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Affirmative Counseling with LGBQQIA Individuals:
A Training and Resource Manual for Mental Health Counselors

Plan B Project Proposal Presented
to the Graduate Faculty of
Minnesota State University Moorhead

By
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In Partial Fulfillment of the
Requirements for the Degree of
Master of Science in
Clinical Mental Health Counseling

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Abstract

This article is a review of literature related to issues associated with working with LGBQQIA clients. Although not an exhaustive review, the literature provides evidence of the need for additional training to improve the confidence and competence of counselors working with this population. Further, information is provided on what makes a counselor competent to work with LGBQQIA clients and evidence-based practices that have been shown to be effective in working with them. Following this review, a training and education manual will be presented to help fill the need of additional training related to working with this population.

Keywords: LGBTQ, LGBQIQA, affirmative counseling, affirmative therapy, competency, ALGBTIC competencies

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Introduction

Many counselors today do not feel they have the competence necessary to work with members of the LGBTQ population (Rutherford et al., 2012). Counselors receive inadequate training that consists only of an overview of working with sexual minorities in their preparatory programs. This leaves them with the need to find additional trainings themselves in order to be knowledgeable about the mental health needs of this population (Rutherford et al., 2012).
In fact, sexual minorities who receive mental health services report more dissatisfaction with mental health services than their heterosexual counterparts (18% versus 8%), (Rutherford et al., 2012; Owen-Pugh & Baines, 2014). Despite this, as a historically marginalized population, individuals that identify as LGBTQ seek services at a significantly higher rate than their cis-gender and heterosexual counterparts (Luke and Goodrich, 2015; Quiñones et al., 2017; Rutherford et al., 2012). This shows that the need for counseling professionals who have competence in working with LGBTQ individuals is high.

The American Counseling Association's Code of Ethics (2014) is clear that discrimination against individuals based on their sexual orientation is not condoned. However, exactly what that looks like in a counseling setting is not addressed in that document. To expand understanding of appropriate counselor behavior towards individuals in the LGBTQ communities, the ACA ALGBTIC LGBQQIA Competencies Taskforce (2013) has developed the ALGBTIC Competencies for Counseling LGBQQIA Individuals. These competencies are intended to expand counselor knowledge in providing a safe, supportive, and caring counseling experience for members of these populations. An additional set of competencies has also been created for working with individuals that identify as transgender. It is important to understand that the needs and lived experiences of these individuals are distinctly different from the needs

and lived experiences of those who identify as LGBQQIA and are therefore addressed in separate documents prepared by the ACA (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013; Farmer et al., 2013). In acknowledgement of these differences, the training and resource manual that is included after the literature review is focused on LGBQQIA individuals only. The training and resource manual provides a guide for counselors in training and current counselors to understand the special needs and considerations of counseling individuals that identify as part of these populations.

Literature Review

The Need

Rutherford et al. (2012) conducted a study to explore how providers with LGBTQ-focused practices have developed their competency. One of the conclusions of this study is that few training opportunities for addressing the mental health needs of the LGBTQ populations exist. Rutherford et al. (2012) continues by stating that the training received through pre-licensure education is inadequate. Carlson et al. (2013) also report that Couples and Family Therapy training programs have failed to prepare students to work competently with LGBTQ clients and to utilize affirmative training practices. More current information on the state of affirmative counseling therapy training in pre-licensure educational programs shows that progress is being made towards preparing new counselors to work with LGBTQ clients, but that more work is still needed (Bidell, 2014; Bidell, 2017; Farmer et al., 2013; Owen-Pugh & Baines, 2014; Pepping et al., 2018.)

In the United States, mental health disparities exist between individuals who identify as LGBTQ and those who identify as cis-gender and heterosexual (Bidell, 2014; Bidell, 2017; Hinrichs & Donaldson, 2017.) LGBTQ individuals have higher rates of mental health problems, including depression, anxiety, alcohol and other substance dependence, and suicide (Austin & Craig, 2015; Bidell, 2014; Bidell, 2017; Farmer et al., 2013; Owen-Pugh & Baines, 2014; Pepping et al., 2018; Quiñones et al., 2017; Rutherford et al., 2012). In fact, statistics show that they are 2.5 times more likely to have attempted suicide and have higher levels of suicide ideation than cis-gendered heterosexuals (Rutherford, et al, 2012, Quiñones et al, 2017.) They also have a 1.5 times higher risk for depression and anxiety disorders (Rutherford et al., 2012). These are but a few of the physical and mental health challenges individuals who identify as

LGBTQ face. As counselors and counselors in training, we must learn to meet the challenge of meeting the needs of these clients through training and education.

Physical and Mental Health Challenges

Along with the statistics showing higher rates of anxiety, depression, substance abuse, and suicidality, members of the LGBTQ community have a higher risk of trauma, stress, assault, and abuse (Ginicola et al., 2017). In fact, up to 33% of bisexual or gay males have been physically abused and 50% of lesbian and bisexual women and 20% of bisexual men report having been sexually abused (Quiñones et al, 2017). These statistics are said to be due to their minority status, including direct experience of prejudice and discrimination, living with one or more stigmatized identities, implicit and explicit homophobia which may be internalized, and general expectations of rejection (Ginicola et al., 2017; Quiñones et al., 2017; Pepping et al., 2018). Chronic minority stressors associated with societal stigma depletes an individual's coping resources and contributes to poor mental health (Pepping et al., 2018.) According to a meta-analysis done by Pepping et al. (2018), between 55% and 80% of LGBTQ individuals have experienced homophobic verbal harassment and 28% have experienced physical assault. This can cause members of these groups to attempt to conceal their sexual identity which, in turn, increases their mental stress (Quiñones et al, 2017). While these statistics are evidence as to why competent counselors are needed, LGBTQ individuals often have a difficult time finding counselors that are competent or trained to provide care and address their specific needs (Bidell, 2014; Bidell, 2017.) In fact, LGBTQ individuals are often wary of counseling providers because of historical pathologizing by the counseling community and negative experiences with counselors that have not received training or experience to improve their competence levels

(Ginicola et al., 2017; Owen-Pugh & Bains, 2014; Rutherford et al., 2012; Singh & Shelton, 2011).

Issues with Training

While reports of lack of training opportunities were given in earlier years, (Rutherford et al., 2012; Carlson et al., 2013) greater emphasis on including training in pre-certification education programs has occurred in recent years (Bidell, 2014; Farmer et al., 2013; McGeorge et al., 2018; Singh & Shelton, 2011). LGBTQ affirmative training practices have been shown to predict clinical competence with LGBTQ clients (Carlson et al, 2013). The ACA encourages counselors to educate themselves regarding LGBTQ counseling competencies (ALGBTIC LGBQQIA Competencies Taskforce, 2013). However, despite the increase in numbers of multicultural courses that include LGBTQ education and LBGTQ-specific elective courses, doctoral students and new counselors consistently report that they have inadequate training and levels of competence in working with LGBTQ populations (Bidell, 2014; Bidell, 2017; Farmer et al., 2013; Owen-Pugh & Baines, 2014; Pepping et al., 2018; Sing & Shelton, 2011).

One area that has been utilized to improve training related to LGBTQ issues is through inclusion in multicultural counseling courses (Bidell, 2014). Bidell's study (2014) shows support for improvements in competency based on this inclusion. However, a single multicultural course is not sufficient in improving the knowledge and skills needed by counselors regarding LGBTQ affirmative counseling (Bidell, 2014). More hours of training in LGBTQ affirmative counseling have been shown to improve competency and attitudes about working with individuals that identify as LGBTQ (Pepping et al., 2018). Nevertheless, limitations within counseling preparation programs due to time constraints restricts the amount of information that can be imparted to students about specific cultural groups (Owen-Pugh & Bains, 2014). In fact, it is

believed that counseling students are not gaining enough competency and skill to effectively treat clients that identify as LGBTQ, which can lead to counselors failing to screen for mental health problems that impact individuals that affect these clients (Bidell, 2017; Owens-Pugh & Baines, 2018). Farmer et al., (2013) state that pre-certification education is mandated by ethical and accreditation standards of the American Counseling Association (ACA) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) to provide adequate training for working with LGBTQ clients but that it is unclear if these mandates are being met.

Recommendations for Training

While current curricula offered by some colleges is far more inclusive of content related to multiculturalism, including LGBTQ issues, it behooves us to examine what has been shown to be effective, evidence-based practices for both training new counselors and for working with clients that identify as LGBTQ. According to McGeorge et al. (2018), LGBTQ affirmative training must include the following: specific course content on LGBTQ topics, self-reflection, experience working with LGBTQ clients, and an overall inclusive training environment. Ginicola et al. (2017) state that the curriculum should include instruction on traditional models of LGBTQ identity development, couple's relationships, parenting, LGBTQ experiences as members of a family, legal and workspace issues, intersectionality of identities, and basic cultural competence.

The ACA competencies for counseling LGBTQ individuals are split into two categories: competencies for counseling with LGBQQIA (lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual) clients and competencies for counseling with transgender clients. Each of these sets of competencies are broken down into eight categories: human growth and development, social and cultural foundations, helping relationships, group work,

professional orientation and ethical practice, career and lifestyle development, assessment, and research and program evaluation. These competencies include working with allies and intersex individuals as well (ALGBTIC LGBQQIA Competencies Taskforce, 2013).

