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AFFIRMING CARE: A CULTURAL ASSIMILATOR FOR RURAL CLINICIANS WORKING WITH LGBTQIA+ POPULATIONS

BY

CRAIG BRANDON CREECH, M.S.

DOCTORAL SPECIALITY PROJECT APPROVED:

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Affirming Care: A Cultural Assimilator for Rural Clinicians Working with LGBTQ+ Populations

by

Craig Brandon Creech, M.S.

Submitted to the Faculty of the Graduate School of Eastern Kentucky University

in partial fulfillment of the requirements for the degree of

Doctor of Psychology

2021

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Abstract

Although the juggernaut of progress continues to provide minority groups, including members of the LGBTQIA+ population, opportunities to achieve equal representation and protection under the law, numerous challenges remain. Significant prejudicial and discriminatory actions, fortified by heterosexism and heteronormativity, not only threaten this community's continued advancement, but also poses an existential threat to the physical, emotional, psychological, and social well-being of its members. Therefore, it is imperative that psychological clinicians receive adequate academic and practical skills-based training to thoroughly understand and respond to the unique obstacles faced by LGBTQIA+ clients. This goal, while laudable, is made even more difficult for those clinicians hailing from, or residing within, a rural milieu, given these clinicians' access to culturally informed training opportunities to learn more about the LGBTQIA+ population. However, if a clinician is unable to proffer such services, there is an increased danger manifested by decreased physical, emotional, and psychological functioning, as well as continued stigmatization, internalized homo- and transphobic attitudes, and increased risk of suicide. The current project was borne from the desire to provide expanded training to clinicians so that they will be equipped with a better understanding of, and increased comfortability with, the LGBTQIA+ community. These goals will be accomplished by the creation of a cultural assimilator program which presents the participant with a plethora of thought-provoking scenarios and a variety of responses to choose from that explain the interaction. By completing the training, each learner will gain requisite knowledge relating to the community, as well as a greater sense of mastery in providing supportive, affirming therapeutic services. In turn, this

serves to strengthen the therapeutic alliance between the clinician and the client, leading to improved clinical outcomes.

Dedication

I would like to dedicate this work to the memory of my father, Craig Creech, who selflessly and tirelessly devoted his life to our family; his love and support were instrumental in shaping the person that I am today.

Acknowledgements

There exists no space large enough in which to adequately express the gratitude that I feel toward my family, friends, and colleagues. First and foremost, I must thank Dr. Michael McClellan for the dedication he consistently exhibited throughout this lengthy, arduous process; without your guidance and support, this project would have never come to fruition. Additionally, I am grateful for your mentorship throughout my graduate career and am thrilled to call you both a colleague and friend. A special thanks is also due to the amazing faculty of the EKU Psy.D. program including Drs. Botts, Moore, Bundy, Palmer, Wygant, and Osbaldiston; I am truly in awe of the knowledge, talent, and professionalism that each of you impart to our university. Thank you for fostering my growth professionally and personally. To my fellow cohort members who serve as a constant source of inspiration and support; may you find the success and happiness which is so richly deserved. Alex and Casey, thank you so much for being an excellent source of love; I look forward to many more years of friendship! To my mother, sister, and grandparents, I would not be at this point in my life without you. Every day, I become ever more aware of how fortunate I am to be a part of such a wonderful, loving family; it is impossible to describe the amount of love that I hold for each of you. Chris, you are, and will continue to be, the best friend that I have ever had; you have been with me every step of the way on this journey and without your support, this project would not exist. To Terry and Linda, thank you for being my second parents; I cannot imagine my life without either of you. Justin, thank you for being such an amazing partner and source of love and support; I know this project consumed so much of my time and energy, so I am appreciative of your patience.

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I. Introduction

Introduction of the Topic

The LGBTQIA+ community residing within the United States has consistently been subjected to abhorrent experiences of prejudice and discrimination, resulting in significant challenges to one's functioning across various life domains including social/familial (Brumbaugh-Johnson & Hull, 2019; Solomon, 2015), education (Demissie et al., 2018; Kitchen & Bellini, 2012), employment (Embrick et al., 2007; Pizer et al., 2012; Tilcsik, 2011), housing (Kattari et al., 2016; Levy et al., 2017; Yilmaz & Göçmen, 2016), and religion/spirituality (Lassiter et al., 2019; Lease et al., 2005; Sherry et al., 2010). In addition, sexual orientation and gender minorities are at greater risk for the disparate provision of medical care (Lisy et al., 2018; Rhodes & Yee, 2013; Zeeman et al., 2019) leading to higher prevalence rates of various physical illnesses (Fredriksen-Goldsen et al., 2013; Haviland et al., 2020; Scheer et al., 2020; Stepleman et al., 2019), sexually transmitted illness (STIs; Bimbi et al., 2006; Bird et al., 2017; Hall et al., 2007; Rasberry et al., 2015), substance misuse (McCabe et al., 2010; Rosario et al., 2009; Substance Abuse and Mental Health Services Administration, 2020; Weber, 2008), and poor psychological health (Hatzenbuehler et al., 2009; Meyer, 2009; Salim et al., 2019), and suicidality (Meyer et al., 2008; Price-Feeney, 2020; Su et al., 2016).

These trends are especially salient for those residing within rural areas of the country as there generally exist inherent obstacles to receiving adequate psychological services including decreased access to providers (Brems et al., 2006; Fullen et al., 2020; Jensen et al., 2020), issues of accessibility due to service costs, lack of transportation, and distance (Jensen et al., 2020; Johansson et al., 2019; Merwin et al., 2006); a priori

knowledge of mental health issues (Thorne & Ebener, 2020), culturally reinforced beliefs and values which serve to stigmatize those who seek services (Jensen et al., 2020; Jensen & Mendenhall, 2018; Whealin et al., 2017), and issues of confidentiality (Cheesmond et al., 2019; Haynes et al., 2017; Thomas & Brossoie, 2019; Young et al., 2015). However, LGBTQIA+ persons must also contend with the fear of engaging with rural medical providers due to past experiences of discrimination (Gottschalk, 2007; Rosenkrantz et al., 2017).

Definition of the Problem

Given the fact that this community seeks out mental health services at rates higher than their heterosexual, cisgender counterparts (Berg et al., 2008; Cochran et al., 2017; Platt et al., 2018), it is essential that providers receive adequate education and training to address the unique challenges faced by sexual orientation and gender minorities. However, the complex, and, at times, distressing relationship between the LGBTQIA+ population and mental health professionals has resulted in immense harm to the former in a multitude of ways including the pathologizing of same-sex desires and behaviors (Bieber, 1962; Reuben, 1969; Socarides, 1968). Although massive changes have been made within the mental healthcare field, providers, especially those residing in rural communities, often receive inadequate education and training in issues pertinent to the queer community (Couture, 2017; Knight et al., 2014; Pachankis & Goldfried, 2013); unfortunately, this increases the likelihood of poor outcomes for an oft marginalized group (Logie et al., 2015; Matza et al., 2015).

Statement of Significance

The American Psychological Association (APA) has formulated five general principles which members of the psychological community should aspire to follow and include a commitment to beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity. Although the principles are in no way enforced by the organization, it is expected that ethical clinicians enter each therapeutic relationship with a desire to implement each ideal so that a client's well-being is paramount (American Psychological Association, 2019). Additionally, the APA has published the *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (APA, 2012) as well as the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA, 2015). Even though the field of psychology has dedicated itself to improving access to appropriate care for sexual orientation and gender minority clients over the past several decades, significant challenges remain to ensuring that each provider can meet the needs of this population (Sue & Sue, 2016).

As such, the current program will provide a thorough review of the existing literature related to the provision of therapeutic services to the LGBTQIA+ community while also creating a novel training program for rural clinicians who are not equipped to proffer culturally informed care to this population.

Purpose

The purpose of the current program is to aid providers in the proliferation of their extant knowledge of, attitude toward, and skills in working with sexual orientation and gender minorities. This goal will be accomplished through the delivery of 5 fictional

vignettes of interactions between a mental health professional and a LGBTQIA+ client using a computer application format. Upon completing each entry, the reader will be posed a question which requires them to critically analyze the story in a manner which considers important themes of culture and identity. Several possible option choices will be given from which the trainee will choose the best possible answer. The individual will be informed if they choose the correct or incorrect response, and a detailed explanation will be provided for each selection.

By completing this experiential training, rural clinicians will increase their *a posteriori* understanding of the queer experience; in turn, this may aid in the provision of proficient services for those who are members of the LGBTQIA+ community. Furthermore, clinicians who complete the training will be better equipped to appreciate the unique issues that sexual orientation and gender minority clients encounter. The completion of the program will also reduce the anxiety experienced by clinicians with limited understanding of or experience with this population.

II. Literature Review

Method of Conducting Literature Review

Articles were accessed by utilizing Academic Search Complete and Google Scholar databases through the Eastern Kentucky University Library website. Using these databases, entries within catalogues including, but not limited to PsycINFO and APA PsychARTICLES were utilized. The keywords utilized while searching databases included, but not limited to, “lesbian,” “gay,” “bisexual,” “transgender,” “questioning,” “LGBT,” “LGBTQ,” “orientation,” “identity,” “development,” “marginalized,” “risk factors,” “physical health,” “emotional health,” “mental illness,” “religion,”

“spirituality,” “discrimination,” prejudice,” “homophobia,” “transphobia,” “microaggressions,” “internalized homophobia,” “heterosexism,” “heteronormative,” “cisgenderism,” and “cultural assimilator.” Multiple print sources were also utilized in the development of this doctoral specialization project and have been included in the references section.

LGBTQIA+ Terminology

To provide culturally informed services to LGBTQIA+ clients, a clinician must possess a thorough knowledge of the unique experiences and challenges faced by this population; this includes both understanding and implementing the wide array of terminology related to the community (Sue & Sue, 2016; Turner et al., 2013). Although this might be considered a daunting undertaking, it is essential to ensuring that the client believes that the clinician is invested in the process (Ferris, 2013). This, in turn, can aid in creating and maintaining a supportive, reciprocal therapeutic alliance, leading to positive outcomes for the client (Knutson et al., 2019). Conversely, if the clinician exhibits either an unfamiliarity with, or unwillingness to learn, the requisite terminology, the client will likely feel invalidated or misunderstood which can lead to a therapeutic rupture (Knutson et al., 2019).

The importance of creating and refining one’s repertoire of LGBTQIA+ terminology is underscored by Henry (1955) who wrote, “unless the word homosexual is clearly defined, objective discussion regarding it is futile, and misunderstanding and erroneous conclusions are inevitable.” This sentiment is no less valid in today’s world, especially with the community’s continued struggle to achieve equality. Moreover, Rutherford et al. (2012) found that mental health providers felt that their professional

training involving terminology left them unprepared to properly engage with LGBTQIA+ clients; unfortunately, this can lead to deleterious consequences including the use of discriminatory language or even the exclusion of integral questions relating to sexual- and gender-identity.

Sexual Orientation

Sexual orientation encompasses the gamut of one's sexual behavior toward, attraction to or lack thereof, and personal identity in relation to members of the same and/or opposite sex, occurs along a spectrum, and can be fluid throughout the lifespan with the latter being especially true for females (APA, 2012; Forssell, 2017; GLAAD, n.d.; Ventriglio & Bhugra, 2019). In fact, while all humans exhibit such fluidity regarding sexual attraction, this is often more salient within sexual minority communities (Ventriglio & Bhugra, 2019). While much remains to be discovered about the origins of sexual identity, Garnets (2002) posits an extant scientific view that both one's genetic make-up and social environment determine their sexuality.

The umbrella term *gay* denotes an individual who is typically attracted to members of the same gender; specifically, this includes gay or *transgender males* who are attracted to other men and *lesbians or transgender women* who are attracted to other females (GLAAD, n.d.; Human Rights Campaign, 2019; Rutherford et al., 2012). Although the term *homosexual* is ubiquitous, many within the LGBTQIA+ community dislike its continued usage due to the association with psychopathology; in addition, the term is often used disparagingly by religious groups (e.g., homosexual agenda, homosexual lifestyle) in reference to minority sexual populations (GLAAD, n.d.). Those who identify as *bisexual* are attracted to members of both sexes and/or male or female

genders; however, a caveat should be noted that some individuals eschew this term as it infers a binary designation (Human Rights Campaign, 2019; Rutherford et al., 2012; Singh, 2018). *Asexual* individuals report a general lack of sexual attraction although they may seek out both romantic or platonic relationships; others identify as *aromantic* and lack a desire for romantic connections but might experience sexual attraction (Rutherford et al., 2012; The Asexual Visibility & Education Network, n.d.). A person who identifies as *pansexual* typically reports attraction to all genders and/or sexes, while those who are *polysexual* experience attraction to many genders (Human Rights Campaign, 2019; Singh, 2018). In addition, a *demisexual* individual experiences sexual attraction for another person following the establishment of a strong emotional connection (Learning for Justice, 2021). Furthermore, those who identity as *questioning* are engaging in a personal exploration of their sexual orientation and/or gender identities (Human Rights Campaign, 2019).

Recently, the term *queer* has been reclaimed by many members of the LGBTQIA+ community and refers to anyone whose sexual orientation is unaligned with heterosexuality; additionally, the term also describes those whose do not identify as cisgender (GLAAD, n.d.). Given the problematic history and pejorative use of the term, there is significant contention surrounding its use within the community; while younger individuals prefer the moniker, older members of the population eschew labeling themselves as queer due to past experiences of verbal abuse (Parsons & Grov, 2012). In addition, Battle et al. (2002) noted that only 1 percent of Black LGBT participants surveyed self-identified as queer; it was posited that this finding might be due to the connotation of the word with White activists who have either discriminated against racial

minorities or ignore the deleterious effects of racism, classism, and other forms of privilege on the Black community. In fact, most respondents preferred the terms gay, lesbian, bisexual, or same-gender loving (Battle et al., 2002). Therefore, Knutson et al. (2019) recommend affording clients an opportunity to express their own preferred terms through the use of gender-neutral intake demographic questions and open dialogue.

Gender Identity

Over the past several decades, there has been an increased focus on, and subsequent understanding of, gender identity; however, there exists a substantial contingency of mental health professionals who experience significant apprehension surrounding the provision of services to those who identify as transgender or gender-nonconforming/gender diverse. To meet the unique therapeutic needs and goals of this population, the clinician must possess a thorough lexicon of terms related sex, gender, and gender identity. *Assigned sex/birth sex* refers to the postnatal binary classification of either male or female sex based upon one's external genitalia in addition to other biological variables including genetic material, hormones, gonads, and later secondary sex characteristics; in contrast, *gender*, broadly defined, is a socially constructed concept of expected masculine and feminine characteristics and roles exhibited by individuals (Kirk & Kulkarni, 2006; World Health Organization, n.d.).

While the presumption of static, separate physical, emotional, and behavioral differences between males and females previously dominated Western culture, findings from contemporary research have challenged these seemingly archaic notions by highlighting significant overlap between the sexes (Hyde et al., 2018; Olezeski et al., 2020). *Gender identity* is defined as an individual's innate, personal recognition of the

self as male, female, a combination of the two, or neither (Kirk & Kulkarni, 2006; Sandil & Henise, 2017). In contrast, one's expressed *gender presentation* consists of external characteristics such as wardrobe choices, hairstyles, and affectations (Sandil & Henise, 2017).

While *cisgender* individuals assume a gender identity which reflects their assigned sex or gender, the umbrella term *transgender* refers to those whose gender identities do not align with the sex or gender designated at birth. Interchangeable terms for the latter classification are *gender variant, gender nonbinary, gender non-conforming,* and *gender diverse*, but all include a vast array of self-identities including transsexuals, cross-dressers, drag kings and queens, and two-spirit people (Anti-Defamation League, 2014; Kirk & Kulkarni, 2006; Sandil & Henise, 2017). Although many t*ranssexual* persons might decide to undergo surgical procedures and/or hormone-replacement therapy in order to transition from *male-to-female/MTF*, *female-to-male/FTM*, others have determined that no medical treatment is necessary due to a lack of conflict between their genitals and chosen gender; it is important that a clinician understands that the term *transsexual* may be perceived as offensive due to its association with historical binary classification systems (Bilodeau & Renn, 2005; Kirk & Kulkarni, 2006;Sandil & Henise, 2017).

Within First Nations peoples, those who identify as Two Spirit "are attracted to people of the same gender or of more than one gender, and/or may be trans, and/or someone who carries the gifts of both female and male spirits in them" (Everett et al., 2013, p. 17). Moreover, within many tribal communities, those who identify as Two Spirit typically hold prominent roles as spiritual elders due to their perceived unique

connection with the spirit world (Adams & Phillips, 2009; Sanhil & Henise, 2017). Finally, the term *nonbinary* can be further bifurcated to include those who identify as *genderqueer* and/or *agender*; those in the first camp might assume an amalgam of both male and female genders, vacillate between the two across multiple domains, or classify themselves as holding multiple genders, while someone who identifies as *agender* might refuse to subscribe to any particular gender identity or may recognize themselves as an alternate or third gender (Sanhil & Henise, 2017). Finally, any individual whose gender lies on the spectrum somewhere between male and female but expresses aspects of both concurrently is *androgynous*. Specifically, the practice of engaging in atypical gender behaviors (e.g., males who exhibit emotions traditionally associated with femininity) is termed *behavioral androgyny*; however, there is an implied flexibility which is contingent upon the situation in which one finds themselves (Knox & Milstein, 2020; Refinery29, 2018).

Intersex individuals are those whose external genitalia or internal reproductive anatomy, as a result of atypical genetic, chromosomal, or hormonal variations, are either ambiguous or they have both male and female sex characteristics; examples of this condition include Klinefelter Syndrome (e.g., XXY) and congenital adrenal hyperplasia (CAH) (Intersex Society of North America, n.d.; Sanchez & Vilain, 2012). Although the term *hermaphrodite* was commonly used in the past, it is now considered outdated and offensive; instead, many researchers prefer the use of *Disorders of Sex Development* (DSD) when describing these phenomena (GLAAD, n.d.; Sanchez & Vilain, 2012). Unfortunately, the latter term is also not without controversy, as the intersex community and its allies cite the use of labels like “disorder” as an impetus for the medical

community to enforce binary gender norms through the use of postnatal surgical procedures and long-term hormonal treatments (Intersex Society of North American, n.d.; Kirk & Kulkarni, 2006). Unintended consequences of such interventions have been shown to increase risk for serious physical, emotional, and psychological difficulties within this population (Leidolf et al., 2008; Thorn, 2014).

Individuals who engage in *cross-dressing* behavior for multiple reasons including recreation, amusement, stress relief, or sexual pleasure; additionally, most cross-dressers identify as heterosexual males. Traditionally, the term used for members of this community was *transvestite*; however, the word fell out of use due to its pejorative nature (Cairns, 1997; Kirk & Kulkami, 2006). Interestingly, Newton (1979) found that gay males disapproved of cross-dressing behaviors exhibited by other gay males, as it was believed that such actions engendered undesirable stereotypes of the community. Those who engage in comedic drag performances include *drag queens* and *drag kings*; the former are males who perform under a female persona while the latter involves females performing under a male persona to subvert traditional masculine and feminine norms and stereotypes often using comedy (Egner & Maloney, 2016; National Center for Transgender Equality, 2017). While performers are typically members of the LGBTQIA+ community, drag queens and drag kings can be any gender (Schacht, 2002).

LGBTQIA+ Demographics

Of particular interest to social science researchers is the approximate number of those who identify as LGBTQIA+; however, this task has proved difficult for several reasons including a dearth of survey data specifically requesting information relating to respondent sexual and gender identities, small sample sizes, poorly defined terminology,

and underreporting due to fear of discrimination, prejudice, or violence (Gates, 2012). Paniagua (2014), as well as Sue & Sue (2016) reported the number of LGBT adults living in the United States in 2011 at 9 million (3.5%); however, millions of other respondents, while choosing not to self-identify as LGBT, reported same-sex attraction and behaviors, 19 and 25.6 million respectively. In addition, Gates (2012) found that while 3.4% of female respondents identified as lesbian or bisexual and 3.6% of male respondents identified as gay or bisexual, only 0.3% self-identified as transgender. Due to continued public awareness of, and tolerance toward the community, there was an increased rate of millennial respondents who identified as LGBT when compared to adults in general (Sue & Sue, 2016). This trend was also salient in Gallup polling data published in 2017, as the rate of self-identified LGBT respondents increased to 4.5% from 3.5% in 2012 (Newport, 2018).

Recently, the US Census Bureau (2019) reported that there were over 543,000 same-sex married households, 469,000 same-sex unmarried households, and 191,000 children being raised in same-sex households. In relation to geographic distribution, increased percentages of same-sex couples live in urban and metropolitan areas rather than more socially conservative rural communities (Gates, 2012). While challenges remain in collecting exact numbers of the LGBTQIA+ population, it seems as though respondents feel more comfortable in self-identifying as members of the community. The importance of such data cannot be understated, however, as this information can be used by local, state, and federal governments when determining how to best serve and invest in populations with specific challenges and needs.

LGBTQIA+ Identity Models

Overview of Identity Models

Forging an identity is central to understanding oneself in both an intra- and interpersonal manner, navigating one's immediate environment as well as the norms, beliefs, and values of the larger society, and answering the primeval question of "who am I?" In essence, our identity propels us to perceive ourselves, others, and the world in various, and, at times, idiosyncratic ways. Without an integrated identity, the person is a rudderless ship, tossed to-and-fro by the waves of life, unable to find safe harbor. Therefore, it is imperative that clinicians have a comprehensive grasp surrounding the complexity and importance of the multiple roles held by the client. Identity is both the totality of our innermost being and an amalgam of our, among others, gender, sexual orientation, religious, cultural, racial, ethnic, vocational, personality, and physical identities (Santrock, 2016).

Many stage theories of identity development are based upon an understanding of human development as comprising continuous, stable, and, at times, catastrophic, steps wherein each subsequent level builds upon a previous stage with negligible variability among individuals (Hayslip et al., 2006). However, other researchers argue that this process, while lengthy in nature, consists of individuals revisiting and refining their identities; in essence, a discontinuous trajectory in which one's journey toward identity integration is not static throughout the lifespan, and, instead, involves instances of moving back and forth or revisiting stages (Azmitia et al., 2013; Bilodeau & Renn, 2005; Santrock, 2016). Interestingly, Johns and Probst (2004) surveyed self-identified sexual minorities (N = 143) and found that most participants viewed the construction of sexual

identity as consisting of only two phases rather than multiple, variegated stages; the individual is viewed as either *fully integrated* or *unintegrated*.

Moreover, the work of Marcia (1966) provides the scaffolding upon which most stage models of sexual orientation and gender/sex identity development are built; importantly, he applies the variables of crisis and commitment to the topics of religious belief, political ideology, and future vocational choices. However, the process was later revised to include the process of sexual identity formation (Schenkel & Marcia, 1972). Marcia (1966) posits that crisis is defined by a realization that there are alternatives to the values, beliefs, and expectations imposed by one's family, surrounding community, and larger cultural milieu. Therefore, the individual is provided an opportunity to explore novel ideas and experiences if they so choose. Moreover, commitment is theorized as deciding on a particular course of action which will determine the way in which one identifies and navigates their individual life journey. There are four possible states introduced by Marcia (1966) including foreclosure, moratorium, identity achievement, and diffusion. Foreclosure occurs when the individual is completely attuned to the perspective of those in authority, especially parents or guardians; during this stage, the individual engages in little, if any, contemplation of other possible ways of being and often "follow rules, maintain conventional relationships, and typically demonstrate inflexible thinking" (Patton et al., 2016). Inherent in this process is the lack of crisis and the decision to commit to the prescribed rules of family and society. In contrast, those in the moratorium stage experience crisis, resulting in sincere reflection of one's personal values in relation to the expectations of surrounding entities; however, this stage is also defined by a lack of commitment. In essence the individual is unable to determine a

course of action and are viewed by others as "either as sensitive or anxiety-ridden, highly ethical or self-righteous, flexible or vacillating" (Marcia, 1980, p. 161). However, most individuals who find themselves in the stage of moratorium will eventually enter identity achievement (Patton et al., 2016). During the identity achievement process, the individual has entertained many ways of thinking and behaving, trying each out to see goodness of fit; eventually, they will have forged a new identity which defines their perspective and interactions with others. Specifically, Marcia (1966) argues that the individual who is in this stage has "reevaluated past beliefs and achieved a resolution that leaves him free to act…even though his ultimate choice may be a variation of parental wishes" (p. 552). Finally, those in the diffusion stage experience neither crisis nor commitment; instead, they aimlessly allow themselves to be tossed about from situation to situation and tend "to conform, have difficulty with intimacy, are easily manipulated, and lack cognitive complexity" (Patton et al., 2016).

Furthermore, there exists no consensus among researchers in relation to the foundations of one's sexual or gender identities; those who subscribe to the *essentialist* view describe identity as biologically determined and invariable whereas the *social construction* position emphasizes the integral role of cultural values and customs in the development of the self (Fitzgerald & Grossman, 2018). The latter posits that sexual orientation and gender identity are not static, and, instead, are fluid throughout the lifespan. Bohan (1996) writes that sexual orientations are "products of particular historical and cultural understandings rather than being universal and immutable categories of human experience" (p. xvi). Although research findings ranging from behavioral genetics to neurobiology suggest a biological predisposition for sexual

orientation, any discussion must also include the effects of social and cultural forces (Bailey & Benishay, 1993; Hu et al., 2008; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010; Ponseti et al., 2007).

Furthermore, according to Garnets and Kimmel (1993), although there are numerous stage models of sexual orientation and gender identity development, there is significant overlap regarding the progression from confusion to integration:

> First, nearly all models view homosexual identity formation as taking place against a backdrop of stigma. The stigma surrounding homosexuality affects both the formation and expression of homosexual identities. Second, homosexual identities are described as developing over a protracted period and involving several "growth points or changes" that may be ordered into a series of changes. Third, homosexual identity formation involves increasing acceptance of the label homosexual as applied to the self. Fourth, although coming out begins when individuals define themselves as homosexual, lesbians and gay males typically report an increased desire over time to disclose their homosexual identity to at least some members of an expanding series of audiences…Fifth, lesbians and gays develop increasingly personalized and frequent social contacts with other homosexuals over time. (p. 195)

Cass Gay and Lesbian Identity Model

Cass (1979, 1984) proposed a linear, six-stage model of sexual identity development which was measured from adolescence through adulthood; while the importance of this work cannot be overemphasized, the developmental process was limited to those who self-identified as either gay or lesbian. In addition, Cass (1979)

identified one's social interactions with others as largely responsible for the salient behaviors, including identity change, in each stage; due to the ubiquitous nature of institutionalized heteronormativity and homophobia, the individual begins the journey under the premise that they are "nonhomosexual" (p. 222). Furthermore, the time required for identity integration fluctuates among various individuals, with progress between stages being fomented by a sense of incongruency experienced within one's private and public milieus (Cass, 1979). Within this model, growth is expressed as comfortability with, and appreciation of, one's self-identification as a sexual minority, the determination to share their identity with others, and the creation and maintenance of a strong connection with the community (Cass, 1984). However, it is possible that the "stranger in a strange land" might engage in identity foreclosure or the decision to prematurely terminate their journey; unfortunately, this resolution can result in significant levels of distress if the individual should encounter any future situation which calls into question the established identity (Cass, 1979, 1984; Eriksson et al., 2020).

Stage 1. The preliminary phase of the Cass (1979, 1984) model is termed *identity confusion*, and is defined by the internal realization that one might identify as gay or lesbian due to an amalgam of same-sex cognitions, emotions, and/or actions; however, of great import is one's same-sex behavior, as a theoretical concept of homosexuality is insufficient to induce confusion. Due to the stigmatization assigned to the community by the dominant culture, the individual will likely experience a disorienting maelstrom of intense, distressing feelings, leading to a sense of disbelief and dread. In turn, this dissonance can lead to several potential routes that one can choose to traverse; first, the individual can tentatively accept the label as gay or lesbian, repress the feelings, or

entirely reject the possibility of identification as a sexual minority. For those who decide to entertain the notion that they are gay or lesbian, a decision to expand one's knowledge through the consumption of information relating to sexual minorities might be undertaken; however, they are unlikely to share this realization with others (Cass, 1979).

In contrast, the second person might accept the proposition that they are, in fact, gay or lesbian, but subsequently decide to inhibit "homosexual" behavior; avoid, to the best of their ability, material about and/or contact with sexual minorities, and/or exhibit internal and external anti-LGBTQ+ beliefs. Lastly, one might engage in identity foreclosure by reformulating the definition of gay or lesbian to exclude any undesirable emotional or physical aspect that the individual believes to embody homosexuality; in essence, some behaviors or feelings are acceptable while others denote the "identity" to be eschewed (Cass, 1979, 1984).

Stage 2. *Identity comparison* is the second stage found in this model and is characterized by a sense of isolation, especially from those who are identified with the heteronormative culture; while some individuals found in this stage will seek out interactions with other sexual minorities, most choose to do otherwise (Cass, 1979, 1984). Moreover, the individual might assume that "I am the only one in the world like this," leading to further physical and/or emotional detachment (Cass, 1979, p. 225). In addition, after identifying as gay or lesbian, the person acknowledges that societal norms and expectations demanded of heterosexuals may no longer be applicable to their future.

During this stage, there are, again, multiple ways in which one might react. Firstly, the individual can willingly accept their identity, while engaging in "passing" behaviors to navigate an environment laden with heteronormative landmines.

