need to show. Prince (1957) mentioned that evidence of a true homosexual was when someone was having contact with individuals of the same sex, a male acting in a feminine way, adopting a feminine style of clothing or entering an occupation that was recognized to be only for females. Druss (1967) stated that a homosexual act is a "bodily contact between persons of the same sex actively undertaken or passively permitted with the intent of obtaining sexual gratification or any proposal, solicitation or attempt to perform such an act" (p. 62). He argued that engaging in this behavior made individuals unfit for certain activities such as entering military service.

Another attempt to describe homosexuality was categorizing different ways to be homosexual. Smith (1953) introduced two ways to organize experiences of homosexuality, one that he called situational homosexuality and one that he called exclusive homosexuality (or true homosexuality). He defined situational homosexuality as heterosexual individuals who indulged in sexual relationships with persons of their own sex in order to satisfy their own sexual desires. Yet, differentiating this situational homosexuality from true homosexuality proved to be a challenge for clinicians. According to Smith (1953), relying purely on patient self-report about being true homosexuals could lead to misdiagnosis. He identified the need to have an authority to rely on who could give a diagnosis based on a precise description of who was considered a true homosexual. It was not enough to rely on what individuals stated about their condition since there was room to lie about their homosexuality to avoid unpleasant situations.

Northrup **(**1959) identified true transsexuals as those who considered suicide and had an urge to be castrated or to castrate themselves and those who felt comfort when they were affirmed by people accepting their feminine name, gender expressions and occupation. He described these true transsexuals as being able to create an optical illusion that made everybody around them treat them as a woman. Aligned with this effort to describe the true transsexual, some clinicians talked about development in biological ways. Stoller (1973) stated that natural transsexual males had been feminine since their childhood and often started expressing that they wanted to be a girl by the age of 4 while also playing with girls and taking female roles. Clinicians used this narrative to create a profile of who should be considered a transsexual and they tried to explain it in different ways. They created more terms in the attempt to be specific. Some terms that emerged besides transvestite and transsexualism were psychic hermaphroditism, metatropism, intersexuality of the highest degree and possible chromosomal intersexuality (Northrup, 1959). Of particular note was the rigid distinction that emerged between true transsexualism and transvestism with "true transsexuals" being defined as "those who bring their body with their mind together through medical science, surgery" while "transvestites are the ones who want to wear clothes of the opposite sex, sometimes they use hormonal therapy" (Gershman, 1968; Smith 1953). Pauly (1965) named transsexualism a syndrome which had as a final stage of the treatment the approximation to the female anatomical structure.

The treatment for transvestites and transsexuals desiring gender affirming surgeries was even more complex for clinicians who hesitated in providing the treatment that these clients were requesting. For example, Gutheil (1954) wondered why his patients wished to be women. According to him, clinicians who performed these surgeries in the past adapted a mentality of correcting an error of nature, since they castrated the patient and built a vagina. He questioned

this thinking and compared this experience with suicidal ideation in patients "Should physicians comply with the patient's desire to commit suicide?" He saw his role as educating his clients about their own experiences. He stated that transvestites do not want to be a woman; they wanted to be seen by others as a woman. He believed that transvestism was the result of psychopathological factors such as homosexuality with a complex of castration, sadomasochistic, exhibitionistic, fetish and narcissistic components. In a similar vein, Worden & Marsh (1955) stated that transvestites and transsexuals were incapable of providing an adequate history of their past lives. The authors described the patients as in need of recognition, attention, and acceptance mixed with their feelings around rejection and being ignored.

Within this broader context of trying to identify "true" homosexuals and transsexuals were also efforts to develop treatment plans to cure these deviancies. The treatment for "true" homosexuals consisted of a team effort from caseworkers and psychiatrics to address the behavior. The team was invested in doing reality checks with clients through providing "ego support" that kept them engaged in activities that redirected the aggression and sexual impulses (Wasserman, 1960). This was in alignment with the general therapeutic goal of conversion to heterosexuality with the assumption that clients wanted to engage in this change. In addition, clinicians believed that homosexuals were not integrated human beings and the goal for them was to be supported to get integrated and gain maturity (Gershman, 1968).

In the case of transsexual people, efforts were made to differentiate true transsexuals from those engaged in transvestism in order to determine who should be provided with access to sex reassignment surgery. Benjamin (1969) suggested that the drug Dilantin, which was used to prevent epileptic attacks, could be used to help make this differentiation. He noted that while this drug helped transvestites eliminate their obsessive desire to dress as a woman it did not work for

transsexual patients. He stated that "sex reassignment surgery is requested by almost all true transsexuals" One major concern clinicians had with these supposed true transsexuals were the fact that they often expressed desire for castration and inflicting self-harm in order to be seen as their desired gender (Pauly, 1965). Some of these behaviors were suicide attempts, self-mutilation and intense stress. They were seen as "tormented…disturbed, unhappy people who deserve sympathy and attention" (Benjamin, 1969). Northrup (1959) described a castration research study lead by Dr. Karl Bowman at the Langly Porter Clinic. The individuals interested in being castrated also known as orchidectomy needed to receive medical and psychiatric examinations. Among the findings were neural-psychiatric disorders, a history of transvestism in the family and people refusing to engage in psychotherapy (Benjamin, 1969). Among the treatment that was suggested was psychotherapy to bring the psychological sex into conformity with the anatomy, surgeries and endocrine therapy designed to relief the stress.

During the end of this time period, a counter-discourse began to rise to prominence within the scholarly literature on homosexuality. Some clinicians began to challenge this pathological frame and instead pointed to oppression as the primary cause of the many mental health struggles of homosexuals (Gochros, 1972). These clinicians began to shift the conversation away from the idea that homosexuals were disturbed but rather instead argued that homosexuality was simply a different "style of life" (Osman, 1972; Gochros, 1972). These clinicians stated that homosexuals were not sick people who need to be cured but were rather people who encountered oppression based on their lifestyle (Osman, 1972). Gochros (1972) argued that dominant pathologically framed clinical approaches stemmed from clinicians trying to manage their feelings of discomfort around homosexuals, which generated resentment with clients who they then treated as mentally ill. Gochros encouraged clinicians to support

homosexuals with their process of coming out, guilt and exploring different settings to socialize beyond bars, steam baths and public toilets. Additionally, he asked clinicians to adapt to different roles with them, such as the role of being a marital counselor in their romantic relationships. The main goal was to help homosexuals to reach a satisfactory life and changing societal attitudes against homosexuality to protect their human rights.

As we can see previously, the contrast in the approach of clinicians when working with homosexual, transsexuals and transvestites, there were different ways to talk about clients and about treatment. Most of this era was defined by discourses of pathology that connected homosexuality and transsexuality with mental illness. However, another group of clinicians began to challenge this perspective and point to oppression as the root cause of the challenges confronting queer people (Drescher, 2015). This perspective aligned with the historical resistance that sparked the 1969 Stonewall riots in New York City. In line with these shifts, queer activists fought to remove homosexuality from the DSM (Dawson, 1994). During the APA conferences in 1971 and 1972 many queer activists created panels to talk about the stigma that the diagnosis created in the homosexual community including panels such as “Gay is God” with Frank Kameny, Barbara Gittings and Dr. John E. Fryer (Drescher, 2015). As a result of this activism along with changing framings within the field, the APA removed the diagnosis of homosexuality from the DSM in 1973 and the association of Lesbian and Gay Psychologists (ALGP) was created the same year. ALGP entered the APA with the goal of creating queer affirmative policy statements (Morgan & Nerison, 1993). This era ends up with high expectations envisioning new ways to provide clinical services to clients. Removing the diagnosis from the DSM was an important milestone for clinicians who were committed to developing queer affirmative therapy.

Era 3: Tracing discourses of pathology into the present

As explored above, pathologizing clinical frames in relation to queer clients have a long history within the United States. While homosexuality was removed from the DSM in 1973, discourses of pathology continue to frame clinical approaches to working with queer clients. Discourses around trans bodies being disabled or needing to be rehabilitated from disability remains the dominant framing in the field because of the DSM, which after the removal of homosexuality sought to create new ways to prevent behavior deemed homosexual (Puar, 2013). Originally it was included in the DSM as transsexualism (APA, 1980). While the DSM shifted the diagnosis away from transsexualism to gender identity disorder (GID) and most recently gender dysphoria (GD), all of these diagnoses frame gender nonconformity as a mental illness (Cohen & Pfa¨fflin, 2010). It leaves out of the conversation the ways that heteronormativity reinforces pathology and violence against people who do not conform to the society's gender expectations (Yep, 2003).

Aligned with this idea, Newman (2000) highlights that the thinking process of professionals in the mental health care field is primarily asking "how can I be sure that this patient is a true transsexual and is not saying what she/he thinks I want to hear in order to get treatment?" The posture that mental health providers adopt is the one that says that it is their professional responsibility to find the truth, through policing and monitoring, enacting the role of a gate keeper of services claiming to do it in the name of the well-being of trans clients. In contrast, trans people have to navigate this ideology to gain access to clinical services. They are guided by the questions according to Newman (2000) of "how can I convince this skeptical doctor that I am a true transsexual and have the right to surgeries?" In this way, Borba (2015)

states that the "DSM text is a vector of social control that attempts to maintain the current matrix of gender intelligibility."

In another vein, the discourses of pathology also continue to be reproduced in more covert ways. Specifically, the dominant way of framing the challenges confronting queer people continues to individualize the impact of oppression with a strong focus on "risk factors" and "resiliency." For example, queer people are typically described as being at high risk for alcohol use disorders (Cochran & Mays, 2017), increased risk of HIV infection (Mustanski et al, 2011), greater risk of suicidal behavior (Meader & Chan, 2017) and as having higher levels of psychological distress than heterosexual people (King et al, 2003). Studies have also attempted to link sexual orientation with cardiovascular risk factors, (tobacco use, obesity and stress) (Cochran & Mays, 2017). While this work has shone an important light on the challenges confronting the queer community, it often does so in ways that obscure the heteronormativity that lies at the root of their victimization.

This individualizing of oppression connects with the tendency of the mental health field to continue to medicalize the oppression of queer people. Conrad (2007) defines medicalization as the process wherein non-medical problems are defined as medical problems and usually described in terms of disorders and illness. In this vein, the literature uses the terms "stigma" and "stress" to describe how queer people react to adversity (Meyer, 2015). Discussions of stigma frame challenges confronting the queer community as connected to individual stress that needs to be challenged through individual behavioral changes through what Turner & Roszell (1994) call "personal agency." Another way that this has been discussed in the literature is through discussions of resilience. Resilience is defined in the literature as the quality to survive, thrive and adapt to minority stress while facing a variety of ongoing challenges and risks (Meyer 2015).

This approach typically relies on individualistic narratives that reinforce the idea that changing individual behaviors will solve the oppression that queer people confront as part of their daily lives while reinforcing the hegemony of the state and capitalist relations of power (Foucault, 1978).

In short, pathological frames continue to be used to describe queer people in the present. With this in mind, let us return to the two cases that began this paper. Manny was seen as a black youth who had an "unstable family background" where the parents were not present to provide guidance and support. Due to the fact that he ended up in hands of the foster care system he was already policed regarding his behavior while interacting with his foster family and in school. He was trying to express his romantic feelings towards a cisgender heterosexual boy. The main idea here is that his "deviant" tendencies were a threat to the always protected cisgender heteronormative matrix. None of the professionals thought about what is age appropriate to discuss in relation to sexual desires with the two boys. The conversation instead was framed around alleged sexual harassment that was targeting patriarchal heterosexuality. Hegemonic sexual desires as reproduced in schools leave many queer youth alone in both understanding their sexual desires and navigating the discourses of pathology are often ascribed to them. Due to this framing, the first thought from everybody involved was in punishment with the primary reliance being on the criminal justice system. The idea of calling police on a black gay youth seemed to be a good solution for all the professionals involved. This solution did not contemplate the institutional intersectional violence that black and queer bodies have experienced for generations. The mental health field was also complicit in this. After Manny verbalized feelings of suicidality, he was seen as at risk to himself and he was sent to treatment, where he was labeled and medicated. The result of this situation was to put the burden on Manny, a 12-year-old black

youth to manage the systematic and historical failures of all the institutions working together which were supposed to take care of his well-being.