The following manual will focus on important aspects of each of the competencies outlined by the ALGBTIC LGBQQIA Competencies Taskforce. Although many of the competencies align between those for working with LGBQQIA individuals and those of working with transgender individuals, it is important to understand that there are differences. Therefore, the following manual will focus on training counselors to work with LGBQQIA populations. One recommendation for a future project is to complete a similar training manual for working with individuals that identify as transgender. As a part of this training, not only will learning objectives be covered, but also the characteristics of LGBQQIA competent counselors.

Characteristics of LGBQQIA Competent Counselors

It is important to dispel the idea that to be competent with LGBQQIA clients, the counselor must also identify as part of that population. Competent counseling can be done by counselors of any sexuality or gender who wish to become competent in these skills (Rutherford et al., 2012.) The next area of note is that the foundational counseling skills of active listening, validation, and normalization of the client's experiences, creating a feeling of acceptance, and creation of a safe and non-judgmental therapy environment, are a part of all effective counseling, regardless of client identifications (Quiñones et al, 2017). Counselors also need to utilize client centered counseling techniques as well as specific knowledge of LGBQQIA cultures (Quiñones et al., 2017).

Competent counselors acknowledge that sexual orientation is relevant in therapy with LGBQQIA clients, but do not place primary focus on sexual orientation when it is not relevant to

the issue(s) for which the client has come to counseling (Owen-Pugh & Baines, 2014; Quiñones et al., 2017). As with any form of multicultural competency, counselors need to become aware of their own biases (Halliwell, 2019). Finally, competent counselors need to know that being able to talk openly about sexuality with a client is not the same as affirming their sexual identity (Quiñones et al., 2017).

Some counselors believe that clients should be allowed to seek professional help to change their sexual orientation through conversion or reparative therapies (Quiñones et al., 2017). However, counselors have an ethical obligation use evidence-based approaches that minimize the potential for harm of their clients (American Counseling Association, 2014; Ginicola et al., 2017). Competent counselors understand that attempts to repair, convert, or change ones affectional or sexual orientations are detrimental and may even be life-threatening to their clients and must not be undertaken (ALGBTIC LGBQQIA Competencies Taskforce, 2013; Chazin & Klugman, 2014). Further, effective counselors help clients seek answers for themselves and work with them to decrease possible shame and internalized homophobia (Quiñones et al, 2017). Counselors need to be knowledgeable about safety risks and possible rejections by family, friends, and the general population, to assist clients in the coming out process, if the client desires to do so (Ginicola et al., 2017).

Affirmative and Evidence Based Practices

Although some counselors feel that they have received inadequate training (Bidell, 2014; Bidell, 2017; Carlson et al., 2013; Farmer et al., 2013; Owen-Pugh & Baines, 2014; Pepping et al., 2018; Rutherford et al., 2012), the truth is that many of the affirmative and evidence-based practices for working with individuals that identify as LGBQQIA are the same or only slightly modified compared to using them with any client. Affirmative therapy is not a technique, it is a

frame of reference and an attitude that can be utilized with all clients (Ginicola, et al, 2017; Hinrichs & Donaldson, 2017; Johnson, 2012). Following are some of the ways that counselors can provide affirmative counseling by implementing methodologies that they may already use.

Building Rapport

A strong therapeutic alliance and relationship between a therapist and their client is a critical part of working with any client, but especially with those who identify as LGBQQIA (Johnson, 2012). To create such an alliance, the therapist must begin by building rapport with their client. Building rapport with clients who identify as LGBQQIA is the same as building rapport with any client. Counselors build rapport by expressing a nonjudgmental, accepting attitude, and appear to be kind, warm, and caring. Counselors further build rapport with clients by being active listeners, providing support and reassurance, and giving the client the space to think, feel, reflect, and talk about the issues that concern the client without imposing their own thoughts and beliefs. The key difference in building rapport with clients that are LGBQQIA is that counselors should have knowledge about LGBQQIA issues that may impact their client but take care not to assume that the issues facing the client are about their sexual or affectional orientation (Ginicola et al., 2017). Further, a client may not disclose their sexual orientation for fear of judgement; therefore, utilizing affirmative practices will help build rapport even if a counselor is unaware of the client's sexual orientation (McGeorge & Carlson, 2011; Moradi & Budge, 2018).

Assessment, Diagnosis, and Goals

Affirmative counselors should understand that there is, or may be, a connection between the issues facing their client(s) and minority stress including microaggressions they may face on a regular basis. The client may be dealing with chronic stress related to prejudice and

discrimination from not only the general public, but also from friends and family members. This type of chronic stress needs to be accounted for when assessing, diagnosing, and setting goals with clients that identify as LGBQQIA (Ginicola et al., 2017).

It is also important to be aware of coming out issues that may be affecting LGBQQIA clients. Coming out may be a smooth process that strengthens relationships within the family and friends. However, it may also be a long process filled with stress, rejection, and prejudice. While the reasons for coming to therapy may not include stressors related to the coming out process, assessment should include awareness of this possibility (Chazin & Klugman, 2014; Johnson, 2012).

Counseling Practices

Family Systems Approach. Counselors can explore the client's lived experience to gain understanding of the client's personal frame of reference. Counselors will need to show empathic awareness of strengths and struggles to provide for positive and affirmative counseling (Doyle, 2018; Luke & Goodrich, 2015).

Narrative Therapy. Narrative therapy can be used to assist individuals and families in reauthoring their stories from a strengths-based perspective. This can help to build the confidence of the client and improve relationships within the family (Luke & Goodrich, 2015).

Systems Theory Interventions. At the micro level, psychoeducational and counseling groups can provide support and education for the client and/or their families. At the meso level, counselors can work with religious leaders, schools, and community groups to create an atmosphere of personal value to the client, increase resilience, and promote relationship within the community. At the exo level, counselors can provide and receive supervision to develop competence in working with clients that identify as LGBQQIA and their families. At the macro-

level, counselors can provide advocacy for their clients either individually or in a socio-political context (Luke & Goodrich, 2015).

CBT (Cognitive Behavioral Therapy). CBT can be utilized to address dysfunctional thoughts related to being LGBQQIA (Austin & Craig, 2015, Ginicola et al., 2017, Pachankis et al., 2015). It is important, however, to determine whether or not the thoughts are dysfunctional or if they represent actual experiences of discrimination or oppression. It is also important to question the helpfulness of thoughts rather than their validity. If the thoughts are unhelpful, it is important to work with the client to reframe them. Actual experiences of oppression and discrimination should be explored for their effect on the client and to help the client to externalize the blame rather than internalizing it (Ginicola et al., 2017).

Other Evidence Based Practices. Flores & Sheely-Moore (2020) published a study showing the effectiveness of Relational-Cultural Theory-based interventions in helping to reduce the influence of prejudice and discrimination on their internal self-image and help them to make connections with others. Levy et al. (2016) report that Attachment-Based Family Therapy (ABFT) has been used effectively with depressed and suicidal LGBQQIA individuals. Counselors can integrate affirmative therapy with other traditional approaches and with creative therapies such as art therapy, psychodrama, and sand tray activities. Any adaptations made should be in line with the cultural norms and experiences of the client(s) and counselors should work to accept the client and their families as they are, while helping them to grow and develop into healthy functioning systems (Ginicola et al., 2017). The favored view of LGBQQIA affirmative therapy is not population specific, but rather as practices that should be applied in all therapy to all clients (Moradi & Budge, 2018).

Themes in Affirmative Counseling

Moradi & Budge (2018) cite defining themes and affirmative practices for working with all clients. These themes are based on best practices for working with clients regardless of sexual orientation. First, they dispute viewing gender and sexuality as binary choices. They discuss the fact that neither gender nor sexual orientation are yes or no options but are both on a spectrum. By allowing individuals to self-describe their sexual orientation, rather than choosing from a just a predetermined set of options, we do not assume responses or show judgement that only those options are acceptable. On intake forms, this can be done simply by providing a line for "other" and alphabetizing any options listed. This removes the hierarchical judgement of the first option (often listed as heterosexual) as the "best" option (Hinrichs & Donaldson, 2017; McGeorge & Carlson, 2011; Moradi & Budge, 2018).

The first defining theme is the affirmative attitude of the counselor. This means that counselors must counteract their own biases that may pathologize or oppress LGBQQIA individuals. This includes assuming that the client's concerns are all related to their sexuality, overidentifying or being overly enthusiastic about relating to a client who identifies as LGBQQIA and operating on stereotypes based in heteronormativity. Affirmative counselors utilize inclusive language and use preferred language related to their client's relationships, partners, and themselves as well as using inclusive language in materials made available to clients (Chaney & Whitman, 2020; McGeorge & Carlson, 2011; Moradi & Budge, 2018).