Alternatively, others might continue to entertain the idea of identifying as a sexual minority, but they create rationalizations for same-sex thoughts, feelings, and/or behaviors. This can be accomplished in multiple ways including attributing their actions to interactions with only one other sexual minority, endorsing a bisexual identity, believing that their sexual minority identity is only a passing phase, or denying control over their actions (Cass, 1979). A third option involves self-identifying as gay or lesbian but deciding to refrain from engaging in both overt and covert behaviors or continuing to only act covertly; the former allows the individual to posture as asexual which results in a temporary reduction in dissonance. Finally, others refuse to accept oneself as gay or lesbian, instead opting to identify as asexual or heterosexual by inhibiting any undesired homosexual behaviors; however, this can lead to internalized homophobia and an increased risk of suicidality (Cass, 1979, 1984).

Stage 3. The third stage is *identity tolerance*; at this point the individual's identity development, they have adopted a stronger attachment to the gay or lesbian label. As this occurs, there is typically a realization of an extant conflict between one's perception of self as a sexual minority and the perception of the individual held by others. Therefore, the desire to seek out connections with other members of the gay and lesbian community is integral to decreasing the feelings of loneliness, improving socialization skills, and providing affirmation (Cass, 1979, 1984). At the same time, the individual begins a process of self-separation from those who identify heterosexual. While this realignment is empowering to one's sense of personal agency, the individual places significant focus on the positive or negative qualities of interactions with other sexual minorities; experiences classified as the former result in a reinforced sense of self, while the latter, which Cass

(1979) defines as being affected by "poor social skills; shyness; low self-esteem; and fear of exposure, of the police, of the unknown" leads to pejorative views of the self as gay or lesbian as well as others who identify as such (p. 230). If the number of harmful experiences outnumbers those perceived as encouraging, the individual might react by limiting contact with other sexual minorities or by refusing to partake in any activities labeled "homosexual." The first decision implies the possibility that the individual still self-identities as gay or lesbian while the latter, if successfully implemented, indicates identity foreclosure.

Stage 4. Cass (1979, 1984) conceived the next stage, *identity acceptance*, as consisting of the gay or lesbian individual taking complete ownership of the sexual minority status that previously resulted in confusion and isolation. Instead, the person seeks out increased social contacts with other members of the community to reduce the ambiguity experienced within the *identity tolerance* stage; in turn, these positive interactions lead to a galvanized sense of self as separate from the dominant sexual culture, while also providing opportunities for continued exploration. However, Cass (1979) argues that there are two distinct courses that can be taken during this stage; the individual might connect with those who embrace both public and private displays of one's sexuality which leads to a pronounced sense of anxiety due to the dominant cultures disapproving attitudes exhibited toward the community. Alternatively, one might subscribe to the views of those who believe that it is best to avoid public acknowledgement of sexual minority status, opting, instead, to "pass" as heterosexual, limit extensive contact with heterosexuals, or only coming out to select members of the dominant culture (Cass, 1979). If the individual is successful in compartmentalizing their

sexual identity, they will have reached identity foreclosure. For those who either feel uncomfortable with or refuse to accept this reality, there will be continued development.

Stage 5. The next level of Cass's model (1979, 1984) is the *identity pride* stage, in which the individual is more attuned to the discordance between one's sexual minority status and the harmful, heteronormative attitudes and values promulgated by society; the latter serve to delegitimize, isolate, and disenfranchise the person and their community. This, in turn, increases the aversion to, and antagonism toward, any group or institution associated with heterosexuality, and one typically adopts a position of advocate to advance the needs and goals of the community. In fact, Cass (1979) argued that the gay or lesbian individual engages in a form of tribalism, bifurcating others into one of two groups: "good" or "bad" (p. 233). Those viewed favorably enjoy membership within the minority sexual community and embody the attitudes, beliefs, and values of the group, while anyone positioned outside is viewed with disdain as they represent the hegemony of heterosexuality (Cass, 1979, 1984). As one moves through this stage, they decide to disclose, both publicly and privately, their gay or lesbian identity, which might result in several outcomes. If members of the immediate environment react positively, the individual's identity is strengthened and they feel more confident; however, if their declaration is met with opprobrium, increased feelings of antipathy toward the dominant culture leads to identity foreclosure and continued disconnection from those who are heterosexual (Cass, 1979).

Stage 6. The final stage is *identity synthesis* wherein one recognizes that although differences exist between the dominant and minority sexual cultures, the demarcation is less clearly defined as there exists evidence that not all heterosexuals are antagonistic

toward the individual and their community (Cass, 1979, 1984). Although substantial feelings of pride relating to one's identity are salient, there is an understanding that increased contact with supportive heterosexuals is preferable to continued insularity. Additionally, there is continued advocacy to decrease the effects of heterosexism and heteronormativity espoused by the dominant culture. At this point, the individual will have experienced an integration of sexual identity into other domains of the "self;" this incorporation allows for continued self-acceptance and improved functioning across multiple domains (Cass, 1979, 1984).

Although the Cass model continues to contribute meaningfully to the dialogue surrounding sexual identity development, its limitations, including the assumption of linearity and exclusion of those who identify as something other than gay or lesbian, must be fully appreciated (Bilodeau & Renn, 2005; McCarn & Fassinger, 1996; Yarhouse, 2001). With the passing of several decades since the introduction of this model, considerable social changes, coupled with an advanced understanding of sexual and gender identity, has led to expanded theoretical paradigms which include additional populations (e.g., those who identify as bisexual, asexual, transgender, etc.). Each novel model serves to highlight the inherent, awe-inspiring diversity found within the human species in relation to sexual orientation and gender identity.

Lev's Transgender Emergence Model of Development

As previously discussed, many traditional stage models of identity development did not include vital information related to gender identity. Thankfully, several researchers have greatly contributed to the current understanding of the complex development of human gender identity. Lev, (2004) in developing the Transgender

Emergence Model, argued that those who identified as transgender or gender-variant, not only contended with the typical stresses of identity development and acquisition but were also faced with the added pressure of following societal norms related to gender-appropriate thoughts, feelings, and behaviors. Inherent in this conflict is the increased risk of internalized transphobia, leading to feelings of intrapersonal loathing and subsequent inability to cultivate a cohesive sense of self. This six-stage model is non-linear; instead, Lev (2004) reports that mental health professionals might observe this process when working with clients who present with gender dysphoria.

Stage 1. The *awareness* stage consists of the individual becoming conscious of the incongruence between their pre-existing, culturally reinforced sense of gender identity and a newfound sense of "otherness" (Lev, 2004). Of course, there exists great variability within the timeframe in which this occurs; for many, the discomfiting feelings of gender dysphoria is common in early childhood while others begin to experience this at the onset of puberty or even later in early adulthood (Lev, 2004). Whatever the age at which one enters this awareness, the resulting confusion, fear, and dread typically serves to disrupt one's sense of intra- and interpersonal stability; however, for others this realization is a time of intense happiness and relief. Additionally, there will be a plethora of ways in which one might react in this stage, ranging from attempts to reduce or eliminate the thoughts and/or feelings (e.g., reparative therapy, religious rites including prayer) to individual acceptance and exploration (Lev, 2004).

Stage 2. During stage two, *seeking information/reaching out*, the individual begins the process of proclaiming, "I am transgendered (or transsexual, or whatever word he or she uses to describe himself or herself). This is who I am" (Lev, 2004). It is a period

devoted to self-discovery and involves the process of seeking out information regarding diagnosis of, and treatment for, individuals who exhibit gender dysphoria; personal accounts written by others, and historical narratives pertaining to the injustices faced by the trans community; each of these serves as a piece of the puzzle that is identity integration (Lev, 2004). Moreover, one might decide to create and maintain personal connections with fellow-travelers; this can occur through the medium of in-person and online social/support groups, chat rooms, affirming religious organizations, or political advocacy movements (Lev, 2004). While many feel a sense of comfortability in reaching out to others who identify as trans, some "will express defensive projection, verbalizing an intense hostility toward other transgendered people and not wanting to identify with 'them'" (Lev, 2004, p. 244). These adverse, yet powerful, reactions underscore the malignant nature of internalized transphobia cultivated through the persistent cacophony of distortion and misinformation bellowed by the dominant culture. Therefore, the process of reaching out is vital to the individual's eventual self-acceptance; in fact, Rachlin (1999) found that female-to-male (FTM) individuals rated their connections with others who identified as such aided in making essential medical decisions related to the process of transition. These relationships are vital in serving to augment one's knowledge about the community and treatment options, increase social support, and improve the sense of personal agency.

Stage 3. In the *disclosure to significant others* stage, the individual embarks on the journey of revealing their gender identity status to others, including family members, friends, colleagues, and even therapists (Lev, 2004). Unfortunately, this process is wrought with intense emotions emanating from a fear of personal rejection; oftentimes,

the hesitancy to come out serves to maintain a connection with loved ones. However, deciding to sustain the status quo comes at significant cost to the individual, as sense of intrapersonal incongruence between one's inner truth and the outward façade can result in increased anxiety, depression, and suicidality (Lev, 2004). Family members, including parents, siblings, spouses, and even one's children are likely to experience a plethora of uncomfortable thoughts and feelings as well; this can range from anger, disbelief, confusion, guilt, or shame to a sense of joy or relief. Lev (2004) highlighted ways in which this process can be exceedingly difficult for the romantic partners of those who are trans; due to the latter's decision to no longer deny or stifle their newfound identity, they might unilaterally decide to begin the process of transition, including seeking out medical interventions, without engaging in discussion with their partner. This, of course, can be traumatic and isolating and lead to a profound rupture within the relationship.

Stage 4. Within the fourth stage, *exploring identity and transition*, one investigates what being trans means in relation to their personal experiences, thoughts, and emotions; this is a time defined by a commitment to understanding and accepting the inner sense of self (Lev, 2004). This is manifested by continued experimentation with outward expressions of one's gender or sex identity including "roles, clothing, and mannerisms…begin to explore their future options for transition, its impact on loved ones, and their future vocational and financial needs" (Lev, 2004, p. 255). While these experiences can be immensely invigorating, there is often the accompanying fear of rejection from family or friends, as well as the potential of being verbally or physically accosted in public (Lev, 2004; Lev & Lev, 1999).

Stage 5. As one enters the *exploring transition and possible body modification*, there exists numerous options to investigate in determining whether to not to engage in the transition process; this includes electrolysis to remove unwanted facial hair, hormonal replacement therapy, and surgical interventions (e.g., vaginoplasty, feminizing augmentation mammoplasty, facial feminization surgery, chest masculinization/top surgery, phalloplasty, metoidioplasty, scrotoplasty). Every alternative must be thoroughly examined in relation to its desired effects, potential health risk, availability, and financial burden (Lev, 2004). This journey is highly variable and subject to the individual's desire and understanding of what it means to be a particular gender and/or sex; while some decide to fully transition, others might find it preferable or necessary to travel between multiple gender identities, or even refuse to seek out medical intervention (Lev, 2004). Interestingly, Bolin (1988) refers to the transition process as "the transgender rite of passage…rich with ritual and symbolic metaphors of becoming, of transformation, and of the death of a man and birth of a woman" (p. 15).

Stage 6. The final stage, *integration and pride*, is a time in which the individual has achieved integration of their gender and/or sex identities, thereby adopting a newfound sense of self wherein they are comfortable with the entirety that is their being. Again, there is no true one-size-fits-all model; instead, the spectrum ranges from those who have eradicated the previous identity and live full-time as male or female to others who are quite comfortable identifying in some other way. In addition, there is often a desire felt by many to continue engaging in political advocacy to advance the rights and dignity of those within the community (Lev, 2004).

See Appendix D for additional information regarding other sexual orientation and gender identity models.

Limitations of sexual orientation and gender/sex identity development models

Although the sexual orientation and gender/sex identity development models described above provide a wealth of knowledge surrounding the difficulties experienced by sexual and gender minorities in the journey of self-acceptance; however, there are multiple limitations inherent in such frameworks (Bilodeau & Renn, 2005; Horowitz & Newcomb, 2001; Lev, 2004).

Firstly, many developmental models are based upon small sample sizes consisting of White, gay, cisgender males hailing from middle-class, Western cultures (Cass, 1979, 1984; Coleman, 1982; Troiden, 1979, 1989) which calls into question the generalizability of these frameworks to other sexual minority groups, especially those who identify as bisexual (Lev, 2004; Horowitz & Newcomb, 2001; Yarhouse, 2001), transgender (Bilodeau, 2005; Devor, 2004; Lev, 2004), or racial and ethnic minorities (Adams & Phillips, 2009; Loiacano, 1989; Parks et al., 2004; Yarhouse, 2001). This is especially true when attempting to explain sexual orientation and gender identity development in relation to intersectionality with additional identities, as there exists innumerable iterations of the process (Horowitz & Newcomb, 2001; McDonald, 1982; Morris, 1997). Therefore, the stage model is not sufficient in describing the experiences of many sexual orientation and gender minorities.

Secondly, by viewing development through stage models, there is an inherent tendency to define successful navigation of the process as full integration (Marcia, 1966). However, this is problematic as many individuals engage in identity foreclosure before

pursuing or achieving integration, and, are therefore, viewed as emotionally deficient or delayed (Rosario & Schrimshaw, 2012). Although there is copious evidence to suggest serious psychological, emotional, and physical consequences for an unresolved identity, it is fatuous to argue that one could never achieve happiness or contentment if they did not pass through all stages of any particular model (Erikson, 1956, 1980; Marcia, 1966; Rosario, Schrimshaw, & Hunter, 2011). Several prominent theorists acknowledge that the models cannot provide a path for every individual contemplating their sexual orientation and/or gender identities; in fact, Troiden (1989) posited that "progress through the various stages of increases the probability of homosexual identity formation, but does not determine it fully" (p. 48). Additionally, Heyl (1989) argues that "behavior, emotions, and identities do not necessarily develop into stable packages that can be easily labeled as heterosexual, gay or lesbian, or even bisexual, even though the individual or the society or the gay community might desire such consistency" (p. 333).

Intersectionality of Sexual Minority Status and Other Identities

Although great progress has been achieved in relation to the acceptance of, and affirmation toward, sexual minorities within both the United States as well as nations abroad, many obstacles remain for those whose sense of self is comprised of other important minority identities in addition to sexual orientation and gender/sex status including age, disability (both congenital and acquired), religious/spiritual orientation, race and ethnicity, indigenous heritage, national origin and immigrant status. Although these various components are vital to establishing an integrated identity, each also imparts unique challenges that must be navigated by the individual. Black feminist theory provides the foundation upon which LGBTQIA+ intersectional research is built;

Crenshaw (1991) argued that the convergence of racism, sexism, and classism was chiefly responsible for the difficulties encountered by Black women within a legal system which served to protect White, wealthy men. In explaining the intersectional nature of discrimination, she argued:

> Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happens in an intersection, it can be caused by cars traveling from any number of directions and, sometimes, from all of them. (Crenshaw, 1989, p. 149).

These ideas were later expanded by other scholars to include other oppressed groups such as members of the LGBTQIA+ community, especially those who hold multiple, intersecting identities like queer people of color (Sarno et al., 2015). Additionally, both the APA *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (APA, 2012)and *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA, 2015) describe the importance of clinician understanding of the role that intersectionality plays between a client's sexual orientation and/or gender identity and other essential identities including their age, disability status, religious/spiritual status, race and ethnicity, indigenous heritage, national origin and immigration status, and rurality.

Age

An enormous debt is owed to those who came before and fought tenaciously to secure civil rights for the LGBTQIA+ community; their sacrifices often included careers, physical safety, family, and, for many, even life itself (Cervini, 2020). The costs paid through their blood, sweat, and tears were the foundation for a more secure and hopeful

future for sexual orientation and gender minorities. However, millions within these older generations are often made to feel invisible even by other sections of the community; their needs ignored or forgotten, they are subject to the combined forces of societal heteronormativity, heterosexism, and ageism (David & Knight, 2008).

Bowling and Gabriel (2007) conducted a study in which elderly research participants were asked about the aspects of life that resulted in a feeling of overall well-being; the majority indicated that the most important included physical, emotional, and mental health, with the latter being described as vital in leading to "acceptance and mental harmony and strength, a feeling of being lucky, unstressed, a focus on good memories rather than bad…helped people to look forward to things, and to be satisfied with life" (p. 827). These predictors of one's quality of life are no less important for older members of the LGBTQIA+ community; in fact, this population is at increased risk to experience social isolation, loneliness, and a feeling of invisibility (Brotman et al., 2003; de Vries & Croghan, 2014; Grant, 2010; Waling et al., 2019), physical health problems including heart attacks, diabetes, cancer, and weakened immune systems (Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen et al., 2017; LGBT Movement Advancement Project and Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders, 2010), higher prevalence rates of anxiety and mood disorders (David & Knight, 2008; Grant, 2010; McCann et al., 2013; Shenkman et al., 2018), suicidality (Fredriksen-Goldsen et al., 2011; McCann et al., 2013), pronounced substance use (Fredriksen-Goldsen et al., 2017; Ompad et al., 2014) increased risk of being victims of violence (Gardner et al., 2014; Stacey et al., 2018), higher poverty rates (Grant, 2010; LGBT Movement Advancement Project and Services and Advocacy for Gay, Lesbian, Bisexual

and Transgender Elders, 2010), and increased risk of experiencing discrimination in retirement and long-term healthcare facilities (Hughes, 2009; Jackson et al., 2008; Johnson et al., 2005; Rosenberg et al., 2018). While there is a dearth of research on the experience of older transgender individuals, Fredriksen-Goldsen et al. (2013) found that most study participants (N = 174) reported significantly higher rates of chronic physical illnesses and disability, depression, victimization, and perceived stress than did the cisgender control group. Therefore, it is vital that medical professionals are attuned to the specific needs of aging sexual and gender identity minorities, as they are at increased risk for a host of physical, emotional, psychological complaints.

Even though there has been a positive trajectory in acceptance exhibited toward the LGBTQIA+ community, sexual minority youth continue to experience the deleterious effects of discrimination and rejection by family as well as peers; subsequently, there is a growing body of empirical evidence which suggests that these interactions have long-lasting, devastating impacts on one's development across all domains. Within the last decade, growing tolerance has resulted in a larger number of youths who self-identify as LGBTQ; in fact, Conron (2020) reported that 9.7% of individuals between the ages of 13-17 indicated membership in the community. Although it is much more common for LGBTQIA+ youth to observe and interact with others in the community, systemic heterosexism and heteronormative values continue to permeate society. In turn, many continue to internalize negative messages that serve as caustic agents, thereby damaging one's sense of self. Such experiences lead to a host of mental illnesses including depression, anxiety, and PTSD among others (Hall, 2018; Kann et al., 2016; Mustanski et al., 2010), increased risk of suicide (Bojarski & Qayyum, 2018; Fish et al., 2019;

Grossman & D'Augelli, 2007), eating disorders (Calzo et al., 2017; Watson et al., 2017), and high prevalence rates of substance use (Kelly, Davis, & Schlesinger, 2015; Magette, 2018; Marshal et al., 2008; Robinson, 2018). Regarding the latter, Marshal (2008) reported that the overall odds of LGB youth substance use and abuse was 190% greater than that of their heterosexual counterparts. Furthermore, the scourge of LGBTQIA+ youth suicide continues to become more salient; in fact, Puckett et al. (2017) found that 37.7% of the LGBT participants surveyed had attempted suicide and listed several predictive factors including "losing friends after coming out as a sexual minority, feeling guilt and shame when realizing one was same-sex attracted, internalized heterosexism, and experiencing psychological maltreatment from caregivers" (p. 705).

Additionally, LGBTQIA+ youth experience much higher rates of verbal, physical, and sexual assault than do their heterosexual peers; Sterzing et al. (2019) surveyed sexual and gender minority adolescents (N = 1,177) and found that participants were more likely to have experienced lifetime physical assault (81.3%), bullying victimization (88.8%), sexual victimization (80.6%), child maltreatment (78.8%, property victimization (80.1%), and indirect or witnessed forms of victimization (75.0%) due to their identity. While these trends are distressing, there has been a concerted effort to provide sexual and gender minority children and adolescents with adequate social supports within educational settings; this has significant effects in the reduction and/or prevention of mental illness and alcohol abuse (Colvin et al., 2019; Heck et al., 2011).

Disability

For those who identify as a sexual and/or gender minority and have a congenital or acquired disability status, there exists the characteristic struggle against oppression

manifested through institutionalized heteronormativity and the culturally enforced concept of the gender binary; however, these individuals must also confront the inequitable, biased effects of ableism (Henry et al., 2010; Miller et al., 2018). According to Sherry (2004), the similar experiences of marginalization and invisibility of the two communities is salient in several ways including a feeling of separation from loved ones due to the individual's identity, an increased risk of suffering physical and verbal abuse, the pervasive nature of harmful stereotypes and discriminatory actions, attempting to "pass" to meet societal standards, and the difficulties associated with disclosing one's identity. When there is an intersection between one's membership in the LGBTQIA+ community and disability status, the resultant stress can be overwhelming; in fact, those who simultaneously hold these identities report bullying and abuse, higher rates of mental and emotional disorders, a sense of isolation, and increased risk of suicidality (Dinwoodie, Greenhill, & Cookson, 2020; Elderton et al., 2014; Fredriksen-Goldsen et al., 2012; Sherry, 2004).

Unfortunately, many individuals recount experiencing mistreatment not only at the hands of those members of the dominant culture, but also from other sexual and gender identity minorities; this abuse often takes the form of ableist microaggressions, which serve to reduce feelings of social support (Conover & Israel, 2019; Ellis & Carlson, 2009; Harley et al., 2002; Shakespeare, 1999). One such example was provided by a participant interviewed by Hulko and Hovanes (2018); speaking about the intersectionality of their gender and disability status identities, he reported:

> The only thing I have ever been called is retard…I am [disabled] so they assume that I am mentally handicapped because of that…even if it is a group like this, I

> am always scared I'm going to be judged for being [disabled]. And if I am in a place where there [are] enough people [who are disabled] I can be judged for being a girl looking like a guy. So no matter where I go, I am always scared of being judged for something. (p. 443)

Therefore, it is essential to the individual's well-being to find a community of support in which to explore and integrate one's disability status and sexual and/or gender minority identities. By achieving this internal state of self-acceptance, the individual may be more well-prepared to navigate heterosexist and heteronormativity experienced within the disabled community as well as forms of ableism exhibited by other sexual and/or gender minorities (Toft, 2020).

Furthermore, for those whose disability status intersects with their sexual orientation and/or gender identity, there is an acute awareness that their sexual desires are either dismissively minimized or outright rejected by many of those with whom they come into contact (Lofgren-Martenson, 2009). This is especially true for those with severe disabilities who reside in long-term care homes; Abbott and Howarth (2006) interviewed employees of such facilities and found that the majority reported significant reticence in acknowledging the sexual needs of their clients, especially for those who identified as sexual or gender identity minorities; when pressed about the reasons for such hesitation, staff indicated an amalgam of variables including paucity of knowledge surrounding such issues, a lack of clear, consistent organizational policies, few opportunities for training, and a fear of negative responses from client parents or caregivers. Thompson et al. (2001) argues that those who are disabled are often labeled as asexual by both the dominant culture as well as other sexual and/or gender minorities;

this, in turn, serves to intensify the isolation and invisibility of this population (Schulz, 2009) and increases the risk for contracting sexually transmitted disease as this population is not provided with comprehensive sexual education (McClelland et al., 2012). Oftentimes, those with both visible and invisible disabilities must attempt to obscure their sexual orientation or gender identity in order to protect their well-being; in fact, Moreno et al. (2017) found that a significant number of those presenting with neuroatypicality due to traumatic brain injuries, intellectual disabilities, autism spectrum disorder, dementia/HIV-related dementia, spinal cord injury, and epilepsy cited the fear of being denied adequate medical care as a significant factor in refusing to share their minority status.

Religion & Spirituality

For a multitude of those within the LGBTQIA+ community, the complex relationship which exists between one's sexual and or gender identity and religious or spiritual identity is often a source of intense confusion, frustration, guilt, and fear, internalized homophobia/homonegativity, depression, and suicidality (Barnes, 2013; Rodriguez et al., 2019; Sherry et al., 2010). Jeffries et al. (2014) interviewed young, gay and bisexual men diagnosed with HIV (N = 44) relating to their religious and spiritual experiences and beliefs; unsurprisingly, only 16% felt comfortable in disclosing their sexual orientation with fellow congregants while 37% espoused the view that homosexuality was sinful. Furthermore, the respondents reported frequent negative interactions between themselves and religious family members including "estrangement from families; statements that homosexuality was an 'abomination' to God; and hearsay that HIV was an appropriate punishment for being gay or bisexual"

(p. 1075). Therefore, one can see the deleterious effects that participation in an unaffirming religious community including the potential for significant internalized homophobia which can lead to increased sense of intrapersonal incongruency. These experiences are especially salient for LGBTQIA+ youth whom, due to the obstacles posed in integrating one's sexual and gender identity with a religious or spiritual identity, often report internalized homophobia/homonegativity, decreased overall sense of well-being, nonsuicidal self-injury, and suicidality (Gibbs, 2015; Longo et al., 2013; Meanley et al., 2015; Page et al., 2013).

However, Stern and Wright (2018) argue that differentiating between religiosity and spirituality is essential in providing context to the experiences of sexual and gender minorities; the authors conceptualize the former as a social endeavor through participation with institutionalized religious organizations while the latter is "an individual relationship with some higher power or intrinsic belief that motivates behaviors and provides meaning and purpose" (p. 1072). Moreover, findings from their research suggest that those who identified as highly religious exhibited increased internal homonegativity and heteronormative beliefs while spiritual participants reported greater self-esteem and self-acceptance of LGB identity. Therefore, it is conceivable that partaking in spiritual practices can serve as a protective factor for sexual and gender minorities as a source of strength and resilience (Lassiter et al., 2019; Schmitz & Woodell, 2018; Scroggs et al., 2018). In fact, Rosenkrantz et al. (2016) surveyed self-identified LGBTQ adults (N = 314) who also described themselves as religious and/or spiritual; the successful integration of one's sexual/gender identity with the religious/spiritual identity was associated with self-acceptance, empathy, openness, and

compassionate behaviors; experiencing deeper meaning and purpose, increased connectedness with others, increased sense of capability in coming out as a sexual and/or gender minority, and coping with prejudice related to sexual minority status. Therefore, it is important to note that one's religious or spiritual identity has the potential to serve as both a risk and protective factor in navigating the unique challenges faced by those in the LGBTQIA+ community (Hart et al., 2018).

Bearing this reality in mind, there exists multiple ways in which sexual minorities can react to, and interact with, religious and spiritual beliefs, rituals, and institutions. Although many LGBTQIA+ individuals decide to reject a religious/spiritual identity, others attempt to nurture their faith through self-imposed celibacy or involvement in reparative therapy (Wood & Conley, 2013). However, findings from a 2014 Pew Research Center suggest that religious and/or spiritual identity is central to a significant portion of the queer community as although 41% identified as religiously unaffiliated, 48% reported membership in various Christian denominations. Furthermore, 11% of respondents identified as belonging to a non-Christian faith tradition. Ultimately, while there is significant variation within the LGBTQIA+ community regarding acceptance of religion and spirituality, the ability to successfully integrate these identities is vital to ensuring physical, emotional, and psychological well-being. Therefore, it is essential that therapists, especially those who identify as heterosexual, are aware of the heterogeneity found in religious and spiritual adherence among sexual orientation and gender minorities (Cerbone, 2020).

Race & Ethnicity

As difficult as identifying oneself as a sexual and/or gender minority can be, the experiences of those who are also racial and ethnic minorities are often even more challenging; this is due to the continued impact of systemic, institutionalized racism, prejudice, and discrimination which permeates our society and consistently deprives these populations of equitable treatment across social, economic, educational, legal, and cultural domains (Battle et al., 2002; Jackson et al., 2020; Parra & Hastings, 2018).

For those who identify as LGBTQIA+ people of color (LGBTQIA+-POC), there is a resultant risk for mental illness (Balsam et al., 2011; Jackson et al., 2020; Parra & Hastings, 2018; Takeda et al., 2021), suicidality (Diaz et al., 2001; O'Donnell et al., 2011; Vargas et al., 2020), prevalence rates of HIV/AIDS and other sexually-transmitted diseases (Brennan et al., 2015; Han, 2009; Lelutiu-Weinberger, 2015; Lieb et al., 2011), and substance abuse (De Santis et al., 2014; González-Guarda et al., 2016; Voisin et al., 2017).

Additionally, LGBTQIA-POC are subjected to other stressors related to their multiple identities that their privileged White counterparts do not experience; this includes significant pressure to navigate the complexities of being a sexual and/or gender minority in racial/ethnic minority communities that exhibit strong biases against those who do not conform to heteronormative and traditional gender-binary expectations and roles (Corsbie-Massey, 2017; Estrada et al., 2011; Fields et al., 2015; Koken et al., 2009). One noteworthy example of this pressure is highlighted by the experience of a participant surveyed by Bowleg (2013); the individual reported that:

In general the Black community is not as accepting of homosexuality and so it's

> kind of this thing that's not talked about. It's there but it's more hush-hush and people just ignore it. A lot of families are embarrassed by it so it is very rare you find people that are out and can be themselves and are fully supported in their life. (p. 762)

However, Elias et al. (2017) found that while Black heterosexuals were more likely to hold pejorative views about members of the LGB community than were White or Hispanic participants, the former were less likely to exhibit microaggressions toward sexual and gender minorities; the authors posit that these results may be due to the Black community's experiences with racism, prejudice, and discrimination. Although there might be increased disdain for the queer community, Black individuals understand the destructive effects of microaggressions better than most (Elias et al., 2017).