In the case of Lorena, the dominant narrative about third world countries are that they are less educated and transphobic but clearly Lorena continued experiencing transphobia in the US. In her attempts to have access to a life full of dignity she applied for political asylum, where she was already seen as a person who was not trusted by the system, not only for being an immigrant but also because she was trans. The screening process for trans immigrants seeking to change their immigration status is to prove that they are a person who has experienced political persecution based on their identity. Because of this, Lorena needed to prove to immigration officials that what she was saying about her gender identity is true—that she is a trans woman. A representative of the mental health system, a therapist is the authorized professional who can provide an assessment and testify about whether Lorena is a "true transgender," using as a reference the diagnosis of gender dysphoria within the DSM. Lorena in her conversation with the therapist needed to express her strong and consistent desire to be a woman, and she needed to describe that she dressed and lived her life mostly as a woman. As her therapist, I was the professional who was expected to testify in an affidavit that Lorena did, in fact, meet the criteria for gender dysphoria. That is, Lorena's testimony about her own gender identity was not sufficient. I, as the mental health provider was the one who had final authority over if and how her gender identity would be recognized. Lorena understood that receiving a diagnosis from me not only opens the possibility to validate her gender identity with immigration officials but also opens up the possibility for health insurances to authorize her medical transition. That said, this doesn't change the fact that I as a mental health professional have inherited a discourse of pathology that has shaped our field since its founding.

Conclusion

What is consistent across these three eras is the discourse of pathology that frames the queer experience. In all three eras this discourse of pathology was called science—a science that many professionals believed and continue to believe have no bias and was created from evidence-based practices. Yet, this idea of science is a violent act that promotes normalization and homogeneity. Anything that goes against this idea of normal or homogenous is described as perverted, abnormal, deficient, ill, etc. This discourse of pathology is not just about the history of the mental health field but also about its present. The consistent and dominant narratives of talking about symptoms and risk is a continuing issue in the mental health profession that keeps centering the clinician's position of power and is designed to make them feel comfortable while pathologizing their queer clients. This is a reductive narrative that limits the ways that the field conceptualizes the struggles that queer people face. This discourse of risk being managed rather than systematic oppression that needs to be dismantle is designed to protect the status quo. Yet, queer clinicians and activists have produced counter-narratives to these discourses through efforts to develop queer affirmative therapy. In the next paper, I examine the knowledge generated by queer-identified clinicians as a point of entry for challenging this discourse of pathology.

References

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.

Arrington, W. W., & Grossmann, G. (1942). Potential functions of the psychiatric social worker under the Selective Service Act. *American Journal of Orthopsychiatry*, *12*(4), 603.

Baughey-Gill, S. (2011). When Gay Was Not Okay with the APA: A Historical Overview of Homosexuality and its Status as Mental Disorder. *Occam's Razor*, *1*(1), 2.

Benjamin, H. (1969). Newer aspects of the transsexual phenomenon. *Journal of Sex Research*, *5*(2), 135-141.

Borba, R. (2015). How an individual becomes a subject: discourse, interaction and subjectification at a Brazilian gender identity clinic. *Working Papers in Urban Language and Literacies*.

Cochran, S. D., & Mays, V. M. (2017). Advancing the LGBT health research agenda: differential health trends within the lesbian, gay, and bisexual populations.

Cohen-Kettenis, P. T., & Pfäfflin, F. (2010). The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Archives of sexual behavior*, 39(2), 499-513.

Conrad, P. (2007). Medicalization. In P. Conrad, the medicalization of society. Baltimore, MD: Johns Hopkins Press.

Cuber, J. F. (1945). Functions of the marriage counselor. *Marriage and Family Living*, *7*(1), 3-5.

Dawson, P. J. (1994). Contra biology: a polemic. *Journal of advanced nursing*, 20(6), 1094-1103

D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2005). Parents' awareness of lesbian, gay, and bisexual youths' sexual orientation. *Journal of Marriage and Family*, 67(2), 474-482.

Drescher, J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioral Sciences*, *5*(4), 565-575.

Druss, R. G. (1967). Cases of suspected homosexuality seen at an army Mental Hygiene Consultation Service. *Psychiatric Quarterly*, *41*(1), 62-70.

Fahey, D. A. (1952). *A study of twenty-three cases involving homosexual behavior* (Doctoral dissertation, Boston University).

Foucault, M. (1978). The history of sexuality. New York: Pantheon Books.

Getsy, D. J. (2014). Capacity. *Transgender Studies Quarterly*, *1*(1-2), 47-49.

Gershman, H. (1968). The evolution of gender identity. *American journal of psychoanalysis*, *28*(1), 80-90

Gochros, H. L. (1972). The sexually oppressed. *Social Work*, *17*(2), 16-23.

Gutheil, E. A. (1954). Transsexualism and Transvestism: The Psychologic Background of Transsexualism and Transvestism. *American Journal of Psychotherapy*, *8*(2), 231-239.

Henry, G. W. (1948). *Sex variants: A study of homosexual patterns*. PB Hoeber.

Howarth, E. (1949). The scope of social casework in helping the maladjusted. *Social Work (1939-1970)*, *6*(3), 326-332.

Jagose, A. (1996). *Queer theory: An introduction*. NYU Press.

Kawa, S., & Giordano, J. (2012). A brief historicity of the Diagnostic and Statistical Manual of Mental Disorders: issues and implications for the future of psychiatric canon and practice.

King M., McKeown E., Warner J., et al. (2003) Mental health and quality of life of gay men and lesbians in England and Wales: controlled, cross-sectional study. *British Journal of Psychiatry* 183, 552–558.

Meader, N., & Chan, M. K. (2017). Sexual orientation and suicidal behavior in young people.

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity*, 2(3), 209.

Morgan, K. S., & Nerison, R. M. (1993). Homosexuality and psychopolitics: An historical overview. *Psychotherapy: Theory, Research, Practice, Training*, *30*(1), 133.

Mustanski, B. S., Newcomb, M. E., Du Bois, S. N., Garcia, S. C., & Grov, C. (2011). HIV in young men who have sex with men: a review of epidemiology, risk and protective factors, and interventions. Journal of sex research, 48(2-3), 218-253.

Newman, L. K. (2000). Transgender issues. *Women's Health: Contemporary international perspectives*, 394-404.

Northrup, G. (1959). Transsexualism: Report of a case. *AMA archives of general psychiatry*, *1*(3), 332-337.

Osman, S. (1972). My stepfather is a she. *Family Process*, *11*(2), 209-218.

Pauly, I. B. (1965). Male psychosexual inversion: Transsexualism: A review of 100 cases. *Archives of General Psychiatry*, *13*(2), 172-181.

Ploscowe, J. M. (1951). Homosexuality, sodomy, and crimes against nature. *Pastoral Psychology*, *2*(8), 40-48.

Prince, C. V. (1957). Homosexuality, transvestism and transsexualism: Reflections on their etiology and differentiation. *American Journal of Psychotherapy*, *11*(1), 80-85.

Puar, J. K. (2013). Bodies with New Organs: Becoming Trans. Becoming Disabled. Indiana University-Bloomington.

Puar, J. K. (2014). Disability. *Transgender Studies Quarterly*, *1*(1-2), 77-81.

Smith, C. E. (1954). The homosexual federal offender: A study of 100 cases. *The Journal of Criminal Law, Criminology, and Police Science*, *44*(5), 582-591.

Socarides, C. W. (1962). Theoretical and clinical aspects of overt female homosexuality. *Journal of the American Psychoanalytic Association*, *10*(3), 579-592.

Stoller, R. J. (1973). The Male Transsexual as' Experiment. *International Journal of Psycho-Analysis*, *54*, 215-225.

Turner, R. J., & Roszell, P. (1994). Psychosocial resources and the stress process. In W. R.

Ullman, P. S. (1960). Parental Participation in Childrearing as Evaluated by Male Social Deviates. *Pacific Sociological Review*, *3*(2), 89-95.

Wasserman, S. (1960). Casework treatment of a homosexual acting out adolescent in a treatment center. *Mental hygiene*, *44*, 18-29.

Worden, F. G., & Marsh, J. T. (1955). Psychological factors in men seeking sex transformation: A preliminary report. *Journal of the American Medical Association*, *157*(15), 1292-1298.

Yep, G. A. (2003). The violence of heteronormativity in communication studies: Notes on injury, healing, and queer world-making. *Journal of homosexuality*, 45(2-4), 11-59.

PAPER TWO:

EXPLORATION OF QUEER AFFIRMATIVE APPROACHES WITH QUEER IDENTIFIED CLINICIANS: A QUALITATIVE STUDY

Luis Ramírez, LCSW

University of Pennsylvania

Paper Two:
Exploration of queer affirmative approaches with queer identified clinicians:
A qualitative study

Abstract

According to the available literature there is a lack of queer affirmative training for clinicians. As a result, queer people struggle to find clinicians who are prepared to help them resist systemic marginalization and who address the reproduction of dominant discourses in the clinical room. Queer-identified clinicians' expertise is a significant and untapped resource to explore how to counteract frames of pathology and contribute to the fostering of a therapy that is responsive and affirming of the variety, fluidity and intersectional experiences of queer peoples' lives. This study examines the experiences of 8 queer-identified clinicians who have a range of experiences working with queer clients. The findings of this study are used to develop principles as a guide to provide queer affirmative therapy.

Key words: queer affirmative therapy, queer theory, intersectionality, pathology, heteronormativity

Introduction

Removing the diagnosis of homosexuality as a psychological disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973 (Krajeski, 1996) was an important milestone in changing how the mental health field approaches sexual orientation. The depathologizing of homosexuality has since led to the development of affirmative clinical practice for Lesbian, Gay and Bisexual people (Grzanka & Miles, 2016). Despite these efforts, there is still a need to continue addressing the oppression that therapists often enact in clinical settings when working with LGB people (Grzanka & Miles, 2016; McGeorge & Stone Carlson, 2011). For example, according to the National Alliance on Mental Illness (NAMI), LGB people report often having to hide their sexual orientation from those in the mental health system for fear of being ridiculed or rejected. In addition to continued challenges confronting the mental health profession in enacting clinical approaches that are affirmative of the sexual orientation of LGB people are the unique challenges confronting the field in supporting transgender people.

According to Alexander (1998) queer clients often report more fears or concerns around engaging in therapy than heterosexual and cisgender counterparts. Approximately 46% of queer clients have experienced a homophobic clinician and 34% have encountered a clinician who has refused to acknowledge their sexual orientation or gender identity or has viewed their sexual orientation or gender identity as a temporary situation (Nystrom, 1997). In addition, a 2018 LGBTQ youth report from the Human Rights Campaign states that LGBTQ youth still continue facing challenges when looking for queer affirming counseling services due to a lack of providers having LGBTQ specific training (Kahn et al, 2018). Much of this discrimination is caused by a lack of competency among mental health professionals in working with queer populations. Many clinicians report feeling inadequate when working with gender identity and

sexual orientation (Doherty & Simmons, 1996). In addition, Godfrey et al (2006) state that there is not enough guidance and training available on the theoretical background, personal and professional experiences and practical skills that clinicians should foster to be qualified to work with queer people and their families.

The need for queer affirmative therapy is especially urgent in light of the many mental health challenges that confront LGBTQ individuals. LGBTQ people are at risk of physical and mental health challenges due to their experiences of victimization and negative peer relationships (Ryan et al, 2010). In addition, research documents the role of family rejection as a predictor of physical and mental health challenges among LGBTQ people. Existing research also documents the protective and nurturing role of families against major health risk behaviors for queer youth (Resnick et al, 1997). Family acceptance in adolescence is connected to positive outcomes and is a protective factor against negative outcomes in LGBTQ people (Ryan et al, 2010). Importantly, the improvement of family relationships can occur when parents become more sensitive to the needs of their LGBTQ children (D'Augelli et al, 2005). This suggests the importance of ensuring that parents of LGBTQ youth receive appropriate supports in creating queer affirmative households for their children. However, approaches to family therapy have typically been informed by heteronormative frames with little existing research to support family therapists in supporting parents in this important work (Hudak & Giammattei, 2014). While there is a small body of research that has focused on gay and lesbian couples (Hudak & Giammattei, 2014), little research to date has focused on the experiences of transgender people. In addition, the small body of research in family therapy that does focus on issues related to sexual orientation typically reinforces a pathologizing framing of LGB people with the current language they use to

describe LGB families framed around "helping" families to manage non-heterosexuality (Stone-Fish & Harvey, 2015).