The second theme involves counselors gaining accurate knowledge about LGBQQIA experiences and heterogeneity. It is important to learn and understand the stigma and oppression associated with labels associated with being LGBQQIA. Affirmative counselors take the time to learn about the sociopolitical oppression that has affected the LGBQQIA communities

historically and currently. This includes knowledge about stigma, minority stress, identity formation, family structures, and workplace experiences as well as support communities that are available. Affirmative counselors also recognize the strengths and resilience that may have developed to overcome or cope with the minority stress that affects their LBGQQIA clients. (Moradi & Budge, 2018).

The third theme described by Moradi & Budge (2018) is for counselors to transform their knowledge about the LGBQQIA communities and experiences into appropriate therapeutic practices. One way to do this is by helping the client to externalize the stigma and oppression and to not internalize and self-blame. Maintaining a client-centered approach that recognizes individual differences and life experiences without over- or under-emphasizing the client's identity as a sexual minority, is another way to transform a counselor's knowledge into affirmative practice.

Finally, the fourth theme described by Moradi & Budge (2018) is engaging in and affirming challenges to power inequities. This theme is carried out by counselors applying affirmative counseling principals to all clients and being an ally both within the counseling setting and without.

Conclusion

The ACA code of ethics prohibits us from denying treatment with those whose lifestyle we don't approve of on moral grounds and has developed competencies for counseling the LGBQQIA community. Nevertheless, research shows that many counselors do not feel qualified or comfortable treating members of this community. This need for improved confidence and competence in counseling individuals in the LGBQQIA community is why this author has chosen to research affirmative practices for working with this community and share the findings

in the form of a live training along with a resource and education manual directed towards students and counselors who would like to improve their competence and confidence in working with this historically marginalized community.

Training and Resource Manual Introduction

The preceding literature review provided the foundation for the creation of the following manual which is intended as a resource for counselors in training, new counselors, or veteran counselors who wish to improve their competence in working with clients that identify as LGBQQIA.

The training and manual include information based on terminology, human growth and identity development, social and cultural diversity, helping relationships, professional orientation and ethical practice, group work, assessment, and competencies needed as an ally of LGBTQ individuals. This information has been arranged by subject area rather than by competencies as there are overlaps in competency areas. This training is designed to be presented as a 3-hour training that includes two 10-minute breaks. It may also be broken into three 1-hour sessions where each session is ended at the points where the breaks are indicated.

The live training slides and script are included in this document along with the companion reference manual. In presenting this information, a copy of the manual should be made for each participant in the training. Participants can follow along with the presentation and utilize the manual to take notes, and complete exercises as the training is presented.

Prior to the start of training, participants will complete a pre-test to evaluate their current knowledge and confidence in working with LGBTQ individuals. The presenter will then begin the training by handing out copies of the manual to each participant and introducing the topic and purpose of the training. Following the training, participants will complete a post-test/evaluation to assess acquired skills and confidence levels based on the training.

Training Presentation

Slide 1

Time: 1 minute

Script: Hello. Welcome everyone to this training session. Today we are going to be learning about affirmative counseling with LGBQIQA individuals and I promise I will explain what all of those letters mean in just a moment.

My name is Tena Prestidge. I am a student at Minnesota State University – Moorhead in the Clinical Mental Health Counseling graduate program. I have both personal and professional experience with individuals who identify as part of the LGBTQ community which has led me to realize how high the need is for counselors that understand and have competence in working with clients that identify as LGBTQ.

Today's training will provide a foundation for that competency and for an increase in confidence when working with this population.

Slide 2

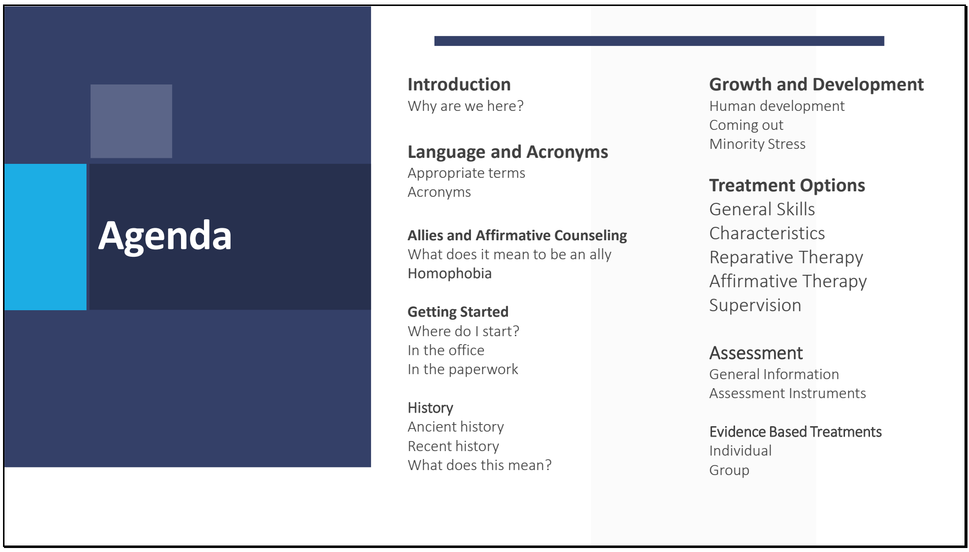
Time: 35 seconds + ~3 min wait time

Script: Before we get started, please turn to page 4 of your handout and complete the pre-training assessment. There are no wrong or right answers. This is just a way for you to gauge where you are currently. For anonymity, feel free to assign a random participant number to your survey instead of using your name. Just be sure to remember what it was because you will need it again for the post-training survey.

<<pause to give group members a chance to complete survey>>

OK, go ahead and gently tear this page out and place them in a stack, face down, on the table in front of us.

Slide 3



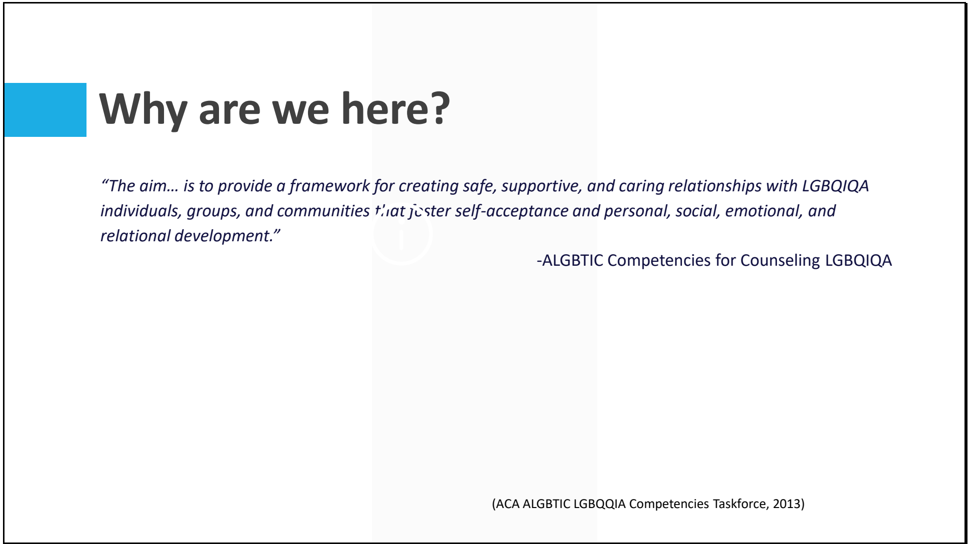
Time: 30 seconds plus wait time for questions (1-3 min)

Script: Today's training will cover several areas which you can see listed here. But first of all, are there any questions before we get started?

<<wait for questions and write them on a whiteboard. If they will be covered in the training, let them know. If not, answer the questions to the best of your knowledge.>>

So now I have a question for you…what brings us to this training?

Slide 4



Time: 1:05 minutes plus wait time (1-3 minutes)

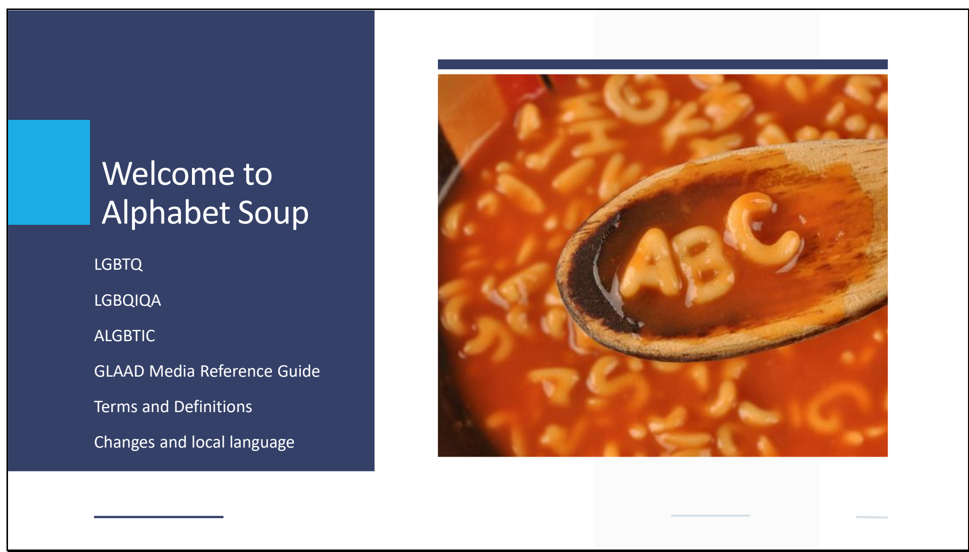
Script: <<Wait for responses. Provide affirmation for why each person has come to the training.>>

These are all very real and valid reasons for being here and I thank you for joining me. We are here primarily because many counselors do not feel qualified or comfortable working with members of the LGBTQ community. The desire for competence and confidence in counseling individuals that identify as LGBTQ is what this training is all about.