Furthermore, LGBTQIA+-POC experience discriminatory behaviors and sentiments within the queer community in the form of microaggressions, exclusion from groups and spaces, feelings of invisibility, and racialized sexual objectification and fetishization (Bryan-Davis & Moore-Lobban, 2019; Felipe et al., 2020; Flores et al., 2018; Han, 2007; Jackson et al., 2020; Nadal et al., 2015; Teunis, 2007; Ward, 2008).

Indigenous Heritage

The historical experiences of indigenous populations are replete with accounts of colonialism, including the rape, physical and emotional torture, and genocide of millions through murder and disease; moreover, the ancestral lands of these various communities were purloined by hordes of European invaders (Dass-Brailsford, 2007). Another horrific practice included the institution of so-called Indian boarding schools which were intended to forcefully assimilate millions of native children into Westernized society by

depriving them of access to their respective families and cultural heritage (Dass-Brailsford, 2007). Horrifically, the purported goal of such a system was to "kill the Indian, save the man" (p. 42) (Garcia, 2020). The widespread decimation of First Nations peoples was striking as it has been estimated that the indigenous population numbered well over 18 million prior to the arrival of Christopher Columbus to the Americas in 1492; however, due to the aforementioned tragedies inflicted against native groups, this populace was reduced by between 95% and 99% (Stiffarm & Lane, 1992). Today, First Nations peoples comprise just 1.7% of the total population of the United States (Norris et al., 2010).

The intergenerational trauma incurred by indigenous populations continues to be augmented today by persistent social, economic, and political inequalities; such marginalization is manifested by increased prevalence rates of mental disorders, substance use, suicide, physical maladies, and risk of injury and death due to interpersonal violence (King et al., 2009; O'Keefe et al., 2021; Sarche & Spicer, 2009). Even more troubling is the experience of those who hold indigenous heritage but also identify as a sexual and/or gender identity minority; this is due in no small part to the difficulty in navigating the confusing messages encountered by this group. Although there is ample evidence for acceptance of, and, at times, reverence for those who experienced life outside of traditional heterosexism and the gender binary, many First Nations communities have adopted Western cultural beliefs and proscriptions against those who act on their inner truth (Garrett & Barret, 2003; Gilley & Co-Cké, 2005).

Unfortunately, such interactions result in efforts to conceal one's LGBTQIA+ status from family, peers, and the surrounding community. The repercussions of such

decisions are devastating to all parties, as attested by a Native HIV/AIDS prevention worker, interviewed by Gilley & Co-Cké (2005), who describes the relationship between the shame experienced by gay American Indian (GAI) males and risky sexual behaviors:

> I would say that seventy-five percent of [rural GAI] men are married with biological females as wives, and they do not want anyone in the community to find out that they are gay. I have found out though, that these men are engaging in unprotected sex and then going back to their wives and having sex with them. A lot of these men come to [an urban center on the Plains] to drink and party and have sex with urban GAIs and then again go back to their wives and put them at risk for STDs. (p. 295)

Additionally, Burks et al. (2011) surveyed Native American gay men (N = 42) regarding safe-sex practices and HIV/AIDS education; the authors reported several troubling themes including the ubiquitous use of alcohol when "hooking up," increased rates of anonymous sex with other males, a lack of comprehensive sexual education relating to risky sexual behaviors, reduced access to, and use of, condoms; mistrust of HIV/AIDS prevention organizations and other medical providers, and dearth of access to STD testing sites. Sadly, such experiences are not restricted to adults, as Barney (2003) found that gay American Indian and Alaska Native adolescent males were more likely to report symptoms of depression, including sadness and a general sense of hopelessness, as well as increased risk of attempted suicide and lack of concern over contracting HIV/AIDS than were their heterosexual counterparts. The author hypotheses that the latter can be attributed to the concept of social marginalization "where homophobia, racism, and

sexism all work to diminish self-respect and, thereby, contribute to the continued spread of HIV" (p. 151).

In addition to the pressures felt by sexual minorities within indigenous communities, there is also a co-occurring sense of ostracization from the queer community due to racial and ethnic identity (Balsam et al., 2004; Gilley & Co-Cké, 2005). The ramifications of such dual marginalization to those of indigenous heritage who also identify as a sexual or gender identity minority are widespread and devastating; in addition to the aforementioned mental health issues, substance use, and somatic ailments, this population also encounters sexual and physical violence at the hands of others, including intimate partners, at higher rates than heterosexuals (Metheny & Stephenson, 2020; Simoni et al., 2006).

National Origin & Immigration Status

For countless millions, the process of immigrating from one's country of birth to another nation often includes an amalgam of emotions including exhilaration, joy, sadness, fear, and trepidation; often, such a journey is undertaken due to a desire to experience live in a new environment. However, there are times in which the impetus for such movement is related to experiences of oppression due to one's "race, religion, nationality, or membership in a particular social or political group" (Dass-Brailsford, 2007, p. 226). Unfortunately, refugees are at increased risk for the development of mental illness, including posttraumatic stress disorder (PTSD), depression, anxiety disorders, substance abuse, and other emotional and behavioral issues (Bapolisi et al., 2020; Turrini et al., 2017). In fact, Kien et al. (2019) conducted a meta-analysis to determine the prevalence rates of various mental disorders experienced by refugees; shockingly, the

authors found that significant variability among dozens of studies for PTSD (between 19.0 and 52.7%), depression (10.3 to 32.8%), anxiety disorders (8.7 to 31.6%), and emotional/behavioral problems (19.8 to 35.0%). The stress of experiencing oppression in one's country of origin, uprooting one's entire life and moving to a new cultural environment, and potentially being separated from family and peers without any certainty that there will not be continued marginalization diminishes any sense of safety and security (Kien et al., 2019).

For those who are also members of the LGBTQIA+ community, this process can be even more daunting. Such fears were echoed by a service provider working with queer refugees in Canada and interviewed by Kahn et al. (2017); the individual reported that, "They come here, and they don't believe that they can be safe. They just hope they can be safe" (p. 1170). This is especially true for those who have immigrated from a country which criminalize same-sex behaviors; for citizens of many several nations (e.g., Iran, Saudi Arabia, Afghanistan, Brunei) who have been convicted of such "crimes," punishments range from imprisonment to the death penalty (Human Dignity Trust, 2021).

Navigating an entirely new environment, even if it were a utopia, would be difficult; however, doing so in a milieu where one can still experience systematic racism, sexism, homonegativity, and heteronormativity can result in significant feelings of frustration, fear, and sadness. Therefore, for immigrants who also identify as queer, the LGBTQIA+ community can serve as a refuge; in essence, they should be able to feel protected by a population which has experienced years of oppression at the hands of a dominant culture. However, Gray et al. (2017) found mixed reactions among gay/queer male participants (N = 13) regarding their opinions and experiences within the

community; for many, there was a sense of connectedness and support from other sexual and gender minorities. For example, one participant reported:

> [The LGBT community] sort of legalizes that you exist in a sense as for who you are…especially in my case, if you have been told throughout your teenage years that you were not right, that there was something wrong with you, I think it sort of negates that and says no, there is actually this. They have been lying to you. You exist as a person. (p. 206)

Others recounted feeling disconnected and invalidated by the community, especially from members who hailed from the dominant racial and/or ethnic culture. This frustration was perfectly encapsulated by the comments shared by another participant:

> I think their interests are very, like I said, self-serving. It's about what interests them. It's like this whole Prop 8 thing…everyone's fighting for that. That's fine, but you know minorities are fighting for other things. But, but still the White elite…the Dream Act, or other stuff? We don't see them. (p. 206).

A similar sense of isolation and invisibility, driven by experiences of racism, serves to place these populations at risk for increased stress which negatively impacts one's physical, emotional, and psychological well-being (Adames et al., 2018; Huang & Fang, 2019).

Rurality

For inhabitants of rural communities, there exist significant barriers to receiving medical care, including the provision of mental health services; such impediments include decreased access to providers (Brems et al., 2006; Fullen et al., 2020; Jensen et al., 2020), issues of accessibility due to service costs, lack of transportation, and distance

(Jensen et al., 2020; Johansson et al., 2019; Merwin et al., 2006); a priori knowledge of mental health issues (Thorne & Ebener, 2020), culturally reinforced beliefs and values which serve to stigmatize those who seek services (Jensen et al., 2020; Jensen & Mendenhall, 2018; Whealin et al., 2017), and issues of confidentiality (Cheesmond et al., 2019; Haynes et al., 2017; Thomas & Brossoie, 2019; Young et al., 2015). While momentous onus is placed upon this population in obtaining services, the advent and increased provision of telehealth has aided in reducing such burdens while also increasing willingness to engage with providers (Bischoff et al., 2004; Schopp et al., 2006; Simpson & Reid, 2014). Furthermore, research findings suggest the efficacy of telemental health services among multiple populations including veterans (Acierno et al., 2016; Bumgarner et al., 2017; Lu et al., 2014; Yuen et al., 2015), rural individuals with mild cognitive impairment and dementia (Burton et al., 2016), children and adolescents (Gloff et al., Helm et al., 2016; 2015; Miller, 2005), indigenous communities (Doorenbos et al., 2010), rural individuals with co-occurring psychiatric disorders (Gonzalez Jr., & Brossart, 2015), rural survivors of domestic violence and sexual assault (Gray et al., 2015), and elderly clients (Lichstein et al., 2013). Members of the LGBTQIA+ community face the aforementioned challenges in addition to other stressors related to sexual and or gender identity minority status (Meyer, 2009).

Geographic location is central to the formation of the dominating schemas relating to one's beliefs about self, others, and the surrounding world; as such, human beings are, in large part, a culmination of their experiences within a community (D'Augelli, 1994). Although systems of belief are ever evolving, the area in which an individual is born and raised plays a powerful role throughout one's lifetime (D'Augelli,

1994). This is especially true for sexual and or gender identity minorities residing in rural environments; their ability to fully explore and integrate their innate sense of self, live a life of intra- and interpersonal congruence, and navigate various relationships is oftentimes contingent upon the beliefs, perceptions, and behaviors of other rural residents (Rosenkrantz et al., 2017). If the individual is treated with dignity, compassion, and respect in relation to their sexual and or gender identity status, there is decreased risk to overall well-being (Kennedy, 2010). In contrast, if one resides in an area in which they experience discrimination and prejudicial treatment due to these aspects of self, the results can be devastating (Rosenkrantz et al., 2017). Eldridge et al. (2006) surveyed students (N = 123) attending a university in Eastern Kentucky regarding their comfortability with sexual minorities; the authors reported that significant percentages of the participants felt uncomfortable speaking with a sexual minority at a party (39%), attending social functions with sexual minorities (38%), discovering that their physician identified as LGBT (43%), or being labeled attractive by a member of the same-sex (54%). Participants who held the opinion that homosexuality was a choice, as well as those who feared the transmission of HIV/AIDS were less likely to feel comfortable interacting with sexual minorities (Eldridge et al., 2006).

A 2019 report published by the Movement Advancement Project (MAP) indicated that between 2.9 and 3.8 million LGBT individuals live in rural communities; in addition to the typical challenges facing rural Americans including poverty, unemployment, and limited access to health care providers, members of the queer community are also confronted by other unique challenges including risk of experiencing discrimination and stigma related to sexual identity (Barefoot et al., 2015; Oswald & Culton, 2003; Preston

et al., 2004; Yarbrough, 2003), internalized homonegativity (Cody & Welch, 1997; Fisher et al., 2014; Gottschalk, 2007), social isolation (Kennedy, 2010; Rosenkrantz et al., 2017; Yarbrough, 2003), distrust of medical providers due to experiences of discrimination and stigma (Gottschalk, 2007; Rosenkrantz et al., 2017), prevalence of substance misuse (Fisher et al., 2014; Poon & Saewyc, 2009; Rosenkrantz et al., 2017; Whitehead et al., 2016), risky sexual behaviors leading to increased risk of HIV/AIDS transmission (Bowen, et al., 2004; Kakietek et al., 2011; Schwitters & Sondag, 2017), poor mental health (Fisher et al., 2014; Rosenkrantz et al., 2017; Whitehead et al., 2016), chronic disease (Rosenkrantz et al., 2017; Whitehead et al., 2016), reduced access to health insurance (Fisher et al., 2014; Rosenkrantz et al., 2017), and suicidality (Poon & Saewyc, 2009). Swank et al. (2013) found that rural LGB individuals reported higher rates of homophobic experiences, employment discrimination based on sexual and gender identity, and incurred property damage than their urban counterparts.

Although living within a rural community presents many obstacles to those who identify as sexual and or gender minorities, there are also positive aspects of a bucolic existence. For instance, Wienke and Hill (2013) surveyed gay and lesbian participants (N = 632) living in the United States and found that those living in a rural area experienced greater happiness than those living in small cities or an urban setting; furthermore, gay males and lesbians residing in urban centers reported poorer health. Even though there is a palpable sense of isolation for rural sexual minorities, Cody and Welch (1997) found that multiple gay men living in such areas argued that this necessitated the formation and maintenance of platonic and romantic relationships; this view was perfectly encapsulated by one participant who remarked, “Rural gays have it better [than urban gays] in the long

run. Our relationships are long and deeper, and you have to rely on your partner much more" (p. 61). Such sentiments underscore the importance for the creation of a family of choice for rural sexual and gender minorities which serves as a source of resilience, support, and affirmation of one's identity (Oswald & Culton, 2003).

Discrimination & Prejudice

Coming-Out & Familial/Peer Rejection

Deciding to come-out or disclose one's sexual orientation and/or gender identity is described by members of the LGBTQIA+ community as one of the most frightening, anxiety-evoking actions one could undertake. Oftentimes, a pervasive sense of existential dread often accompanies the thoughts of revealing such an integral component of self to family and peers. For countless sexual and gender minorities, the process of discovery and self-acceptance includes sharing one's innermost truth with those they hold most dear. This decision, however, is also fraught with peril as engaging in such action holds the potential for the rupture of close relationships, rejection, and physical violence; experiencing rejection of such magnitude is both jarring and traumatic, often leading to adverse outcomes for all parties (Brumbaugh-Johnson & Hull, 2019; Solomon, 2015). It is also essential to understand that the coming out process is typically never only a single experience. Instead, sexual and gender minorities usually engage in this action innumerable times throughout their lives (Cassar & Sultana, 2016). With each interaction, the individual is faced with a plethora of emotions and possible reactions which could have momentous, long-lasting repercussions.

Traditional stage models of identity development expound on the importance of divulging one's sexual orientation and gender minority status as central to successful

integration of the concept of self (Cass, 1979, 1984; Coleman, 1982; Troiden, 1979, 1989); if the individual fails to do so, there is a perception that they are somehow less well-adjusted than those who have completed such an arduous undertaking. However, McCarn and Fassinger (1996) argued that self-disclosure of sexual and/or gender identity is not essential for resolution. Instead, the coming out process is highly heterogenous due to personal and cultural variables that impact such decisions (McCarn & Fassinger, 1996). Furthermore, D'Augelli (1994) was careful in explaining development, including the decision to disclose one's identity, in relation to the multidirectional relationships between the individual and their family, peers, community, and larger sociocultural institutions while considering the role of cultural beliefs, values, and expectations. Additionally, Klein et al. (2015) interviewed queer youth (N = 15) and found that many of the participants challenged the view of the coming out process as being essential to an integrated sense of self or a sense of psychological health; instead, they rated other factors as equally important to verbal disclosure of sexual identity including "financial stability, access to social support, and having a positive relationship with their family" (p. 318). Conversely, Schope (2004) surveyed gay adult men (N = 443) and found that although the participants who had not disclosed their identity to others were spared from experiencing discrimination in comparison to those who were out, they were also more likely to exhibit an increased external locus of control and fear of negative evaluation; therefore, the author argued that practitioners must be attuned to both the positive and negative consequences of coming out process while being comfortable in asking the client about the process.

Although many sexual orientation and gender identity minorities choose to come out in all social situations, others may decide to only divulge this aspect of self to a select group of family and/or peers or never share this information with anyone. However, the decision to reveal such a fundamental component of one's identity often has widespread consequences, which, depending on specific situations, can either be beneficial or undesirable. Gattamorta and Quidley-Rodriguez (2018) interviewed sexual minority youth (N = 20) and identified several factors related to the decision to share their sexual and gender identities including contemplating the possible range of reactions which would be expressed by loved ones, whether the other person was a member of the LGBTQIA+ community, and the cultural background of the participant. The latter variable was exceedingly salient for those who also identified as Hispanic due to the added dynamics of *machismo*, *marianismo*, and *familism*. For Hispanic males, the concept of masculinity permeates all domains of life; men are expected to act in accordance with specific gender behaviors which denigrates any expression of femininity; conversely, Hispanic females must receive cultural reinforcement to espouse aspects associated with the Virgin Mary, including submissiveness to existing patriarchal systems, devotion to one's husband and children, and sexual virtuousness (Gattamorta & Quidley-Rodriguez, 2018). In addition to the imposing forces of traditional gender roles, Hispanic participants also described the importance placed upon maintaining the integrity of the family unit even when it comes at the expense of the individual. One individual interviewed by Gattamorta and Quidley-Rodriguez (2018) explained how familism affected their decision to come out in the following manner:

> We come from very united families where everybody gets in everybody's business. So everybody had an opinion and that opinion can influence in a good or bad way…My aunts could have a certain influence on my mother. (p. 757)

Villicana et al. (2016) compared subjective perception of well-being among White and Hispanic gay males in relation to the verbal disclosure of participant sexual identity; although the evidence suggests that coming out was positively correlated with reported well-being for White, male sexual minorities, this pattern did not hold true for Hispanic participants. Therefore, it is important to understand the intersectionality at play for those who hold multiple minority identities while acknowledging that determining not to disclose one's sexual minority status does not preclude the individual from experiencing a sense of well-adjustment.

However, the research literature is replete with extant evidence suggesting that successfully engaging in the coming out process is integral to an overall sense of relief (Fenwick & Simpson, 2017; Manning, 2015; Neville et al., 2015), improved psychosocial well-being (Brownfield et al., 2018; D'Amico & Julien, 2012; Kranz & Pierrard, 2018), and reduced internalized sexual stigma/homonegativity (Pistella et al., 2016). The complex nature of this multifaceted decision was underscored by Szymanski and Sung (2010) who argued that the decision to refrain from coming out might prevent the development of mental illness in some sexual and gender minorities "because it reduces the likelihood of experiencing external heterosexism and bringing shame to the family" (p. 853). However, for many, this decision could act as an impetus for experiencing significant distress, resulting in poorer psychological well-being (Szymanski & Sung, 2010).

Ultimately, the reactions of family and peers, whether positive or negative, play a significant role in the subsequent physical, psychological, emotional, and social health and functioning of sexual and gender minorities; for instance, Ryan et al. (2015) found that negative family responses to the coming out process was associated with an increased risk of depression and decreased self-esteem. Unfortunately, Eaton and Rios (2017) reported that 68% of participants encountered some form of negative reaction from family, peers, or work colleagues; these encounters included ruptures within significant relationships, physical or verbal assault, pathologizing the individual's sexual or gender identity status, and a tendency to reframe the coming out conversation to discuss the negative effects of the disclosure on the loved one. In addition, deciding to conceal one's identity or experiencing rejection from support systems, including family, has been correlated with increased prevalence of depression (Bybee et al., 2009; Michaels et al., 2015; Pollitt et al., 2017), feelings of shame and guilt (Bybee et al., 2009), decreased self-esteem (Ford, 2004), and risk of suicide, especially for LGBT youth (Baams et al., 2015; Rimes et al., 2019). Shockingly, Puckett et al. (2017) reported that lesbian, gay, and bisexual youth were 29 times more likely to attempt suicide if peer relationships were ruptured during the coming out process.

Therefore, the importance of experiencing affirmative reactions from one's closest family members and peers cannot be overstated and certainly serve as a protective factor against physical, emotional, and psychological risks. Moreover, the coming out process is emotionally charged for all parties, requiring a thorough understanding of the sources of negativity espoused and exhibited by others. Trussell (2017) conducted interviews with the parents of sexual minority youth (N = 7) and found that two major

themes were prevalent; firstly, the participants expressed a significant sense of loss relating to heterosexist ideals and desires for their respective children; this grieving process was explained by one father who recalled:

> My wife and I talked about it, we both felt like a death in the family. Our hopes and dreams for beautiful brides, and grandkids, and kids running around the Christmas tree when we're older…they're gone. (p. 49)

Although many of the participants were initially distressed by the verbal disclosures of their progeny's sexual minority status, there was an acknowledgement of a potential reframing of future expectations which provided an opportunity for eventual affirmation of the child's identity. Secondly, several participants described their initial reactions in relation to the fear of losing friends or being viewed negatively by peers, including members of their faith communities; this often resulted in a decision to conceal their child's sexual identity status. However, as time progressed, there was often an awareness that the relationship between parent and child far outweighed the importance of other social connections. Similar experiences were reported by Huang et al. (2016) who interviewed heterosexual siblings of sexual minorities regarding the impact that coming out by the latter had on their relationships with one another; while there was a great deal of variance in initial reactions to the disclosure, some of the participants perceived the process as allowing for the strengthening of the familial bond, as well as an opportunity to better understand the experiences of the LGBTQIA+ community. Consequently, for those sexual and gender minorities who experience acceptance and affirmation from loved ones, these positive experiences aid in facilitating self-acceptance of one's identity (Haxhe et al., 2018).

Educational Discrimination

Each day, tens of millions of elementary, secondary, and post-secondary students enter the nation's vast network of schools, colleges, and universities to obtain a quality education while also engaging in peer socialization. Unfortunately, these environments, wherein one should feel a sense of safety and support, are, instead, associated with incurred hostility and fear for a vast number of LGBTQIA+ students (Demissie et al., 2018; Kitchen & Bellini, 2012). A report published in 2019 by the Gay, Lesbian, and Straight Education Network (GLSEN) found that an overwhelming number of LGBTQ students reported feeling unsafe at school because of their sexual and/or gender identity status (59.1% and 42.5%, respectively), while over a third of those surveyed admitted to attendance issues due to issues of safety or comfortability. Moreover, 17.1% of sexual and gender minority students were forced to change school systems due to continued harassment related to their identity. Additionally, participants reported avoiding spaces in which they were likely to be isolated from others including bathrooms and locker rooms, refusing to attend extracurricular or sporting events, being subjected to homophobic, transphobic, and heterosexist language from peers, faculty, and other school staff; experiencing both physical harassment and assault, and enduring cyberbullying. Even though many students attempted to report harassing behavior or physical assault to school administration, 60.5% indicated that no actions were taken to investigate the incidents; over half of those surveyed stated that they decided not to report abuse due to the perception of apathy expressed by school staff. Furthermore, significant percentages of participants recounted discriminatory experiences including being prevented from using lavatory and locker room facilities which conformed with their gender identity, receiving

punishment for public displays of affection in which straight, cisgender students were allowed to engage, using their preferred names and/or pronouns, denied the opportunity to choose LGBT topics about which to research or write, were refused participation in sports activities due to their identity, and denied the opportunity to create a gender-sexuality alliance (GSA) group (GLSEN, 2019). Such experiences serve to increase the risk for adverse consequences for sexual and gender minority populations including a sense of isolation, poor academic performance, depression, decreased self-esteem, and increased suicidality (Clark et al., 2014; Kosciw et al., 2009; Kosciw et al., 2019). Conversely, school systems which are perceived as supportive of LGBTQIA+ students' needs have been associated with decreased levels of both depression and anxiety symptoms (Colvin et al., 2019).

Consequently, it is essential that school employees receive adequate training in identifying and hindering the verbal, physical, emotional, and psychological harassment and discrimination of LGBTQIA+ student populations, as doing so could potentially save lives impacted by institutionalized heteronormativity and cisnormativity. Specifically, educators are perfectly positioned to provide support for students who identify as sexual and gender minorities (Vega et al., 2012). Vega et al. (2012), however, posited that many teachers were unwilling or unable to intervene due to lack of knowledge and training surrounding LGBTQIA+ issues, purported unfamiliarity with school policies on reporting bullying, lack of administrative personnel support, and even fear of themselves being falsely labeled as a member of the queer community. Smith (2018) interviewed secondary school teachers (N = 9) regarding their responsibilities as educators in creating a safe environment for LGBTQ students; although most participants intimated a

willingness to serve as an ally, they were still unlikely to explicitly address the social exclusion experienced by this population. Predictably, others were oblivious to the unique experiences and challenges faced by queer students; for instance, one participant argued that, "I guess I don't know that it's any different for, you know, a student who is gay, transgendered (sic), etc., you know, as compared to my role for any other student" (Smith, 2018, p. 309).

In addition to the role that affirming, supportive teachers play in fostering safe academic and social environments for LGBTQIA+ students, the formation of groups tailored to the specific needs of sexual and gender minorities, namely GSAs, can reduce the risk for substance misuse, depression, and mental health distress by serving as a protective factor against harassment while also facilitating social connections among members (Heck et al., 2011). Moreover, the inclusion of targeted LGBTQ-curriculum has been instrumental in aiding students in recognizing, and subsequently challenging, institutionalized heteronormativity and cisgenderism while also increasing their sense of visibility as members of an often-underserved population (Dinkins & Englert, 2015); sentiments of this nature are quite salient in conversations with queer youth surveyed by Snapp et al. (2015). One student, Snapp et al. (2015) noted, recounted the importance of such academic materials, stated:

> I have learned about the LGBT community in many ways through my teachers. They teach about ways LGBT people are viewed in the past, present, and how they made a difference in the world. I have discussed them in GSA and in history/government classes. In health, my teacher made sure to cover ways same-

sex couples can be safe. I surround myself with very educated friends, so I also learn from them. (p. 254).

Another crucial area of growth for local, state, and national educational organizations is the provision of comprehensive sexual education to all students, especially those who identify as sexual and gender minorities. However, most districts implement abstinence only until marriage (AOUM) programs which focuses upon refraining from all sexual activity rather than promoting the practice of engaging in safe sexual behaviors including the use of condoms and other forms of birth control (Hall et al., 2016). Lindberg and Maddow-Zimet (2012) posited that access to sexual education programs was correlated with healthier sexual behaviors in adolescents and young adults as manifested by delayed age of first sexual contact and increased condom and contraception use. Even when an expanded curriculum is introduced, there is a dearth of inclusive sexual health information relating to the needs and experiences of LGBTQIA+ individuals which can lead to shame or increased confusion related to one's sexual identity, increasing the risk for unwanted pregnancy, sexually transmitted infections (STIs), and experiences of sexual violence (Gowen & Winges-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Kosciw et al., 2019; Meadows, 2018). Additionally, Baams et al. (2017) argues that comprehensive, inclusive sexual education was correlated with an increased desire to intervene when sexual and gender minorities were being verbally harassed in educational settings.

Workplace Discrimination

In 2020, the Supreme Court ruled in *Bostock v. Clayton County, Georgia* that federal, sex-based discrimination prohibitions should be amended to include sexual

orientation and gender identity minorities as a protected class; therefore, according to Title VII of the Civil Rights Act of 1964, "private employers, employment agencies, and labor unions with hiring halls or at least 15 members – are now prohibited from discriminating against employees because of sexual orientation or gender identity" (Bennett & Wallen, 2020, para. 2). Although the LGBTQIA+ community was finally afforded a modicum of workplace protections against prejudicial actions exhibited by employers, significant obstacles remain as numerous state legislatures refuse to enforce such a ruling. The history of workplace discrimination enacted against sexual and gender minorities is rife with atrocious experiences in which individuals were harassed, denied promotions, and terminated at the whim of employers for no reason other than identity (Cervini, 2020). Although significant progress has been made regarding employment rights, millions of members of the queer community continue to encounter such vocational difficulties. Pizer et al. (2012) reported that 37% of lesbian and gay employees had experienced harassment from employees and coworkers while 47% of trans workers recounted having experienced discriminatory practices in workplace hiring, selection for promotions, and termination due to gender identity status. Research conducted by Tilcsik (2011) underscored the difficulty for sexual minorities in even obtaining employment interviews; the author wrote 3,568 fictional resumes, creating two groups of self-identified applicants: straight and gay. After submitting the resumes to 1,769 advertisements for white collar positions, the heterosexual "applicants" received interview invitations at a higher rate than their gay counterparts (11.5% v. 7.2%). Troublingly, Embrick et al. (2007) found that 90% of managers surveyed at a large

company indicated that they would never extend employment offers to anyone perceived as a member of the queer community.

In the United States, following the conclusion of World War II, there was a concerted effort between the federal and individual state governments to eradicate the "scourge" of deviant social groups who were believed to contribute to the nation's moral decline; considerable attention was directed toward the denizens of the queer community. Appallingly, between the years of 1946 and 1957, 29 states modified existing legislation related to the criminality of homosexuality. Prior to this period, individuals charged with engaging in acts of sodomy were incarcerated; following the adoption of these changes, homosexuals were now perceived as "*mentally ill* criminals subject to psychiatric remedies, which included shock therapy, castration, and lobotomies" (Cervini, 2020, p. 38). Unfortunately, the arrest rates of sexual minorities continued to skyrocket; in fact:

> homosexual arrests—including those for sodomy dancing, kissing, or holding hands—occurred at the rate of one every ten minutes, each hour, each day, for fifteen years. In sum, one million citizens found themselves persecuted by the American state for sexual deviation" (Cervini, 2020, p. 4).

After an individual was arrested and charged with a violation of a state's sodomy laws, they oftentimes experienced continued repercussions in the form of being involuntarily outed to their community by the publication of personal information, including the offender's name, address, and vocation, in local newspapers (Cervini, 2020). One can only imagine the abject terror and shame which culminated by such a violation of privacy, especially as these reports were damaging to every domain of the person's life, both personal and private. Unfortunately, innumerable employees charged as deviants

found themselves unemployed, as employers were unable or unwilling to tolerate such unconscionable behavior. Therefore, millions of Americans were forced to conceal their deepest yearnings out of fear of job loss and financial insolvency.