Indeed, researchers have documented the continued lack of competency and training that many therapists show when working with LGBTQ people (Corturillo, McGeorge & Carlson, 2016, Bernstein, 2000; Godfrey et al, 2006; Green, 1996; Long & Serovich, 2003). These issues highlight the need for continued training of therapists in a queer[1] affirmative approach that entails engaging with LGBTQ clients in an affirming and inclusive way (Corturillo, McGeorge & Stone Carlson, 2016). According to McGeorge & Carlson (2011) in order to become a queer affirming therapist, it is necessary that a therapist get involved in a process of self-awareness to understand how heteronormative frames have shaped the therapist's personal and professional life and how privilege and oppressive assumptions are enacted in clinical settings. In line with centering the oppression and resistance of queer people, researchers have argued that there is a need for queer affirmative trainings to incorporate the systematic challenges that queer people encounter. This includes addressing the heteronormative bias of clinicians and incorporating knowledge around queer people's concerns and needs. In addition, this entails identifying and addressing the pathologization of queer identities when conceptualizing cases and resisting misdiagnosis. Importantly, researchers also call for addressing the multiple oppressions that queer people may confront based on race, gender, social class etc. (Buhrke & Douce, 1991; Clark & Serovich, 1997; Dworkin, 1992; Murphy, Rawlings & Howe, 2002; Ritter & Terndrup, 2002). Yet, due to the lack of clarity around what queer affirming therapy entails when dealing

[1] In this article, the term queer is used as an umbrella term to refer to lesbian, gay, bisexual, transgender, questioning and all their variations. The term will be used to address the fluidity of how people experience gender identity and sexual orientation. While the term is used as an umbrella term it is important to highlight the different identities in the LGBTQ community experience and to avoid as much as possible the universalizing of any one queer experience.

with sexual orientation and/or gender identity, therapists often fail to be queer affirmative (Grzanka & Miles, 2016).

One resource that can be utilized in better understanding how to successfully implement queer affirmative therapy is to tap into the expertise of queer-identified clinicians who make working with queer clients central to their work. It is important to understand how current queer-identified clinicians work with queer clients in ways that seek to counteract frames of pathology and address the lack of queer affirmative training. Most of the experts creating clinical frames to work with queer people have historically and continue to be white, cisgender and heterosexual. Those are the dominant voices in the history of the mental health field. This article offers a counternarrative to this dominant framing by focusing primary on the voices of the queer clinicians whose voices have often been ignored at best or treated with suspicion at worse.

This article explores the findings of a qualitative study focused on understanding how current queer-identified clinicians work with queer clients in ways that seek to counteract frames of pathology. The findings of this study are used to develop principles as a guide to provide queer affirmative therapy, that is, therapy that is responsive and affirming of the variety, fluidity and intersectional experiences of queer peoples' lives while supporting queer clients and their families to resist systemic marginalization.

Toward Queer Affirmative Therapy

This article seeks to highlight the current gaps in providing mental health to queer clients, outline queer affirmative strategies and culminates in the creation of principles for queer affirmative therapy. The theoretical frameworks that are used to guide this effort are the following: queer theory alongside trans studies and queer of color critique. It is important to

highlight that due to limitations of each of these theories and the fluidity of the experiences of queer people I will be incorporating each in order to develop my approach.

Queer Theory

In the early 1990s, queer theory emerged in the academy as an intervention to denaturalize the binary framing of gender and the presumption of heterosexuality as a way of acknowledging the fluid and dynamic ways that many people experience and express their gender and sexual identities (Jagose, 1996). Queer theory is a critical theory in an ongoing process of formation, with characteristics of elasticity. This theory represents a rupture with gay liberationist and lesbian feminist models and increases debates about questions of lesbian and gay identity (Jagose, 1996). It seeks to deconstruct institutional and oppressive narratives that create problematic frames of normalization related to gender and sexuality (Jones, 2014). Some of the frames that queer theory challenges are the idea that two genders (female/male) are the only possibilities that people can identify with, that it is determined by genitalia and biology, that the default of sexual orientation is heterosexuality, or that attraction is only experienced towards the opposite "biological sex."

Trans studies

While queer theory offers an important contribution to challenging heteronormativity, it has been criticized for not being able to fully account for trans bodies. For this reason, trans studies must play an important role in developing queer affirmative therapy. Halberstam (2016) describes how trans studies seeks to center the narratives of trans people. By doing this, trans studies de-centers the experiences of cisgender queer people and deconstructs the transmisogyny that has often lied at the core of queer theory and highlights the limitations and static characteristics of models of gender and identity (Getsy, 2014). Yet, it does not do so by creating

an essentialist notion of what it means to be trans. Instead, trans studies recognizes that the lexicon that trans people use to describe their experiences keeps evolving through generations and each generation has a different narrative and relationship to that language (Halberstam, 2016). In this way, trans studies can help clinicians to understand that being trans is not a static experience and that many trans bodies experience variability in their gender identities. It is not a process that needs to be completed or resolved but rather a continuum that continues resisting processes of normalization and opens up to a wide range of meanings.

Queer of color critique

Queer theory and trans studies can support the work of clinicians, so they can hold the complexities of experiences that queer clients come with to the clinical setting. Yet, they offer few tools for addressing the multiple oppressions experienced by queer individuals. Intersectionality theory provides a sharper lens for analyzing and deconstructing systems of oppression. The concept of intersectionality was coined by Black feminist Kimberlé W. Crenshaw to highlight the failure of white feminism and antiracist discourses in understanding the marginalization of Black women based on both gender and race (Crenshaw, 1991). It is not an attempt to map multiple identities (Crenshaw, 2016) but rather an approach to understanding how overlapping oppressions impact the lives of marginalized populations.

One way that intersectionality has informed queer theory is through queer of color critique, which has pointed to the ways that queer is often produced within a framework of whiteness that does not account for the experiences of queer people of color (Brockenbrough, 2016). Queer of color critique as an intersectional analysis that can help increase clinicians' awareness of their roles as gatekeepers for gender affirming surgeries and offer them strategies for affirming queer familial structures. In addition, it will help them to hold the multidimensionality of the queer

community where, romantic relationships are not only monogamous or heteronormative. Clinicians will be able to challenge the mainstream and white dominant discourse around the queer identity and be more present with the story of their clients.

Furthermore, as part of this queer of color critique, the concept of disidentification will be a helpful frame to better understand the data generated from the interviews with queer identified clinicians, many of whom also identify as people of color, examined below. According to Munoz (1999) disidentification is a concept that describes the different strategies that minority subjects engage in that have the goal of negotiating with dominant discourses that marginalize those who do not conform to what he calls the phantasm of normative citizenship. He defines disidentification as "a strategy that works on an against dominant ideology" adding that "instead of buckling under the pressures of dominant ideology (identification, assimilation) or attempting to break free of its inescapable sphere (counterindentification, utopianism), this 'working on and against' is a strategy that tries to transform a cultural logic from within, always laboring to enact permanent structural change while at the same time valuing the importance of local or everyday struggles of resistance" (p. 11-12). As people who navigate multiple overlapping forms of oppression, Muñoz argues that examining the cultural practices of queer people of color can offer unique understandings of this process of disidentification. In line with this perspective, I will use this as a point of entry for looking into the ways that queer identified clinicians, most of whom also identified as people of color, dialogue with discourses of pathology and how they generate new knowledge that seeks to work with and against these discourses in ways that seek to enact transformative clinical practices. I am interested in looking into the result of that exchange between the pathological frames and the subjectivity of the queer identified clinicians.

In addition, work examining the intersection of gender, class, race and sexuality in trans studies has pointed to the ways that trans bodies are always becoming and they are multiple in essence (Halberstam, 2016; Tompkins, 2014; Garner, 2014; Getsy, 2014; Castañeda, 2014). Trans studies has also worked in conjunction with Black feminism to deconstruct gender and sexuality (Ellison et al, 2017; Aultman, 2014). Trans studies has also examined the intersection of the discourses of disability and trans identity where trans bodies are seen as disabled bodies that need to be normalized and taken out of the state of vulnerability using pathologizing and stigmatizing frameworks (Puar, 2014).

Putting Them Together

Combining queer theory and trans studies with queer of color critique provide a helpful framework for supporting clinicians in engaging in conversations with queer clients about the overlapping systems of oppression that impact their lives. They offer an opportunity to center the intersectional oppressions that are often reproduced in the clinical room, where clinicians often reproduce heteronormativity, patriarchy, white supremacy, etc. Queer theory and trans studies can support them in becoming more reflective about how they engage in conversations about gender identity and sexual orientation and make them more conscious of the ways that they may inadvertently seek to police their clients' queer identities. Queer of color critique can help to contextualize how clients experience gender identity and sexual orientation in combination with other experiences of oppression, such as the case of trans women of color. In relation to providing diagnosis, these frameworks can help clinicians be more mindful of how they can reproduce dominant discourses that impact their clients' lives when diagnosing clients without thinking of the consequences for giving a diagnosis. The concept of disidentification can help clinicians to explore new possibilities of clinical frames when working with queer clients, while

fostering a curiosity to contextualize and look into the history of clinicals frames and work with and against them while using them in their practice.

For example, when clinicians ask questions in relation to gender identity such as "When did you know you were gay/trans/bisexual/gender non-conforming?", "Do you have a boyfriend/girlfriend?", "How do you know that you are really a woman/man/gender non-conforming?" or "it will take us time to adjust to your gender identity, don't be impatient, we will help you regulate your anxiety and mood" the clinician is reproducing heteronormative structures and binary frames that create ongoing violence and policing towards queer people. If queer clients hold another subjugated social location, another layer of oppression can be enacted. For example, while trying to affirm client's gender identity, clinicians might reproduce oppression of their other subjugated identities. For example, a clinician might say "it will be easy to pass as a real woman after hormone replacement therapy (HRT) since you have an Asian background and people from your culture are more feminine and not really hairy." Clinicians intending to be supportive and without assessing client's family acceptance might state: "I am sure your family doesn't understand that you are gay, it is hard for a 'machista' culture to understand this easily." Clinicians in an inpatient setting intending to affirm the gender identity of a trans black woman might say "you need to act like a lady and not to be loud or sound angry when speaking or people are going to treat you badly." These three comments besides being heteronormative and sexist, have a racist framing that intersectionality helps to explain.

One way of developing tools to counteract these pathological frames is to learn from queer-identified clinicians who have both been victimized by these systems of oppression and are now actively working to resist them in their clinical work. With this objective in mind, this study

seeks to document the clinical practices of queer-identified clinicians in the hopes of developing general principles for implementing queer affirmative therapy.

Methodology

A qualitative study was conducted that included a sample of 8 queer-identified clinicians. Participants identify within the spectrum of queerness in the following ways. In the category of gender as gender non-conforming/non-binary, cisgender women and cisgender male. They identified as queer, lesbian, gay, pansexual and bisexual. In regard to racial background, participants identified as Black, Latinx, mixed racial and white (see table 1). The study had as a goal to understand how queer-identified clinicians who provide services to queer people talk about gender identity, sexual orientation and oppression along with how they talk about diagnoses with their clients, how they learned how to work with them and how they made decisions about self-disclosure. The reason I decided to focus solely on queer-identified clinicians is in line with my theoretical framework that seeks to center and understand the voices and experiences of marginalized people.

Research Design

The research design was informed by Grounded Theory (GT). According to Padgett (2016) the main contribution of this theory is to help the researcher to explain a topic and develop a theoretical framework. In this study, GT was helpful to collect information from the interviews with queer identified clinicians and the available literature around the lack of training in queer affirmative therapy to support the development of principles that will help train clinicians in queer affirmative therapy. It integrates the researcher into the process of the theory making and interpretation. In addition, it encourages the researcher to get involved in the process of reflexivity within the generation of knowledge that is produced in the interviews (Padgett,

2016). GT was helpful in identifying the themes that emerge from the data related to queer affirmative therapy. With the support of GT, I started looking into individual cases, incidents or experiences clinicians shared in their interviews and I developed categories to synthesize, explain and understand data to identify patterns (Charmaz, 2007).