This training session is based on current evidence-based practices, and it is guided by the ACA Code of Ethics and the ACA's ALGBTIC Competencies for Counseling LGBQIQA in order to provide a framework for creating safe, supportive, and caring relationships with LGBQIQA individuals, groups, and communities that foster self-acceptance and personal, social, emotional, and relational development.

And if you don't know what all those acronyms mean, bear with me, I will explain those in a moment.

Slide 5



Time: 2:50 minutes

Script: Knowing what terms to use can be confusing and they can vary by state, region, and person. The best way to know which terms to use with an individual in counseling is to ask them what they prefer. For example, during intake you can make it routine to ask all of your clients "What are your preferred pronouns?" If you ask this of all clients, it becomes easier as you get more comfortable with the idea that what you perceive may not be their reality.

Beyond that, a general understanding of appropriate language to use is a way to show that you have some knowledge of the culture. A great place to start is the ACA's competencies terms and definitions. For the most up to date listings of what terms are most currently seen as acceptable, you can also reference the GLAAD Media Reference Guide.

To get a head start on this, lets start with a few acronyms that you have heard already today. Most of you have at least heard LGBTQ.

LGBTQ stands for "Lesbian, Gay, Bisexual, Transgender, and Queer." This is an inclusive acronym for all individuals who identify as other than cisgender and heterosexual. This term will be used when referring to all individuals of these communities.

LGBQIQA stands for "Lesbian, Gay, Bisexual, Queer, Intersex, Questioning, and Ally." This will be used when including all individuals of the LGBTQ community other than Transgender, Genderqueer, or non-binary. This training focuses on the needs of the LGBQIQA community specifically, as the needs and experiences of Transgender, Genderqueer, and non-binary

individuals are unique and are outside of the scope of this training though there are many suggestions that are appropriate for this population as well.

ALGBTIC – This is the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling which is a part of the American Counseling Association and is the name of the group who developed the competencies we will be covering. This group, however, has now revised its name to be more inclusive and is now known as SAIGE (Society for Sexual, Affectional, Intersex, and Gender Expansive Identities.)

Slide 6

Time: 1:15 minutes

Script: You have heard me say the word "competency" several times already. So just what are these competencies that we are talking about?

The ACA/ALGBTIC Competencies are broken down into 10 different areas.
- Human Growth and Development
- Social and Cultural Diversity
- Helping Relationships
- Professional Orientation
- Career and Lifestyle Development
- Assessment
- Research and Program Evaluation
- Being a Competent Ally
- Counseling People who are Intersex
- Counseling Allies

This training will cover 6 of these competency areas listed and each section of the training will include a list of competencies covered in that section. This training is not designed to give you everything you need to know, but to give an overview and a starting place for developing your own comfort, confidence, and competence in working with the LGBTQ communities.

Slide 7

Time: 4:20 minutes plus wait time for questions and answers (4-8 minutes)

Script: Knowing ourselves is the first step towards knowing how to work with the diverse clients that we see.

Awareness is knowing your own identity, in all of its facets, and your biases. It is knowing how your identity is both similar to and different from individuals who identify as LGBTQ. And it is this awareness that helps us work towards minimizing the effect of those biases on our clients.

Our identities consist of many intersecting parts. We identify ourselves by race, ethnicity, indigeneity, socioeconomic status, religion, spirituality, gender identity, sexual orientation, age, abilities or disabilities, immigration or refugee status, primary language, education level, appearance, profession, and many other intersecting parts.

This intersectionality is a framework for conceptualizing a person, a group of people, or social problem affected by a number of discriminations and disadvantages. It takes into account people's overlapping identities and experiences in order to understand the complexity of prejudices they face based on their self-identification. (DEI, 2021)

To understand intersectionality is to understand and acknowledge that everyone has their own unique experiences of discrimination, oppression, and marginalization. (Taylor, 2019)

These pieces of each person’s identity can lead to bias.

Biases are inclinations or prejudices for or against someone or something. To have personal biases is to be human. We all hold our own subjective world views and are influenced and shaped by our experiences, beliefs, values, education, family, friends, peers, and others. As counselors, we need to be aware of how our biases and/or privileges may influence our assessments, choice of treatments, and cause us to overlook challenges faced by an individual. (Psychology Today, n.d.)

The Harvard education web site has a page that helps a person explore their biases. Even if you think you know yours, it is interesting to see what results they provide. (https://implicit.harvard.edu/implicit/selectatest.html)

Let's take a moment now to complete Exercise #1. The first part of this exercise is designed to get you thinking about your own identity. Go ahead and start listing the ways you identify yourself. The second part is to help you think about biases you have encountered personally. Once you have finished the first part, go ahead and do the second. I'll give you just a few minutes to work on this.

<<Wait 2-3 minutes as trainees think and fill in their answers. When it looks like most people have finished go ahead and call them back.>>

OK, would anyone care to share a little about your own identity?

<<Allow volunteers to share a little bit about how they identify>>

As you can see, we all have differences in how we identify ourselves. Some are personal, some are professional. Some we can control. Some we cannot control.

Each of us has also faced bias, either positive or negative, for parts of that identity.

As counselors, we need to understand how our biases can affect our actions and demeanor towards our clients. Regardless of how each of us feels personally about individuals who are part of the LGBTQ population, we are ethically required to set aside those feelings and provide competent counseling.

So what does it mean to be an ally?

Being an ally is more than just being professionally competent in working with individuals from the LGBTQ community. Being an "ally" is taking the next step beyond competence in your counseling sessions and stand up against marginalization and prejudice in your home, workplace, and community.

Competent allies will:

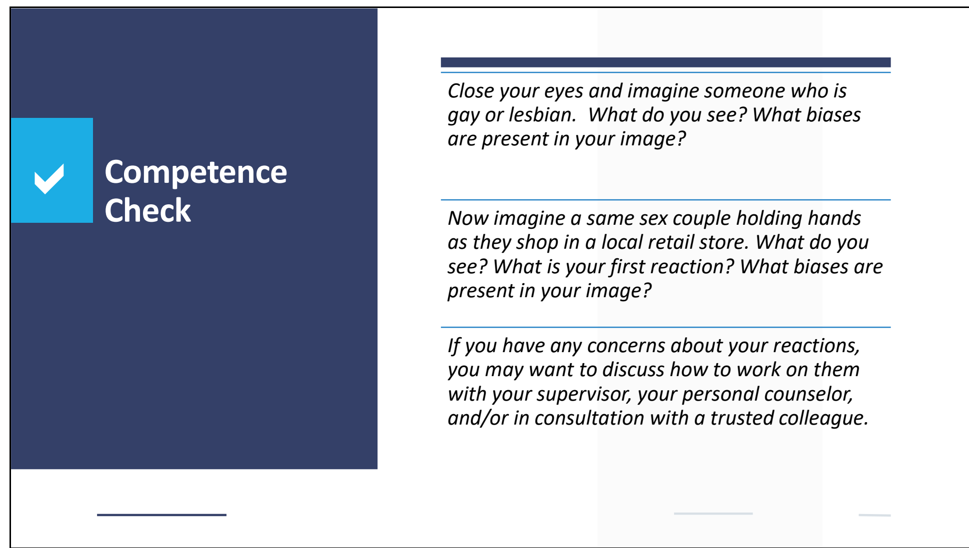
- Have awareness of how their own identity is similar to and different from individuals who identify as LGBTQ.
- Know and understand issues both past and present that have affected the LGBTQ community, including socio-cultural, political, and economic climates and their effect on institutional practices, laws, and policies.
- Support individual's decisions about coming out.
- Facilitate supportive environments in their practice and their community.
(ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013)

Take a moment and reflect on what people can do to show that they are an ally. Fill in your thoughts on page 9 of your workbook.

<<give 2-3 minutes for participants to complete the questions for Exercise 2>>

Would anyone like to share their thoughts? <<give time to discuss>>

Slide 8



Time: 1:45 minutes + wait time (1 min)

Script: Ok, time for a quick **Competence Check.** As I describe each scenario, I want you to close your eyes if you are comfortable doing so. I am going to ask some questions and I don't need you to answer out loud. These are just for your own reflection.

Close your eyes and imagine someone who is gay or lesbian. What do you see? <<pause>>Look at the details of this person.<<pause>> How are they dressed?<<pause>> What is their hair like?<<pause>> What is their body language?<<pause>> Do they look just like everyone else or are there differences?<<pause>> Think about what biases might be present in your image?