As terrible as the consequences were for private employees, sexual minorities laboring on behalf of the federal government were being monitored even more closely for signs of degeneracy; in the 1950s, a movement created to stamp out the influence of international communism, which had been mistakenly conflated with homosexuality, sought to draw attention to federal employees whose sexual identity placed them at increased risk for blackmail by foreign powers. In a meeting with United States Senators in July 1950, Admiral Roscoe Hillenkoetter, the director of the Central Intelligence Agency, laid out a 13-point explanation as to why the federal government should refuse to employ sexual minorities which included:

> (1) Homosexuals experience "emotions as strong and in fact actually stronger" than heterosexual emotions. (2) Homosexuals are susceptible "to domination by aggressive personalities." (3) Homosexuals have "psychopathic tendencies which affect the soundness of their judgement, physical cowardice, susceptibility to pressure, and general instability, thus making a pervert vulnerable in many ways" (4) Homosexuals "invariably express considerable concern" about concealing their condition (5) Homosexuals are "promiscuous" and often visit "various hangouts of his brethren," marking "a definite similarity to other illegal groups such as criminals, smugglers, black-marketeers, dope addicts, and so forth." (6) Homosexuals with "outward characteristics of femininity—or lesbians with male characteristics—are often

> difficult to employ because of the effect on their co-workers, officials of other agencies, and the public in general." (7) Homosexuals who think they are discreet are, in reality, "actually quite indiscrete [*sic*]. They are too stupid to realize it, or else due to inflation of their ego or though not letting themselves realize the truth, they are usually the center of gossip, rumor, derision, and so forth." (8) Homosexuals who try to "drop the 'gay' life and go 'straight'…eventually revert to type." (9) Homosexuals are "extremely vulnerable to seduction by another pervert employed for that purpose by a foreign power." (10) Homosexuals are "extremely defiant in their attitude toward society, "which could lead to disloyalty." (11) "Homosexuals usually seem to be extremely gullible." (12) Homosexuals, including "even the most brazen perverts," are constantly suppressing their instincts, which causes "considerable tension." (13) Homosexuals employed by the government "lead to the concept of a 'government within a government." This is so noteworthy. One pervert brings other perverts. They belong to the lodge, the fraternity. One pervert brings other perverts into an agency…and advance them usually in the interest of furthering the romance of the moment." (Cervini, 2020, pp. 33-34)

These prevailing pseudoscientific views later served as the impetus for President Dwight D. Eisenhower's decision to enact Executive Order 10450, which ordered the purge of thousands of government employees who exhibited "criminal, infamous, dishonest, immoral, or notoriously disgraceful conduct" (Cervini, 2020, p. 35). Distressingly, this misinformation permeated throughout the country, leading millions of

private citizens to continue leading a dual life out of concern for their ability to maintain the personal and financial security which derives from long-term employment. One of the unintended consequences of such archaic dictates was the rise of queer activist groups, including the Mattachine Society and the Daughters of Bilitis, whose members railed against the defamatory, destructive forces of heteronormativity so prevalent in society; the toil of such movements throughout the decades following World War II helped in creating an environment amenable to the introduction to a wide array of governmental protections for sexual and gender minorities.

The ubiquitous nature of workplace harassment and discrimination creates an unnecessary onus upon sexual and gender minorities. Specifically, when LGBTQIA+ applicants are refused interviews, denied promotions, terminated, or subjected to maltreatment, their ability to accumulate wealth and provide for their partners or families is severely weakened; consequently, the creation of such financial inequities leads to continued deprivation which can negatively impact the physical, emotional, and psychological health of this population (Mohr & Fassinger, 2012; Preston Jr., et al., 2013). Due to queer advocacy and increased public support for the implementation of workplace protections for sexual and gender minorities, the leadership of numerous companies are responding positively by fostering an environment in which all employees, regardless of identity, feel valued and experience equitable treatment.

Housing Discrimination

Another area of concern for sexual and gender minorities is the ability to obtain safe, affordable housing without the threat of one's decision to engage in identity disclosure resulting in widespread discriminatory reactions; unfortunately, the cancer that

is heterosexism has infiltrated all aspects of society, often resulting in the denial of equal opportunity and rights to members of the LGBTQIA+ community which extends to the housing market (Friedman et al., 2013; Kattari et al., 2016). Levy et al. (2017) found that although lesbian couples were treated comparably to heterosexual counterparts when attempting to obtain rental housing, gay men and trans folx were less likely to receive an appointment from property owners than were heterosexual applicants. Furthermore, the monthly rental price offered to potential gay renters was $272.00 more than quoted for straight males. Similar findings regarding the inflated rates charged to sexual and gender minorities were reported by Yilmaz and Göçmen (2016); the accompanying frustration associated with obtaining affordable housing was perfectly encapsulated by the experiences of one individual surveyed who argued:

> If you are a homosexual and if the standard rent for a flat is 500, they can easily demand 850, 800-900 Liras from you. Why? Because you are a homosexual and you have no choice since nobody rents you a house; you either have to accept these prices or you won't rent it. (p. 481).

The levels of discriminatory housing policies, including eviction or rental denials, occur as significantly increased levels for individual who identity as trans; in fact, James et al. (2015) surveyed tens of thousands of transgender individuals and discovered that 23% of respondents reported having experienced housing discrimination within the last year, while 12% had been homeless over the same period due to their identity. Even more troubling was the mistreatment suffered by those who had to seek services from homeless shelters, as 70% reported suffering harassment, sexual or physical assault, and denial of services due to identifying as trans. Generally, the consequences of housing instability are

quite dire and include depression (Hatem et al., 2020), anxiety (Hatem et al., 2020), risk of HIV infection due to exchanging sexual activities for remuneration (Boyer et al., 2016; Logie et al., 2018; Parker et al., 2016; Stoner et al., 2019), substance misuse (Smith et al., 2017) and poor physical health (Chhabra et al., 2019; Kelly et al., 2018). Therefore, it is vital that appropriate action is taken to ensure that communities at increased risk for housing insecurity, especially due to discriminatory or prejudicial actions, are both legally protected and provided equitable access to resources. However, while such goals are certainly laudable, the creation of such safeguards has moved at a glacial pace within the United States due to the powerful nature of systemic heteronormativity and cisgenderism.

In 1968, President Lyndon B. Johnson signed into law the Civil Rights Act; an important component of the legislation is Title VIII, also known as the Fair Housing Act. Under the latter, refusing to sale, rent, or finance housing to an individual based upon their race, religion, national origin, sex, handicap, and family status is prohibited (HUD, 2021). However, one's sexual and gender minority status were not included as a protected class leading to exclusionary housing policies which continue to negatively impact the queer community in a plethora of ways. Only 27 states and the District of Columbia have codified housing protections for sexual and gender minorities, necessitating the implementation of federal guidelines; currently, such legislation, known as the Fair and Equal Housing Act was introduced in the United States Congress in 2019 but has languished since (HRC, 2021). If passed into law, the act would result in the inclusion of sexual orientation and gender identity status to the text of the Fair Housing

Act, thereby providing true protections against the adverse experiences related to housing discrimination faced by the community.

Religious Discrimination

There exists a complex interplay between the LGBTQIA+ community and dominant religious institutions; the relationship has often been marred by unaffirming, dogmatic teachings which consistently denigrates anyone living outside of traditional sexual mores as well as the resultant feelings of revulsion, distrust, and apathy expressed by many sexual and gender minorities (Baldock, 2014). Even though some religious groups are reevaluating their views in the light of greater scientific understanding of sexual orientation and gender identity, many others refuse to acknowledge the immense suffering caused by the continued barrage of misinformation and hate promulgated by leadership and laypeople alike (Baldock, 2014). Unfortunately, these messages are often internalized by children and adolescents, searing into their mind a sense of self-abhorrence that can continue throughout the entirety of one' life; this internalized disgust only serves to damage the individual and their sense of self (Harvey & Ricard, 2018; Heard Harvey & Ricard, 2018; Huffman et al., 2020; Lease et al., 2005).

One does not have to expend a great deal of energy in looking around their environment to see the emotionally laden culture wars being waged in today's world; this internecine conflict ravages the landscape, laying waste to both communities as seemingly never-ending recriminations abound. Far too often, fundamentalist religious leaders are apt to decry the "gay agenda" and the community's responsibility for incurring God's wrath for their sinfulness. An infamous example of such vitriol was a statement voiced by Reverend Jerry Falwell following the terrorist attack on September

11, 2001; in determining what the cause of such a tragedy befalling the United States, he stated:

> I really believe that the pagans, and the abortionists, and the feminists, and the gays and the lesbians who are actively trying to make that an alternative lifestyle, the ACLU, People for the American Way, all of them who have tried to secularize America, I point the finger in their face and say, "You helped this happen." (Goodstein, 2001, para. 12)

There are thousands of other instances of such inflammatory rhetoric espoused by those who view themselves as the divine arbitrators of the nation's moral compass, driven to action by the establishment and political activity of advocacy groups who sought to enshrine and protect the rights of the queer community. Following the tumultuous Civil Rights era in the United States, many citizens felt as though the country was being polluted by progressive policies which called for expanded tolerance and rights for marginalized groups; eventually, this unease turned to anger, resulting in a marriage between the religious and political right. As time passed, the leadership of conservative political and social advocacy groups including the Moral Majority and the Family Research Council turned their attention to sexual and gender minorities and began calling out those who were believed to be most culpable for the country's supposed decline (Baldock, 2014). Across the nation, millions of Christians heard rallying cries similar to the following sermon given by the televangelist James Robinson in 1979 in which he stated being "sick and tired of hearing about all the radicals and perverts and the liberals and the leftists and the communists coming out of the closet…ready for God's people to come out of the closet and take back the nation" (Baldock, 2014, p. 143). The faithful

combined forces with the Republican Party to restore traditional moral values, leading to a barrage of restrictive state and federal legislation, effectively depriving the queer community of a multitude of civil rights often taken for granted by members of the dominant culture. At the same time, many sexual and gender minorities from various faith traditions, inundated by this exclusionary, hateful rhetoric, began questioning the role that religion would continue to play in their daily lives; such experiences created an agonizing sense of incongruence for those who longed to practice their faith while also remaining true to their authentic truth (Baldock, 2014).

It is important to highlight the evolving religious attitudes expressed toward the LGBTQIA+ community; although many religious sects continue to espouse negative, persecutory viewpoints, an ever-expanding number of faith groups have begun to reevaluate their movement's teachings related to sexual and gender identity while deciding to offer affirming environments for marginalized religious pilgrims searching for a spiritual home. Christian denominations offering such services include, but not limited to, the United Church of Canada, the Alliance of Baptists, the Roman Catholic Church, the Episcopal Church, the Disciples of Christ, the Society of Friends (Quaker), the United Methodist Church, and the Metropolitan Community Church (gaychurch.org, 2021). Moreover, other sects of major world religions, including Hinduism, Buddhism, Islam, and Judaism, welcome LGBTQIA+ members (HRC, 2021). Although there has been a great deal of progress in the acceptance of sexual and gender minority congregants, there is an understanding that no faith tradition is truly monolithic. Furthermore, religious belief alone does not denote whether religious groups and followers will treat queer individuals with derision and exclusion; instead, research

suggest that religious fundamentalism and propensity to identify with right-wing authoritarianism is positively correlated with negative attitudes toward sexual and gender minorities (Hunsberger et al., 1999; Jonathan, 2008; Lazar & Hammer, 2018; Tsang & Rowatt, 2007). Interestingly, Hoffarth et al. (2018) surveyed over 215,000 religious respondents and found that higher rates of religious service attendance were associated with antigay bias, even more so in countries that have created legislative protections for LGBTQIA+ citizens; the author's attribute this phenomenon to the role of so-called "culture wars" which foments continued division between marginalized groups and the dominant culture. In addition, Rosenkrantz et al. (2020) found that parents who espoused lower levels of religious fundamentalist beliefs were more likely to accept a child's sexual and gender minority status.

For those raised within fundamentalist or traditional faith systems, a consistent deluge of anti-LGBTQIA+ stigmatization often results in adverse consequences which threaten one's physical, emotional, psychological, and spiritual well-being (Barnes, 2013; Barnes & Meyer, 2012; Freeman-Coppadge & Home, 2019; Lassiter et al., 2019). The traumatic, long-lasting effects suffered by so many of those excluded and attacked by their own faith communities was aptly described by a participant interviewed by Bradshaw et al. (2015); discussing his attempts to change his sexual orientation, the individual shared:

> I prayed, fasted, read scriptures, went to church, went to the temple, lived a very religious life, etc., all in an attempt to be straight. No matter how hard I tried and concentrated on it, I could not make myself straight. It was severely disappointing on every level all the time…I felt God was disappointed with me. I also felt that

> the church and the people in my life would likewise be disappointed if they know…I hated that I felt the way I did. But it would not go away. I guess if you look at it, I was able to hide it and not act upon it for a very long time. The church may view that as a success, but I don't any longer. It's stupid to deny who you are and lie to yourself and everyone you know…You never can have a self-worth when no one (including yourself) really even know who you are. (p. 325)

For many people who share experiences similar to this individual, the journey toward self-acceptance, while extremely difficult, resulted in the decision to remove himself from a religious denomination which refused to affirm the integration of his sexual and spiritual identities; unfortunately, this is quite commonplace as exclusionary beliefs and practices demonstrated by religious institutions force many sexual and gender minorities to abandon faith altogether (Barnes & Meyer, 2012; Lapinski & McKirnan, 2013; Sherry et al., 2010) as 47% of Americans who identified as LGBT also described themselves as non-religious (Newport, 2014). However, for those who can reconcile these pieces of their innermost self, affirming religious or spiritual beliefs serve as a protective factor against other life stressors (Rostosky et al., 2008; Schmitz & Woodell, 2018; Scroggs et al., 2018).

Interpersonal Violence

One can only imagine the stygian nightmare experienced by those who were in attendance at the Pulse nightclub on Saturday, June 12, 2016; the venue was hosting Latin Night, and hundreds of patrons were enjoying the music, dancing, and social interactions, unaware that this joyful night would soon be tragically interrupted by the sound of firearms, the panic felt by the people attempting to flee, as well as the screams

of those who had been shot and lay dying (Zambelich & Hurt, 2016). Around 2:00 AM, Omar Mir Seddique Mateen entered the establishment, armed with a handgun and assault-style rifle, and began opening fire on the other clubgoers (Zambelich & Hurt, 2016). Over the next few hours, Mateen would murder 49 people and injure an additional 53 individuals (Zambelich & Hurt, 2016). While this attack was the deadliest mass shooting in American history, there is conflicting information regarding Mateen's motives; several witnesses testified that he had struggled with his sexuality, while Mateen informed law enforcement officers during 911 calls that these actions were related to his alleged membership in the terrorist groups of al-Qaida and Hezbollah (Zambelich & Hurt, 2016). Furthermore, his father recalled having been present with Mateen on the day of the shooting; the latter had become enraged after observing a gay couple kissing in public (Zambelich & Hurt, 2016). For the traumatized survivors of this horrific event, the images of their friends and loved ones, who departed this life far too soon, serve as tragic reminders of the unique safety concerns posed toward members of the queer community (Zambelich & Hurt, 2016). For so many LGBTQIA+ individuals, the phenomenon of interpersonal violence often looms overhead each day; consequently, these fears engender an existential threat to one's sense of safety, identity, and overall health and well-being. While Mateen's true motives may never be revealed, this attack is one among a copious number of atrocious assaults experienced by sexual and gender minorities which serve to challenge any semblance of personal security and stability. Stults et al. (2017) conducted a study in which LGBTQ participants were surveyed about perceptions of individual and peer safety in light of the Orlando shooting; the results suggested that although the attack on the queer community resulted in significant concern, this

experienced anxiety was greater in those who held multiple marginalized identities than those with even a modicum of privilege (e.g., White, cisgender gay males). The authors argue that medical providers should be aware of the ways in which care should be tailored to subgroups within the LGBTQIA+ community to meet unique needs (Stults et al., 2017).

Finkelhor and Kendall-Tackett (1997) define interpersonal violence as "harms that occur to individuals because other human actors behave in ways that violate social norms" (p. 2) and includes traumatic childhood abuse, bullying behaviors, intimate partner violence, and other forms of physical and sexual assault; regrettably, sexual and gender minorities are increased risk for victimization (Balsam & Hughes, 2012). For countless children, experiences of childhood physical, emotional, and sexual abuse are commonplace; such abhorrent interactions often lead to enduring, deleterious effects on an individual's physical, emotional, and psychological health (Rousson et al., 2020). Sadly, LGBTQIA+ youth are subjected to such maltreatment more often than are heterosexual, cisgender children and adolescents (Friedman et al. 2011; McGeough & Sterzing, 2018); in fact, Zou and Andersen (2015) found that LGB adults reported higher rates of experienced childhood verbal, physical, and sexual abuse; parental neglect, perceived household dysfunction, and victimization of school bullying when compared with heterosexual counterparts. Stunningly, Balsam et al. (2005) surveyed LGB adults as well as their heterosexual siblings and found within-family variance in risk for physical, sexual, and psychological abuse; those who identified as sexual minorities reported experiencing greater rates of childhood maltreatment. For many sexual and gender minorities who experience childhood sexual abuse, such trauma increases the risk of

future revictimization during adulthood (Balsam et al., 2005; Balsam et al., 2011; Heidt et al., 2005). Furthermore, queer youth and young adults are often subjected to peer victimization in the form of physical, verbal, and cyber-bullying which is correlated with risk of suicide (Barnett et al., 2019; Choi et al., 2020; Hatchel et al., 2019; Robinson & Espelage, 2013), poor mental health functioning (Kaufman et al., 2019; Mishna et al., 2009; Price-Feeney et al., 2018; Ramsey et al., 2016), nonsuicidal self-injury (Walls et al., 2010), increased alcohol consumption (Dermody et al., 2016; Rosario et al., 2014), substance misuse (Huebner et al., 2014), risky sexual behaviors (Rosario et al., 2014), poor academic performance (Poteat et al., 2011), and decreased self-esteem (Mishna et al., 2009).

Another troubling phenomenon within the LGBTQIA+ community is the increased prevalence of intimate partner violence which includes a wide array of aggressive physical, psychological, verbal, and sexual behaviors which serves to aid the perpetrator in exerting power and control (Edwards et al., 2016; Gillum, 2017; Kelley & Robertson, 2008; Metheny & Stephenson, 2020). Edwards and Sylaska (2012) hypothesized that intimate partner violence among sexual and gender minorities was driven, in part, by stigmatization, internalized homonegativity, and sexual identity concealment; interestingly, the authors, indeed, found that those who engaged in physical intimate partner violence reported higher rates of identity concealment and internalized homonegativity, increased perpetration of sexual violence was positively correlated with internalized homonegativity, and incurred psychological aggression against partners was higher for those who reported prior victimization due to their sexual orientation identity. This suggests that there is an increased likelihood for those who have been victims of

systemic heterosexism and homophobia to then act as perpetrators of such injustices through the practice of intimate partner violence; in effect, these individuals are continuing the cycle of victimization that has ravaged the queer community (Edwards & Sylaska, 2012).

Members of the LGBTQIA+ community across the globe often face the terrifying specter of hate crime victimization perpetrated by those who harbor extreme hatred for sexual and gender minorities; each year, thousands of people are targeted due to their identity. Seemingly, the prevalence of hate crimes incurred by this population has been on the rise over the past decade; according to the Federal Bureau of Investigation (FBI), in 2019, there were 1,429 victims of hate crimes based upon the individual's sexual orientation while another 227 targeted due to their gender identity status (Federal Bureau of Investigation, 2019). For trans and gender non-conforming folx, the rates are even more troubling as worldwide in 2020, 283 individuals were murdered through extremely violent means including gun violence, stabbing, strangling/hanged, stoned, burned, and decapitation (Transgender Europe, 2020). Within the United States, 44 trans and gender non-conforming persons were killed last year (HRC, 2020). Distressingly, although the Matthew Shepard and James Byrd Jr. Hate Crimes Prevention Act was signed into in 2009 by President Barack Obama, several obstacles remain in available actions undertaken by the federal government; importantly, before an accused perpetrator of a hate crime can be prosecuted, it is necessary to ensure:

> (1) the state does not have jurisdiction; (2) the state has requested that the federal government assume jurisdiction; (3) the verdict or sentence obtained pursuant to state charges did not demonstratively vindicate the federal interest in eradicating

> bias-motivated violence; or (4) a prosecution by the United States is in the public interest and necessary to secure substantial justice. (United States Department of Justice, 2019, para. 2)

Furthermore, according to the Movement Advancement Project (2021), only 23 U.S. states, the District of Colombia, the territories of Puerto Rico and Guam protect sexual and gender minorities against hate crimes. Additionally, 17 states either have passed legislation which does not include sexual orientation and gender identity as protected classes or have no hate crime laws in general (MAP, 2021). The devastating effects of frequent hate crimes enacted against the queer community are far-reaching; following the 2016 Pulse nightclub shooting, Jackson (2017) interviewed self-identified sexual and gender minority graduate students (N = 25) and found that the majority reported experiencing complex feelings of distress including sadness, anger, fear, shock, and emotional numbness. Of import was the sense of loss relating to the diminished safety of queer spaces which provide support and inclusion for so many; one participant, speaking to this phenomenon, underscored the battle between fear for personal security and the continuing desire to interact with the community by saying:

> Last night I was out at a queer festival with my sister and thought about what would be the safest reaction if a shooter were to attack. I hate that I need to think about that. I hate that safe spaces no longer feel safe. (Jackson, 2017, p. 164)

Such emotional trauma has been found to increase the risk of decreased life satisfaction, increased stress, anxiety, and depression (Feddes & Jonas, 2020; Paterson et al., 2019). Even though the LGBTQIA+ community must be vigilant against the threat of interpersonal violence, attention should be placed upon the integral role of the fortitude

and resilience exhibited by its members each day. Due to the pressures of navigating an invalidating, and, often, cruel heteronormative environment which places undue strain on sexual and gender minorities in the form of prejudicial and discriminatory messages, behaviors, and legislation, the ability to integrate one's identity and feel connected to a community can serve as a necessary buffer (Shilo et al., 2015).

Breslow (2015) defines resilience as "individual variables that protect minority group members from the deleterious effects of minority stressors" (p. 254). Moreover, individual resilience can take many forms including steps to remove oneself from hostile environments, coming out, using past adverse experiences to develop greater levels of empathy for others, engaging in social and political activism to advance meaningful social change, reducing internalized homophobia, and fostering deep relationships with supportive people and groups (Asakura, 2016; Asakura & Craig, 2014; Russell & Richards, 2003; Shilo et al., 2015). The ability to practice resiliency has been shown to reduce psychological distress (Breslow, 2015; Watson et al., 2018) and improve well-being (Frost et al., 2019; Watson et al., 2018) for sexual and gender minority populations.

Minority Stress Model

As the field of neuroscience expanded during the 20th and 21st centuries, researchers increasingly focused attention away from the effects of environmental factors on the etiology and manifestation of psychopathology to focus upon the burgeoning understanding of genetic underpinnings of behavior; although examining the role of biology is essential in providing a nuanced perspective of the complexity that is the human condition, Dohrenwend (2000) attempted to redirect adequate consideration to the importance of an individual's reciprocal relationship with their respective social milieu

by observing how the multifaceted interplay between socioeconomic status (SES), presence of adversity and stressors (e.g., natural disasters, loss of loved ones, divorce, sexual trauma, unemployment), dearth of personal agency, and genetic predisposition engender the necessary conditions for the development of psychopathology. Meyer (2003) extended this model to incorporate the challenges experienced by sexual and gender minorities, arguing that in addition to everyday stressors experienced by most people, this population encounters additional sources of adversity which increases one's risk for poor physical, emotional, and psychological health (Figueroa et al., 2021). These sources of adversity range from institutional, endemic heterosexism and cisgenderism which deprive those in the LGBTQIA+ community from participating in a multitude of social conventions (e.g., marriage, adoption of children) to the common, insidious experiences of rejection that lead to the decision to conceal one's sexual orientation and/or gender identity or the internalization of homo- and trans-negative beliefs/messages. Diaz et al. (2001) provided evidence for the harmful effects of minority stress on gay males; a majority of participants reported being confronted with harmful messages that gay people "were not normal…grow up to be alone…would damage their family relationships" which resulted in poor mental health and a decreased sense of well-being (p. 930). Although such occurrences often threaten an individual's well-being, having access to affirming sources of support exhibited by family, peers, and community organizations, as well as a sense of belonging provided by interactions with other sexual and gender minorities serve as protective factors, minimizing the likelihood of mental illness (Meyer, 2003; Meyer & Frost, 2012); see Appendix A.

In addition, Hatzenbuehler (2009) argued that while the minority stress model provided a greater understanding of the relationship between interpersonal experiences of adversity and the progression of psychopathology, there was too little detail explaining intrapersonal factors; therefore, he proposed the psychological mediation framework which posits that one's emotional, social, and cognitive responses to environmental stressors unique to the lived experiences of sexual and gender minorities as directly attributable to the subsequent development of mental illness. If the individual can effectively implement coping strategies which reduce maladaptive reactions including rumination, social isolation, hopelessness, and negative self-perception, they are then significantly protected against mental disorders; in effect, the ability to derive meaning from adverse experiences provides a barrier to successfully protect against systemic discrimination (Hatzenbuehler, 2009; Michaels et al., 2019); see Appendix B.

Health Disparities Faced by the LGBTQIA+ Community

Although access to healthcare is essential in maintaining one's physical, emotional, and psychological well-being, there exist numerous factors which serve as barriers to receiving adequate treatment for sexual and gender minorities; firstly, due to systemic discrimination, many members of the LGBTQIA+ community feel uncomfortable in seeking out medical services as they might feel judged, refused treatment, or be provided with inferior care (Baernstein et al., 2013; Lisy et al., 2018; Rhodes & Yee, 2013; Zeeman et al., 2019). A real-world example of the danger posed by such perceptions was illustrated by a study conducted by Milner and McNally (2020) in which they found that sexual minority women were less likely to obtain cervical cancer screenings due to desire to conceal one's identity, fear of stigmatization, provider

rejection, and negative evaluation. Furthermore, sexual and gender minorities have reduced access to healthcare due to financial hardships related to identity status (Mohr & Fassinger, 2012; Preston Jr., et al., 2013); therefore, many individuals cannot afford proper health insurance for themselves or their families (Diamant et al., 2000; Dilley, 2010; Simoni et al., 2012). Additionally, the federal government has failed to invest the time, energy, and financial means necessary to properly investigate the specific health challenges confronted by marginalized groups including the queer community (Boehmer, 2002; Mail & Lear, 2013; Simoni et al., 2012).

Physical Health

Sexual and gender minorities experience numerous identity-related stressors often leading to their participation in behavioral sequelae, including tobacco and alcohol use, which often increases the risk for physical illnesses; such diseases include cardiovascular disease (CVD) (Baernstein et al., 2013; Caceres et al., 2019; Hatzenbuehler et al., 2014; Rhodes & Yee, 2013;), heart attack (Dai & Hao, 2019), stroke (Caceres et al., 2019), cancers (Fredriksen-Goldsen et al., 2017; Haviland et al., 2020; Zeeman et al., 2019), diabetes mellitus (Fredriksen-Goldsen et al., 2013; Scheer et al., 2020), struggles with obesity (Stepleman et al., 2019; Zeeman et al., 2019), asthma (Stepleman et al., 2019), liver and kidney problems (Zeeman et al., 2019), musculoskeletal problems (Zeeman et al., 2019), and sleep difficulties (Patterson & Potter, 2021). Therefore, it is imperative that disparities in access to, and quality of, healthcare between heterosexual, cisgender populations and sexual and gender minorities be addressed to reduce mortality while improving overall quality of life for marginalized groups.

Sexual Health

The provision of comprehensive sexual education continues to engender fierce debate within the United States, often devolving into a political conflagration which only serves to endanger youth, especially those who identify as sexual and gender minorities (Hobaica et al., 2019; Hobaica & Kwon, 2017; Meadows, 2018). Although some progress has been achieved, currently 24 states and the District of Colombia require students to receive sexual education; even more troubling is the fact that 13 states expect that the information provided is medically accurate while only 9 states allow for the inclusion of affirming content related to the queer community (Guttmacher Institute, 2021). Gowen and Winges-Yanez (2014) surveyed queer youth (N = 30) about information relating to sexual and gender minorities communicated during sexual education seminars; unfortunately, most participants recalled little, if any, curriculum specifically devoted to LGBTQ issues. Others reported substantial pathologizing of sexual and gender minorities including statements "that homosexuality goes with disease—disease and drag queens" and "the penis only goes here [vagina], nowhere else. Nowhere else, no matter what, like, its dangerous" (p. 792). The continued deficit of inclusive, comprehensive sexual education most often results in risky sexual behaviors which lead to higher rates of sexually transmitted infections (STIs), internalized homonegativity, and further stigmatization which continue throughout the lifespan (Gowen & Wings-Yanez, 2014; Hoefer & Hoefer, 2017; Kaestle & Waller, 2011).