Table 1

Self-reported participant demographics

#	reported Race/ Ethnicity	Gender Identity	Sexual Orientation	Pronoun	Discipline	Location
1	Latino/ Puerto Rican	Cisgender man	Queer/gay	He/him/El	Social Work	GA
2	Latinx/ Mix racial	Non-confirming Non-binary	Queer	They/them/their	Social Work	NYC
3	African American/ Black	Cisgender woman	Queer/ Lesbian	She/her/her	Human Services	PA
4	Black/ African American	Cisgender man	Gay	He/him/his	Social Work	NYC
5	Black	Cisgender woman	Lesbian	She/her/her	Clinical Psychology	PA
6	African American	Cisgender woman	Lesbian Pansexual Gay	She/her/her	Social Work	NYC
7	White Jewish	Cisgender Man	Queer bisexual	He/him/his	Clinical Psychology	NYC
8	European American	Cisgender Man	Gay	He/him/his	Counseling Psychology	NYC

The first step was the development of an interview protocol (see Appendix) that was informed by the theoretical frameworks described above. An email was sent out inviting queer-identified clinicians who have worked with queer people. The description of the study was sent to different networks of mental health providers, LGBTQ organizations and list serves. A combination of purposive and snowball sampling was implemented for recruitment. Purposive sampling was used to identity queer clinicians that were commended by members of the queer

community and who worked in places where services are dedicated to work with queer people. Snowball sampling was used to recruit queer clinicians who are recommended by other queer clinicians.

Queer identified clinicians selected for the interview were offered to have the interview in the places that they feel more comfortable talking about their work and in a place where confidentiality and privacy was maintained. Some clinicians requested to be interviewed in person, in the researcher's office or via zoom. Interviews were audio recorded and kept in a confidential file. The participants recruited for this study were from the disciplines of Counseling Psychology, Clinical Psychology, Social Work and Human Services all identified as queer and verbalized that they have provided therapy to people who identify as Lesbian, Gay, Bisexual, Transgender, Gender-Non- Conforming, Queer, etc. of any age and/or their families. They all had at least a master's degree in a mental health discipline. The clinicians were required to have provided at least one session of psychotherapy to a queer person within the past 6 months (not exclusively assessment). Participants who did not identify as queer, have not provided services to queer people and/or their families within the six months and did not have a master's degree at the moment of the recruitment were not eligible for this study. In the end, a total of 8 queer-identified clinicians who met the above criteria were interviewed.

All of the interviews were transcribed. The next step was reviewing the data to validate the accuracy of the transcription and starting the process of identifying the emerging themes and classifying them in categories. I paid specific attention to the language that participants were using when talking about their cases and through their reflections. Among the emerging themes were how participants use their personal experiences, learned about their clients and their process of resisting oppressive frames.

This was a qualitative study that had a small sample of queer identified clinicians. For that reason, it is important to highlight that the findings cannot be generalized. As was mentioned before, there is so much fluidity in the experiences of queer people and this research is not looking for the one best way to provide queer affirmative therapy. Interviews were conducted in 60 minutes, limiting the possibility of participants to expand more in relation to their clinical approach. That said, these findings do provide a much-needed look into how queer-identified clinicians are working to challenge pathological frames and implement queer affirmative therapy. It is important to acknowledge that more research on this topic needs to continue.

Researcher Positionality

As part of my research, it is important to reflect on the social position I hold in relation to my queer-identified participants and the data I collected from them. As Holstein & Gubrium (2003) describe subjects are always situated or positioned in relation to the symbolic world. They encourage researchers to accept the multiple discourses and subjectivities such as gender, race, sexuality, class, etc. that they negotiate consistently in daily life but specifically in the process of interviewing and data analysis. The way I currently identify has changed many times through the course of my life. I believe I have and continue experiencing fluidity and mobility in my own exploration. I believe that I will continue finding new ways to describe myself in the future. I continue becoming and transforming as I am learning about myself and my environment. I will continue co-creating my surroundings.

I am a brown Latinx, Mexican American, middle-class gender queer person. My sexual orientation presents in very fluid ways. I am a masculine presenting, non-religious and bilingual immigrant. My pronouns are they/them/theirs. I have been in a relationship with a cisgender Latino man for almost 14 years and we have been legally married for almost 4 years and non-

monogamous. My family is structured by my biological family and my non-biological family and I am close to them. Due to my different social positions in the current socio-political context I experience oppression but also privilege. I am a target of different systems of oppression but at the same time I can join systems of oppression to reinforce the subjugation towards other people who are targeted. I can even potentially benefit from that process. For example, as a gender queer masculine presenting person, I can join patriarchal, misogynist, transphobic violence towards other genders since I am living in a context where this is the consistent message I am getting. Resisting this is an ongoing process for everybody. I believe nobody can be fully aware of the enactment of oppressions that we perpetuate.

In the processes of recruitment, interviewing and coding I was working hard to acknowledge how my positionality informed my selection, interview questions and organization of the data. My intersectional queer subjectivity was present all along the process since my own experiences and curiosity helped me to request for answers and learn from other queer professionals. I have been working as a clinician serving the queer community for more than 9 years. In all those years, I have already created my own opinions of what works and does not work when working with queer people and their families. I trained myself in challenging heteronormative frames. At the moment of the interviews I was in charge of a counseling department in a nonprofit invested in creating opportunities for LGBTQ youth to develop into healthy, independent, civic-minded adults within a safe and supportive community. At the same time, I was working with many queer clients in my private practice. In both contexts I have worked to create queer affirmative spaces for my clients. In short, I could have been a participant in this research study were I not the one conducting it. In my research process, I needed to be open and humble to listen to other professionals sharing their own journeys and hesitations with

an open mind. I was invested in paying attention to the particular co-creation that I had with each of them. However, I acknowledge that my intersectional queer subjectivity is still present and provides a structure and a perspective to the data I collected.

Findings

A major theme that emerged from the data was the fact that participants relied both on formal training and their personal experiences as queer people themselves in developing their approaches to queer affirmative therapy. Furthermore, participants shared the way that they engaged in queer affirming practices in the initial contact with clients, such as the way that they have conversations about gender identity, sexual orientation, family definitions, exploration of close relationships, etc. Also, they shared the ways that they engage with diagnosis from the DSM and acknowledged a problematic frame that the diagnosis generates when working with queer people and all their intersections. Participants shared their process when they had conversation with clients around oppression and privilege. They talked about their own strategies entering these conversations and being involved in the process. They shared their uncertainty around how and when to start this process. Finally, participants provided a peek into how they used themselves in the clinical setting, the journeys they shared with clients, the process they went through and the way that they navigated co-created boundaries with clients.

Significantly, all of the participants reported relying on their own personal experiences as queer identified people in improving their clinical work with queer clients. Being queer gave them access to particular knowledge that can't be obtained in a training. As Ari succinctly described it "I never really received training on how to work with queer people. I think that because it's identity-based work, a lot of it is intuitive and a lot of it is about being present in relational work. So yeah, I think it's been intuitive." Uriel described the natural connection that

he was often able to create with queer clients once they found out he was gay reporting that they would often say things like “I finally found a therapist that is Latinx, that can speak Spanish, and is also gay. So you're like a unicorn!” Finally, Ari highlighted the fact that to do professional work with queer people, some personal learning needs to be fostered in the clinical relationship, ”Anyone can do the work, but to do it in a really thoughtful, thorough and conscious way you have to have some relational component where you've had prior relationships to queer people.” Ari stated their concerns about non-queer therapists:

> If you leave your office and the only relationship you've had is with a client that's queer identified, there is something really missing from the quality of like your real true ability to have empathy and understanding for who you're seeing. So it's like if you're a white therapist and the only people of color you're interacting with are your clients, there's a problem there. If you don't have people of color integrated into your actual life outside your job, that is says to me you have some work to do around your own personal stratification in the world.

Participants also relied on their experiences as queer clients in therapy in informing their work. Often, their therapists were also queer-identified and provided them models for how to engage in queer-affirmative clinical practice. As Marco reported, *“*I learned a lot, at least in terms of how I actually work with queer clients from my own psychotherapy. My therapist also is gay and so I think I've learned a lot from that. I've also done a lot of reading because it's something that I'm personally very interested in.”

Yet, participants also acknowledged the dangers of essentializing queer identities with Uriel noting that *“*identifying as gay, my experience, one, cannot translate to other gay clients, but also cannot translate to other people who identify inside other areas of the queer spectrum.”

With this in mind, many participants reported learning how to be more queer affirmative through mistakes that they or colleagues made in working with queer clients. Ari described this process as "a disidentification training of watching how people make mistakes or hearing about it and then being like, oh wow, this isn't intuitive to people." Donna reported a dynamic process of "trying to learn from my practice and what's been helpful, what's not helpful." In line with this process, Stephanie reported "feeling like I think as a therapist to continue to evolve is to always have some sort of challenges because as long as you have challenges in stretching you and continuing to mold you in your professional identity." Participants acknowledged that formal training was part of their clinical approach but also highlighted that their own narratives and stories as queer people were part of the process to create queer affirmative practices.

In line with that idea, participants described what they do in their practices and how they find different ways to learn from their mistakes to create processes of resistance against pathological frames when working with queer clients. The next section offers a description of the ways participants in this study are queering their clinical settings to the benefit of their clients.

Queering the clinical setting: What queer-identified clinicians currently do

Participants described a variety of ways that they sought to enact queer affirmative therapy. Some of them shared how they engaged in conversation around gender identity and sexual orientation and how they are mindful of being affirming and resisting assumptions when asking questions. Other participants talked about resisting heteronormative frames in how they assess safety and understand patterns and dynamics among those who are considered under the umbrella of family in each client's life. Additionally, participants reflected on their disidentification with diagnoses from DSM in ways that were intended to benefit their queer

clients and develop transformative clinical practices. They described their process of working with and against these diagnoses by acknowledging the history of bias in the DSM while at the same time recognizing the power of strategically using these diagnoses to open access to care for queer clients. Each participant had their own way to disidentify with this history in their clinical practice and their own way to provide psychoeducation to their clients around diagnosis. In addition, participants had conversations about oppression, they described incorporating systematic thinking and they shared the struggles of starting and keeping these conversations going. Some participants shared how oppression is enacted for them too and they shared how they navigated those moments.

Queer Affirmative Intake

Participants verbalized that in the moment that the conversation about sexual orientation and gender identity emerges in the clinical setting there is a need to hear the client closely to understand the ways that they talk about themselves. Most of the participants aligned with the idea of asking the clients directly about how they identify. In the initial contact with clients, Donna emphasized the importance of asking questions to clients in relation to gender identity and sexual orientation noting, “I don't make an assumption based on what somebody looks like or even having fill out an intake form.” Donna argued that providers add some significant questions in their initials intakes, as she does “I actually write on my form, "How do you identify?" I don't just say, "Sexual orientation check something or..." I actually allow them to write in their gender identity and their sexual orientation.” Coinciding with this point, Ari described a similar approach in their practice first with sexual orientation “there's like an online survey and it has multiple locations where the client can write like how they identify their sexual orientation if they want.” Then Ari shared what they ask in relation to gender identity and

pronouns “just how do you identify your gender, if you have a personal, I don't say preferred, but if you have a personal gender pronoun, what is it or what are the pronouns that you use?” In addition, Jasmine reported working hard to pay attention to the spectrum within queerness that need different types of attention and specialty “I would say that there's not a lot on non-binary clients, which I think, not like needs more specialized care, but specialized attention. We talk about gay and lesbian people, and then we talk about transgender people. But I would say bisexual, pansexual, and non-binary people kind of get left out.” In addition, participants emphasized resisting static identities by challenging the idea that clinicians should only ask about identities in the initial intake process. For example, Ari reported when they checked in with clients about their identities regularly noting “I just want to check back in. Make sure I'm using the right language and I've got it right. How does it feel today that I'm thinking of you as queer-identified? Does that sound right? Then someone can say yes or no but that tends to be.” Ari highlights “Constantly checking in feels like a feedback loop of affirmation for the moment.”

Along with this idea of what to do in the initial contact with queer clients, participants also recognized the importance of family and the definition of the term for each queer client. Donna talked about her intake forms and the family section:

> There's a question of family of origin, but also put in parentheses "Your definition of family." I don't like to write off anybody or make any assumption about family. So one of the first questions I ask about is, "Talk to me about family, but in your definition of what a good family is. Because I like to account for chosen family. I don't like to make assumptions that people have the best relationships with their biological family anyway.