<<pause>>

Now imagine a same sex couple holding hands as they shop in a local retail store. What do you see?<<pause>> What is your first reaction?<<pause>> What do you do if they walk in your general direction?<<pause>> What is your facial expression?<<pause>> Think about what biases might be present in your image? <<pause>>

<<pause>>
If you have any concerns about your thoughts or reactions, you can discuss how to work on these things with your supervisor, your personal counselor, and/or in consultation with a trusted colleague.

Slide 9

Time: 3:15 minutes

Script: Right now, society is generally moving towards greater acceptance and understanding of individuals in the LGBTQ community. However, homophobia still exists and can affect these clients' lives greatly.

Our society has a prevalent mindset of cis-gendered, heteronormativity. Even those of us with the best of intentions can sometimes cause hurt through microaggressions. Homophobia is real and it can lead to some horrific actions.

Talking about concepts like homophobia can be tricky. The word homophobia brings to mind extreme situations like Matthew Shepard, who was murdered in 1998 for being gay… or the 49 people who were killed and 53 who were injured in 2016 while at a nightclub in Orlando that was targeted because it was known to be a "gay bar" … or the 44 LGBTQ who were murdered in 2020.

But what about the more subtle forms of homophobia? Where individuals see two same-sex individuals holding hands and feel uncomfortable, so they look away or have their children walk a different direction, so they aren't exposed to it.

Where middle-schoolers and high schoolers bully or ostracize a classmate because they are simply perceived as being gay.

Where individuals find out someone is gay, and curiosity causes them to ask inappropriate questions about their sex life.

Where we see two men give a quick kiss goodbye and our facial expression shows a negative reaction though we quickly hide it because we know it is wrong to judge.

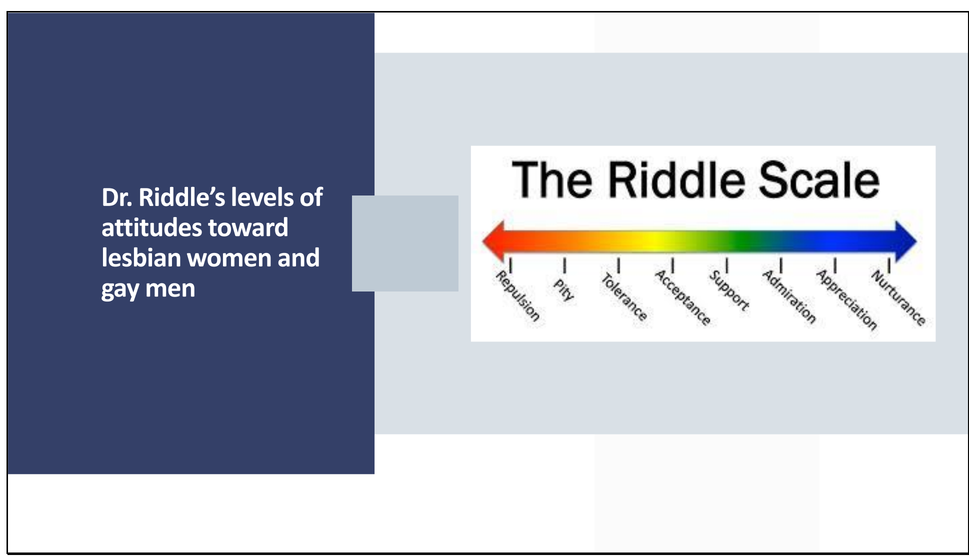
Where we allow our kids to use the term "gay" to mean something is bad. I don't hear this one as often anymore, but for a while, I was hearing "that's so gay" dozens of times a day in the hallways of our schools, at sporting events, and in casual conversations with friends.

Homophobia can be seen in both large and small scale on a day-to-day basis and without the support of allies, young people and adults have to face that pain of rejection alone.

Dr. Dorothy Riddle, a psychologist from Tucson, Arizona, developed what we now call "The Riddle Homophobia Scale" to help us more clearly understand the different levels of homophobia. This scale is presented in your workbook. It shows 9 different attitudes about homosexuality. Four of these are considered negative and four are considered positive "levels of attitude" toward lesbians and gay men. (Betterbeing, 2018).

Some of the descriptions for negative may surprise you. Let's take a look.

Slide 10



Time: 4 minutes plus wait time (3-5)

Script: We start at the far left with Repulsion. Repulsion is the attitude that same-gender sexuality is unnatural - a 'crime against nature." Lesbians and gay men are sick, crazy, immoral, sinful, wicked, …choose the adjective. These individuals believe that helping them "become normal" is to be applauded and anything is justified to change them including imprisonment, hospitalization, aversion therapy, electroshock therapy… whatever it takes to "fix them.."

Moving across, we come to Pity. This is described as heterosexual chauvinism. Heterosexuality is seen as preferable. Any possibility of "becoming straight" should be reinforced, and those who seem to be "born that way" should be pitied.

Next is tolerance. This was once seen as a positive step… to be considered tolerant of people's differences. In this scale, however, it is described as a level where same-gender sexuality is considered just a phase of adolescent development that many people go through and most people "grow out of." Thus, lesbians and gay men are less mature than heterosexuals and should be treated with the protectiveness and indulgence one uses with a child. Lesbians and gay men should not be given positions of authority because they are still working through their adolescent behavior.

Towards the middle, but still on the negative side, is acceptance. Acceptance still implies that there is something to accept. It is characterized by such statements as "You're not a lesbian to me, you're a person!", "What you do in bed is your own business," or "That's fine with me as long as you don't flaunt it!" Again, at one point, having people be accepting was seen as one of

the highest levels that could be expected or hoped for but that was just a step in the right direction.

Looking at the positive end of the scale, the first level seen as positive is support. This is a basic civil liberties position. People at this level may be uncomfortable themselves, but they are aware that homophobia is wrong and work to safeguard the rights of lesbians and gay men.

Next is admiration. At this level, people acknowledge that being lesbian and gay in our society takes strength. People at this level are willing to truly examine their homophobic attitudes, values, and behaviors.

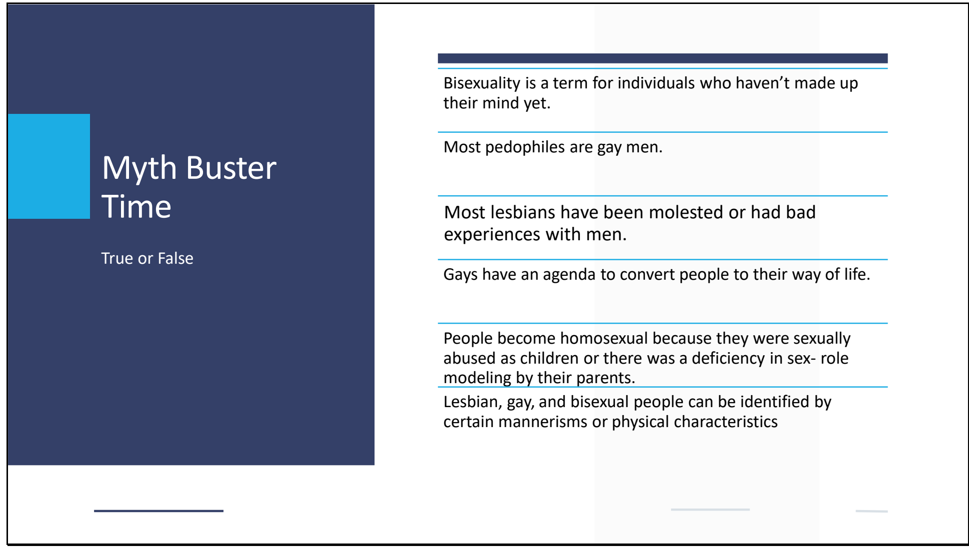
Then comes appreciation. People at this level value the diversity of individuals and see lesbians and gay men as a valid part of that diversity. People at this level are willing to combat homophobia in themselves and others.

Finally comes nurturance. At this level, people assume that lesbians and gay men are indispensable in our society. People at this level view lesbians and gay men with genuine affection and are willing to be allies and advocates. (Adapted from Dorothy Riddle, psychologist. @betterbeing, 2018)

In exercise 3, you have a chance to examine where you are at on this scale as well as if and how you attitudes may have changed over time. Let's take a few minutes to fill in your thoughts about this on page 9 of your workbook. You are not required to share your answers with anyone. This is simply about taking an honest look at where you are at this time.

<<Allow 3-5 minutes for attendees to fill in their answers to exercise 3>>

Slide 11



Time: 4 minutes plus wait time (2-3 minutes)

Script:. Ok, it is time for myth busters. Here is a list of commonly heard statements related to the LGBTQ communities. Take a moment and read each statement and decide if the statement is true or false. You can also find this list on page 10 of your workbook.

<<give participants time to read each statement and write down if they believe it is true or false>>

Alright, Let's take a look at our first statement. "Bisexuality is a term for individuals who haven't made up their mind yet." This is one that I have heard from both heterosexuals and those in the LGBTQ community. This is false.

Some individuals do go through a period of uncertainty as they figure out their sexuality. However, this is not always the case. Some individuals truly are bisexual... and it is not just a phase, experimentation, or indecision. It is who they are. (Cleveland State University. n.d.)

Next statement. Most pedophiles are gay men. This is also false. The majority of child molesters are actually heterosexual men, not lesbian, gay or bisexual people. (Cleveland State University. n.d.)