Although both sexual and gender minorities and heterosexual, cisgender populations are at-risk for STIs, the presence of additional life stressors for the latter including experiences of discrimination, internalized homonegativity, disparities in

access to healthcare resources, and prevalence of substance misuse increase the likelihood of infection (Bimbi et al., 2006; Bird et al., 2017; Logie et al., 2018; Rasberry et al., 2015). Minority stressors such as those previously described are especially salient for queer males due to the prevalence rates of HIV/AIDS within this group; according to the Centers for Disease Control and Prevention (2018), gay, bisexual, and other MSM accounted for 69% of new HIV cases. Furthermore, racial and ethnic minority MSM experience significantly higher rates of HIV infection than do their White counterparts (Herrick et al., 2012). In fact, Hall et al. (2007) found that young, Black MSM were 19 times more likely to be diagnosed with HIV and that Black sexual minority males were less likely than their White counterparts to survive three years following an AIDS diagnosis; these results speak to the additional obstacles posed to racial and ethnic minorities in obtaining proper medical care. However, Henny et al. (2018) found that racial/ethnic minority MSMs who fully accepted their sexual orientation identity were less likely to engage in unsafe sex behaviors, effectively reducing risk of HIV transmission.

Especially problematic for MSM is the role of the syndemic or “a set of cooccurring health conditions that together can lower overall health and increase susceptibility to disease” (Herrick et al., 2012). Gay males who abuse alcohol and illicit substances often engage in unprotected sexual behaviors, amplifying the risk of sexual disease and creating a textbook case of the syndemic (McCarty-Caplan et al., 2014; Ramirez-Valles et al., 2008; Saxton et al., 2018; Starks et al., 2015). Research conducted by Lea et al. (2013) found that gay and bisexual participants who injected drugs experienced employment instability, used other party drugs during sexual encounters, and

were more likely to test positive for HIV and hepatitis C. Even though the scourge of HIV/AIDS has disproportionately impacted gay and bisexual men, Rhodes and Yee (2013) caution that adequate attention must be paid to other less-publicized STIs that affect this community at high rates including syphilis, gonorrhea, herpes, and chlamydia, as each have disastrous effects on those infected.

Additionally, those who have been diagnosed with HIV/AIDS often face external and internalized HIV-stigmatization as well as social exclusion at the hands of both the dominant culture and other sexual and gender minorities (Ferlatte et al., 2017). Hubach et al. (2017) interviewed queer men diagnosed with HIV (N = 23) regarding the marginalization experienced due to their health status; most acknowledged negative interactions with others due to their diagnosis including rejection, difficulty finding romantic partners, and a feeling of disconnectedness from the community. Such invalidating reactions from family and peers, coupled with internalized messages relating to HIV transmission, often results in fear, anxiety, depression, social isolation, and suicide (Cramer et al., 2015; Cramer et al., 2017; Ferlatte et al., 2017). Furthermore, HIV-stigma was found to significantly reduce the likelihood of individuals seeking out regular STD testing, thereby increasing the potential rates of transmission (Gamarel et al., 2018). Thus, it is vital that those at high risk for HIV diagnosis receive necessary education, testing, treatment, and support to ensure overall well-being.

Psychological Health

The Minority Stress model provides a thoughtful explanation of the ways in which sexual and gender minorities who encounter additional life stressors (e.g., internalized homophobia, social stigmatization, prejudice, discrimination) are at

increased risk of developing psychological distress (Meyer, 2009). Meyer (1995) conducted a survey of gay men (N = 741) and discovered a positive correlation between minority stress and feelings of demoralization and guilt as well as subsequent risk of suicide. The deleterious effects of minority stressors on one's mental health was illustrated by findings that sexual minorities living in states or countries which provided fewer legal protections or banned same-sex marriage were at significant risk for various mental illnesses including generalized anxiety disorder, post-traumatic stress disorder, dysthymia, any mood disorder, and substance use disorder (Casey et al., 2020; Hatzenbuehler et al., 2009; Hatzenbuehler et al., 2010). Moreover, Salim et al. (2019) found that bisexual women and trans folx who encountered frequent microaggressions reported higher rates of depression and suicidality. Multiple studies have confirmed a relationship between one's sexual and gender minority status and increased risk for suicidality (Hottes et al., 2015; Liu et al., 2019; Meyer et al., 2008; Su et al., 2016) due to consistent experiences of systemic oppression, discrimination, and isolation. As such, members of the LGBTQIA+ community are more likely to seek mental health services as rates higher than those who identify as heterosexual and cisgender (Berg et al., 2008; Cochran et al., 2017; Platt et al., 2018). Therefore, it is imperative that sexual and gender minorities have equal access to affirming, competent providers who can tailor interventions to address the challenges faced by this population.

Although the queer community is at increased risk for poor psychological health and well-being, the role of supportive family, peer, and community systems cannot be overstated. Such positive interactions have been shown to mediate the effects of discrimination, providing opportunities for growth, self-acceptance, and improved health

outcomes (Kidd et al., 2011; Taylor, 2019; Travers et al., 2020). Pilling et al. (2017) surveyed LGBTQ individuals diagnosed with severe mental illness (N = 16) regarding their experiences and found that those who experienced community support felt more empowered; for instance, one participant adeptly highlighted the importance of such a relationship:

> A lot of what I was going through was internal, I didn't talk to somebody about it. When I realized in my recovery through my mental health, before I sought help with [name of LGBTQ organization]…a lot of it was done on my own. I slowly started to discover that I need to be among others and I could not longer do this on my own. Community was a life saver. (p. 609).

Substance Misuse

According to the 2019 National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), a majority (60.1%) of citizens residing in the United States reported substance use within the past month; this includes both legal (e.g., tobacco products and alcohol) and illicit substances (e.g., marijuana, cocaine, etc.). Furthermore, significant percentages of respondents indicated receiving clinical diagnoses including various substance use disorders (SUDs) and/or a dual diagnosis for a co-occurring mental illness and SUD; shockingly, 12.9% of LGB adults met criteria for a dual diagnosis (Substance Abuse and Mental Health Services Administration, 2020). For millions of people, there exists a daily conflict in successfully navigating the vicissitudes of life without reliance upon drugs or alcohol; while this struggle is salient for all populations, sexual and gender minorities are at an increased risk due to the harm imposed by the ever-constant threat of minority stressors.

Many members of the LGBTQIA+ community turn to substances to dull the anguish resulting from experiences of marginalization, rejection, and self-hatred related to one's innate identity (Baernstein et al., 2013; Card et al., 2018; McCabe et al., 2010; Wilson, et al., 2016). Unfortunately, attempts to escape such trauma serves to increase an individual's risk for chronic, life-threatening physical, emotional, and psychological health problems including obesity, cardiovascular disease, cancer, cirrhosis, mental illness, and STIs (Baernstein et al., 2013; Beatty et al., 2013; Conron et al., 2010; Kirk & Kulkarni, 2006).

Tobacco. For decades, tobacco companies have exhibited a keen awareness of the vast wealth generated from the sale of products to the LGBTQIA+ community; in fact, Washington (2002) cited an internal executive memorandum circulated within the tobacco conglomerate, Phillip Morris, in 1985 which spoke to the power of the gay rights movement; the statement read, in part:

> It seems to me that homosexuals have made enormous progress in changing their image in this country…A few years back they were considered damaging, bad and immoral, but today they have become acceptable members of society…We should research this material and perhaps learn from it. (p. 1088).

Taking advantage of the untapped potential of this market, companies began donating money to queer organizations, increased the number of advertisement campaigns found in LGBTQIA+ media outlets and social establishments, including bars, frequented by members of the community; and hiring sexual minorities to serve as a conduit between tobacco producers and this populace (Smith & Malone, 2003; Washington, 2002). The attempt to provide a sense of inclusion to a group which often felt invisible and excluded

by the dominant culture was quite successful as attested by statements made by Don Tuthill, who served as the publisher for the gay periodical *Genre*. In response to tobacco companies request to advertise, he declared, “I’m just celebrating being part of the mix. We’re not being excluded any longer…a conservative American company fights discrimination against homosexuals by putting its money where its mouth is” (Smith & Malone, 2003, p. 989). However, other voices within the queer community were less exuberant about the creation of such a relationship; Hal Ofen, a spokesperson for the Coalition of Lavender Americans on Smoking and Health (CLASH) wrote, “This is a community already ravaged by addiction. We don’t need the Marlboro Man to help pull the trigger” (Smith & Malone, 2003, p. 990). Sadly, such decisions have resulted in the accumulation of billions of dollars in wealth for tobacco companies and an increased risk for life-threatening illnesses for members of the LGBTQIA+ community. Sexual and gender minorities are more likely than those who identify as heterosexual and/or cisgender to use tobacco products (Beatty et al., 2013; Caputi et al., 2018; Fish et al., 2018); in fact, Tami-Maury et al. (2015) surveyed sexual minority participants (N = 99) and found that 61% of respondents reported using tobacco products, 30% used e-cigarettes, prevalence rates of tobacco use was highest among lesbians, and only 6% of those surveyed listed tobacco use as a major health concern for the LGBTQIA+ community. This underscores the importance of providing comprehensive education surrounding the health consequences of tobacco use for sexual and gender minorities, as well as increased access to smoking cessation programs (Fish et al., 2019; Navarro et al., 2018).

Alcohol. A serious consequence of ubiquitous minority stressors, faced daily by sexual and gender minorities, is heavy alcohol consumption; in comparison to heterosexual individuals, members of the LGBTQIA+ community are at increased risk for alcohol misuse (Corbin et al., 2020; Flores et al., 2017; Sowe et al., 2017; Taliaferro et al., 2014). In fact, King et al. (2008) found that LGB participants experienced higher rates of alcohol dependency especially among sexual minority females. Moreover, Cochran and Mays (2012) argue that alcohol dependency is the second most commonly disorder reported by sexual minority males while sexual minority females detail similar alcohol consumption when surveyed. Roberts et al. (2004) interviewed lesbian participants (N = 1,139) and discovered that significant percentages "had alcohol problems (23%), were heavy drinkers (33%), and alcoholic (28%)" (p. 2).

Such frequent alcohol use often results in additional threats to one's physical, emotional, and psychological health and safety, as inebriated individuals are less inhibited and more likely to engage in risky behaviors including suicide attempts (Bränström & Pachankis, 2018; King et al., 2008). Furthermore, excessive alcohol consumption has been linked to unsafe sexual practices increasing the likelihood of STI transmission (Flores et al., 2017; Eleuţiu-Weinberger et al., 2019).

Illicit Drugs. Another disturbing trend within the queer community involves the frequent use and misuse of illicit drugs; especially troubling are the prevalence rates of so-called "club drugs" often consumed by sexual and gender minorities which include cannabis, cocaine, ecstasy, methamphetamine, amphetamines, amyl nitrate (poppers), ketamine, hallucinogens (i.e., LSD, psilocybin), and tranquilizers (Abdulrahim et al., 2016). Additionally, polysubstance use, which is defined as the "consumption of more

than one substance over a defined period, simultaneously or at different times, for either therapeutic or recreational purposes" (Kecojevic et al., 2016, p. 614) has been linked to sexual and gender minority status (Remy et al., 2017; Wallace & Santacruz, 2017). Again, illicit substance use is positively correlated with an increased risk for STI transmission due to unsafe sexual practices and intravenous injections (Coffin et al., 2014; German & Latkin, 2014; Knox et al., 1999); in fact, Leluţiu-Weinberger et al. (2019) surveyed sexual minority men (N = 2087) and found that participants who experienced stigmatization related to identity were significantly more likely to have engaged in condomless sexual contact while under the influence of illicit drugs and alcohol. Especially problematic is the use of methamphetamine and amphetamines by gay and bisexual males, as prevalence rates have been found to be 10 times higher in this population when compared to other groups leading to high-risk sexual behavior including "unprotected anal sex with an unknown or opposite serostatus partners, syphilis, high numbers of sexual partners, decreased condom use, and condom breakage" (Colfax & Shoptaw, 2005, p. 195). Saxton et al. (2018) posit that sexual minority males potentially engage in illicit substance misuse due to:

> Minority stress, whereby drugs are used as a coping mechanism in response to heterosexism and homophobia; cognitive escape, where certain drugs are valued for their disinhibitory effect; greater exposure to drugs in gay bars and clubs, which are importance social spaces for gay communities; and sexual sensation seeking, where drugs are specifically used to enhance sexual pleasure and experimentation. (p. 181)

Given the substantial toll that alcohol and illicit substance misuse takes upon the sexual and gender minority community, it is essential that substance misuse treatment interventions are built upon a framework which acknowledges that this population faces unique challenges in the form of bias, stigmatization, and discrimination; in addition, clinicians should implement affirmative therapies which aid the client in integrating their identity, leading to improved well-being and greater resiliency (Lyons et al., 2015; SAMHSA, 2012; Talley, 2013). The willingness of provider's to exhibit acceptance of a sexual or gender minority client's identity can be an integral component of successful completion of substance abuse treatment; for instance, Senreich (2010) found that clients who were "open and honest" about their sexual orientation status experienced "satisfaction with treatment, feeling therapeutically supported (feeling accepted, respected, and understood by counselors and clients), and feelings of connection to the treatment program" (p. 376).

Clinician Attitudes

Clinical Training

As sexual orientation and gender minorities seek out mental health services at increased rates in comparison to straight, cisgender individuals, it is vital that clinicians receive thorough, empirically based training which equips the provider with the expertise and skills required for competent care (Berg et al., 2008; Cochran et al., 2017; Platt et al., 2018). However, clinicians are typically trained within a system built upon a heterosexist framework which provides a dearth of opportunities in working with members of the LGBTQIA+ community (Ida, 2007; Pachankis & Goldfried, 2013; Sue & Sue, 2016). Furthermore, having a pellucid understanding of what it means to be culturally competent

is essential to the provision of appropriate care to diverse clients; Sue and Sue (2016) define cultural competency as "becoming aware of their own values, biases, assumptions about human behavior, preconceived notions, personal limitations, and so forth…actively attempt to understand the worldview of their culturally diverse clients…actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills" (p. 56). However, the accumulation of self-awareness, knowledge of others, and useful skills is truly incomplete; instead, the clinician must strive to create and maintain an attitude which prizes "respect for others, an egalitarian stance, and diminished superiority over clients…an 'other orientation'" (Sue & Sue, 2016, p. 62). To successfully meet the unique needs of sexual orientation and gender minority clients, a provider must constantly evaluate and reevaluate their own belief systems, while also recognizing the impact of societal discrimination and stigma on the overall well-being of this population. While this is certainly no easy task, the resulting outcome can, in effect, mean the difference between life and death for those who seek out services. In 2012, the APA (2012) published *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients*; within the Education and Training section, Guidelines 19 and 20 recommend that issues central to the lives of sexual minorities are incorporated into educational and training programs and that individual psychologists should continue to supplement their knowledge and skills through the use of LGB-focused continuing education credits, additional trainings, and supervision, respectively. Thankfully, APA published the *Guidelines for Psychological Practice for Transgender and Gender Nonconforming People* in 2015 with Guideline 16 imploring training programs to recognize that education about LGB clients does not engender the requisite knowledge to

competently provide services to trans and gender nonconforming clients; instead, additional training must include expanded opportunities to learn about the experiences of this population.

Few clinicians feel as though they were adequately prepared to work with the queer community, especially those who are trans identified (Couture, 2017). Moreover, APA surveyed both professional psychologists and graduate students (N = 294) and found that while 52% of participants reported learning about the trans population in their respective educational programs, only 27% responded in the affirmative that they "feel sufficiently familiar with transgender, transexual, and gender-variant (TGTSGV) issues" (APA, 2009, p. 16). Rutherford et al. (2012) conducted a study of LGBT-identified mental health professionals and found that most participants agreed that education and training programs were poorly designed to engage students about information relating to the queer community with one individual sharing that:

> Not everyone needs to be an expert, but people need to have a basic understanding and a basic respect, and I think it would go a long way to provide hopefully a reasonable experience for people so that at least they're not having negative experiences…Right now the unfortunate part is that people really have not had the kinds of education that they really need to have had to feel a level of comfort with [the LGBT] population. (p. 910)

Similar findings were described by Knight et al. (2014) after interviewing over two dozen medical professionals regarding their educational and professional training on LGBT issues; most participants expressed frustration with the lack of information provided by their respective institutions and acknowledged the deleterious impacts that this had on

sexual and gender minorities health. Furthermore, Owen-Pugh and Baines (2014) discovered that straight clinicians felt woefully unprepared to work with LGBTQIA+ clients while some sexual minority-identified clinicians reported having felt significant conflict between having to challenge their professors and fellow classmates or remaining silent. In addition, Murphy (2002) surveyed psychologists (N = 125) about the training that they had received regarding LGB issues; sadly, only 10% recalled having been offered during their graduate education, while 22% of participants reported that their academic programs offered didactic opportunities. Shockingly, most respondents reported interactions with supervisors who exhibited inadequate knowledge about sexual and gender minority clients (Murphy, 2002). Importantly, supervisors can integrate self-report measures including the Attitudes Toward Lesbians and Gay Men Scale (ATLG) and/or Heterosexual Attitudes Toward Homosexuals Scale (ATHS) into clinical supervision so that supervisees are better equipped to recognize, and modify, their own biases toward the LGBTQIA+ community (Van Den Bergh & Crisp, 2004).

Although psychology education and training programs have seemingly implemented a renewed focus upon the specific and unique life experiences of, and challenges faced by, sexual and gender identity populations, there remains significant progress to be made. When clinicians-in-training are deprived of such opportunities to better understand such clients, there is considerable risk to the psychological health of an already marginalized group (Logie et al., 2015; Matza et al., 2015). In addition, Alessi et al. (2016) posited that receiving training about sexual minority issues resulted in the adoption of affirmative attitudes and positive beliefs toward this community and increased clinician feelings of self-efficacy in providing affirmative counseling.

Therefore, it remains imperative that graduate curricula include targeted LGBTQIA+ coursework, knowledgeable supervisors, didactic workshops, and therapy so that clinicians-in-training are competent and confident in working with sexual and gender minority clients (Boroughs et al., 2015; Jimenez et al., 2018).

Clinician Bias

Due to the pervasive nature of societal heterosexism and cisgenderism, it would be naïve to think that anyone, even highly educated professionals, are immune to the dangerous falsehoods perpetrated against sexual orientation and gender minorities; unfortunately, misinformation relating to such clients has often resulted in disparate, discriminatory beliefs and treatment by those within the mental health field (Bieber, 1962; Cochran et al., 2007; Hayes & Erkis, 2000). Furthermore, Daniel et al. (2004) argue that the therapeutic milieu often serves as a reflection of the surrounding society which is built upon principles of heterosexism and cisgenderism. Although clinicians have access to the provisions found within the APA guidelines when working with the LGBTQIA+ community, there continues to exist a tangible threat that the provider engages in a prejudicial manner with a client (APA, 2012, 2015). Sue and Sue (2016) provide several examples of the ways in which clinician bias can creep into the therapeutic alliance including, but not limited to: (a) presuming universal heterosexuality of clients; (b) Viewing homosexuality as tantamount to spiritual sin or a mental illness; (c) attributing a client's presenting problems to their innate sexual or gender identity status alone rather than the effects of persecution or internalized heterosexism; (d) emphasizing sexual or gender identity in session even when inappropriate; (e) engaging in reparative therapy; (f) failing to comprehend the complexity of sexual and gender

identity development or equating identity with sexual acts; or (g) failing to understand the difficulty related to the "coming out" process or pressuring the client to share their identity without engaging in a discussion of potential repercussions. Comparable experiences of both overt and subtle microaggressions in therapeutic situations were identified by LGBQ participants surveyed by Shelton and Delgado-Romero (2013); particularly frustrating to those interviewed were instances in which a clinician attempted to avoid discussing issues of sexuality, even when it was directly related to the client's presenting issues; overidentification with sexual and gender minority clients; and stressing the potential dangers of identifying as queer; the use of outdated or inappropriate terminology (e.g., choice, lifestyle), or refusing to refer to the client by their preferred pronouns. Sadly, the participants recalled several troubling comments expressed by therapists including "Well, you should expect these sorts of things to happen with this lifestyle" and "Of course I have a bad relationship with my family, all gay people have a bad relationship with their family" (Shelton & Delgado-Romero, 2013, p. 65).

Mohr et al. (2001) found that clinicians who held more accepting attitudes toward bisexuality were less likely to experience a negative reaction to a fictious bisexual client or view the client as poorly psychosocially adjusted than those who were less tolerant; additionally, the latter were also more likely to view bisexuality as "repugnant, morally reprehensible, or a sign of psychological maladjustment" and admitted that they were "especially likely to believe that they would impose their personal values on the bisexual client" (p. 220). Moreover, Eliason and Hughes (2004) interviewed substance treatment counselors (N = 351) and found that participants were more likely to hold negative views

about LGBT people if they were uncomfortable with members of this community, self-identified as straight, espoused fundamentalist or conservative religious beliefs, received less formal education, and completed fewer hours of continuing education credits related to issues important to sexual orientation and gender identity minorities. However, even when practitioners do not express overt biases against LGBTQ clients, subtle, yet hostile, messages can still negatively impact the therapeutic alliance. For instance, Kasl (2002) asked straight, cisgender, male therapists how each would feel if their daughter identified as lesbian; unfortunately, the responses reflected subtle heterosexist themes of which the participants were seemingly unaware until engaging in an extended discussion about the impact of such statements. Holding adverse opinions or beliefs about sexual orientation and gender minorities can also significantly impact the decision to provide services to this community; in fact, McGeorge et al. (2015) surveyed family therapists and found that a majority (61.7%) considered referring LGB clients to another provider based solely upon sexual identity as an acceptable practice. Additionally, the authors found that participants who held negative views about these clients were more likely to believe such referrals were ethical especially if their opinions were based upon their religious values (McGeorge et al., 2015). Such referral decisions have been associated with increased risk of incurred harm to the client (Green, 2003).

Potential Harm to LGBTQIA+ Clients

Whenever clinician bias permeates the therapeutic alliance, there is salient risk to the client's well-being which can manifest in various ways. For members of an oft maligned community, the experience of interacting with a practitioner who embraces and exudes a prejudicial, intolerant outlook can act to reinforce heterosexist messages and

increase subsequent internalized homophobia (Mann, 2013; McHenry & Johnson, 1993) or strengthen feelings of being ignored or invisible (Higgins, 2007; Holley et al., 2016;). Consequently, sexual orientation and gender identity minorities who experience negative therapy experiences are more likely to discontinue therapy (Eady et al., 2011; Israel et al., 2008) or refrain from engaging in self-disclosure or discussing identity issues (Mair & Izzard, 2001; McKay & Watson, 2020; Semp & Read, 2015).

Burckell and Goldfried (2006) found that LGB participants (N = 42) rated several clinician attitudes and behaviors as integral in deciding whether to continue pursuing therapy services; these included inadequate awareness of issues affecting sexual orientation minorities, overemphasis of a client's sexual identity status, assumption of a client's heterosexuality, and use of heteronormative terminology. Interactions with clinicians who espouse negative beliefs and attitudes, even unconsciously, about the LGBTQIA+ community serve to reiterate:

> Consistent messages of devaluation, which often become internalized. Queer people learn that being queer is bad, that it is a sin, and that it is disgusting, perverted, wrong, sick, diseased, and weird. These messages are continuously broadcast through media, organized religion, the government, workplaces, schools, and families. (Coolhart, 2005, p. 3).

Thus, it is of immense importance for clinicians to be aware of their own learned biases as well as the substantial, long-lasting impact that these have on the client who is seeking therapy services. Milton et al. (2005) posited that therapists, whether straight or queer, must be cognizant of their stance which is held about their own sexual identity as well as the sexualities of others while also exhibiting a willingness to engage in self-reflection

and education about issues important to sexual orientation and gender identity minorities; in turn, this can lead to increased empathy, an understanding of individual differences between self and others, and positive engagement between clinician and client.

Clinical Interventions

Reparative Therapy

Every year, thousands of people attend psychotherapy to "cure" themselves of the illness that is their sexual orientation or gender identity; unfortunately, such nostrums are not only ineffective but also represent a danger to the physical, emotional, psychological, and spiritual health of the client (Flentje, 2014; Schneider et al., 2002; Venn-Brown, 2000). According to Maccio (2010) the majority of those who seek out these services are largely driven by fear of negative family reactions to their sexual or gender minority status, adherence to religious fundamentalism, and increased spirituality. Attempts to modify one's innate sense of self are typically referred to as conversion therapy; however, due to the controversial nature of these practices, proponents commonly employ other terms, some innocuously worded, including reparative therapy, sexual orientation change efforts (SOCE), and ex-gay ministry (GLAAD, n.d.; Przeworski et al., 2021). According to Martell et al. (2004), the techniques are guided by the "assumption that heterosexuality is the only normal sexual orientation, that changing a person's sexual behavior is a moral imperative, and that clients' lives will be better if they live according to heterosexual norms" (p. 200). Although many therapists within the field of psychology contributed to the idea that sexual and gender minorities could be cured using psychoanalysis, reparative therapy gained significant support from various religious groups during the height of the counterculture movement of the 1960s (Baldock, 2014;

Bieber, 1962; Socarides, 1968). Michael Bussee, a co-founder of Exodus International, previously one of the most influential ex-gay organizations around the world, credited his experiences fielding prayer requests for a Christian telephone hotline as the impetus for the group. He recalled that whenever a queer individual contacted the number:

> The other hotline workers were trying to exorcise demons out of people, or they told the callers they were probably gay because they had been molested. I knew all this was wrong, from not only my own story, but from my education. We [the gay people answering the hotlines] were disturbed that there were support groups for all kinds of issues and nothing for gay people, so we began to field the calls coming in on the hotline from gay people and do the follow-ups. No one had been telling them that God loved them. All we wanted to do was reach out, affirm, and evangelize them. (Baldock, 2014, p. 284).

Bussee and his colleagues named the organization Ex-Gay Intervention Team (EXIT), but the name was changed to Exodus International in 1976. Initially, the purpose of the group was to provide support for LGBT individuals struggling with their sexuality; at this point, Exodus International did not engage in reparative therapy practices (Baldock, 2014). Eventually, several leaders had become aware of a book entitled *The Third Sex*, which had been written by Kent Philpott, a straight evangelist; in the tome, Philpott shared the stories of six men who, through religious conversion, were "delivered" from their sexual immorality and decided to incorporate these teachings into the organization's framework (Baldock, 2014). This shift was readily apparent in the mission statement adopted during a 1976 conference gathering; in part, it read, "EXODUS is an international Christian effort to reach homosexuals and lesbians.

EXODUS upholds God's standard of righteousness and holiness, which declares that homosexuality is sin and affirms His love and redemptive power to recreate the individual" (Grace, 2008, p. 548). In addition to Exodus International, several other reparative therapy groups were created to aid those who wanted to leave homosexuality behind, including the National Association for Research and Therapy for Homosexuality (NARTH), Love in Action (LIA), Love Won Out, and Homosexuals Anonymous (Baldock, 2014). For decades, these groups, often comprised of unlicensed providers, as well as countless other mental health professionals, promised radical change for their clients, many of whom paid exorbitant fees to secure treatment. According to leading reparative therapists, gay males could achieve liberation only by engaging in heterosexual activities and behaviors including:

> (1) participate in sports activities, (2) avoid activities considered of interest to homosexuals, such as art museums, opera, symphonies, (3) avoid women unless it is for romantic contact, (4) increase time spent with heterosexual men in order to learn to mimic heterosexual male ways of walking, talking, and interacting with other heterosexual men, (5) attend church and join a men's church group, (6) attend reparative therapy group to discuss progress, or slips back into homosexuality, (7) become more assertive with women through flirting and dating, (8) begin heterosexual dating, (9) engage in heterosexual intercourse, (10) enter into heterosexual marriage, and (11) father children. (Bright, 2004, pp. 473-474)

A plethora of techniques are utilized in reparative therapy including hypnosis, social skills training meant to facilitate gender appropriate behavior, cognitive-behavioral

strategies such as imagining contacting AIDS when experiencing the desire to engage in same-sex behavior, and other behavioral aversion practices which involve associating pain or nausea, through the use of electric shock or medication, with same-sex images that result in a participant's sexual arousal (Moss, 2014; Przeworski et al., 2021; Shidlo & Schroeder, 2002). Although supporters point to the testimonies of so-called ex-gays as anecdotal evidence of the efficacy of such remedies, studies of reparative therapy are vulnerable to substantial methodological flaws including sampling, observational, and social desirability biases exhibited by researchers and participants, lack of control groups, and poor generalizability (Grace, 2008; Martell, 2004; Moss, 2014; Przeworski et al., 2021).

In contrast, there is voluminous anecdotal and empirical evidence underscoring the potential harm associated with reparative therapy including increased depression, feelings of shame and guilt, self-loathing, decreased self-esteem, suicidality, familial and romantic relationship dysfunction, social withdrawal, substance misuse, high-risk sexual behaviors, and increased internalized homophobia (Beckstead & Morrow, 2004; Flentje et al., 2014; Jacobsen & Wright, 2014; Johnston & Jenkins; 2006). Moreover, an APA task force (2009) concluded that:

> The limited number of rigorous early studies and complete lack of rigorous recent prospective research on SOCE limits claims for the efficacy and safety of SOCE…These studies show that enduring change to an individual's sexual orientation is uncommon and that a very small minority of people in these studies showed any credible evidence of reduced same-sex sexual attraction, though some show lessened physiological arousal to all sexual stimuli. (pp. 42-43)

The task force also emphasized that attempts to implement SOCE violated several principles contained within the APA Ethics Code including Beneficence and Nonmaleficence (A), Justice (D), and Respect for People's Rights and Dignity (E) (APA, 2009).

Given the noteworthy risks associated with the provision of reparative therapy, one would likely be nonplussed by the number of mental health practitioners who either openly or tacitly endorse such measures. McGeorge et al. (2015) interviewed licensed family therapists (N = 762) regarding the ethical nature of conversion therapy; although only 3.5% of respondents reported having engaged in this practice, 19.4% of the sample considered orientation modification to be ethical and revealed that they would provide the services to clients. Similarly, Lingiardi et al. (2015) surveyed licensed psychologists (N = 3,135) and found that 58% of respondents would aid clients in attempting to repair their sexual identity.