Ari added to this idea the relevance of welcoming to their practice all constellations of families “on my website it just says all families welcome. I name a bunch of different ways of seeing

families.” Additionally, Ari provided a definition of family to clients so they can start building up from there “a family is like more than one person.” They added,” I see people and their dogs, I see people and life partners, I see people and married partners.”

In addition to adopting an expansive view of family, participants also reported how they worked to support clients in unpacking their familial relationships. Ari shared that they created their own queering of the Convoy theory of social networks, **“**We'll do concentric circles and they fill the circles with who their closest people are. Then they look at where people fall in proximity to their life. Then we talk about this as a family and we talk about who's in the inner family, who are the extended relatives. Sometimes biological families aren't even on that.” Ari stated, “So that's I think the queering of the genogram maybe.” Donna reported beginning conversations with queer clients early on by asking “Who is family to you? I always ask, is your relationship with your family healthy?" And a lot of times they'll say, "Well, what do you mean by healthy?" And I'll say, "Do you feel safe? Do you feel supported?" Roger described starting this conversation as follows, “I'll ask them if they're out with their family and what that experience was like for them? Whether it's accepting, whether it's been a journey, whether it's been a source of tension or estrangement? The same questions I guess of the siblings about their relationship with them.” Roger paid particular attention to the needs of queer clients with children asking “What it's been like being a queer person with children. I guess how has that impacted your relationship with your parents, with your family or siblings?” Some participants were interested in the narrative of coming out that their clients come with to therapy, for example Jasmine described how she asked about family dynamics “I'm very, very past focused, so kind of getting a sense for family dynamics of childhood memories, and asking about coming to stories explicitly if they are out.” She wondered also about coming out within the family dynamics,

“because coming out is a never-ending process, but what coming out to this family member means versus this other family member.” Jasmine continued “I support whatever they think is the best decision for themselves, and so sometimes it just really is the best decision for themselves not to come out. And that's great that they know that about themselves and can set that boundary.”

Participants relied on their own personal background to inform their first clinical encounter with queer families. As Daniel mentioned “in certain situations for example, a family and their child comes out, having the family thrown into chaos and trying to understand how to navigate that space. I can bring in myself to help them. But I'm careful with that because I have to make sure that I feel safe doing that.” Daniel gave more details about how he used himself as a clinician in his family sessions:

> I would explain to them the importance of naming our social locations, so that we don't make assumptions. We bring in the multiple parts of our identities into a space together. Not assuming that everyone's cisgender or heterosexual. Naming that for me is just bringing my authenticity into the space and then I just go for it and just share how I identify.

In line with this approach, Stephanie mentioned that in her work with youth she is always paying attention to who reaches out for services and how support looks stating **“**I always think about who's reaching out for the services or therapy. And if it's for a queer person and a family, I try to gauge is this queer person being supported?” In addition, Stephanie made an effort to understand if families are reaching out for affirming or conversion services, she wonders while assessing “Is the hope for therapy to somehow change them or make them not queer anymore?”

Extending the conversation around queer families, participants commented about talking about romantic relationships with queer people while being mindful of not using normative lenses, Stephanie commented about this **"**I realized that it was important to normalize same-sex couples, normalize the family structures on some of those folks that I worked with, and just normalize their experience without imposing a heteronormative lens or perspective.**"** Jasmine noted the importance of understanding relationships and agreements to avoid assumptions, **"**I think that queerness and polyamory are often linked together." She agreed with other participants about the importance of "understanding different relationship structures." Ari shared an example of a couple they see who described themselves as being platonic "they're like each other's family member but there's not a romantic or sexual component to the relationship. They live together, they share some finances."

Finally, as part of ensuring their queer clients receive affirmative therapy more broadly participants reported strategically identifying resources for their clients that respect their queer identities while actively working to resist anti-queer sentiment among other providers. Donna reported feeling shocked when she heard stories about clients being misgendered by providers **"**I'm hearing the stories of being mis-gendered by therapists. Of therapists dismissing some of the trauma and stress that they're disclosing. Therapists questioning whether something actually is a trigger or an actual traumatizing event." Based on these experiences, Donna highlighted how deeply she thinks about who she referred clients to, since providers are important relationships for queer clients. She noted, "I won't refer clients anywhere unless it's a resource I'm familiar with or that I've heard good things about. So not having adequate resources to refer to is a big challenge for me." Jasmine shared how she developed a technique of making providers aware of the problematic frame that they were using "is just any time they said she, I would just say they.

And I wouldn't interrupt them, but I would just say they when they said she. And no matter how often it happened, I would just say they. But I wouldn't catch an attitude. I wouldn't scold them. And that worked well enough."

In short, the participants all described the ways that they work to embrace the fluidity of their client's identities and experiences. Participants also shared how they wanted to map out the meaning of their relationships and gather knowledge from their clients to understand what family meant to them. In line with these efforts, participants shared how they start the negotiations with diagnosis in the clinical setting, which will be explored in the next section.

Queer Affirmative Diagnosis

Participants disidentified with the DSM by recognizing diagnosis as a necessary tool for billing and to provide queer clients with access to necessary treatment but refusing to frame the diagnosis as the primary point of entry in meeting their clients' needs. As Marco noted "I personally don't find for most cases diagnosis to be very helpful because I think it can often be reductionistic and not actually describe kind of the depth of people's distress." He continued "I think the reality is that diagnosis is much, much, much messier." Participants mentioned that diagnoses are created to describe symptoms and focus on the interpersonal level. According to Ari contextualizing these symptoms can benefit queer clients noting "thinking of trauma on like a macro level and not just interpersonal level or an identities history through a lens of trauma. That seems to actually open up more spaces to get more complex training."

One way that participants sough to disidentify from diagnoses was by acknowledging that they understood the challenges that diagnosis represented for queer clients and often found themselves apologizing for having to assess for a diagnosis with Ari sharing "I do say, sorry, we got to do this." Likewise, participants shared that when they received clients who were coming to

their offices with a diagnosis given by other clinicians, they found themselves in the position of re-evaluating the process. Jazmin shared her experience around this “My non-binary client does carry a diagnosis of bipolar I disorder with psychotic features. And they were diagnosed with someone who's not me. And I don't agree with that diagnosis.” These strategies were part of broader disidentification efforts undertaken by participants in challenging pathological frames through the implementation of queer affirmative approaches to diagnosis.

The primary way that participants sought to implement queer affirmative approaches to diagnosis was by refusing to make the diagnosis their primary starting point in developing their treatment plans. As noted by Donna “my way of forming the diagnosis is not done in a way that pathologizes their queerness.” Focusing specifically on her discomfort with the gender dysphoria diagnosis that is necessary for providing transgender clients with access to gender affirmative treatment she reported, “I myself have had my internal issues with treating gender dysphoria, but because I believe it pathologizes someone's gender identity and their exploration of it, and I still wrestled with that.” Stephanie elaborates on this point by saying, “I think in terms of diagnosis for queer folks and trans folks, for me, I try not to pathologize the idea of what it means to be trans and queer. But we do also discuss and recognize that certain diagnoses are necessary with accessing medical care, affirming care or accessing other systems of support.” In line with this idea, other participants such as Uriel, acknowledged that diagnosis could be useful as well to navigate other systems such as political asylum cases that required clients to undergo clinical treatment as part of their court cases noting that in one case, “the client agreed it would be a good idea if there was a diagnosis of gender dysphoria, so it somehow validated their identity to the court.” Uriel brought up the fact that “the client was open to that, and we went through the DSM and looked at the criteria and talked about it together about what that meant on a piece of paper.”

This approach was in line with disidentification strategies utilized by other participants such as Donna who acknowledged the importance of having conversations with clients about pathological frames that the DSM carries. Donna mentioned “I'm pretty open about [pathological frames] with my clients because some of them come to me after working with other practitioners who may not have specialized or have advanced training on working with queer clients.” She also expressed concerns about how her queer clients did not always understand the process of diagnosis and how it is done commenting “folks are diagnosed and don't even know what it means. And so when I get the diagnosis, whether it's major depression, adjustment disorder, PTSD, whatever it is, the first thing that I'm doing in that session, when we're discussing the results of an assessment is psycho-education around the diagnosis.” To this point some participants tried to use different ways to help their clients understand diagnosis. Roger shared “sometimes I try to approach it as, one, to bill your insurance, the ease of diagnosis. I guess I try to frame it as much as possible in the language they use coming in and try to also I guess frame it in a way that captures any relevant contextual interpersonal issues that might be playing into the diagnosis.”

In addition, other participants worked collaboratively with their clients to understand their symptoms. Daniel explained to his clients “I'm thinking about diagnoses, you're labeling some sort of condition that's happening. And on the other hand, those labels help us to understand how to move forward and what to look for. What are the characteristics? What are symptoms if you will, depending on what it is?” In the same way Stephanie noted how she supported her clients to reframe and resist pathological frames in diagnoses “I think sometimes folks have this idea that I'm depressed or I am having anxiety because I'm trans so I try to support people with kind of separating and unpacking that.” Stephanie reported telling her clients

"You are a person who has to deal with these symptoms and manage but it does not have to be tied to being trans or being queer does not have to be a terrible thing that makes you have all these symptoms." Stephanie noted that she tries to externalize those ideas "It's society and typically how you have to interact which really brings about those symptoms or makes that something that you have to manage."

Participants were very active about the fact that diagnoses have heteronormative and oppressive biases and they do not provide universal answers to the struggles of queer people and their families. They sought to disidentify from these diagnoses by incorporating systemic thinking in the services they provided to queer people and found ways to collaborate with them to navigate oppression. Participants insisted on challenging the idea that the struggles of queer people come from them (blaming the victim), as well as the frame that symptoms are isolated or only play out at an interpersonal level. Participants insisted on looking at the broader context, the external forces that influence the symptoms. Inevitably, this led to conversation about systemic oppression and privilege that I examine more below.

The elephant in the room: systemic privilege and oppression

Among the themes that came up in the interviews with all the participants was the theme of privilege and oppression when working with queer people. This connected with their commitment to disidentification with pathological frames that dominate the field by extending their work with queer clients beyond interpersonal symptoms of oppression to account for the broader ecological context. As Donna shared in relation to her practice "something that I actively do in my practice is to analyze on a micro level, but also I relate it to the macro so that folks can understand that these behaviors and practices are oppressive. They function within a system." Participants acknowledged that systems impact clients on different levels and that they witness

how these structures get internalized, such as Stephanie who described “we receive messages around homophobia and transphobia so it's natural that a person will want to or need to unpack their own internalized homophobia or transphobia. I don't know if that's necessarily negative but just another step in the process around acceptance and affirming of their identity.” Additionally, Ari highlighted that therapists sometimes do not understand the impact of oppressive systems and how it looks different in each client. “It's not that all queer people have the same lens clearly on anything but there is something often about the emotionality of the work or the secrecy. The way that homophobia sits with people, the way that heterosexism is in the room. I hear stories about therapists who got it right until they didn't.”

While all participants acknowledged the importance of discussing issues of oppression with queer clients, they wondered about how to start these conversations. They believed that it is a vulnerable place to go and they sometimes were not even sure if clients wanted to feel that in the room. As Roger shared “sometimes clients allude to issues of oppression, at least from my reading of it. It feels like sometimes they'll maybe send little possible hints and trying to test the waters and see if this is okay to talk about. I guess when I pick up those, I try and remind myself that it's my job to make it feel comfortable to talk about.” Stephanie shared her thinking around the clients’ perspective about this conversation “folks who may come from an environment where they felt very unsafe or had to suppress a lot, I think it takes some folks a little bit of time to be comfortable and feel reassured that it's safe to discuss.” Additionally, Stephanie shared more about how she wanted to support people to process the impact of oppression on their lives. “It's about helping people understand why they do the things they do, why they see things the way they may do. I think it's something that I'm very intentional with talking about in the very beginning to create that idea that is comfortable to talk about.” In addition, Marco described

feeling a mutual vulnerability when talking about oppression “For my client (talking about oppression) also being vulnerable about those things were extremely difficult, let alone doing so with me.” Marco shared that from his perspective as a clinician “I did learn from that is like how to tolerate the split, how to tolerate being the bad object, the representation of the oppressor.”