Next, “Most lesbians have been molested or had bad experiences with men.” Another of my favorite lines like this is “Lesbians just haven’t been with a real man” or the right man or some variation of this. This is also false. In fact, Many lesbian, gay and bisexual people have early heterosexual experiences, but are still lesbian, gay or bisexual; many avowed heterosexuals have had sexual contact with members of their own sex, but are still heterosexual. (Case Western Reserve University, n.d.)

Next, gays have an agenda to convert people to their way of life. False. If there IS a gay agenda, it is pretty well hidden because none of the gay people I know have ever seen or heard what this agenda is supposed to be. (Granderson, 2012)

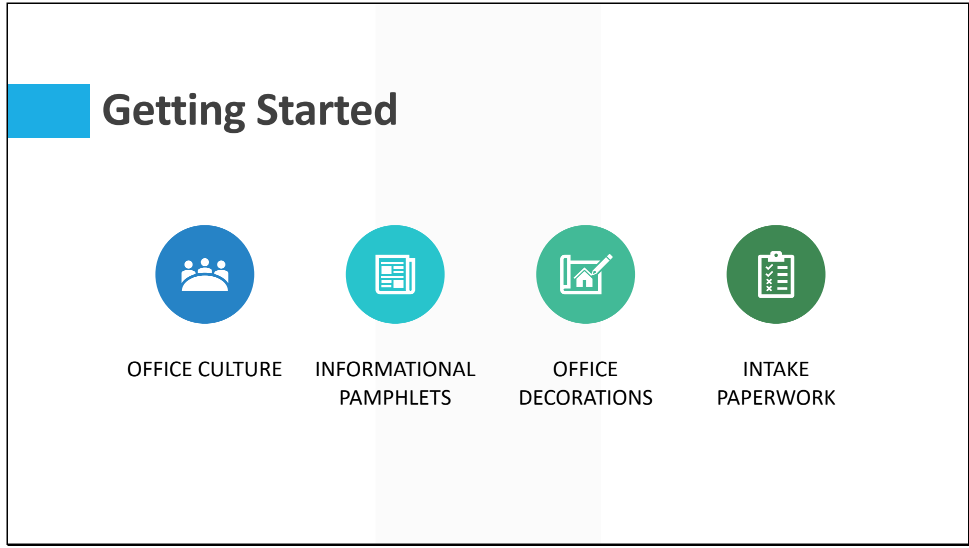
Next item, people become homosexual because they were sexually abused as children or there was a deficiency in sex- role modeling by their parents. False. The truth is, we don’t know exactly what causes one person to be heterosexual and another not to be. What we do know is that modern science cannot state conclusively what causes sexual orientation, but a great many studies suggest that it is the result of both biological and environmental forces, not a personal "choice."(Schlatter & Steinback, 2011)

Next item, lesbian, gay, and bisexual people can be identified by certain mannerisms or physical characteristics. False. “Gaydar” is not an accurate indicator of someone’s sexuality. People who are lesbian, gay, or bisexual come in as many different shapes, colors and sizes as do people who are heterosexual. (Case Western Reserve University, n.d.)

I’m guessing you may have noticed a trend in the answers. Yes, all of these commonly repeated statements are myths. If you want to learn more about some of the myths, do a web search. When I did a search, I found over 6.8 MILLION sites devoted to debunking different myths about the LGBTQ communities.

Now that you have this information, let’s get into what else we need to know to become competent and confident counselors when working with individuals who identify as LGBTQ.

Slide 12



Time: 1 minute

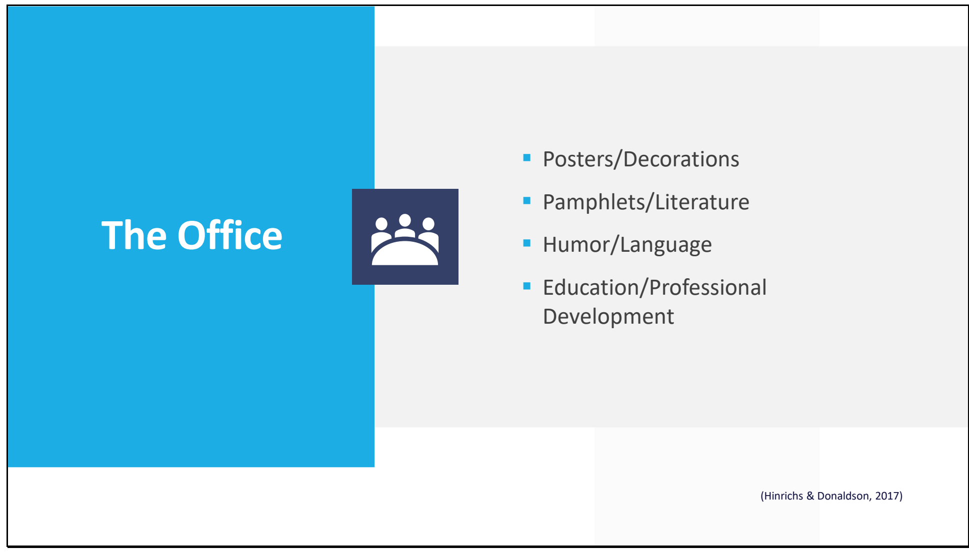
Script:. Are there any questions that you have over what we have covered so far?

<<Pause for questions>>

Ok, so you probably want to know how to make things happen. How do you get started? Well, you are already making the first step towards becoming a competent counselor for LGBTQ individuals by participating in this training. Gaining knowledge and participating in trainings related to working with LGBTQ clients provides an excellent foundation for developing confidence and competence.

The next step is to review your office culture and paperwork. Small changes can make a big difference.

Slide 13



Time: 1:30 minutes

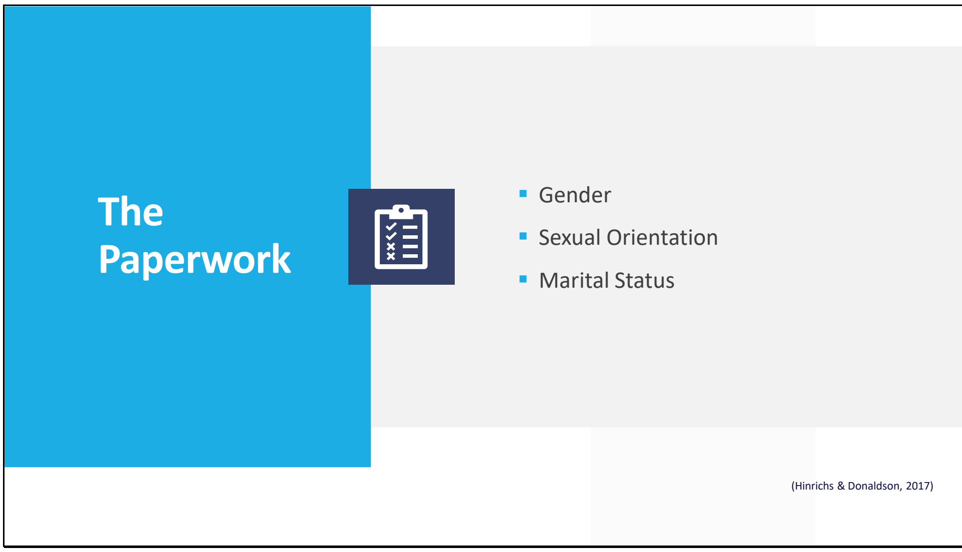
Script: Making your office a place that feels safe and supportive of all individuals is an important part of counseling. One way to do this is to be aware of what they will see when they walk in the door.

- **Literature and Posters.** If you have literature or posters in you waiting area or office, include items that are LGBTQ inclusive. This can include LGBTQ supportive periodicals, books, posters, or take-home LGBTQ-oriented literature. (Hinrichs & Donaldson, 2017).

- **Irrelevant or offensive comments related to gender or sexuality.** You should object to and eliminate jokes or humor that puts down or portrays individuals in stereotypical ways. Further, you need to counter or object to statements regarding gender identity or sexual orientation which are not relevant to decisions, evaluations, or treatment of individuals. (Hinrichs & Donaldson, 2017).

- **Education and professional development.** Counselors need to encourage education and professional development related to intersectional identities and include affectional/sexual orientation and gender identity/expression as a part of embracing a multiculturally diverse workplace. (Hinrichs & Donaldson, 2017).