Due to the considerable number of providers who willfully ignore or dismiss the harm incurred by conversion therapy processes, it is essential to implement institutional safeguards so that the well-being of clients is protected. Furthermore, academic programs should ensure that clinicians-in-training receive copious instruction in LGBTQIA+ affirmative psychotherapy while also explicitly eschewing any efforts to modify client sexual orientation and/or gender identity (Boroughs et al., 2015; Jimenez et al., 2018).

Even though extensive public uproar over the continuation of reparative therapy has resulted in legislation totally or partially banning the practice in twenty-one states, the District of Columbia, and Puerto Rico, a large contingent of mental health practitioners pathologize sexual and gender minorities while promoting disproven, anachronistic, and

dangerous theories which serve to threaten the safety of a community often disparaged by a society that prioritizes and uplifts conventional understandings of human sexuality and gender (MAP, 2021). Mallory et al. (2019) estimated that 698,000 LGBT adults had undergone conversion therapy, with half receiving the services as adolescents. Additionally, the authors contended that at least 16,000 sexual and gender minority youth would be forced into therapy to alter their identity in states which have not banned such practices. Finally, due to loosened restrictions which allow faith organizations to engage in SOCE efforts, it was estimated that 57,000 LGBT youth across the United States would interact with religious or spiritual leaders intent on employing reparative therapy (Mallory et al., 2019).

Affirmative Therapy

As the field of psychology, psychiatry, and social work have acknowledged the existence of various sexual and gender identities, there has been a movement towards providing LGBTQIA+ clients with a welcoming, affirming therapeutic experience; this is defined by Ellis et al. (2020) as:

> an approach to any form of mental health treatment that is aware of, accounts for, and is responsive to the unique effects and consequences of minority stress for AGM [affectional and gender minority] persons…practitioner actively affirming healthy and rewarding expressions of sexuality and gender identity, and challenging the individual's own strongly held internalized homo- or trans-negativity (p. 3).

By forging and maintaining a therapeutic alliance built upon the ideals of genuineness, empathy, and tolerance, the client can explore issues of self-identity within an

environment safe from the deleterious effects of institutional heterosexism and cis-normativity; in turn, this corrective relationship can exude a powerful force in the lives of sexual and gender minorities by providing coping skills and community supports with which to overcome obstacles (Edwards-Leeper et al., 2016; Ellis et al., 2020; Sue & Sue, 2016). Affirmative care also plays an integral role in helping the client reach self-validation and acceptance of their sense of identity, recognize and understand the role of minority stressors in their daily life, build resiliency in the face of continued adversity, challenges internalized homo- and trans-phobic beliefs, increasing connectedness to important community resources, and empowering the individual to engage in personal and group advocacy (Levenson et al., 2021).

The implementation of queer-affirmative psychotherapy has been correlated with a multitude of positive client outcomes including a reduction in symptoms of anxiety and depression, alcohol use, sexual compulsivity, increased condom use confidence and adherence, decreased suicidality, psychological well-being, clinician pro-LGBT attitudes, and counseling self-efficacy (Alessi et al., 2016; Alessi et al., 2019; Lange, 2020; Pachankis et al., 2015). Proujansky and Pachankis (2014) recommend that clinicians can create an affirmative practice by following several principles including:

> (1) normalizing the mental health impact of minority stress, (2) facilitating emotion awareness, regulation, and acceptance, (3) decreasing avoidance, (4) restructuring minority stress cognitions, (5) empowering sexual minority clients to communicate assertively, (6) validating sexual minority individuals' unique strength, (7) building supportive relationships, and (8) affirming healthy, rewarding expressions of sexuality. (p. 118)

As evidenced above, clinicians play a significant role in helping create a safe, supportive environment in which the LGBTQIA+ client may thrive.

Cultural Assimilator

History

Due to the potential for misunderstanding between varying groups due to differences in cultural values, beliefs, and norms, it is vital that all parties have access to information and training opportunities which help address and diffuse any conflict (Fiedler et al., 1971). A commonly employed modality is the cultural assimilator which was initially marketed as a method of introducing and acclimating a member of one country or cultural group to those from other populations; this is typically accomplished using between seventy-five and one hundred short vignettes (Brislin, 1986). Each story describes a problematic experience between two or more individuals, and the reader is asked to review several option choices and then choose the explanation which best explicates the root cause of the misunderstanding (Bhawuk, 1998; Brislin, 1986). If the individual chooses incorrectly, they will be provided information as to the present answer is inappropriate and then asked to choose again (Harrison, 1992). According to Fiedler et al. (1971) this provides a "rationale for interpreting the correctness or incorrectness of his reply and assist him in building up a frame of reference for handling similar situations" (p. 98). The cultural assimilator paradigm has received significant empirical support for its efficacy in expanding participant understanding of, and proficiency in navigating the complexity of, other cultures (Barrett & Bass, 1976; Dossett & Mitchell, 1971; Mitchell et al., 1972; Tolbert & McLean, 1995). Harrison (1992) conducted a study wherein government employees (N = 65) working within and outside of Japan were randomly

assigned to one of several conditions including viewing videotaped behavioral training, completing a cultural assimilator training, a combination of both the behavioral and cultural assimilator training, and no-training. It was determined that those who received the video and cultural assimilator trainings in tandem performed better in role-play scenarios and on learning measures related to Japanese culture than those in the no-training condition (Harrison, 1992). Bhawuk (1998) found that participants (N = 102) scored higher on a measure predicting future cultural behavior modification related to navigating between individualistic and collectivistic cultures after completing cultural assimilator trainings.

III. Original Contribution to Practice

Reintroduction of Topic

Although society has recently begun to exhibit increased tolerance and acceptance toward sexual orientation and gender minorities, this community continues to experience enormous amounts of individual and group marginalization linked to prejudice and discrimination (Embrick et al., 2007; Friedman et al., 2013; James et al., 2016; Solomon, 2015). Sadly, such encounters lead to significant physical, psychological, and behavioral health risks which threaten overall well-being (Baernstein et al., 2013; Casey et al., 2020; Meyer, 2008; Meyer et al., 2009). Moreover, LGBTQIA+ individuals also have unequal access to proper medical care (Lisy et al., 2018; Mohr & Fassinger, 2012; Rhodes & Yee, 2013; Zeeman et al., 2019), lack of contact with qualified, culturally competent mental health practitioners (Brems et al., 2006; Fullen et al., 2020; Jensen et al., 2020), decreased accessibility relating to costs, transportation, and distance (Jensen et al., 2020;

Johansson et al., 2019; Merwin et al., 2006), and hesitancy in seeking out care from rural medical providers due to previous negative encounters (Gottschalk, 2007; Rosenkrantz et al., 2017).

Also, significant numbers of clinicians are poorly trained in issues which affect sexual orientation and gender identity minorities; this is especially true for those who practice within a rural environment (Couture, 2017; Knight et al., 2014; Rutherford et al., 2012). In addition, many academic programs continue to perpetuate a paradigm extolling a heterosexist, gender binary framework, leading to graduates who are entirely incompetent in working with queer clients (Ida, 2007; Pachankis & Goldfried, 2013; Sue & Sue, 2016). Even more troubling is the bias exhibited toward the LGBTQIA+ by far too many clinicians (Cochran et al., 2007; Hayes & Erkis, 2000) which creates an unwelcoming setting that can result in substantial, long-term harm for at-risk clients (Eady et al., 2011; Israel et al., 2008; McKay & Watson, 2020; Semp & Read, 2015).

Goals of the Program

Due to the overwhelming obstacles faced by sexual orientation and gender minority clients when attempting to secure the services of a culturally competent mental health professional in a rural setting, it is essential that the latter have access to trainings which aid in exposing all forms of individual and group biases, while also helping introduce the clinician to the unique vernacular, various life experiences of, and challenges met by members of the queer community. By completing the current program, participants will gain an expanded perspective of a population often attacked and marginalized by multiple facets of society; in turn, such experiences will hopefully increase the clinician's background knowledge, comfortability, and skills required to aid

LGBTQIA+ clients in improving their mental health functioning. Furthermore, those who complete the training serve as a vital resource to other health professionals within their respective community who may feel ill-equipped to provide services to said population.

Importantly, for queer clients, especially those living in rural locales, access to qualified, affirming mental health professionals will prove instrumental in increasing the likelihood that sexual orientation and gender identity minorities will seek out necessary treatment that can have a pronounced impact on their physical, emotional, psychological, social, and spiritual functioning. As such, this connection between client and clinician can also serve as a crucial support system for the former, providing a safe harbor from which the individual can venture in their search for personal growth. Additionally, a knowledgeable clinician can share other social resources to the client so that they might be connected to other groups or organizations which can provide further support and a sense of community.

Program Overview

Prior to the beginning of the cultural assimilator training, participants will be asked to complete several assessments which measure clinician attitudes, knowledge, skills, and overall competency in working with LGBTQIA+ clients. Next, they will begin the online program wherein the individual is presented with various clinical scenarios and asked to read each. After the respective scenario has been perused, the reader will be asked a question relating to the presented situation; each query will be followed with four possible answer choices from which the individual will choose one. If an incorrect answer is chosen, the participant will receive feedback as to why and then they can choose a second option. When the correct answer is selected, an explanation will also be

provided to the reader. Each scenario should take between five and ten minutes to complete, so the initial time frame for the training will range from 25 to 50 minutes. However, as most cultural assimilators include between 50 and 100 scenarios, this program will continue to be expanded to meet these parameters. Therefore, the time required to complete this training will eventually be several hours.

The scenarios will consist of an interaction between a clinician and LGBTQIA+ client(s) wherein the latter reacts to the encounter in an unusual or negative manner. Then, four answer choices will be provided which attempt to explain the behavior, and the reader will be required to draw upon their general clinical knowledge as well as information related to the queer community to select the most appropriate response. The purpose of this training modality is to effectively illustrate the power of implicit and explicit biases in directing the participant's choices. An example of a clinical scenario, sample question, and four answer choices is as follows:

> During an initial intake session with Thomas Jones, Dr. Williams began by obtaining important demographic information from the client. Throughout most of this process, Thomas seemed relaxed and forthcoming. When inquiring about the client's romantic history, Dr. Williams asked Thomas if he was married, to which the latter responded in the affirmative. Dr. Williams then asked, "How long have you and your wife been together?" Thomas, who now looked uncomfortable, shifted in his chair and took a brief pause before replying, "We dated for about five years prior to getting married and we have been married for almost three years." Dr. Williams then proceeded to complete the remaining intake questions. After the end of the session, Dr. Williams praised Thomas for deciding to pursue

psychotherapy, informed him that he could schedule his next session with the receptionist before leaving, and indicated that he looked forward to working together. Thomas thanked Dr. Williams and left the office. Later, Dr. Williams was looking through his appointment calendar and noticed that there was no follow-up meeting scheduled for Thomas. He asked his receptionist about this and was informed that Thomas said that he would call later to schedule the appointment. However, this never occurred.

Question: Why do you believe that Thomas decided against scheduling another session with Dr. Williams?

Answer Choices:

- **A.** Thomas and his spouse have recently encountered interpersonal conflict and when Dr. Williams asked about his marital status, he was aware of overwhelming anxiety. Therefore, Thomas decided against pursuing any further psychotherapy to avoid experiencing these feelings again.
- **B.** Thomas forgot to bring his calendar to the appointment and wanted to review it so that there were no scheduling conflicts.
- **C.** Thomas was upset by Dr. Williams's assumption of his spouse's gender and decided against seeking further therapy services with him.
- **D.** Thomas felt that Dr. Williams was too rigid and impersonal during the initial intake session, so he decided against scheduling a follow-up appointment.

Please see Appendix C for additional clinical scenarios.

Implementation

Target population

In order to determine the efficacy of the current training program, eligible participants must be members of the mental health profession, including, but not limited to, licensed master's or doctoral level clinical or counseling psychologists, licensed clinical social workers, and psychiatrists who provide services to rural clients, especially those who identify as LGBTQIA+. Additionally, students enrolled in accredited, graduate mental health programs may also take part in the completion of the training program. Ideally, the number of subjects for the initial training group is 40 with an additional control group of 40 members.

Accessing the target population

Due to the somewhat controversial nature of the material included in the current program, it might be difficult to obtain an adequate number of participants. One potential method of obtaining program subjects is to employ the aid of websites like SurveyMonkey or Amazon Mechanical Turk; however, self-selection techniques can be problematic for ensuring generalizability as it increases the likelihood of biased volunteer participation. Instead, simple random sampling will be employed to determine membership into either the experimental or control group which, in turn, will improve the internal validity of the program. Therefore, it will be necessary to obtain membership lists from professional mental health organizations which can include the Kentucky Psychological Association (KPA), the Kentucky Counseling Association (KCA), and the Kentucky chapter of the National Association of Social Workers (NASW); after securing

such information, each potential subject will be issued a number and a computerized randomizer will be used to assign participants to the experimental and control groups.

Following this, each participant will be contacted via e-mail address with an invitation to take part in the training; it will be vital to provide a thorough explanation of the program's purpose and importance in improving clinician competency and confidence in working with members sexual orientation and gender identity minority clients. Furthermore, the e-mail will include information relating to informed consent and participant confidentiality. If the contacted individual decides to take part in the program, a link to the training program will also be included in the e-mail.

Measures used

To determine the effectiveness of the current program, a pretest-posttest design will be conducted; therefore, members of both the experimental and control groups will be asked to complete several measures which evaluate clinician knowledge, skills, attitudes, and competency when working with the LGBTQIA+ community prior to the implementation of the training. Following the implementation of the cultural assimilator, both groups will again complete the measures to ascertain whether participation in the training led to changes in clinician beliefs or proficiency. Due to the complex variability of sexual orientation and gender identities within the queer community, it is necessary to incorporate multiple measures into the current program.

Bidell (2017) created the 18-item Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) to measure clinician preparedness, attitudinal awareness, and basic knowledge about healthcare related discrimination and prejudice experienced by this population; the self-report LGBT-DOCSS employs a 7-

point Likert scale ranging from *strongly disagree* (1) to *strongly agree* (7) (Bidell, 2017). Furthermore, the LGBT-DOCSS has demonstrated strong overall internal consistency (α = .86) as well as good internal consistency for each subscale including clinician preparedness (α = .88), attitudinal awareness (α = .80), and basic knowledge (α = .83) (Bidell, 2017). In addition, the instrument has a two-week test-retest reliability of .87 (Bidell, 2017).

Although the LGBT-DOCSS includes questions related to working with trans individuals (Bidell, 2017), participants in the current program will also complete the Gender Identity Counselor Competency Scale (GICCS) which was created by Dispenza and O'Hara (2016) to measure clinician competency with such clients. The GICCS is a 29-item self-report instrument which asks respondents to rate statements on a 7-point Likert scale ranging from *not at all true* (1) to *totally true* (7) and includes three subscales related to clinician attitudes, knowledge, and skills (Dispenza & O'Hara, 2016). Additionally, the GICCS has a strong overall internal consistency (α = .83) including among the attitudes (α = .84), knowledge (α = .76), and skills (α = .79) subscales (Dispenza & O'Hara, 2016; Cor, 2016).

Addressing potential costs

As with any novel training program, it is imperative that a thorough cost analysis is conducted to determine the economic feasibility of the undertaking. For the current training program, it will be necessary to secure the services of a web developer who, on average, will be paid between $50 and $100 per hour worked; therefore, the total cost for the project will depend on its overall complexity (thumbtack.com, 2020). Furthermore, the average annual cost for web hosting and domain fees are $96 and $15, respectively

(thumbtack.com, 2020). If this route is chosen, the developer will be tasked with coding the software required for the program as well as creating a user-friendly interface (thumbtack.com, 2020). When additional scenarios are written, it will be necessary to again employ the aid of a web developer to reflect new materials. The period required to complete the initial creation of the website, including software, will span from three to six weeks (C. Dehart, personal communication, July 6, 2021). Overall, the total cost for these services is estimated at $6,000.00 (C. Dehart, personal communication, July 6, 2021).

However, employing a self-directed, e-learning web development subscription service is another viable choice. By employing this modality, the program creator could reduce the overall cost of development. There are a significant number of companies that provide such an option including Tutor LMS; this service would allow for the creation, maintenance, and modification of the cultural assimilator training (themum.com, n.d.). Moreover, the total lifetime subscription cost for Tutor LMS is $399, which provides "1 site license, lifetime updates, 30-minute video call support, priority email support, and 1 free installation service" (themum.com, n.d.). This package does not include web hosting and domain fees, so these costs must also be considered.

Potential funding sources

Securing funding the creation of the cultural assimilator training is of paramount importance. Thankfully, professional organizations including the American Psychological Association provides various financial grants that would prove integral in defraying the total costs associated with the program. For instance, early career psychologists can apply for the American Psychological Fund Visionary Grants which

"support research, education and intervention projects and programs that use psychology to solve social problems…understanding and eliminating stigma and prejudice (e.g., race, gender, sexual orientation, religion, age, disability and socioeconomic status)" and provide up to $20,000 that can be used to provide project funding (apa.org, 2021). Many other multicultural themed awards are available including the *Wayne F. Placek Grants*, which provides up to $9,000 to "support empirical research from all fields of the behavioral and social sciences on any topic related to lesbian, gay, bisexual, or transgender issues" (apa.org, 2021).

Furthermore, it is expected that the training will be offered to clinicians for a nominal fee. According to the Kentucky Revised Statutes (KRS), licensed psychologists practicing within the state of Kentucky are required to "at least thirty-nine (39) continuing education hours approved by the board pursuant to this administrative regulation within each three (3) year period" (The Kentucky Board of Examiners of Psychology, 2019). If the current training were approved by the Kentucky Psychological Association as a continuing education credit, the cost of program creation could be offset by fees charged to those who complete the course.

Evaluation of Program Efficacy

Program stakeholders

According to Posavac and Carey (2007), stakeholders are "those people who are personally involved with the program, derive some of their income from it, sponsor it, or are clients or potential recipients of the program's services" (p. 30). The two most important stakeholder groups within the current program are the clinicians who participate in the cultural assimilator training as well as LGBTQIA+ clients. Although the

model has been developed with a special focus on rural providers, the training will also prove useful for any mental health practitioner no matter their geographic locale.

Needs of stakeholders

It is essential to accurately determine the unique needs of all stakeholders who utilize or might be affected by the current program. Therefore, to gain a better understanding of how the program could be most helpful for both populations, I plan on employing the use of written surveys as this technique provides a wealth of information in a cost-effective manner (Posavac & Carey, 2007). The surveys will be made available to both clinicians and LGBTQIA+ clients in an electronic format.

Providers will be provided an opportunity to describe their education and training in relation to the needs of the queer community, their experiences working with this population, clinical strengths as well as areas of growth, and issues with which they would like to gain competency in addressing. To address the unmet needs of sexual orientation and gender identity minorities, I plan on reaching out to various LGBTQIA+ groups and organizations and request that the electronic survey is distributed amongst their respective membership. In addition, it might be useful to request that providers share the survey information with queer clients. Important data that can be gleaned from the completion of client surveys include past and current experiences with mental health practitioners including positive and negative interactions, issues of importance in their individual lives as well as the rural LGBTQIA+ community, and how the current program could improve the relationship between providers and minority clients.

Continuing contact with stakeholders

An essential method of measuring of the current program's efficacy is to maintain appropriate contact with the various stakeholders to follow-up on individual outcomes for the providers who completed the training as well as their LGBTQIA+ clients. This will be accomplished via the utilization of post-program surveys and completion of the LGBT-DOCCS and GICCS by the providers six months following their participation in the training. Furthermore, the clinicians will be asked to share a survey with their sexual orientation and gender identity minority clients so that these individuals can disclose their perception of the provider's knowledge of, and competency in addressing, LGBTQIA+ issues. In addition, the clients will be asked to describe in what ways, if any, the therapeutic alliance has improved over time.

Evaluation questions

To adequately measure the usefulness of the current program, there are a plethora of questions which need to be asked of participants; the purpose of these inquiries is to provide a qualitative analysis of the effect of the training on clinician knowledge, awareness, and skills in working with sexual orientation and gender identity minority clients. Examples of potential questions include, but are not limited to: In what ways did the training enhance the clinician's understanding of the unique experiences and challenges faced by the LGBTQIA+ community? How can issues of oppression and privilege be effectively incorporated into treatment plans? Has the training helped the clinician in recognizing their own explicit or implicit biases toward this population? Was the clinician aware of any particularly salient thoughts and feelings related to the

material? Does the clinician feel more competent in working with queer clients? In what ways could the training be improved?

Evaluation method

Prior to the initial training, members of the experimental and control groups will be asked to complete the LGBT-DOCSS and GICCS to measure their knowledge, awareness, and competency in working with the LGBTQIA+ community. Participants will be requested to complete these measures again at a 3- and 6-month follow-up to determine long-term efficacy of the program. Additionally, the clinicians will be asked to provide the aforementioned survey materials to their respective clients to obtain information about the latter's perception of the former's ability to provide adequate and appropriate services to those who identify as LGBTQIA+.

Summary

Given that sexual orientation and gender identity minorities face significant social, religious, political, and medical prejudice and discrimination, the current program was created to provide vital training to rural clinicians so that they are amply equipped to meet the needs of this populace. A knowledgeable, skilled mental health practitioner will be better positioned to aid those who oftentimes feel invisible and marginalized by a society which lacks understanding and acceptance of the "other." However, as previously evidenced, many clinicians receive insufficient education and training about LGBTQIA+ issues. Even more problematic is the fact that some graduate programs present clinicians-in-training with curriculum which continues to perpetuate a heteronormative and cissexist perspective. Therefore, it is hoped that this training can augment such clinical instruction.

Furthermore, the proposed program can be completed at a pace that is suitable to the participant's schedule. Due to the self-directed framework of the cultural assimilator, the individual can complete the training in a comfortable environment without the specter of making mistakes and experiencing judgment from others. Additionally, although not entirely exhaustive, the current program will provide copious amounts of information from which the participant can derive a greater understanding of the psychological needs and life experiences of the queer community.

Although the current program has multiple strengths, attention must also be focused upon any possible limitations. Firstly, even though the proposed assimilator will provide participants with an opportunity to broaden their awareness of LGBTQIA+ culture and clinical needs, it does not guarantee personal or professional growth. Secondly, obtaining a significant sample size of rural clinicians might be problematic given the continued bias exhibited by many segments of these bucolic communities; therefore, some providers may be either unaware of the utility of such a program or unwilling to supplement their current level of education and training in relation to queer clientele. Lastly, given the progressive nature of queer language and culture, it will be necessary to consistently modify the cultural assimilator and associated materials to accurately reflect evolving mores.

Future Directions

Although the current program was designed to provide supplemental training for rural clinicians working with LGBTQIA+ clients, it is my hope that the materials prove useful for any mental health practitioner regardless of geographic location. Therefore, the pilot study will be expanded to include providers living outside of rural locales so that the

efficacy of the cultural assimilator can be further examined. By doing so, the generalizability of the initial study's results can be confirmed.

Also, a list of queer-affirming resources will be added to the program so that clinicians have access to auxiliary information helpful to ensuring continued cultural competency. While this would prove useful to any clinician, it is especially important for those living in a rural atmosphere due to the potential dearth of other service providers. The materials can also be shared with clients who may not have been aware of the existence of such organizational and community groups thereby providing additional social support networks.

Finally, a smartphone companion application will be made available to clinicians so that providers will have access to regularly updated terminology, resources, research, and additional scenarios related to the LGBTQIA+ community. Again, this would better equip mental health practitioners with the most up-to-date information necessary required to provide affirming, empirically supported services to this population. Moreover, a cellphone application modality will prove convenient given our society's predilection to technology.

Conclusion

Even as many societies across the globe continue to adopt a more tolerant, affirming stance toward their sexual orientation and gender identity minority citizenry, extant discriminatory, prejudicial actions continue to threaten the well-being of this oft marginalized and mistreated population. Furthermore, given the prolonged physical, emotional, and psychological effects of such horrific treatment, it is imperative that mental health service providers are cognizant of the potential risks posed by poorly

trained clinicians who lack the awareness, skills, and knowledge required to effectively interact with queer clients. The current project provided a thorough literature review of many salient, pressing issues affecting the LGBTQIA+ community, the deficiencies of current educational and training programs, and the importance of culturally competent clinicians. Furthermore, the inclusion of a queer-specific cultural assimilator model was intended to provide additional instruction and guidance for mental health providers who lack sufficient competency within this area of practice. By meeting the unmet training needs of the rural clinicians, it is theorized that this will also prove advantageous for sexual orientation and gender identity minority clients. Finally, an in-depth evaluation framework was introduced so that the program could be measured for efficaciousness and efficiency.

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Appendix A

Minority stress processes in lesbian, gay, and bisexual populations

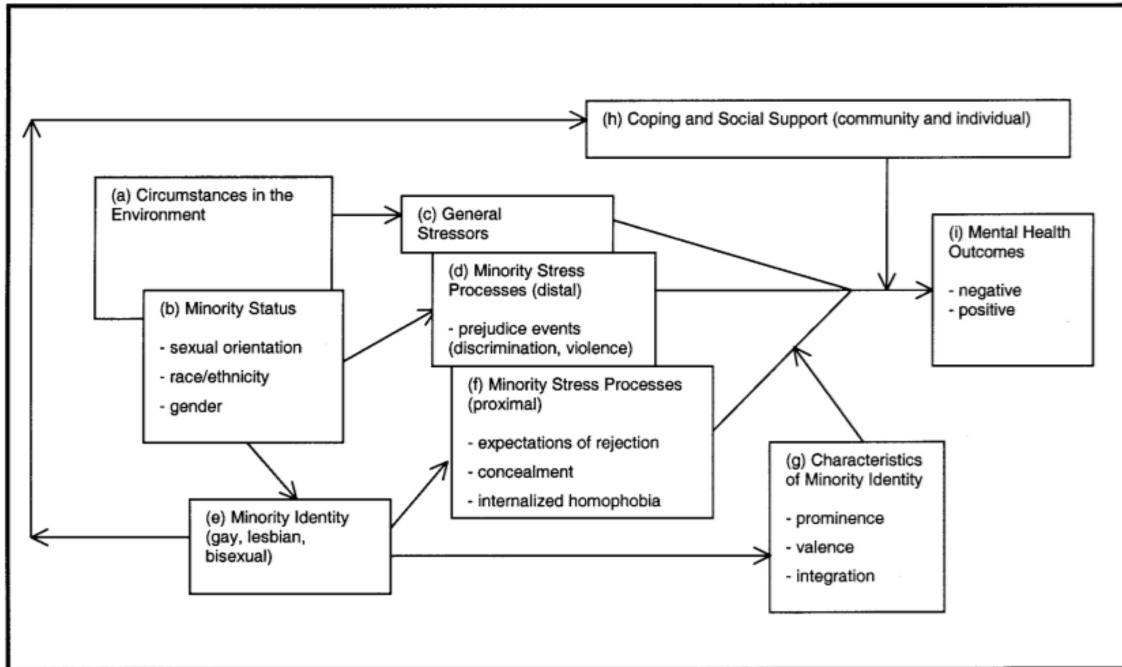
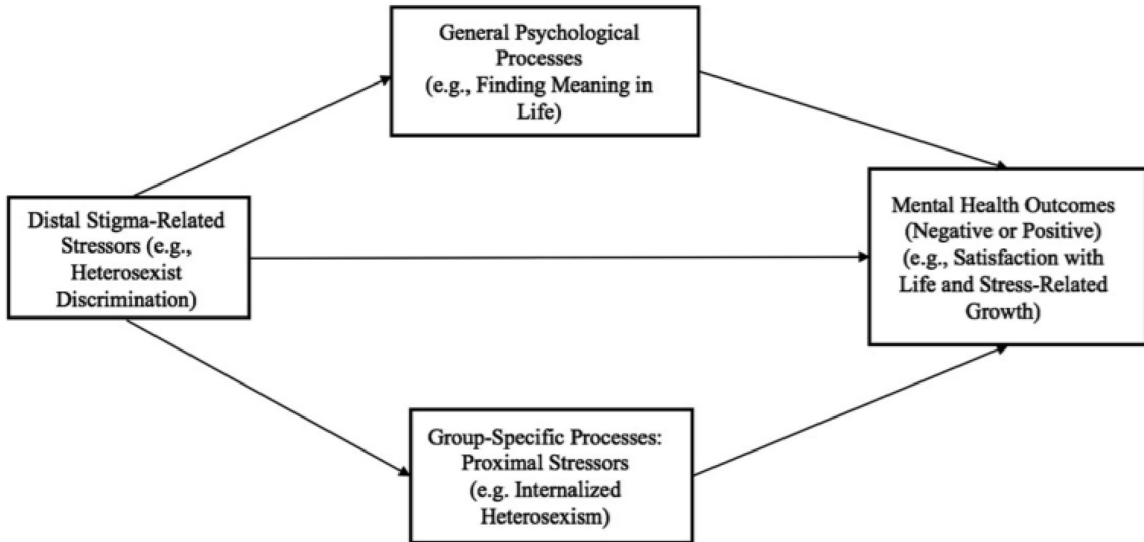


Figure 1. Minority stress processes in lesbian, gay, and bisexual populations.