Participants also reported how both their identities and their clients’ identities impacted these discussions. In the efforts to start conversations around oppression, Daniel mentioned that he felt it was easier to have them with people of color “it comes up often because we're just explicit. I'm asking us to name it and it's understood that this is the process that we go through. In sessions, I think... it probably comes up more with my POC clients.” Similarly, Marco noted that it felt easier to talk about those situations when they caused distress to the client “I'll say that it's much easier to do when I identify less privileged identities like being a woman, being a person of color, being poor, having disabilities, things like that. It's easier for me to address those things in psychotherapy because I think they often cause distress to these, to the clients.” In terms of how the clinician’s identities impacted these discussions, Jasmine shared that clients made assumptions about how she engaged in conversations around oppression based on her identities “And I think part of it is because of my stance on self-disclosure, that also applies to political identity. And I also think since I'm a Black queer woman, no one really ever assumes that I'm conservative.” She described how her identity created a space to talk about conversations around oppression “I would say 99% of people assume that I'm liberal. And so I think that that just naturally creates a more open space or dialogue about political identity, racial identity, whatnot. So I think a lot of how I am in the room kind of reads that.”

Because of their commitment to implementing queer-affirmative therapy, all participants worked to overcome their challenges in facilitating these conversations. One topic that

participants reported exploring with queer clients is heteronormative and gender-based violence. As Ari described:

> There are things that happen because of the binary gender system is so traumatizing for all of us and patriarchy is so traumatizing for all of us. So any person with a gender, which is all people, have experienced gender-based trauma, that's my personal belief. So we learned the particular flavor of your gender-based trauma but it is not about your transness or your trans experience.

In line with this systemic thinking, Stephanie shared her thinking in relation to perceptions of beauty and body shapes in society "there is fat phobia or just systems that impact people of size or larger people, some things like sitting arrangement and to this idea in the medical field that everything has to be tied to your weight and how we have to move in those systems." She continued talking about how violence is generated within this frame "the idea is well, just lose weight or just change things to fit societal standards or norms. But that comes with this idea that it's a sickness or it's wrong if you're a larger person or if you're a person outside of what is considered size that's acceptable." Uriel shared the conversations he had with clients who have been involved in the criminal justice system "some of the conversations have been about working with clients who were incarcerated in the past and being able to find work or a place to live." Uriel shared how clients were talking about their experiences of oppression with this system "We have talked about the justice system, and also how it keeps following them with them trying to make their lives now. Which is, by itself an experience of oppression for them." In the same way, Ari described how they talked about anti-Blackness in the clinical setting and in the first session with clients "We talk about anti-Blackness and treatment. In the first session I acknowledge the history. I'm not Black, I have not had any experience in the world of being

targeted by anti-Blackness. I have had many experiences in the world of being targeted by racism and queer-phobia but I would love to work with you and if this doesn't make sense for you at some point let's talk about it."

One tool that participants used in facilitating these conversations was their own experiences and identities. They shared the things that they do in their lives to resist oppression, such as Donna who mentioned "I talk about ways that I've advocated for myself for just to encourage self-advocacy in that way." Stephanie noted what she talked about with clients in relation to oppression "I share my understanding of navigating those systems, share my nuances as a Black person, as a Black queer person how that maybe supportive in the clinical relationship." In the same way Donna noted "I will highlight where oppression and privilege seems to be playing a part so that they can deconstruct that as well. And so in first addressing the psychological impact of that, we also actually deconstructed it from a systems perspective and relating it." She added "I believe that it's empowering for people to understand the relationship between oppression, privilege, discrimination, the -isms and our mental health."

While the participants were able to effectively use their identities to facilitate conversations about oppression, they also experienced oppression in the clinical room based on their marginalized identities in relation to race, gender identity, sexual orientation, social class, etc. Participants acknowledged that they were present and visible in different ways with each of their clients, and it was not something that they had control over, such as Roger who mentioned "it's hard disentangling my presence in the room as a therapist from my presence as a queer person in society where I find myself always overthinking that question, because depending on the context, it has a certain impact that disclosure can have." In similar fashion, Stephanie shared her struggles with anti-Blackness. Stephanie, as a Black lesbian shared in relation to working

with white clients “I learned to not be as impacted by impostor syndrome and inferiority certainly with engaging with white clients or white queer clients.” Additionally, Ari described their experiences with whiteness and classism. Ari shared their feelings around colleagues when attending trainings, “sometimes I get really terrified going into clinical training spaces because it does often feel like there's so much ego in the room and to not present in that way you're seen as not professional or you're like not white enough.” In relation to classism in the clinical setting, Ari described their struggles when seeing wealthy queer clients “that's my personal challenge around the privilege pieces around class because I'm very aware of who I am in the room financially as compared to that and that's hard to hold. I have to do a lot of work not to feel like I'm paid. There's like a labor component with that class differential where I'm like, oh, I'm just another person paid to do work for you.”

Overall, participants shared the complexity and challenge of naming the oppressions and how they worked to understand more about it in their clinical practice by going beyond the micro level to the macro level. This opened up space for both them and their clients to reflect on the role of oppression in shaping both of their lives and their interactions with one another in the clinical room. However, naming the systemic violence in the clinical room is opening historical and intergenerational wounds that raise feelings and more questions. This is not an easy and comfortable task but participants felt that it was necessary to open dialogues about oppression and how to resist this oppression together. This inevitably also led to difficult conversations about privilege.

Participants agreed that they wanted to introduce the processing of privilege in a way that felt comfortable for clients. However, they shared their struggles with keeping it comfortable. Roger shared “I'm still trying to find a way to do it in a way that feels completely natural and

smooth." He mentioned that he starts sharing reflections around his own privilege, "I guess just comments on the fact that I'm white, cisgender and how I guess with it can come certain blind spots and certain privileges that I guess whether intended to or not get brought into the therapy relationship." He noted that he felt more responsible for recognizing his privilege "especially if I'm working with an individual who is trans, or an individual who's a person of color." In a similar vein, Uriel shared how he reflects about his own positionality of privilege as a clinician in relation to his queer clients "By being queer, like a client of mine identifies as queer, it's not the only identity that we have." Uriel talked about his privileges first in relation to housing, "I know that if I share with my homeless client that I'm also queer, I also know that I have a place to go sleep, and that I may not have to resort to things that they are doing to survive. So it's not going to be the same experience." Uriel also pointed to his citizenship noting "I am also a citizen, I was born a citizen as a Puerto Rican, so I don't have the same experiences as other people.

In addition to reflecting on their own privileges, participants also reported engaging in explicit conversations about privilege with their queer clients. Ari described a reflection process of how they shared things about themselves to model the processing of privilege around race. "I talk about being mixed. I talk about having a white mom. That if my mixedness or light-skinned privilege comes up, which sometimes it does, we talk about that." Ari shared how they process discussions of gender privilege "even though I'm (gender) non-conforming, I fall more on the feminine end. So with trans male clients I'll ask them, would you prefer that I do a referral to a trans male therapist? How does it feel to be talking about transition with someone that might pass with cis privilege?" Donna shared what she does in her practice to start the conversation around privilege with clients, "pretty much always in my practice have these discussions within the first

few sessions." Donna continued describing how she gives clients heads up that they be invited to think about their own social position in relation to privilege "I like for them to know that my practice is an affirming practice and that I have a social justice lens. I let clients and prospective clients know what my identities are per se, but that I am actively working to ensure that I'm de-colonizing my own practice." Donna shared that she understands that talking about privilege is not only about one session and that everybody engages in that conversation differently "it's the people who are not used to examining that or not used to that language, it may take more conversations about it, but I find that people tend to be receptive."

Moreover, Ari shared how they help their clients to process their privileges and how they come together to a mutual agreement "There's agreement that this is a good match therapeutically and it often is and that they have the privilege to see anyone that they want in the city." Ari continued sharing about discussions with their clients "There are many white identified queer therapists who would love to work with them. I would also love to work with them if they would like to be seen by me." In addition, Ari described how the agreement looks like in relation to payment "I have a large sliding scale and if they have a full-time job, I'm asking that they consider paying at the highest end of the scale to subsidize my free trans people of color that I see each week. After we get through that, often they say, yes." Ari noted "They're there by choice, we've talked about class privilege, we've talked about race privilege"

Participants also reported many challenges in confronting privilege in the clinical room. For example, Marco shared "I don't think I do a good job of it, of addressing privilege and oppression and power." He shared his perspective around how he does it "it's easier when folks kind of have non-dominant identities than it is for like my white cis male clients." Marco shared his perspective about processing privilege and experiencing shame "I think it's about getting

people to be honest about who they are without the shame because I do think there's something about wanting to serve everybody but not having the tools and then being ashamed about that and hiding." Another challenge related to their efforts was to disrupt the fragility of privilege. Participants shared their struggles to not take personally their clients' discomfort and resistance when talking about privilege. As Stephanie mentioned "some folks may feel uncomfortable because this idea that all queer folks are oppressed is very true but sometimes you have to get people to also acknowledge their privileges within these oppressive systems in their access." Stephanie continued "So sometimes, that can be very uncomfortable working through initially. Some people feel like frustrated about those systems and may not necessarily about you."

Participants invested a lot in sharing about their own process of having conversations about privilege. They expressed their efforts to make the conversation comfortable for them and their clients. However, the fragility of privilege often arose to protect systems of oppression. Participants shared their vulnerability while some of them struggled to recognize their privileges. Conversations around privilege are not comfortable and the fragility that is generated for challenging the system sends the message that productive conversation around privilege only happen when somebody feels comfortable and safe. Unfortunately, people with dominant identities are the ones who end up having their safety prioritized. Having conversations around privilege and oppression in the clinical room lead participants to reflect and share about how they are systematically located in relations to their queer clients, which I examine more below.

Self-disclosure and use of self: Experiences of queer clinicians

The question of self-disclosure is one that consistently emerged in the interviews. Participants wondered why, how and when to disclose information about themselves in the

clinical setting when working with queer clients while being thoughtful about the variety of social locations they hold as queer identified- clinicians. Participants shared that they have gone through the process of disclosure many times in sessions and in different ways with each of their clients. Stephanie talked about how disclosing is about fostering a space that invites clients to talk about themselves "being able to talk about being a Black person or being able to talk about being a Black queer person, a person of size, being able to create space for people to talk about that is how we kind of start the conversation." In line with this stance participants wanted to use self-disclosure as part of efforts to normalize challenging cultural experiences. As Daniel explained "I certainly have self-disclosed for many reasons, some of which are building rapport with the clients and normalizing an experience for them that may be culturally or just personally, they may find challenging." Participants talked about their exploration of when to disclose things about themselves and the consequences for that. Some of the participants shared that disclosing in thoughtful and unique ways to queer clients provides possibilities of visibility, representation, feelings of being normal, belonging, connection and provides an environment of honesty in the clinical relationship. In addition, according to participants, it challenges assumptions and resists ideas of neutrality in the clinical room.

Most of the participants reported disclosing their identities in the first session. Stephanie specifically described the impact of queer visibility. She described the meaning of disclosing her queerness and being visible with queer youth **"**It's always interesting and a good thing to see some sort of sigh of relief or some sort of light that lights up in people when you identify as queer. I think that makes me feel good." Stephanie shared a story with us "I can think of an instance with a small girl who's working through and processing her identity and when I identified as queer in our consultation, how she lit up and it modeled to her that I'm another

person, a person of color, and that those things are okay.” Donna shared how she identifies in relation to gender identity and sexual orientation “I'm out. I'm completely out as a cis lesbian. So it's not a secret per se.” She continued describing her thought process in relation to queer clients “When I do disclose and I do share about my identities, I do it so that it's forwarding or supportive of the client and not based on my own needs or that I'm not necessarily feeding into just any curiosity that's not going to help them therapeutically.” Donna explained how she shares about her own story to provide possibilities to queer clients about how they deserve a future in this society:

> I've shared my coming out story countless times as a reinforcement for clients who say, "I want to come out to my family but I'm afraid, blah, blah." And if they don't necessarily share any legitimate reasons to be concerned about their safety or anything of that nature, I'll share my story. Especially as a woman of color like I said, when I work with queer people of color, at least the feedback I get is, "Wow, that's good validation."

In a similar vein, Jasmine mentioned that she has shared personal experiences with her clients when they wanted to feel understood “I've disclosed things about my disability with someone who shares the same disability just because they were frustrated that they wanted a community, or they wanted to be understood in that way. And we're both young, and they were kind of frustrated that no one their age had this problem.”