Slide 14



Time: 3:30 minutes

Script: The use of inclusive language on your intake paperwork helps in providing a safe and comfortable environment for members of the LGBTQ community. Following are some ideas for inclusive language on intake paperwork:

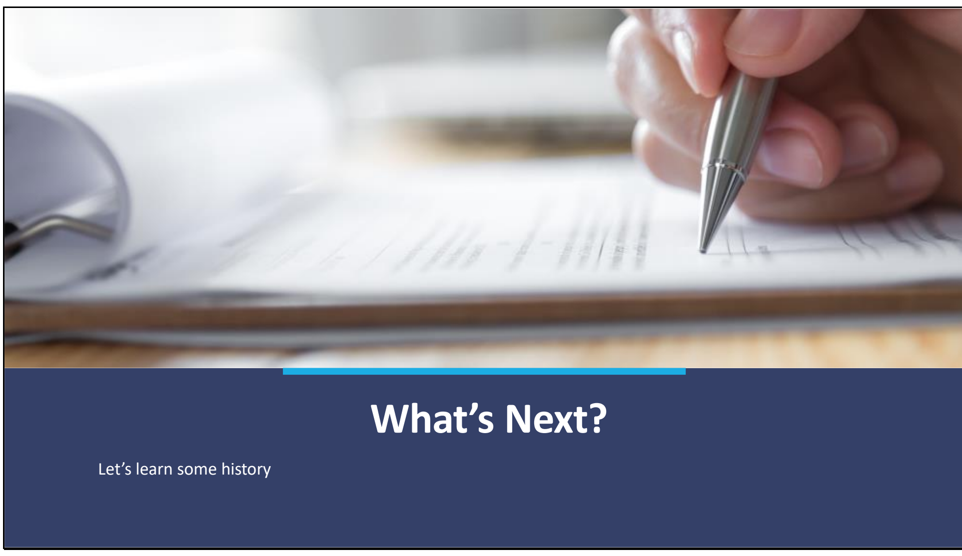
- **Gender.** Any document that asks for gender should include not only male and female options, but also a place for those who do not identify as either. One way to be inclusive and to have affirmative language when it comes to self-identification, is to have gender be a fill-in-the-blank option so the client is free to indicate how they identify. Another option is to include Female, Male, Non-binary, Trans Female, Trans Male, and Other: ________, with the option to write in what "Other" means to them. Previously, simply having male, female, or other was seen as a step in the right direction. However, having only male and female listed while anything else is "other" also shows a form of bias, giving the impression that anything other than male or female is a lesser option. (Hinrichs & Donaldson, 2017).

- **Sexual/Affectional Orientation questions.** Like gender, affectional (or sexual) orientations are not binary. In the past, people were labeled as either straight or gay. For some individuals, these terms are adequate. However, there are many labels to describe one's sexual and/or affectional orientation. Having questions of this nature be open to self-identification is by far the most inclusive option. Another option is to list several of the more common orientations, with the option of "other," is again acceptable. For example:

Asexual, Bi/Pansexual, Heterosexual, Homosexual, Other: _______. Notice that this list is arranged alphabetically. By alphabetizing, it avoids the impression of being arranged hierarchically and thus, avoiding the perception of heterosexism. (Hinrichs & Donaldson, 2017).

- **Marital Status.** With the legalization of same-sex marriage, this is somewhat less antagonizing than it has been historically. However, when thinking of inclusion, we need to think of other possible answers than "Single" or "Married." Having other options, such as Divorced, Married, Partnered, Single, Widowed, and Other: _______, allows for individuals to identify their current status. It can also allow for individuals to share additional information such as living in a poly-family or that they are engaged. Each of these options can make a difference in one's support system and in some of the issues they may face. By allowing multiple or different options, we allow individuals to share information that can be an important part of their treatment. (Hinrichs & Donaldson, 2017).

Slide 15

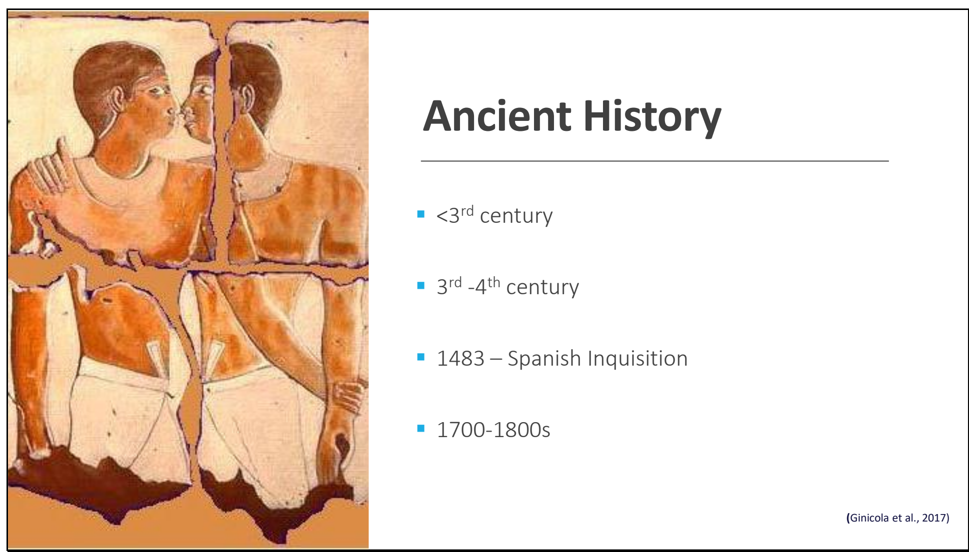


Time: 1:00 minutes

Script: Setting the stage for a comfortable and safe place for individuals that identify as LGBTQ is a positive move towards making your practice more affirmative. However, just LOOKING like a place that offers affirmative counseling does not mean that you are quite there yet…but it is a good start.

Members of the LGBTQ community have historically been pathologized by the mental health community. This has led to a general feeling of mistrust towards mental health practitioners. In order to overcome that history, we need to know a little bit about it and the history of the LGBTQ movement.

Slide 16



Time: 1:00 minutes

Script: Prior to the 3rd century, homosexuality, transgender, and third gender were considered normal and even celebrated in certain societies. (Anderson, 2018, Ginicola et al, 2017).

In the 3rd and 4th centuries, with the rise of Christianity, homosexuality started to be seen as immoral. Laws were passed to outlaw same-sex marriage and eventually, same-sex sexual acts became punishable by death. (Ginicola et al., 2017).

In the following centuries, many laws were passed that outlawed homosexuality. In 1483, during the Spanish Inquisition, over 1,600 individuals were stoned, castrated, and burned for being "sodomites." (Ginicola, n.d.)

In the 1700-1800s, some countries began decriminalizing homosexuality. However, in America, laws against homosexuality were being enacted. (Ginicola et al., 2017).

But that is ancient history…isn't it?

Slide 17

Recent History

- STONEWALL UPRISING (PBS.com, 2020)
- DE-PATHOLOGIZING OF HOMOSEXUALITY (Ginicola, n.d.).
- MILITARY SERVICE (Encyclopaedia Britannica, n.d.).
- HATE CRIMES (CNN.com, n.d.).
- MARRIAGE (History.com, 2018).
- FAMILY (Biden, 2021).

Time: 5:30 minutes

Script: Let’s look at things that are a little more recent.

In 1969, police raids on bathhouses and gay bars were common. That year, police raided a mafia-run bar that was a known hang-out for gays, lesbians, and cross-dressers. This time was different than usual. Instead of the patrons being arrested or fleeing, they resisted. This was the start of the Stonewall Riots which lasted 6 days and became a turning point in the gay civil rights movement. (PBS.com, 2020)

As a side note, an interesting documentary about the Stonewall Riots was produced by PBS and can be found online. The site address is listed in the workbook.

Following the Stonewall uprising, the LGBTQ civil rights movement became more prominent. In **1973**, the APA removed homosexuality from the DSM. Until this time, homosexuality was perceived to be a mental disorder that needed to be treated and “cured.” (CNN.com, n.d.)

In **1978** – Harvey Milk, a leading political activist for the gay community and one of the country’s first openly gay elected officials, was murdered. (History.com, 2018)

It wasn’t until **1992** that the World Health Organization removed homosexuality from its list of illnesses. (Ginicola, n.d.).

In **1993** - Defense Directive 1304.26 was issued. This directed that military applicants were not to be asked about their sexual orientation. This policy became as known as "Don't Ask, Don't Tell." This was adopted in 1994 as the official federal policy on military service, requiring sexuality be kept in the closet and if it wasn't, consequences could follow, including discharge from service. (Encyclopaedia Britannica, n.d.).

In **1996** the Defense of Marriage Act (DOMA) was passed into law. This law defined marriage as between one man and one woman. It also instructed that neither states that banned same-sex marriage or the federal government were required to recognize same-sex marriages performed in states where it was legal. (Defense of Marriage Act, 1996).

It wasn't until 2009 that the United States Hate Crimes Act, originally passed in 1969, was expanded to include crimes motivated by a victim's actual or perceived gender, sexual orientation, gender identity, or disability. (CNN.com, n.d.).