Appendix B

Hatzenbuehler Integrative Mediational model



Appendix C

Sample cultural assimilator scenarios

Scenario 1:

During an initial intake session with Thomas Jones, Dr. Williams began by obtaining important demographic information from the client. Throughout most of this process, Thomas seemed relaxed and forthcoming. When inquiring about the client's romantic history, Dr. Williams asked Thomas if he was married, to which the latter responded in the affirmative. Dr. Williams then asked, "How long have you and your wife been together?" Thomas, who now looked uncomfortable, shifted in his chair and took a brief pause before replying, "We dated for about five years prior to getting married and we have been married for almost three years." Dr. Williams then proceeded to complete the remaining intake questions. After the end of the session, Dr. Williams praised Thomas for deciding to pursue psychotherapy, informed him that he could schedule his next session with the receptionist before leaving, and indicated that he looked forward to working together. Thomas thanked Dr. Williams and left the office. Later, Dr. Williams was looking through his appointment calendar and noticed that there was no follow-up meeting scheduled for Thomas. He asked his receptionist about this and was informed that Thomas said that he would call later to schedule the appointment. However, this never occurred.

Question: Why do you believe that Thomas decided against scheduling another session with Dr. Williams?

Answer Choices:

B. Thomas and his spouse have recently encountered interpersonal conflict and when Dr. Williams asked about his marital status, he was aware of overwhelming anxiety. Therefore, Thomas decided against pursuing any further psychotherapy to avoid experiencing these feelings again.

Feedback: You selected A. Although discussing difficult issues in psychotherapy can be emotionally evocative for a client, there was no information provided in the scenario to indicate that Thomas was experiencing relationship problems. Please choose again.

B. Thomas forgot to bring his calendar to the appointment and wanted to review it so that there were no scheduling conflicts.

Feedback: You selected B. While it is reasonable to conclude that a client would want to refrain from making an appointment without ensuring there would not be a scheduling conflict, it is unlikely that Thomas would have forgotten to contact the office as he had indicated to Dr. Williams and the receptionist that he would do so. Please choose again.

C. Thomas was upset by Dr. Williams's assumption of his spouse's gender and decided against seeking further therapy services with him.

Feedback: You selected C. This is the correct choice. As a gay male, Thomas was taken aback by Dr. Williams's presumption of the client's heterosexual identity. Within many communities, heteronormative, cisgender standards dictate the ways in which individuals perceive romantic relationships and societal institutions including marriage. Therefore, sexual orientation and gender identity minorities are often bombarded by microaggressions like the one exhibited by Dr.

Williams. Even when unintentional, such statements are hurtful, invalidating, and damaging to the physical, emotional, and psychological well-being of LGBTQIA+ individuals. If an incident of this nature occurs, the client might decide to seek out another provider or abandon psychotherapy altogether. Therefore, it is important that clinicians never attempt to assume aspects of the client's identity, and, instead, use inclusive, gender-neutral language. Moreover, when a clinician mistakenly employs problematic language, the best course of action is to apologize to the client while also seeking out resources to become more culturally competent.

D. Thomas felt that Dr. Williams was too rigid and impersonal during the initial intake session, so he decided against scheduling a follow-up appointment.

Feedback: You selected D. Because intake sessions are often highly structured and formal, clients may perceive that the clinician is unfriendly or uninterested. However, as Dr. Williams was described as lauding the client's decision to pursue therapy while also seeming excited about future clinical interactions, it is unlikely that this was factored into Thomas' choice to not seek treatment. Please choose again.

Scenario 2:

Whitney Jones was attending psychotherapy with Terry Andrews, LCSW, to aid in alleviating symptoms of depression. After beginning their weekly psychotherapy session, Terry was aware that Mrs. Jones was slightly less talkative than usual. Typically, Mrs. Jones was highly engaged and had previously expressed how helpful the process was in reducing her feelings of sadness. However, Terry continued with that day's agenda

instead of asking Mrs. Jones about her behavior; instead, she administered the Beck Depression Inventory (BDI) to the client and found that the score was in the normal range indicating low levels of depression. Halfway through the session, Mrs. Jones expressed excited about attending an upcoming function at her church. This struck Terry as odd, and she responded, "Hmmmm…I would not have guessed that you would be that into religion." Mrs. Jones asked why she thought this, and Terry said, "Well, because you are a lesbian and most churches are anti-LGBTQIA+. It just seems weird that you would want to be a part of something that isn't accepting of everyone." Instead of replying to Terry, Mrs. Jones nodded her head and quickly changed the subject to another topic. Throughout the remainder of the session, Mrs. Jones offered brief answers to Terry's inquiries with no elaboration. Later, while Terry was writing her session note, she thought back to how quiet Mrs. Jones had been during the appointment and wondered why this was the case.

Question: What might account for the client's decision to refrain from engaging in the psychotherapy session?

Answer Choices:

A. Mrs. Jones was preoccupied with having to help plan her church's upcoming social function, so she was not as invested in the therapy process during this session.

Feedback: You selected A. Although Mrs. Jones had shared information about feeling excited about this event, there was no mention of her role in relation to its planning. Even though it is likely that clients are not talkative at times, Terry did not ask any probing questions after initially noticing Mrs. Jones behavior. Please

choose again.

B. Mrs. Jones was offended by Terry's statement about her church attendance and did not feel comfortable participating in the remainder of the session.

Feedback: You selected B. This is the correct choice. Although some organized religious groups are unaccepting of or hostile toward the LGBTQIA+ community, many faith traditions and Christian denominations have reevaluated their teachings on human sexuality and gender identity. Therefore, more and more sects are engaging with the queer community in an affirming manner. Although the history between religion and sexual orientation and gender identity minorities is replete with stories of humiliation, guilt, and mistreatment, it is important to remember that many queer folx find comfort and support within their respective faith communities. Others, who might eschew traditional religious beliefs and practices, espouse a spiritual identity which helps them find personal meaning and purpose. Terry's ill-informed statement invalidated the significance that Mrs. Jones places on religion or spirituality while also conveying judgement for her decision to attend church services. Thus, Mrs. Jones was likely frustrated and hurt by these comments, resulting in her remaining atypically reserved during the remainder of the session.

C. Mrs. Jones had decided to terminate therapy with Terry and was nervous about informing her of this information.

Feedback: You selected C. Although it would likely be anxiety-evoking to inform one's therapist about the decision to stop attending therapy, there was no indication that Mrs. Jones had decided to do so. In fact, she was described as a

"highly engaged" client. Even though she was quieter during the first portion of the session than normal, she had later exhibited excitement about the upcoming church function. Following Terry's statement about her church attendance, Mrs. Jones became disengaged and less communicative. Please choose again.

D. Mrs. Jones was experiencing acute symptoms of depression, leading to her disengaged behavior.

Feedback: You selected D. While it would be reasonable to suspect that a client's detached state might be due to depression, psychotherapy had helped reduce Mrs. Jones symptoms. Furthermore, she expressed excitement about participating in her church's social function which denotes the absence of anhedonia. Finally, Mrs. Jones scores on the BDI were in the normal range. Therefore, it is unlikely that her behavior was due to symptoms of depression. Please choose again.

Scenario 3:

Dr. Moreno had been providing psychotherapy services to James McBride for several months; Mr. McBride, who identifies as a bisexual male, reported experiencing significant anxiety whenever he is in social situations. Throughout the course of therapy, Mr. McBride had revealed to Dr. Moreno the fact that he was not out to his family and had no plans to do so. Dr. Moreno theorized that the source of Mr. McBride's anxiety was the inability to share his sexual orientation identity with his relatives and has repeatedly urged him to come out. On each occasion, Mr. McBride denied that this was the source of his feelings of anxiousness. During their most recent session, Mr. McBride was recalling an incident in which he had agreed to attend a party with other friends who identify as LGBTQIA+. After arriving to the event, he was overwhelmed with panic and

decided to leave. Again, Dr. Moreno informed him that she believed he would feel less anxious if he were honest with his family about his bisexuality. Frustrated, Mr. McBride screamed out, “That’s not my damn problem, so stop making me feel like it is!” Dr. Moreno, shocked by this unusual outburst by the client, stared at him in silence. He started crying and ran out of her office.

Question: Why did the client become frustrated with Dr. Moreno during the session?

Answer Choices:

A. Mr. McBride is tired of feeling pushed to come out to his family by his therapist.

Feedback: You selected A. This is the correct choice. While many individuals decide to share their sexual orientation and gender identity with friends, family members, and others, some do not. There are many reasons one might not publicly disclose their queerness including fear of negative reactions and rejection by loved ones, loss of employment, societal ostracization, or simply a desire to retain a sense of privacy. Some members of the LGBTQIA+ community choose to come out to certain people in their lives, but not others. Although research findings suggest that disclosing one’s sexual orientation and gender identity status can lead to a sense of relief, improved psychosocial well-being, and reduced internalized homo- and trans-negativity, the process is highly personal and the individual should never feel coerced to undertake such action. Although Dr. Moreno’s exhortations were likely based upon an honest desire to aid her client in reducing his levels of anxiety, many therapists automatically assume that symptoms of a mental disorder exhibited by sexual orientation and gender

minorities are directly associated to their identity status. Mr. McBride reported experiencing anxiety in multiple social encounters, including attending the party with friends who also identified as members of the LGBTQIA+ community; however, Dr. Moreno focused attention on the client's decision not to disclose his identity to family, resulting in a rupture in the therapeutic alliance.

B. Mr. McBride is unsatisfied with the relationship he currently has with his family members and became emotionally overwhelmed during the session.

Feedback: You selected B. Even though many queer folx face significant levels of familial conflict related to their identity, there is no indication that this is the experience for Mr. McBride. Furthermore, according to the scenario description, he was attending therapy to address social anxiety. Please choose again.

C. Mr. McBride's was emotionally distraught due to feelings of internalized homonegativity, causing him to displace his anger onto Dr. Moreno.

Feedback: You selected C. Most societies are based upon heteronormative, cissexist beliefs, values, and norms which perpetuate negative stereotypes, falsehoods, and stigmatization about any group who does not perfectly exemplify these ideals. For many sexual orientation and gender identity minorities, consistently encountering such hateful discourse results in the internalization of these messages. Oftentimes, this leads to significant feelings of personal shame, guilt, and self-hatred of one's identification as a member of the queer community. In turn, the individual is at increased risk physical, emotional, and psychological health problems, as well as difficulties creating and maintaining social

relationships. Although it might be reasonable to conclude that Mr. McBride has experienced internalized homonegativity to some extent, during his life, there is no indication that this led to his outburst during the session. Please choose again.

D. Mr. McBride did not come out to his family as bisexual because he has been unable to accept that he is gay. Therefore, he felt uncomfortable when Dr. Moreno brought up this issue, resulting in his outburst.

Feedback: You selected D. Many myths continue to be promulgated about bisexual people, even within the queer community. Such falsehoods include, but are not limited to, the belief that bisexuality does not exist, those who identify as bisexual are just confused about their identity, they are going through a "phase" and will eventually decide to identify as lesbian or gay, and bisexual individuals are promiscuous. Although some gay or lesbian people might initially identify as bisexual in order to reduce their own feelings of discomfort related to sexual orientation, sexuality is viewed by many as having a dimensional quality with bisexuality representing just one of many possible statuses. There is no indication that Mr. McBride is struggling to accept his bisexual identity. Please choose again.

Scenario 4:

James Wynn, a Black male in his early twenties, has been attending psychotherapy with Dr. Jonathan Milton, to deal with resultant trauma from a past automobile accident. During a recent session, the two were discussing Mr. Wynn's fear of experiencing panic attacks whenever he had to drive to work. While informing Dr. Milton that his boyfriend, Richie, had been helpful in those moments by offering to transport him, he indicated an

awareness that this was not tenable in the long-term. Dr. Milton, a White, gay male, said, "That is really kind of Richie. Many gay guys would love to find such a thoughtful partner!" Mr. Wynn replied, "Yeah, he is great. My family is always telling me how lucky I am to have found him. But, I am not gay." Dr. Milton said, "Of course you are, we were just talking about how great your boyfriend is." Mr. Wynn shook his head and said, "Yeah, he is my boyfriend, but we aren't gay." Dr. Milton laughed and replied, "That makes no sense to me. How can you have a boyfriend and not consider yourself a gay man? I am sensing that you might be a little confused. Maybe you hit your head a bit harder than we thought in that accident." Mr. Wynn, who was now very frustrated, said, "How dare you! I am not confused at all, and I don't have to deal with your condescending attitude." He immediately walked out of the room, leaving a nonplussed Dr. Milton wondering what had just happened.

Question: Why did Mr. Wynn become frustrated with Dr. Milton?

Answer Choices:

A. Mr. Wynn was upset because Dr. Milton seemed romantically interested in his boyfriend, Richie; feeling that this was completely inappropriate, he decided to leave the appointment before Dr. Milton could make any additional comments.

Feedback: You selected A. Although Dr. Milton referred to Richie as "thoughtful," his rather innocuous statement did not denote any romantic interest or intent. It is unlikely that Mr. Wynn's reaction was based in feelings of jealousy. Please choose again.

B. Dr. Milton's assertion that Mr. Wynn was gay threatened his sense of masculinity, resulting in the outburst.

Feedback: You selected B. Many LGBTQIA-POC experience additional stressors, including negative reactions from their respective families and communities, based upon the intersection of their racial or ethnic identity and sexual orientation or gender identity status; this is especially true for Black and Hispanic males who are expected to uphold traditional ideals of masculinity. However, these experiences cannot be generalized to all LGTQIA-POC individuals. Furthermore, from Mr. Wynn's statements, there seems to be no incongruence related to his sense of masculinity. Please choose again.

C. While discussing the need to resume driving himself to work, Mr. Wynn experienced a panic attack and extricated himself from the situation to avoid these feelings.

Feedback: You selected C. Even though emotional avoidance is a common reaction to the recollection of traumatic memories, Mr. Wynn did not seem troubled when discussing his need to drive himself to work. Instead, his frustration with Dr. Milton was the result of the latter's contention that Mr. Wynn was a gay male. Additionally, the scenario did not describe Mr. Wynn as experiencing any symptoms of a panic attack. Please choose again.

D. Dr. Milton's labeling of Mr. Wynn as a gay male did not accurately reflect the latter's sense of sexual orientation identity.

Feedback: You selected D. This is the correct choice. For some LGBTQIA-POC, many commonly used terms used to denote sexual orientation and gender identity are based upon a Eurocentric worldview, reflecting White culture. Unfortunately, racism and ethnic prejudice and discrimination are far too often encountered by

LGBTQIA-POC even within the context of the larger queer community. As such, terms like "gay" and "lesbian" do not accurately reflect the lived experiences of this community. Instead, alternative Afrocentric terms are sometimes used including "same-gender loving" or "men loving men." Furthermore, some individuals who have sexual relationships with same-sex partners do not assume a sexual orientation minority status; it is important to remember that issues of sexuality and gender identity are quite complex. Dr. Milton's repeated attempts to reinforce the use of a term associated with a movement that often excluded people of color likely made Mr. Wynn feel invalidated and uncomfortable. Additionally, Dr. Milton's ignorance of the history of such terminology might also have resulted in the client's belief that the former was ill-equipped to meet his clinical needs. Therefore, it is important that clinicians never assume a client's sexual orientation and gender identity status, while also maintaining awareness of various terms that might be employed.

Scenario 5:

Tony Roberts, a trans male, and his partner, Lisa Holt, who identifies as a lesbian, are attending psychotherapy with Dr. Sandra Locke, a straight therapist who specializes in couples counseling. Tony and Lisa have been dating for nine years but are experiencing conflict due to issues of personal intimacy and a recent move due to Lisa's job. Dr. Locke, who considers herself a LGBTQIA+ ally, was thrilled to work with her first queer couple. Two weeks after commencing treatment, although Tony and Lisa indicated that they enjoyed engaging in the therapy process, they voiced concern that their relationship was failing to improve. Therefore, Dr. Locke recommended a book that details ways that

couples can improve communication and intimacy. Tony and Lisa were excited as Dr. Locke walked over to her desk and retrieved a copy for each person; after handing them the books, she said, “Your homework for next week is to read chapter one and we will talk about your reactions to the material.” As Tony was skimming through the book, he realized that it was written by a straight, cisgender couple. When he brought this to Dr. Locke’s attention, she said, “Oh, I think it is still a useful book. After all, at the end of the day, a relationship is a relationship, right?” He replied, “I guess that is true.” Dr. Locke responded, “I think you two will love reading this together.” As Tony and Lisa were leaving Dr. Locke’s office, she said goodbye and added, “Oh by the way, do not worry about paying for the books today. The receptionist can send you a bill later.” A few days before their next scheduled appointment with Dr. Locke, Lisa called and cancelled. Unfortunately, they never returned to Dr. Locke’s practice.

Question: Why did Lisa and Tony decide to discontinue services with Dr. Locke?

Answer Choices:

A. The couple was upset that Dr. Locke requested payment for the two books that they were asked to read.

Feedback: You selected A. While some clinicians may ask that clients purchase books or journals that will be used in therapy, others, to reduce incurred costs, might provide the book for free or allow the client to borrow the text. As it is important that providers consider the individual financial capabilities of each client as well as ethical guidelines regarding gifting items, Tony and Lisa may have been frustrated that Dr. Locke assumed they could afford the books. However, there is a better answer choice. Please choose again.

B. Dr. Locke's book recommendation did not meet the couple's needs and brought into question her ability to provide adequate services to Tony and Lisa.

Feedback: You selected B. This is the correct choice. Even though same-sex and heterosexual relationships share many qualities in common like the desire to enter into a loving, committed partnership, there are also significant differences between the two including the ways in which gender differences affect partner roles, household duties, and parenting; sexual intimacy, finances, and extant societal stigma and discrimination. Additionally, some LGBTQIA+ individuals eschew the idea of monogamy or traditional marriage, as it is equated with heteronormative values. In essence, no two relationships, whether straight or queer, look exactly alike. Moreover, Dr. Locke's contention that the book would prove useful for Lisa and Tony's conflict did not take into account the unique dynamics and challenges found in their relationship. While her message might be construed as an endorsement or acceptance of all types of relationships, this statement also served to invalidate Tony's concerns that it the book was written for a straight, cisgender audience. If a queer couple encounters a therapist who engages in such behavior, even when it is unintentional, they are likely to feel a great deal of uncertainty as to the latter's competency in providing adequate services to LGBTQIA+ clients.

C. Tony and Lisa decided that they would attempt to repair their relationship without employing the aid of a therapist.

Feedback: You selected C. While it might be reasonable to conclude that some couples determine that therapy is not beneficial, Tony and Lisa were described finding meaning in the process. Additionally, they were initially excited to read the book recommended by Dr. Locke. Please choose again.

D. Tony and Lisa did not wish to continue therapy with a straight therapist.

Feedback: You selected D. For many LGBTQIA+ clients, there is a desire to participate in therapy with a clinician who also identifies as a member of the community. Even though this does not guarantee a positive outcome, a queer clinician is more likely to understand issues of sexuality and gender identity. Additionally, having shared life experiences can aid in building rapport between clinician and client which is integral in helping the latter meet their therapy goals. However, if a straight, cisgender clinician strives to improve their cultural competency by immersing themself in LGBTQIA+ history and culture, learning current terminology, pondering the effects of privilege and oppression, and advocating for the social, political, religious, and medical needs of this community, they are positioned to be an effective service provider to sexual orientation and gender identity minority clients. The scenario does not indicate that Tony and Lisa were under the impression that Dr. Locke was a member of the LGBTQIA+ community. While this is a reasonable option, there may be a better answer choice. Please choose again.

Appendix D

Additional LGBTQIA+ identity models

Coleman's Sexual Identity Developmental Model

Coleman (1982) proposed a five-stage model of homosexual orientation development which operates under the assumption that while many situational factors will affect an individual's personal journey, complete identity integration is dependent upon achieving closure of each stage.

Stage 1. The *pre-coming out* stage is a period in which a child gains awareness of either subtle or pronounced thoughts, feelings, or behaviors representative of sexual minority status (Coleman, 1982). In response to this disparity, the child will likely rely upon internalized messages and sexual scripts promulgated by their familial system, faith traditions, surrounding community, and larger social institutions to navigate this newfound knowledge of self. Similar to Troiden's (1979, 1989) *sensitization* stage, often the individual cannot adequately define their experiences as same-sex attraction; instead, they are aware that there is some "difference" between themselves and others in their environment (Coleman, 1982). Unfortunately, due to the stigmatization of sexual minorities, several maladaptive responses exhibited at this stage include "behavioral problems, psychosomatic illnesses, suicidal attempts, or various other symptoms…lowered self-esteem and depression" (Coleman, 1982, p. 33). If the individual is to fully integrate their identity, there must be a commitment to entertain and further process these feelings.

Stage 2. During the *coming out* stage, the individual has accepted the salience of personal same-sex attraction and decided to share this information with others in either

private discussions or a public proclamation. Importantly, due to the risks posed by disclosing one's sexual minority status, the reactions of those who are informed are vital to the individual's sense of self-worth with positive, affirming experiences providing continued fortitude to explore and accept their innate identity. Unfortunately, if this process is comprised of an unwelcome barrage of adverse responses or rejection by others, especially those held in high regard by the individual coming out, then there exists a greater risk to one's physical, emotional, and psychological well-being (Coleman, 1982). Since many family members will react in a nonplussed, and, at times, hurtful manner, Coleman (1982) recommended that this process only be undertaken after the individual successfully shared their identity with supportive peers; prior positive experiences might serve to reduce the harm incurred by a harsh familial response (Coleman, 1982).

Stage 3. If one successfully navigates this process, they will enter the *exploration* stage which is marked as a time wherein the individual seeks out contact, both platonic and sexual, with others who identify as sexual minorities; integral to this process is the development of adaptive interpersonal skills, as "having been socialized as heterosexual, individuals with homosexual preferences may lack the skills necessary to develop same-sex relationships" (Coleman, 1982, p. 36). Moreover, sexual exploration will lead to a greater sense of proficiency but also represents risk to the individual if not conducted safely; therefore, Coleman (1982) recommends that therapists working with clients in this stage provide essential psychoeducational materials about safe-sex practices. Furthermore, as the individual's sexual identity could be classified as existing in its nascent stage, there is an increased danger of associating one's self-esteem to their sexual

prowess. This is especially commonplace if one comes to terms with their identity at a later age; although this period is integral to personal development, social norms dictate that such sexual behaviors are “immature, immoral, and merely promiscuous” (Coleman, 1982, p. 36). Grace (1977) posits that these views emanate from the heteronormative privilege afforded to heterosexuals which facilitate the exploration of one’s sexuality in a developmentally timely manner; conversely, sexual minorities are denied these opportunities due to *developmental lag*, and, as such, might not be able to express themselves sexually until adulthood. Unfortunately, Coleman (1982) also reported that this stage often correlates with the increased use of sex, alcohol, and/or illicit drugs to dull any discomfort produced by continued issues of low self-esteem or mistreatment by the dominant culture.

Stage 4. The *first relationships* stage is founded upon the desire to achieve a state of emotional and physical intimacy with another member of the community; however, the deleterious effects of heterosexist culture and misinformation relating to sexual minorities and their inability to create and maintain long-lasting romances can be devastating on a budding relationship (Coleman, 1982). Furthermore, due to a dearth of representative, successful same-sex relationship models, there may exist a sense of heightened expectations related to continuous positive emotionality fostered by the bond, as well as what each partner is responsible for in maintain the connection. Coleman (1982) argues that it is important that each partner have engaged in the coming out and exploration processes prior to entering a romantic relationship; if this has not occurred, the resulting difficulties will jeopardize any connection. If the relationship is unsuccessful, the individual might, again, rely on previous internalized messages about same-sex

relationship and determine that any such paradigm is an illusion. However, many will learn from the mistakes made in previous relationships when seeking out future romantic connections with others (Coleman, 1982).

Stage 5. Finally, if the individual reaches the *integration* stage, they have merged "their public and private identities into one self-image" (Coleman, 1982, p. 39). By accepting and relying upon the newfound self, one is better equipped to handle the typical difficulties experienced by all beings in addition to the unique challenges posed by one's sexual minority status. An integrated self-image and understanding acts as a protective factor to weather an ever-evolving world, defined by both opportunities to enjoy periods of joy and sadness.

Fassinger's Model of Lesbian Identity Development

McCarn & Fassinger (1996) developed a sexual orientation developmental model for those who identify as lesbian; this was due, in part, to the prevalence of prior constructs which relied heavily on the experiences of White males and distinguished between an *individual sexual identity* and *membership in an oppressed minority group*. Therefore, the four-stage model presents the various experiences of the individual in relation to one's dual personal and group identities; however, several assumptions undergird this process. Namely, the model operates as a cyclical, rather than a non-linear process, and is not reliant upon one's decision to self-disclose their sexual minority status as evidence of progression through each level (McCarn & Fassinger, 1996). In addition, while most of those who engage in the process experience the individual and group phases concurrently, this is not true of everyone.

Stage 1. The first phase is labeled *awareness* and, within the individual framework, is denoted by a general recognition that one's desires or behaviors conflict with the surrounding heteronormative culture (McCarn & Fassinger, 1996). As with other identity development models, the realization causes initial feelings of a sense of bewilderment. Additionally, the group membership *awareness* phase is initiated by the understanding that there exists a group that identify as non-heterosexual; therefore, the individual is introduced to the concept of heterosexism and its potential effect on their life (McCarn & Fassinger, 1996).

Stage 2. McCarn & Fassinger (1996) introduced *exploration* has the second phase; within the individual domain, the person contends with several questions relating to sexual attraction toward other females. However, while the emotional components are investigated, many individuals within this phase will not engage in same-sex sexual behaviors. Relating to group membership dynamics, someone traversing this phase begins to acquire knowledge about lesbianism and will possibly contemplate the possibility that they also identify as such. However, of great import is the internal beliefs held about sexual minorities; for those who feel antipathy toward this group, the process will be more emotionally complex, potentially resulting in significant self-blame and anger due to their prior acceptance of heterosexist views. Those who successfully navigate the intricacies of this phase will likely experience positive emotions (McCarn & Fassinger, 1996).

Stage 3. For the individual, the *deepening/commitment* phase involves a continuation of self-exploration of one's sexual identity; this will likely result in a decision to accept the self as lesbian. Regarding group membership, the person will more

readily interact with others who identify as lesbian, while also constructing a thorough understanding of the oppressive nature of institutionalized, societal heterosexism and heteronormativity and the effects of this system on both the individual and the group. Subsequently, many will insulate themselves from the dominant culture, instead forming connections with other group members. Furthermore, the individual will likely experience intense feelings of frustration due to continued oppression as well as internal and external pride in relation to one's newfound sexual identity which is termed the "discover of sisterhood" (McCarn & Fassinger, 1996, p. 525).

Stage 4. Finally, as one enters the *internalization/synthesis* phase, there is an understanding that the individual is truly, completely lesbian and, consequently, fulfills the desire to initiate and maintain emotional and sexual same-sex relationships (McCarn & Fassinger, 1996). At this point, the person has fully integrated their sexual identity into the overall sense of self, while also deciding whether to share this information with others; this is especially important due to contextual factors including continued oppression. However, McCarn and Fassinger (1996) are clear that while the individual will likely disclose their identity to both those inside and outside of the community, resolution of the process is not contingent upon this decision. Speaking from the group perspective, the individual will understand that there exist heterosexual allies which often diminishes feelings of anger directed towards the dominant culture; therefore, while one continues to have awareness of heterosexism, there is an acknowledgement of similarities between the sexual majority and minority groups (McCarn & Fassinger, 1996).

Fassinger and Miller (1997) attempted to extend the model from only a lesbian perspective to include a diverse sample of self-identified gay males across multiple

variables including age and racial/ethnic identities. In fact, the majority of participants endorsed an awareness of distinctive, yet related, individual and group membership phases related to sexual identity development. Therefore, the model helped to explain the various ways in which one perceives and integrates their personal identity in relation to self, other sexual minorities, and members of the dominant sexual culture (Fassinger & Miller, 1997). Due to the model's validation in using a sample of gay males, the authors argue that future research should include a population of self-identified bisexual participants as this group often experiences discrimination from both heterosexual and queer communities; this would provide an opportunity to view the effects of group membership on bisexual identity development (Fassinger & Miller, 1997).

D'Augelli's Homosexual Lifespan Development Model

D'Augelli (1994) proffered an explanation of sexual identity development as emanating from two parallel processes; in essence, the individual must extricate themselves from culturally enforced heterosexuality while attempting to navigate the complexity of integrating a sexual minority identity. This journey is made even more perilous owing to the surrounding environment's unremitting attempts to conceal this community and it's struggles; when this proves unsuccessful, the overwhelming response is the barrage of social opprobrium and ostracization as well as punitive legal restrictions (D'Augelli, 1994). Importantly, this model integrated the experiences of those who identify as bisexual; this community has long been viewed as "fence sitters" who are described as either homosexuals afraid to embrace their "truth," or promiscuous heterosexuals. However, this pronouncement is based upon an archaic understanding of sexual orientation through the lens of a binary paradigm (Fitzgerald & Grossman, 2018).

Additionally, D'Augelli (1994) based his lifespan model around an acknowledgement of the interactions between the individual, social and familial relationships, larger existing cultural beliefs and expectations, as well as the effects of the society's historical narrative. Moreover, there is a recognition of significant within-group variance, developmental plasticity, and the power of personal agency (D'Augelli, 1994). Within this model, sexual orientation is viewed as existing along a continuum from invariability and fluidity (Bilodeau, 2005).

Stage 1. The first stage of D'Augelli's (1994) model is labeled *exiting heterosexual identity* and encompasses an internal acknowledgement of one's identity as gay, lesbian, or bisexual. Following self-confirmation, the individual, in an effort to combat the ubiquity of heteronormativity of the larger culture, will engage in the "coming out" process by informing others of their newfound identity. Furthermore, this process will consistently occur throughout the entirety of their lifespan (D'Augelli, 1994).