Participants talked about how they support their clients in understanding what they are doing clinically. Daniel talked about the conversation he has with his clients noting:

> I usually open up and then explain why I'm sharing. I would explain to them the importance of naming our social locations, so that we don't make assumptions. That we bring in the multiple parts of our identities into a space together.

He also shared how he fosters an environment where clients are invited to think of their own process of making assumptions. Daniel noted how important it is for him to send the message to his clients to not assume “that everyone's cisgender or heterosexual. Naming that for me is just bringing my authenticity into the space and then I just go for it and just share how I identify.” He noted how invested he is in challenging the idea of invisibility in the clinical room:

> When we don't name our parts of our identity, they go unspoken, they go unacknowledged. Our whole selves aren't in the room. Not everyone in there is straight, not everyone in the room is cisgender. Not everyone has the same experiences because of the differences in their cultures, religions, spirituality and whatnot.

Ari mentioned that they present to their clients with all their fullness as a human being, challenging the pathological idea that therapists hold neutrality in relation to clients **“**I have identities that matter that they're constantly an interplay with who I'm working with. That we acknowledge that we talk about it, we name it that I am a human in the room, I have reactions. I'm not a blank slate.” Ari described what they share with queer clients “I will disclose yeah, like where I live, I talk a lot about race, class, how I was raised, my dad's a vet, he's an immigrant. I talk about that, people ask.” In addition, Ari reflected on how identities and conversations around them can be very activating to clients “I talk about identity being really activating. To be honest, we end up often talking about, that's usually when newer clients will talk about other therapists, they've had that were "unreadable." Ari described more about the relationship of trauma and an unreadable therapist in the clinical setting “I do a lot of psycho ed about trauma work being intentionally very readable. So we talk about the neurobiology of trauma and why it's very unhealthy for someone who has a traumatized brain to be in a room with someone who is "unreadable." Finally, Ari noted how they advise their colleagues about their concerns about not

doing a good job when working with queer people “bring yourself into the room with honesty and transparency. Do the work on yourself so that you can do that because you're doing a disservice to queer people if you're not.”

Together with the idea that disclosing to queer clients could be a beneficial and productive experience, participants shared their hesitation and thought process around disclosing. For Marco, the pressure to remain neutral, at least to some extent, made self-disclosure more difficult for him**.** He shared how he goes by thinking about when to share “If it's very early on in a treatment, I think I would be much more reluctant to share, to share my identity whereas if it was someone that I had a longer relationship with, I would have a better idea how they would take it, what it would mean for them. And also even disclosing my own emotional reactions.” In line with this idea, when Roger was asked about his reaction when talking about his own gender identity and sexual orientation with his clients, he shared his hesitation of fully himself showing thinking of how his supervisors would disagree with that kind of visibility in the clinical room “I think the first thing is I imagine my old supervisor having a stroke. In my training, it's a reflex of we need to be neutral and they [clients] don't really need to know that about us.” Yet, other participants reported hesitation in self-disclosing their queer identities not based on desires for neutrality but because of their fears about homophobic and transphobic family members of queer clients. As Daniel described it, “if I'm working with a parent that's not accepting at all or rejecting or homophobic or transphobic. Jumping into that self-disclosure without being thoughtful, or without having an established rapport with those parents, I can imagine that it could create tension.”

Other participants shared challenges in knowing how most effectively to use self-disclosure for the benefit of their clients. Daniel shared the anxiety that he experiences when

sharing marginalized identities while holding the responsibility to think how helpful it would be for the clinical process:

> I've had parents or clients ask me out of context, about my sexual orientation and that can produce a little anxiety. I'm being careful with how I push back or question the intent and then trying to assess whether or not, well what's the harm? Can I do this? Is it okay for me? And if I shared it with this person, would it somehow be helpful? And in that particular instance it was helpful.

He also shared challenges he has experienced after he has disclosed some information to clients. One example was a case of a caregiver that expressed their anxiety with Daniel after knowing that Daniel is not a parent "well if you don't have children, how do you understand what I'm talking about?"

Related to this point, participants admitted that they sometimes experience discomfort sharing certain aspects of themselves and they tried to understand how that specific vulnerability is connected with respect for their clients. Donna shared "I don't give details of any relationships that I'm in or that I've been in. That's definitely a no-no. for the reasons of privacy for my partner, but I just feel like that's just crossing the line. I think I can say I've never shared any details of any relationship that I've been in." Additionally, she shared "I don't necessarily talk about my own specific journey and exploration of my sexuality." Ari had a similar comment in relation to questions around their sexual practices, "sometimes I'll say like, well that's a really interesting question. I wonder what you're looking for right now. What would be helpful to hear? What do you imagine the answer is?" Ari shared their clients' reaction to not answering the questions directly "sometimes they say, I don't know, I just suddenly realized I don't know this about you. I'll say, do you have other people in your life that you want to know that about?

Sometimes that works where then we can look at other people in their lives that they might not have the kind of relationship they want with. But sometimes I've just said, I'm sorry it's not a question I can answer." Similarly, Stephanie also shared her discomfort about the specific curiosity of queer clients "I had some people asked me that who do you sleep with? Are you married? Are you dating? Did you ever sleep with a man before? Did you have your children naturally? "She shared some of the reactions she had with those questions and "how you have to find a way to deflect but not really shut the person down because at this point, you're trying to cultivate a clinical relationship or a therapist-client relationship. Focused on a different aspect of her identity Jasmine shared "I never disclose my age ever because I'm 24, and I feel like a child. And I don't feel like my age equates with gaining respect from clients."

Finally, participants pointed to the ways that self-disclosure was not always something that they had control over. Jasmine talked about the visibility of her racial background "I'm Black, so that's really apparent when they meet me." Align with this idea, Stephanie mentioned in relation to her racial background and her appearance "I mean my identity as fat, as race that I'm a Black person just kind of already is not a hidden identity so that's something I'll identify or at least discuss especially when working with non-people of color just really being really clear." Conversely, Jasmine's femme presenting behaviors often led clients to assume she was heterosexual, which also made her uncomfortable. As she noted, "I don't like when people assume, I'm straight, it just makes me uncomfortable. I very much love being a lesbian, and I think it's a really important part of my identity."

Participants utilized a range of strategies to disclose personal information to queer clients with the goal being to normalize their experiences, encourage queer visibility and representation, while avoiding assumptions and reflecting about traumas that might be triggered in the process.

They shared the challenges of disclosing, such as what to do with the concept that many clinicians have learned in the beginning of their careers to "keep neutrality intact" and "protect objectivity." In addition, they explored the meaning of volunteering information and negotiating mutual boundaries with queer clients. In line with this idea, participants shared that disclosing information verbally is a different experience than non-verbal disclosure, in which they might not experience some control over. All these conversations led the participants to think about a wish list of things that they were interested in learning and exploring in their clinical practice when working with queer people and their families.

Advanced Trainings in Queer Affirmative Therapy

Participants reported having little formal training in queer affirmative therapy either in their coursework or ongoing professional development post-graduation. The few trainings they reported receiving focused on basic terminology that participants were already familiar with as members of the queer community themselves. Most of them agreed that there is a need for more advance trainings with Uriel noting "A lot of the training out there, it's very basic sometimes. And that's great for people that are at that developmental stage in their personal and professional paths on learning." Participants desired more advanced training that helped them to further develop their clinical knowledge in ways that are queer affirmative.

As Ari matter-of-factly stated, "I definitely did not get any training in a classroom setting." This was reiterated by Uriel who reported having "to do my own reading and learning and talking to others on consultation, but not necessarily in my master's program, or through my master's program." Ari also described the lack of queer affirmative expertise in their field placements and jobs describing therapists they have worked with "who have like no concept of

what appropriate or standards of care are around gender and sexuality." They also mentioned the lack of advanced training when working with queer people noting that

> Lot of the trainings that are available for, at least for any SW and for mental health counselors tend to be very 101. They're very language-oriented, terminology and basic stuff around how to be affirmative in a space. But they're not designed for more advanced clinicians to really talk about countertransference, issues of transference in the room, stuff around like whiteness that comes up if you're both queer. Those kinds of more nuanced parts I think come from individual supervision but they're not standards in the fields.

This points to the importance of both prioritizing queer affirmative therapy for all mental health providers while also tailoring trainings to queer clinicians who already have a great deal of knowledge about queer issues based on their own lived experience.

In response to this lack of training, participants reported relying on their own resources to strengthen their clinical practice with queer people. One strategy that they used was proactively looking for up to date research and paying attention to new trainings and conferences that they could attend to improve their clinical practice. As Roger reported "I try to keep up with the clinical and the research literature. I'm part of some organizations on doing research, psychological research with gender and sexual minorities." As queer people themselves, the participants also reported specifically seeking out queer community voices through attending community meetings. As Uriel noted, "I've attended presentations from community members basically saying what they would like to see from their mental health providers. I was attending this particular workshop from transgender Latinas in Texas that were sharing their experiences,

not only their migration experiences, but their experiences with healthcare professionals and mental health professionals and the court system."

Participants also reported actively seeking out supervision from mentors who were queer affirmative. As Daniel reported, *"*I process (clients' cases) within peer supervision, with my colleague. I have two supervisors, so I use them. I also have a peer group that's separate from my work here. It's a POC peer group that I put together." However, not every queer-identified clinician has the same supervisory and supportive access to feel safe to process about their queer clients. For example, Roger reflected about wanting to process the fact that a client was flirting but deciding not to mention it to his heterosexual supervisor because of a lack of safety both for himself and his client. He wondered about, "working with heterosexual supervisors and how do I approach this?" adding "I don't know if I was making it more complicated because of I guess my client and I shared identities or if it was just legitimately a complicated case. I don't know. For whatever reason, I just did not feel quite as safe to really dive in and explore." In all of these cases the participants reported prioritizing the needs of their queer clients by either actively seeking resources or choosing to remain quiet in order to protect them from homophobic environments.

While being proactive at seeking our resources, participants still reported a desire for more advanced trainings on queer affirmative therapy. In particular, participants reported a desire for more training in queer family therapy. Stephanie mentioned "I would have liked just training around even instances like genograms for queer and chosen families or training around couples counseling for LGBTQ folks especially with the themes of open relationships and polyamory." Roger said that he would like to learn more about parenting "how LGBTQ identities intersect in all different realms in terms of working with families in which maybe a child is struggling with

their identity or even working with queer parents and working how I guess the experiences that they deal with that are unique to them and certainly how I guess trans-generational issues might impact that." Daniel mentioned that he was interested in learning about **"**How do I work with queer couples or groups of people?" He continued "Overcoming whatever challenges connected to intimacy, love and what that looks like across different culture." Apart from this, Daniel highlighted the importance of using intersectional lenses "If you're thinking just queerness and then you're thinking about ethnicity, you're thinking about culture and how those influences play into that**.**" Along with this idea, Ari emphasized what they would like to learn more about "I think queer couples work around having children. What happens when we add children to a queer family?" They continued "that feels like an emerging body of training because a lot of queer couples are now staged with figuring out where they want to fall with that. So how to navigate queer relationships when one partner wants a child and the other maybe doesn't."

Participants mentioned that they understand that there are certain parts of the spectrum that needs more attention and exploration, such as the trans and gender nonconforming experience. Uriel notes about what kind of trainings are in need, "trainings would be great besides just talking about the gay, lesbian, sometimes bisexual individuals, and that we have more information, more trainings on transgender and gender nonconforming individuals." He continued "including for example intersex individuals in the spectrum. It's not something that we get a long of training on." Additionally, Jasmine mentioned that more trainings about affirming medical services is necessary for providers especially the way hormones affect emotions. "Just because if I were to have a client who started hormone replacement therapy, I would want to not pathologize something that's happening due to their medical treatment."

Participants mentioned the relevance of providing a therapeutic environment that adopt an intersectional approach to queer affirmative therapy. Roger shared “It would be great to see just to make sure they (new theoretical frames) can be thoughtfully applied, especially since it seems like most therapeutic approaches are designed on heterosexual white people. I would imagine also maybe just working with aging queer people.” Stephanie shared that she is interested in the developmental stages with the intersection of gender identity, transitioning and aging. She wondered about “how to support older adults who maybe transitioning or exploring their identity.” Within the spectrum of aging, some participants verbalized their interest in learning about earliest stages in the life of queer people and the mobility that they present with new generations. Donna noted “I would love to learn more about effectively working with LGBTQ youth and queer youth.”

Some participants also expressed their interest in learning more about self-disclosure, such as Marco shared “I'm interested in how and when to disclose, when is it clinically useful. Are there times where it's not? It might be even contra-indicated. I think that's a big one for me.” Other participants mentioned their need to learn how to navigate dual relationships when working with queer people, such as Ari “I think that queer therapists need to also have a lot of training. It'd be amazing to have better training around navigating dual relationships. Because I've been doing that since I was 21 and I'm still not good at it at all.”

In summary, participants highlighted the need for more advanced training in queer affirmative approaches. They did not disregard the need for initial trainings that provides terminology, statistics around the queer experience and information about pronouns but they called for more specialized training. They highlighted the importance of continued research about the topic and queer affirmative supervision, where intersectionality is included. In

addition, they noted that their interest in exploring gender expansive frames, family expansive and fluid definitions, as well as the attention to development of queer individuals and their relationships and self-disclosure in the clinical setting.

Discussion and Implications

This article centers the contributions of queer-identified clinicians in developing queer-affirmative therapy in their clinical work. The voices of queer clinicians, in particular queer clinicians of color, offer a counternarrative in the mental health literature that has to dated been dominated by white, cisgender and heterosexual voices. Centering their voices in the literature is an act of resistance to the legacy of normativity and pathology in the mental health field. Exploring the knowledge generated by queer clinicians can foster new ways to provide queer affirmative services and generate new clinical practices in working with queer people. Their queer affirmative practices were consistent attempts to expand their clinical approach in ways that understand different queer subjectivities by using systematic, intersectional and depathologizing thinking. Additionally, they named the limitations that current theoretical frames hold and the ways that they disidentified with these frames in their work with queer clients. Most notably, the disidentification process that they described in their approach to diagnosis and treatment offer a possible point of entry for all clinicians to adopt in their work with queer clients. While work to develop a disidentification stance can and must begin in coursework and internships, they can also be explicitly incorporated into the more advanced, research and training for mental health providers that participants in this study desired.

As all of the participants expressed, there still is a need for more research around queer affirmative therapy to inform the practice of clinicians in the mental health field. Queer people

deserve services that refuse to pathologize their experiences and are committed to challenging their oppression. More training needs to be available for new generations of clinicians interested in specializing in working with queer communities. Based on all the approaches that queer identified clinicians shared in these interviews, some principles were created to guide this work. A queer affirmative clinician is someone who can use these principles to guide their practice.

1.) Taking history of pathology into account

Clinicians must be committed to learning about the history of pathology in the mental health field that has informed dominant approaches to working with queer people and their families. This knowledge can be used to help clinicians to disidentify with discourses of pathology that undergird dominant approaches to describing clients, doing assessment, working on treatment plans. In addition, clinicians must incorporate systemic thinking in their practice, so they can have consistent conversations informed by knowledge based on how clients get impacted from the micro to the macro level.

2.) Avoiding heteronormative assumption

Clinicians must pay specific attention to the language they use to describe their clients being mindful of using consistent strength-based and queer affirmative language. In this process the clinician must resist making assumptions about monogamy and find ways to ask questions around romantic relationships status that are not based in assumptions of normativity. They must also resist making assumptions about gender allowing the clients to narrate their own identities. One way to do this is for clinicians to ask pronouns and share their own pronouns as a model. The client is the only one who can provide such important information and clinicians must respectfully ask them. Clinicians must avoid using essentialist and stereotyped ideas around queer people and their experiences and struggles. In addition, clinicians must resist making

assumptions around who is part of the family (biology should not be prioritized). Asking about what family is for them and who is part of that is an important factor.

3.) Facilitating conversations about privilege and oppression

The clinicians must have an active role in facilitating conversations about privilege and oppression even if it makes them and/or their clients feel uncomfortable. It is important to honor the processes of resistance that queer clients verbalize as well as make an effort to identify and de-center dominant and oppressive narratives in the clinical setting. Finally, clinicians must be willing to disclose thoughtfully to queer clients about their own experiences and co-create boundaries around the conversations in the clinical setting.

4.) Advocating for broader institutional and social transformation

Clinicians must challenge clinical approaches used in the field that are heteronormative inside the clinical room and outside. It is important to work together with the client to develop strategies of disidentification that support them in navigating systems around them in a way that benefits the clients, as well as finds ways to connect to different parts of the queer community in public spaces to hear their concerns. Clinicians must also learn about new policies and legislations that might impact the well-being of their queer clients.

Together these four principles provide a roadmap for developing queer affirmative therapy. My hope is that these principles offer a point of entry into the developing of more affirmative approaches that positions clinicians (both queer and non-queer) as playing an active role in dismantling systems of oppression that impact the queer community. The intent of these principles is not to universalize an approach to work with queer people, but my hope is that these principles can foster curiosity and possibilities to learn individually and to learn mutually in the clinical and supervisory relationship as well as inform a queer affirmative therapy.

References

Alexander, C. J. (1998). Treatment planning for gay and lesbian clients. *Journal of Gay & Lesbian Social Services*, 8(4), 95-106

Bernstein, A. C. (2000). Straight therapists working with lesbians and gays in family therapy. *Journal of Marital and Family Therapy*, 26(4), 443-454.

Brockenbrough E. (2016). Queer of color critique. In N.M. Rodriguez, W.J. Martino, J.C. Ingrey, & E. Brockenbrough (Ed). *Critical Concepts in Queer Studies and Education*. (pp.285) Palgrave Macmillan.

Buhrke, R. A., & Douce, L. A. (1991). Training issues for counseling psychologists in working with lesbian women and gay men. *The Counseling Psychologist*, 19(2), 216-234.

Castañeda, C. (2014). Childhood. *Transgender Studies Quarterly*, *1*(1-2), 59-61

Charmaz, K., & Belgrave, L. L. (2007). Grounded theory. *The Blackwell encyclopedia of sociology*.

Clark, W. M., & Serovich, J. M. (1997). Twenty years and still in the dark? Content analysis of articles pertaining to gay, lesbian, and bisexual issues in marriage and family therapy journals. *Journal of marital and family therapy*, 23(3), 239-253.

Corturillo, E. M., McGeorge, C. R., & Carlson, T. S. (2016). How Prepared Are They? Exploring Couple and Family Therapy Faculty Members' Training Experiences in Lesbian, Gay, and Bisexual Affirmative Therapy. *Journal of Feminist Family Therapy*, 28(2-3), 55-75.

Crenshaw K. (2016). *On Intersectionality - keynote – Women of the World Festival (WOW) 2016*. Retrieved from https://www.youtube.com/watch?v=-DW4HLgYPlA

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. Stanford law review, 1241-1299.

D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2005). Parents' awareness of lesbian, gay, and bisexual youths' sexual orientation. *Journal of Marriage and Family*, 67(2), 474-482.

Doherty, W. J., & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and thier clients. *Journal of Marital and Family therapy*, 22(1), 9-25

Dworkin, S. H. (1992). Some ethical considerations when counseling gay, lesbian, and bisexual clients. *Counseling gay men and lesbians: Journey to the end of the rainbow*, 325-334.

Ellison, T., Green, K. M., Richardson, M., & Snorton, C. R. (2017). We got issues: Toward a black trans*/studies. *Transgender Studies Quarterly*, 4(2), 162-169.

Garner, T. (2014). Becoming. *Transgender Studies Quarterly*, *1*(1-2), 30-32.

Getsy, D. J. (2014). Capacity. *Transgender Studies Quarterly*, *1*(1-2), 47-49.

Godfrey, K., Haddock, S. A., Fisher, A., & Lund, L. (2006). Essential components of curricula for preparing therapists to work effectively with lesbian, gay, and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy*, 32(4), 491-504.

Green, R. J. (1996). Why ask, why tell? Teaching and learning about lesbians and gays in family therapy. *Family process*, 35(3), 389-400.

Grzanka, P. R., & Miles, J. R. (2016). The problem with the phrase "intersecting identities": LGBT affirmative therapy, intersectionality, and neoliberalism. *Sexuality Research and Social Policy*, 13(4), 371-389.

Halberstam, J. (2016). Trans*-Gender Transitivity and New Configurations of Body, History, Memory and Kinship. *Parallax*, *22*(3), 366-375.

Holstein, J., & Gubrium, J. F. (2003). Inside interviewing: New lenses, new concerns. Sage.

Hudak, J., & Giammattei, S. V. (2014). Doing family: Decentering heteronormativity in "marriage" and "family" therapy. In Critical topics in family therapy (pp. 105-115). Springer International Publishing.

Jagose, A. (1996). *Queer theory: An introduction*. NYU Press.

Jones, R.G. (2014). Divided Loyalties: Exploring the intersections of queerness, race, ethnicity and gender. In S.C. Howard (Ed.) Critical articulations of race, gender and sexual orientation (pp. 23-45). Lanham, MD. Lexington Books.

Kahn, E., Johnson, A., Lee, M., Miranda, L., (2018) 2018 LGBTQ youth report. New York City

Long, J. K., & Serovich, J. M. (2003). Incorporating sexual orientation into MFT training programs: Infusion and inclusion. *Journal of Marital and Family Therapy*, 29(1), 59-67.

McGeorge, C., & Stone Carlson, T. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy*, 37(1), 14-26.

Muñoz, J. E. (1999). *Disidentifications: Queers of color and the performance of politics*. Minneapolis: Univerrsity of Minnesota Press.

Murphy, J. A., Rawlings, E. I., & Howe, S. R. (2002). A survey of clinical psychologists on treating lesbian, gay, and bisexual clients. *Professional Psychology: Research and Practice*, 33(2), 183.

Nystrom, N. M. (1997). Oppression by mental health providers: A report by gay men and lesbians about their treatment (Doctoral dissertation, ProQuest Information & Learning).

Padgett, D. P. (2016). Qualitative methods in social work research (3rd). Los Angeles: Sage.

Puar, J. K. (2014). Disability. *Transgender Studies Quarterly*, *1*(1-2), 77-81.

Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., & Ireland, M. (1997). Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health. Jama, 278(10), 823-832.

Ritter, K., & Terndrup, A. I. (2002). Handbook of affirmative psychotherapy with lesbians and gay men. Guilford Press.

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(4), 205-213.

Stone Fish, L. & Harvey, R. G. (2015). Nurturing queer youth: Family therapy transformed. New York: WW Norton & Co.

Suess, A., Espineira, K., & Walters, P. C. (2014). Depathologization. *Transgender Studies Quarterly*, *1*(1-2), 73-77.

Tompkins, A. (2014). Asterisk. *Transgender Studies Quarterly*, *1*(1-2), 26-27.

APPENDIX

Interview Protocol
1. How did you learn about how to provide clinical services to queer clients? a. Please describe what training or courses you took to provide services to queer clients? b. Can you summarize the topics you learned in trainings or courses about working with queer clients? c. What else would you like to learn about providing clinical services to queer clients?
2. Can you describe how you assess gender identity/sexual orientation with your clients? a. What kind of questions do you ask clients when assessing gender identity/sexual orientation? b. What are your clients' reactions during the assessment of gender identity/sexual orientation? c. How do you respond when asked by clients about your gender identity/sexual orientation? d. Can you describe how you discuss or talk about your own gender identity/sexual orientation with your clients? e. Can you describe your reactions when talking about your gender identity/sexual orientation with your clients?
3. Can you describe how you start the conversation about diagnosis with your queer clients? a. What do you say about your reasons for diagnosing? b. What are your clients' reactions to the diagnosis?
4. Can you describe your process of self-disclosure with your queer clients? a. How do you decide what to share about yourself? b. What are your reactions when asked by clients about yourself?
5. Can you explain how you assess family dynamics with your queer clients? a. How do you start the conversation about their families/partners? b. Can you describe how you document the family dynamics of your clients?
6. Can you describe how you bring the conversation about oppression/privilege into the clinical setting? a. How do you decide how and when to start the conversation about privilege and oppression? b. Can you summarize the reactions of your queer clients when you had this conversation with them? c. How do you start conversation about race? d. How do you start conversations about Gender Identity? e. How do you start conversations about Sexual orientation? f. How do you start conversations about ableism?
7. Can you describe a moment when you experienced a challenge in your clinical work with queer clients? a. Can you describe how you processed that challenge with your client? b. Can you describe what lessons you learned from this challenge?