Stage 2. Next, the individual will enter the *developing a personal lesbian-gay-bisexual identity status* stage; here, there is an acceptance of LGB "thoughts, feelings, and desires" (D'Augelli, 1994, p. 326). Additionally, there must be a recognition of the noxious myths surrounding the community, including the historical view of gay men as exhibiting an uncontrollable, unquenchable lust for consistent, emotionally disconnected, sexual encounters, or those who identify as sexual minorities are the by-product of dysfunctional families and subject to a life of disappointment and loneliness (D'Augelli, 1994). This stage requires the individual to be action-oriented by seeking connections to members of the community; creating and maintaining interpersonal relationships with

others aids in dismantling the internalized self-hatred inculcated by years of hyperbolic heteronormativity and homophobia (D'Augelli, 1994).

Stage 3. D'Augelli (1994) described the stage of *developing a lesbian-gay-bisexual social identity* as expanding the number of people, including those belonging to the dominant culture, who are aware of one's sexual identity. Reactions are fraught with uncertainty and can be malleable depending on various contextual factors including the willingness of the other to face scrutiny by affirming the identity and experiences of the sexual minority; if tolerance, rather than affirmation, is exhibited by one's family and peers, then there exists an increased risk of further alienation (D'Augelli, 1994).

Stage 4. In relation to the effect of sexual orientation and subsequent familial connections, D'Augelli proposes the *becoming a lesbian-gay-bisexual offspring* stage; herein, the LGB person seeks to reestablish any fragmented bonds which, oftentimes, were damaged by reactions after the decision to share their identity with members of the family. This process is, of course, both daunting and potentially harmful to the individual's well-being, especially if the family unit as a whole, or singular actors, refuse to act in an affirming manner while desiring to "contain the deviance as much as possible" (D'Augelli, 1994, p. 327).

Stage 5. According to D'Augelli (1994), the individual will also need to navigate the process of *developing a lesbian-gay-bisexual intimacy status*; this is even more challenging given the relative dearth of imagery that popularize or celebrate successful same-sex relationships due to the continued domination by heteronormative culture. This, coupled with both the onslaught of damaging beliefs surrounding the supposed inability of sexual minorities to enjoy lasting romantic connections and continued attempt to enact

legislative proscriptions against such relationships, required the community, especially in the past, to generate and implement novel adaptations to the problem including commitment ceremonies as well as a progressive attitude toward nonmonogamy (D'Augelli, 1994).

Stage 6. The last stage of D'Augelli's (1994) model of identity development is *entering a lesbian-gay-bisexual community*, which involves engaging in political and social advocacy to undermine the foundation of established cultural norms and values constructed with the bricks of heterosexism and heteronormativity. According to D'Augelli and Garnets (1995), the desire to create a community of lesbian, gay, and bisexual individuals is born from the understanding that "their invisibility and their oppressed status have hampered their efforts to find one another…the affiliative links they develop to kindred others without regard to proximity" (p. 298). One must acknowledge and understand the effects of past mistreatment and subjugation of sexual minorities by the dominant culture, as well as the power inherent in a united LGB front; however, D'Augelli (1994) posits that not all members of the community will engage in this conflict as some are content maintaining a private identity while others are hesitant to risk significant, long-lasting consequences of public advocacy.

Of note, D'Augelli (1994) does not seem to espouse the typical tenets of developmental stage theories. Namely, the individual may not progress through the various stages in any particular order. Additionally, there is a recognition that the process is highly variable and dependent upon multitudinous variables that each person adds to the equation (D'Augelli, 1994).

Troiden's Homosexual Identity Development Model

Troiden (1979) initially developed a sexual identity development model for gay males, but later generalized the findings to lesbians as well (Troiden, 1989); this paradigm included four unique stages.

Stage 1. The first, *sensitization,* occurs prior to the onset of puberty and is marked by a negligible consciousness of same-sex thoughts or feelings for most individuals; however, others reported no such awareness during the same period (Troiden, 1979). In addition, many participants acknowledged a growing awareness that they were sexually divergent from their peers during this period. This concept of feeling dissimilar to one's peers was also found by Bell et al. (1981); specifically, gay (72% vs. 39%) and lesbian (72% vs. 54%) participants endorsed the opinion that they felt different from others at a much higher rate than their heterosexual counterparts. According to the participants, this perception was due, in part, to a lack of desire in expressing socially accepted norms of typical masculine or feminine traits, as well as experiencing same-sex attractions (Bell et al., 1981). Interestingly, Troiden (1989) argues that although there is a rudimentary sense of one's sexual variance, only a small number label themselves as gay or lesbian.

Stage 2. During the *identity confusion* stage, the individual experiences a sentience of one's possible status as a sexual minority; specifically, there exists dissonance between past and current definitions of sexual self-identity (Troiden, 1979, 1989). Inherent in this uncertainty are feelings of puzzlement and fear that one might be gay or lesbian, driven, in part, by the intense, widespread stigmatization of, misinformation surrounding, and discrimination perpetrated against sexual minority communities by the dominant culture (Troiden, 1979, 1989). According to Troiden

(1989), to successfully navigate this period, there must be an expanded awareness that "homosexuality and homosexuals exist, learn what homosexuals are actually like as people, and be able to perceive similarities between their own desires and behaviors and those of people labeled as homosexual" (p. 55). Moreover, a plethora of potential responses to this information can be exhibited, including denial, repair, avoidance, redefinition, and acceptance of same-sex thoughts, emotions, and behaviors (Cass, 1979; Goode, 1984; Humphreys, 1972; Troiden, 1977).

Denial includes a total repudiation of one's sexual minority status, while those who attempt to "repair" the defective, undesirable identity will often employ the services of mental health professionals and/or members of the clergy (Goode, 1984; Humphreys, 1972; Troiden, 1977). Cass (1979) identified various ways in which the individual engaged in avoidance including refraining from engaging in activities or behaviors associated with sexual minorities, remaining romantically unattached in order to conceal one's lack of carnal interest in the opposite sex, avoiding information related to the LGBTQIA+ community, adopting and/or exhibiting homophobic attitudes, seeking out heterosexual relationships in an attempt to progress beyond their sexual minority status, or using alcohol or illicit substances to escape same-sex thoughts, emotions, and/or behaviors. For those who attempt to redefine their sexual identity to reduce the feelings of stress and anxiety caused by continued sexual incongruence, it is common to attribute a past same-sex experience to situational factors never again to be repeated, define past experiences as a transitory stage of life, or even entertain the possibility of identifying as bisexual (Cass, 1979; Troiden, 1977). Finally, if the individual decides to pursue self-acceptance, there is often a feeling of relief as they can provide a label to their feelings

and behaviors. Furthermore, this realization can reduce the significant sense of interpersonal isolation, as one can begin the process of reaching out to others in the community (Cass, 1979; Troiden, 1977).

Stage 3. The third stage, *identity assumption*, involves adopting an internalized sexual minority identity, while also maintaining a heterosexual public persona for those outside of the LGBTQIA+ community (Troiden, 1989). However, this process of self-definition is pursued during this stage in varying degrees and methods. For instance, lesbian respondents were much more likely to define their sexuality in the context of same-sex emotional attachments (Cronin, 1974; Schafer, 1976), while gay males are much more likely to seek out physical relationships with other men (Dank, 1971; McDonald, 1982; Troiden, 1979). The latter phenomena, according to de Monteflores and Schultz (1978), is attributable to reinforced sociocultural gender norms wherein "male sexuality is seen as active, initiatory, demanding of immediate gratification, and divorced from emotional attachment; female sexuality emphasizes feelings and minimizes the importance of immediate sexual activity" (p. 68). Alternatively, Troiden (1989) argues that the rise of the AIDS (Acquired Immunodeficiency Syndrome) crisis, which disproportionately affects gay males, coupled with greater public recognition and acceptance of sexual minorities, has resulted in an increased number of those men who self-define as gay in relation to their emotional connections with other men.

Stage 4. Socialization with other members of the LGBTQIA+ is integral during the *identity assumption* stage, as it typically provides the individual with a better understanding of what the sexual minority identity truly entails, how to navigate their newfound environment, and vital interpersonal connections that can aid in reducing any

lingering feelings of guilt related to sexual identity status (Troiden, 1989). Unfortunately, due to the ubiquity of homophobia and heteronormativity, there is usually a concerted effort to engage in behaviors aimed at reducing the stigmatization experienced by the community; this can be accomplished in several ways including avoiding same-sex behaviors due to continued internalized homophobia/heterosexism, acting in an intensely caricatured manner which highlights the surrounding culture's stereotypes attributed to sexual minorities, creating dual lives so that the individual can "pass" as heterosexual in order to protect themselves from perceived threats, or "aligning" with the LGBTQIA+ community while eschewing involvement with many, if not all, oppressive aspects of the dominant culture (Humphreys, 1972). If one decides to accept their identity as a sexual minority, their path will progress into the next stage.

Stage 5. *Commitment*, the final stage of Troiden's (1979, 1989) sexual identity model is defined by a desire to engage in an action-oriented way that allows for both internal and external acceptance as a member of the LBTQIA+ community. The former is accomplished in multitudinous ways including a newfound congruence between one's physical and emotional needs, fully acknowledging one's sexual identity as acceptable and desirable, and a continued evolution of what it means to self-identify as a sexual minority. Outwardly, this is manifested through the pursuit of same-sex romantic attachment as well as the decision to "come out" to heterosexual friends, family members, and colleagues. (Troiden, 1989). In essence, the individual comes to terms with the "truth of their existence" that had previously resulted in intense feelings of dread or anxiety. This commitment is a powerful reminder of one's personal agency in creating a life built upon the foundations of congruency and satisfaction. Troiden (1979) conducted

a study of the relationship between successful internalization of sexual identity status and perceived levels of happiness experienced by gay males; in all, 91% of participants reported feeling "more happy" after acceptance of their identity, while only one subject reported being "less happy."

Bilodeau's Transgender Identity Model

Bilodeau (2005) argued that few theories of identity development provide a thorough, non-pathological view of those who identified as transgender, including "genderqueers, drag kings and queens, cross-dressers, and transsexuals who cannot afford or do not desire surgery-identities that are often embraced by today's transgender college students" (p. 31). Therefore, this six-process model, based upon a framework similar to D'Augelli's, views identity development within the context of the interconnections between the individual and their surrounding social environments.

Stage 1. The first process is *Exiting a Traditionally Gendered Identity*; within this phase, the individual first comes to an awareness of their gender as existing outside of conventional cultural norms enforced by one's society. Following this realization, one might provide a label to themselves or their experiences which include the term "transgender." Furthermore, it is common that one's gender is affected by other personal identities including race, ethnicity, religious orientation, and sexual orientation (Bilodeau, 2005). Inherent in this process, the individual will encounter novel situations which highlight the dissonance between their innate gender identity and the expectations of the dominant culture; this, in turn, often results in a desire to continually refine one's understanding of the self which may include the implementation of several descriptive

terms including transgender, non-binary, gender non-conforming, or genderqueer (Bilodeau, 2005).

Stage 2. Subsequently, the individual will enter the *Developing a Personal Transgender Identity* phase; during this process, there is a decision to seek out others with similar experiences to gain a better understanding of the various manifestations of gender identity. These social interactions often provide opportunities to discuss the unique challenges that face this community, allow for the expression of one's thoughts and feelings related to the journey, and the creation of safe, secure environments which facilitate the process of exploration and discovery (Bilodeau, 2005). The importance of such activities cannot be overstated and is beautifully illustrated through the sentiments of two research participants interviewed by Bilodeau (2005); according to the first individual, "Alix and I spent shaped our gender identities together. We spent so much time talking and debating" (p. 35). Moreover, the second participant expressed the importance of their experience adding, "Alix and I went through our entire coming out process together, though our trans identities are completely different. We spent hours and hours in her dorm room, laughing and crying about it" (Bilodeau, 2005, p. 35). Again, the integral nature of these interpersonal processes is quite salient throughout such interviews; by connecting with others in a supportive environment, one is better equipped to endure the inherent difficulty in navigating gender identities.

Stage 3. Next, the individual expands their personal identity into the public sphere in the *Developing a Transgender Social Identity*; this is accomplished through participation with trans-affirming organizations which provide opportunities to meet with other sexual and gender minorities while strengthening the understanding and subsequent

acceptance of their inner truth (Bilodeau, 2005). By engaging in this process, the private and public self becomes more fully integrated, which, in turn, can have significant positive impacts on one's physical, emotional, and psychological well-being.

Stage 4. The fourth process, *Becoming a Transgender Offspring*, involves coming out to one's family members as a gender minority; for many, even contemplating engaging in such a revelation is fraught with fear and feelings of uncertainty due to the potential for negative, invalidating reactions. This reality is all too common for numerous members of the transgender community, resulting in a decision to refrain from such action. Of course, this decision carries certain consequences, including strained familial relationships and a continued sense of incongruence between personal and public sense of self (Bilodeau, 2005).

Stage 5. During the *Developing a Transgender Intimacy Status* phase, the individual seeks out romantic relationships which satisfy both emotional and sexual needs; in essence, there exists an intense, interpersonal connection that ostensibly provides stability and support for all parties (Bilodeau, 2005). This is especially important for someone who identifies as transgender; Jordan, a research participant interviewed by Bilodeau, spoke to the benefits of such relationships by reporting, "The relationship I'm in now is the best I've ever had…since I've come out as trans…Because I wasn't comfortable with myself before…My girlfriend is in a place that she really rejects the labels. She is attracted to me as me" (Bilodeau, 2005, p. 40). Again, these bonds serve as a protective factor against the continued barrage of transphobia and traditional gender demands of the dominant society.

Stage 6. Finally, the individual engages the process of *Entering a Transgender Community*; here, there is a commitment to continued advocacy for the individual and the larger transgender community. This can be accomplished through engaging with providing support for others who are navigating their own identities, joining organizations whose goal is to dismantle the oppressive, destructive forces of institutionalized discrimination and prejudice, and fighting for expanded civil rights for transgender citizens (Bilodeau, 2005). Taking advantage of such opportunities can aid the individual become more comfortable with their integrated gender identity, resulting in significant intra- and interpersonal growth which increases the likelihood of living their truth more completely and confidently.

Devor's Transsexual Identity Formation Model

Devor (2004) introduced a fourteen-stage identity formation model for those who self-identify as transsexual or transgender; while this framework is closely aligned to the Cass (1979, 1984) model of gay and lesbian identity development, there is greater import placed upon the complex relationship between biological and social variables. The model is founded upon several assumptions; firstly, there exists a cultural assumption of binary, sex and gender which are stable across the lifespan: male and female. Secondly, masculine and feminine sex and gender are inextricably linked through one's public persona as manifested by physical appearance and socially acceptable behaviors and mannerisms. Thirdly, although one could identify with and portray a sex or gender rather than that assigned at birth, this presentation will always be in jeopardy if one's birth sex characteristics are revealed to others. Therefore, Devor (2004) argues such incongruence can only be conquered through the provision of gender affirming surgery. However, he

acknowledges that this model is not a one-size-fits-all explanation of gender identity; although many individuals might feel that the framework captures their experience quite well, others likely find themselves developing a gender identity along a much different pathway that excludes the possibility of medical interventions (Devor, 2004).

Furthermore, this model also includes two integral concepts; the first is witnessing and the second is mirroring. As social creatures, human beings must contend with the complexities of interpersonal exchanges. We strive to connect with others in both superficial and deeper levels; those who experience difficulties in achieving such bonds are at increased risk for physical, emotional, and psychological maladjustment (Devor, 2004). Witnessing is the by-product of interchanges between the "self" and the "other;" in essence, those family, friends, peers, or colleagues who are different than the individual. If members of such groups are affirming of the individual's sex and gender identity, a congruence between the private and public self is maintained. However, if the words and behaviors experienced invalidate one's sense of self, there can exist a jarring, and, at times, unbearable sense of discordance (Devor, 2004). Conversely, mirroring is when the individual can see the "self" in the "like other," or those whom we believe ourselves to resemble. If this occurs, then there is an understanding that one is not alone, and, in fact, is part of an expanded community which provides greater meaning to their existence (Devor, 2004).

Stage 1. The first stage, *abiding anxiety*, is one in which the individual begins to experience incongruence between their assigned sex and/or gender identity; this manifests itself through a desire to seek out social relationships with and engage in behaviors ascribed to one's unassigned gender. However, this, of course, can result in a

sense of anxiety and impeded belonginess. If left unresolved, there is an increased risk of continued anxiety, isolation, substance use, and suicide (Devor, 2004).

Stage 2. During the second stage, *identity confusion about originally assigned gender and sex*, the individual acknowledges the dissonance between one's assigned sex and/or gender and their self-perception. In response to this, there may be a personal decision to appraise others of this information; unfortunately, due to the threat posed to the dominant culture's view of sex and gender, any such attempts will likely be met with derision from family, peers, and larger cultural institutions. When this occurs, one can responds in several ways; first, "many children simply stop talking about it, fantasize a different future for themselves and wait for puberty to bring about the changes that they believe are their due" (Devor, 2004, p. 48). However, for those who never experience such transformation, there is a tendency to engage in harmful, even life-threatening, behaviors meant to numb the resultant feelings of depression, shame, and isolation (Devor, 2004). Alternatively, others, due again to the weight of traditional social norms of sex and gender imposed by the surrounding culture, are unlikely to share their thoughts and emotions with others due to fear of being labeled as abnormal or atypical; instead, these individuals will make sincere efforts to live a life of verisimilitude, defined by their assigned sex and/or gender even when this results in feelings of uncertainty and self-deceit (Devor, 2004).

Stage 3. The next stage, *identity comparisons about originally assigned gender and sex*, the individual attempts to successfully navigate their immediate surroundings by seeking out versions of their assigned sex and/or gender identities that comport with their innate sense of "otherness;" in other words, they will assume characteristics of other

males or females that exhibit similar behaviors that, while considered alternative, are still, to an extent, are not entirely rejected by the dominant culture (Devor, 2004). For instance, someone assigned a female sex and/or gender identity might engage in actions attributed to a "tomboy;" this provides an opportunity to pursue interests typically enjoyed by males without experiencing significant social opprobrium. However, if the post-pubescent individual continues to engage in said activities, then there is an increased risk of criticism and rejection by others (Devor, 2004). While this route might be fruitful for girls, the same is not true for boys who adopt behaviors or mannerisms considered effeminate; unfortunately, they will be the target of significant maltreatment at the hands of their family and peer groups.

Numerous individuals will attempt to ease the sense of sex and/or gender identity incongruence by entering a same-sex relationship which allows for expanded opportunities to express their innermost feelings of "otherness" in a physical, emotional, or sexual manner, while others, who publicly identify as heterosexual, cisgender males, might engage in cross-dressing behaviors. Although these actions might temporarily quell the desire to live as a sex or gender different than that assigned at birth, they are in conflict with the strict expectations of the surrounding heteronormative culture which continues to espouse and perpetuate discriminatory action toward sexual minority groups (Devor, 2004).

Stage 4. The fourth stage, *discovery of transsexualism or transgenderism*, involves the individual recognizing the existence of transgenderism as a concept, realizing that others have experienced similar feelings of confusion between the assigned sex and/or gender at birth and their innate desires and decided to live life as their

authentic selves; essentially, "it is an 'Aha!' kind of moment where everything that they have been feeling finally falls into place. Finally, they have found a mirror in which they can see themselves" (Devor, 2004, p. 52). Truly, it is difficult to truly grasp how life-altering this epiphany could be in explaining the disconcerting thoughts, emotions, and behaviors experienced throughout one's life. For many this moment is powerful in that it provides a label to an individual's sense of self, and they almost instantaneously assume their newfound identity. However, this process is likely to take a longer period to negotiate for some (Devor, 2004).

Stage 5. During the *identity confusion about transsexualism or transgenderism* stage, after recognizing that many people identify as a sex and/or gender other than that assigned at birth, the individual might entertain the notion that they, themselves, are transgender as well. As such, the next step is determining in what ways this might manifest itself in their intra- and interpersonal existence; this is accomplished in seeking out additional information about the community (Devor, 2004).

Stage 6. The sixth stage, *identity comparisons about transsexualism or transgenderism*, the individual begins the process of fully embracing their newfound identity by engaging in a social comparison between "oneself and transsexed and transgendered people, between oneself and people from one's originally assigned gender and sex, and between oneself and people of the gender and sex to which one might be moving" (Devor, 2004, p. 54). This is completed to establish a more thorough understanding of the similarities and differences which exist between the self and others; subsequently, the group with which there exists a greater resemblance or mirroring of the individual's personhood will provide a sense of belonging (Devor, 2004). For many, this

experience will satiate their curiosity, creating an environment in which they feel comfort in identifying as transgender; others will desire to continue the journey, entering into the next stages (Devor, 2004).

Stage 7. If, after traversing through the previous stage, an individual continues to feel hesitation about adopting the label of transgender, they will enter the *tolerance of transsexual or transgendered identity* process which involves an ongoing conflict between one's assigned gender or sex and their desired identity. However, the latter becomes more prominent and powerful during this stage, as there is a renewed confidence in one's decision to explore this newfound gender and/or sex identity (Devor, 2004).

Stage 8. According to Devor (2004), the processes of witnessing and mirroring are especially vital during the *delay before acceptance of transsexual or transgendered identity* stage; here, statements of affirmation about the death of one's assigned gender or sex and rebirth as the desired sex help to facilitate a more fully integrated identity. There is, of course, a risk of rejection from the individual's family, friends, or romantic partners; if this should occur, one might respond by refraining from adopting the label transgender, and, instead, reverting to a less threating, although imperfect, descriptor. Others, who are rebuffed by loved ones, are galvanized by the experience, and strongly identify as their desired gender or sex (Devor, 2004). During this stage, additional stress is often placed upon male-to-female individuals in the form of powerful internalized gender roles, as well as continued abuse from the dominant culture; this results in intense feelings of ignominy and many will eschew, both privately and publicly, any exhibition of femininity (Devor, 2004).

Stage 9. By the time that an individual enters the *acceptance of transsexual or transgendered identity* stage, they have acknowledged and nurtured their newfound sense of self while also understanding the significant implications that this will have on existing familial, platonic, and romantic relationships (Devor, 2004). However, this awareness is often accompanied with the solace generated by self-acceptance. Inherent in this stage are lingering questions surrounding the possibility of physical transition into one's innate gender or sex; unfortunately, this process can result in significant anxiety as well.

Stage 10. Within the tenth stage, *delay before transition*, substantial amounts of time will be devoted to contemplating whether to proceed with the transition process, what actions are involved, as well as the assumed physical, emotional, psychological, and financial costs (Devor, 2004). These questions are not to be approached lightly, as there exists a potential for tremendous consequences, both positive and negative. Additionally, there is a tendency for those in this stage to strengthen connections with those who share their desired gender or sex identity; this provides an opportunity to engage in vicarious visualization of what life for their newfound self might be like post-transition (Devor, 2004).

Stage 11. Next, the individual moves into the *transition* stage, which includes multitudinous options including "changes in social presentation of self, psychotherapy, hormonal treatments, and a variety of surgeries which together accomplish gender and sex reassignment" (Devor, 2004, p. 61). Dependent upon one's understanding of what defines individual transition, this process can be truncated or quite lengthy, and ranges from simple exchanges of witnessing and/or mirroring by others to procedures that facilitate both hormonal and physical modifications (Devor, 2004). Furthermore, the

individual is apt to experience a plethora of emotions during this stage, as every change and social interaction creates an opportunity for positive and negative reactions from oneself, others, and the surrounding environment; this often includes a sense of grieving the former identity while simultaneously celebrating the resultant birth of the nascent self (Devor, 2004).

Stage 12. In the *acceptance of post-transition gender/sex identity* stage, there can be an accompanying sense of uncertainty or self-doubt about one's entry into a community of those who hold similar identities; this is the result of the "recentness of their transition, because of the approximate nature of their physical transitions, and because of the fact that they required transitional procedures to gain them their claim in the first place" (Devor, 2004, p. 63). However, with every positive novel interaction and experience, the individual gains a sense of mastery over their gender or sex identity; this increases self-confidence and self-esteem allowing for an unprecedented appreciation and integration of self.

Stage 13. Following the individual's entry into a post-transition world via the *integration* stage, there becomes a greater amalgamation between one and their environment; the decedent identity has lost its magnitude, allowing for decreased rumination on past experiences (Devor, 2004). Unfortunately, is it doubtful that one can completely escape the stigmatization forced upon the community by the dominant culture; therefore, the individual must determine how best to navigate the process of informing others of their transition. Furthermore, while some may decide that there is no need to either acknowledge or discuss these issues with those they encounter, many are

able to successfully integrate their past and post-transition identities into a consummate sense of self (Devor, 2004).

Stage 15. Finally, the *pride* stage is dominated by a sense of personal agency, fortitude, and advocacy for trans rights; as long as acts of discrimination, prejudice, and violence are perpetrated against the community by those who demand conformity to archaic concepts of gender and sex identity. By engaging in social and political movements, one can aid in establishing greater tolerance toward, affirmation of, and expanded rights for those who find their inner truth (Devor, 2004).

Appendix E

LGBTQIA+ terminology guide*

Androgyny/androgynous- an individual who expresses male and female qualities.

Aromantic- a lack of desire for romantic relationships with others; however, aromantic individuals may still experience sexual attraction.

Asexuality/asexual- a lack of sexual attraction to members of the same and/or opposite sex and/or gender; however, asexual individuals may seek out romantic bonds with others.

Assigned sex/birth sex- this term refers to the postnatal binary classification of either male or female sex based upon an individual's external genitalia, genetic material, hormones, gonads, as well as secondary sex characteristics developed at puberty.

Behavioral androgyny- the practice of engaging in atypical gender behaviors associated with one's assigned sex and/or gender.

Bisexuality/bisexual- sexual attraction to members of both sexes and/or both genders; however, some members of the LGBTQIA+ community dislike this term due to its inference of binary sex and/or gender.

Cisgender- a gender identity which coincides with one's assigned sex and/or gender at birth.

Cross-dressing- the act of wearing clothing associated with another sex and/or gender for the purpose of recreation, amusement, stress relief, or sexual pleasure; many cross-dressers are heterosexual men.

Demisexual- sexual attraction for another person following the creation of a strong emotional connection.

Disorders of Sex Development (DSD)- a term describing intersex medical phenomena that is considered less pejorative than previous terms including intersex conditions; however, many individuals prefer Difference of Sex Development due to the negative connotation association with the word “disorder.”

Drag- the act of dressing in exaggerated wardrobes or costumes to satirize gender stereotypes often for comedic effect.

Drag king(s)- a drag performer, often female, who engages in drag dressed in male attire to satirize stereotypical masculinity.

Drag queen(s)- a drag performer, often male, who engages in drag dressed in female attire to satirize stereotypical femininity.

Essentialism/essentialist- the assertion that one’s sexual orientation and/or gender identity is biologically determined and invariable.

Gay- An umbrella term which denotes individuals who are typically attracted to members of the same sex and/or gender; this can include gay or transgender males who are attracted to other men and lesbians or transgender women who are attracted to other females.

Gender- a term denoting the socially constructed concept of expected masculine and feminine characteristics and roles exhibited by individuals.

Gender identity- an individual’s innate, personal recognition of the self as male, female, a combination of both, or neither.

Gender presentation- external characteristics such as wardrobe choices, hairstyles, and affectations which denote one’s gender.

Hermaphrodite/hermaphroditic- An outdated, pejorative term used to describe individuals who are intersex.

Homosexuality/homosexual- sexual attraction to the same sex and/or gender; one who is attracted to others of their identified sex and/or gender. This term is viewed as pejorative to some members of the LGBTQIA+ community due to its historical association with psychopathology and use by some religious groups to demean sexual orientation and gender identity minorities.

Intersex- individuals whose external genitalia or internal reproductive anatomy are ambiguous or composed of both male and female sex characteristics due to genetic, chromosomal, or hormonal variations.

Lesbian- a female who is sexually and emotionally attracted to other women; this can include transgender women who are attracted to other females.

LGBTQIA+- a commonly used acronym describing various sexual orientation and gender identities found within the queer community including lesbian (L), gay (G), bisexual (B) transgender (T), queer and/or questioning (Q), intersex (I), asexual, agender, and/or aromantic (A), and + (all non-heterosexual people).

Nonbinary- an individual who does not simply identify as male or female; instead, they might view themselves as both male and female, neither male or female, a third or other variant gender, or no gender at all. Other commonly used words include genderqueer and agender.

Pansexual- attraction to all genders and/or sexes.

Polysexual- sexual attraction to several genders and/or sexes.

Same-gender loving- a term sometimes used by Black, queer individuals to describe those who are attracted to people of the same sex and/or gender; this term was coined due to the association between White culture and terms like gay or lesbian.

Social Constructivism/social constructivist- the assertion that one's sexual orientation and/or gender identity is/are heavily influenced by societal or cultural values and customs.

Questioning- an individual who engages in a personal exploration of their sexual orientation and/or gender identity.

Transgender- an individual whose gender identity does not align with the sex and/or gender assigned at birth; other commonly used terms include, but are not limited to, gender variant, gender nonbinary, and gender nonconforming.

Transsexuals- an individual whose gender identity does not align with the sex and/or gender assigned at birth; however, this term is considered archaic and pejorative to some within the LGBTQIA+ community.

Transvestism/transvestite- an outdated, pejorative term used to describe those who engage in cross-dressing behaviors.

Two-Spirit- a term which often used by First Nations people to describe tribal members who do not assume a male or female identity; rather, these individuals are viewed as a third, separate gender outside of the traditional binary. Additionally, they may be attracted to members of the same or opposite gender as themselves.

Queer- a term used to denote anyone whose sexual orientation and/or gender identity is other than heterosexual and cisgender.

*The terms listed above are not an exhaustive representation of the vocabulary used by or to describe the LGBTQIA+ community.