On September 20, 2011, Don't Ask, Don't Tell was finally ended. Over 10,000 service members previously discharged for their LGBTQ+ status were offered re-enrollment and future recruits were advised that they would no longer face discrimination when trying to serve their country. **(CNN.com, n.d.).**

In **2013** – Supreme Court ruled that Section 3 of DOMA was unconstitutional. This meant that the federal government had to recognize the legal marriages of same-sex couples. Because Section 2 of DOMA was not found unconstitutional, the ruling still did not require any state to legalize or recognize these marriages. **(CNN.com, n.d.).**

In **2015,** the Supreme Court ruled that states cannot keep same-sex couples from marrying and must recognize their unions, thereby granting the right to same sex marriages in all 50 states. **(History.com, 2018).**

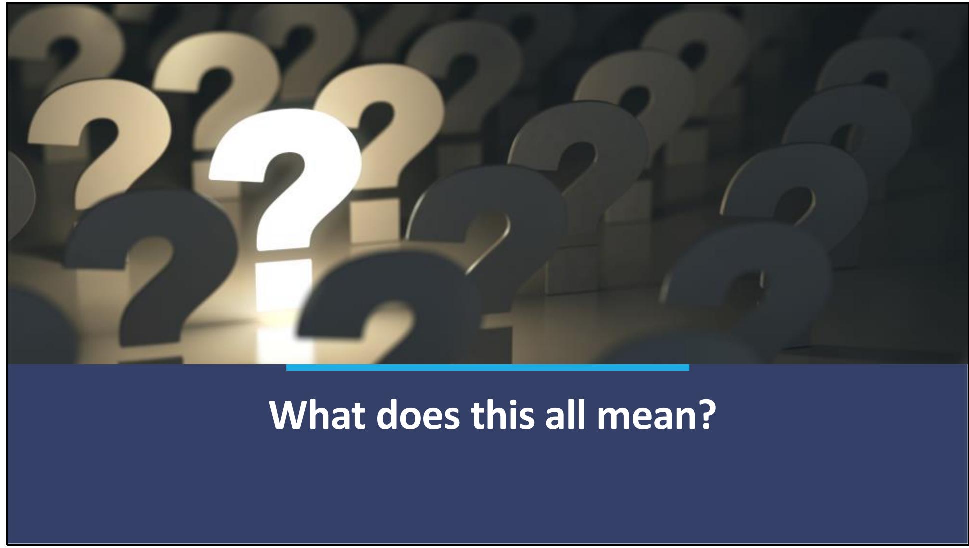
In **2016,** 56 years after being banned from service, transgender individuals were allowed to serve in the US military. In 2017, this ban was reinstituted and then seemingly some waffling went on in the government about the people they had just started letting to serve and if they should be allowed to continue serving or not. Eventually this boiled down to transgender individuals being allowed to serve with specific conditions. Most of those conditions required them to serve as individuals with their biological sex rather than their preferred sex. (Diamond, 2017).

In 2021, Military service by transgender individuals was allowed again but this time with no restrictions. **(Biden, 2021).**

In 2022 the Texas governor attempted to take trans youth away from supportive parents, stating that gender affirming medical services for trans youth is "child abuse." Lawsuits are pending related to this matter.

Other lawsuits are pending in several other states related to denial of coverage for treatment of trans youth. The ACLU's website has more information on these cases. **(Biden, 2021).**

Slide 18

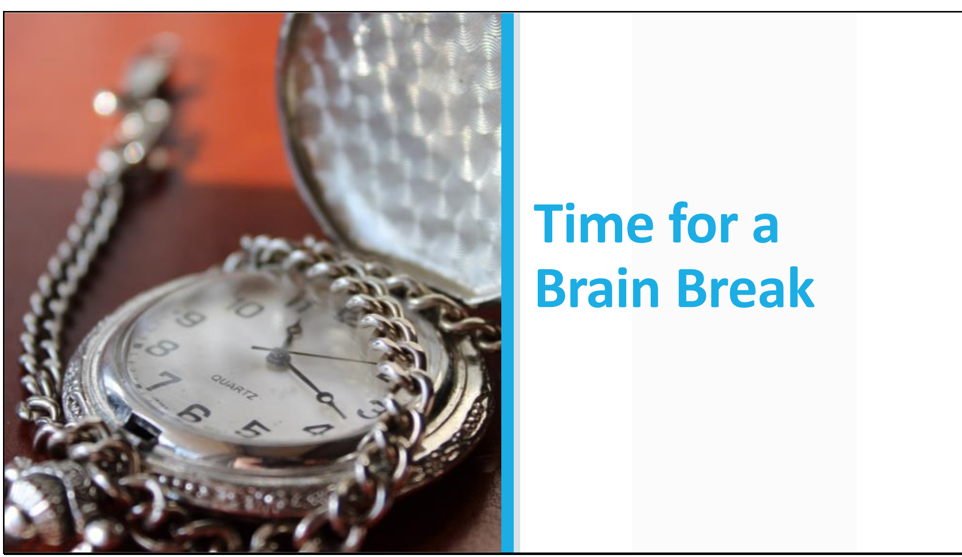


Time: 1:00 minutes

Script: To boil it down, the socio-political environment in America is improving for LGBTQ individuals…but there are still groups in this country that, while some mean well, marginalize, terrorize, and otherwise try to invalidate the value of these individuals as human beings. From hate crimes to microaggressions, these can build up to a terrifying existence for some members of the LGBTQ community.

One thing to remember is that people are more than their sexual or gender identity. There are many intersecting parts that make each person's experience unique.

Slide 19

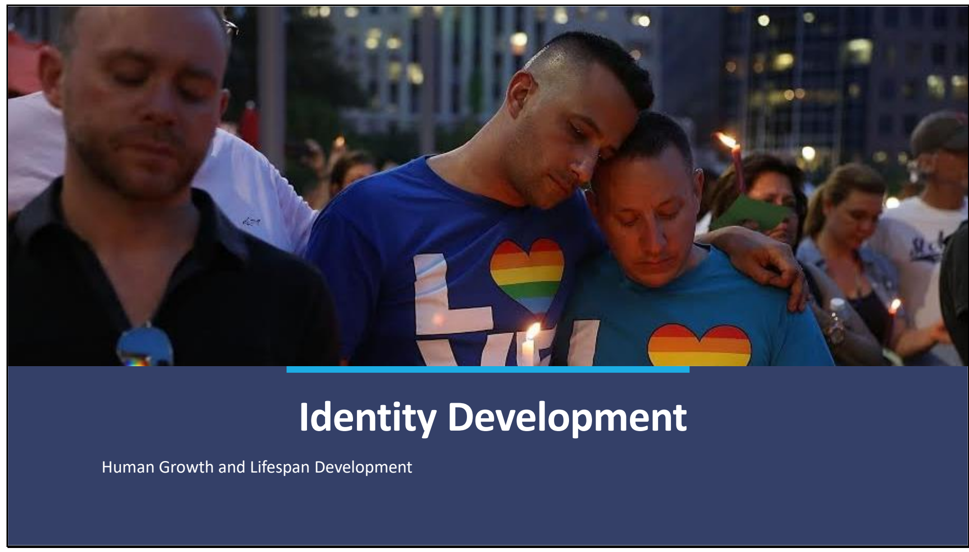


Time: 0:30 minutes plus break of approximately 7-10 minutes

Script: So far, we have talked about a lot of internal work for being aware of our own attitudes and behaviors, terminology, setting up your office space, and some history of the LGBTQ civil rights movement. Let's take a short break so you can stretch your legs, use the restroom, or find some coffee.

<<Give attendees a 7 - 10-minute break…When break is over, bring them back to focus>>

Slide 20



Time: 0:30 minutes

Script: I hope you had a refreshing break. Let’s get back to the topic at hand.

WE have looked at some terminology, our identities and biases, homophobia, and some socio-political issues related to being LGBTQ, and a little about intersecting identities. Now let's look more closely at how individuals who identify as LGBTQ develop their identities.

Slide 21

Time: 0:30 minutes

Script: Most of us have heard of Maslow's hierarchy of needs. In this theory, Maslow states that as needs are met at lower levels, needs from higher levels emerge.

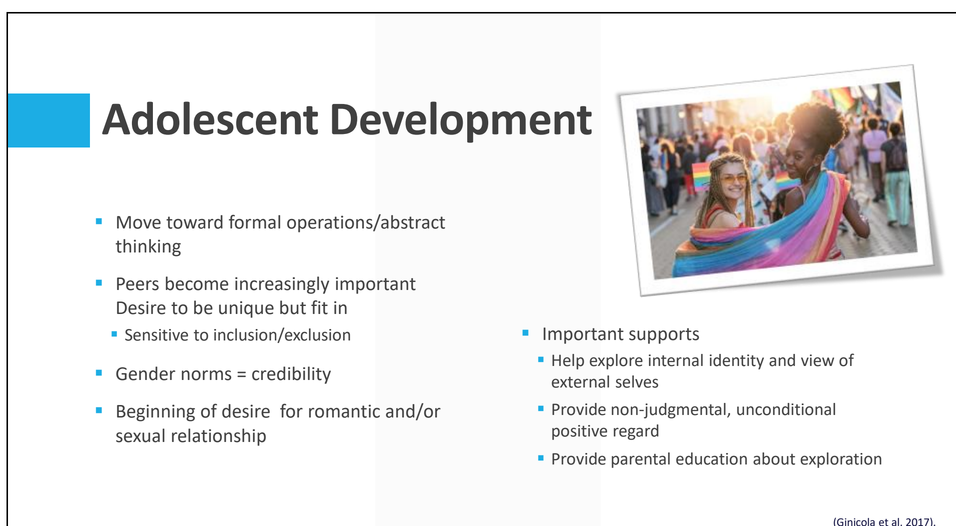
In short, this diagram helps us to understand that all individuals need safety, belonging, love, and respect to grow and develop in a healthy way.

Slide 22

Time: 1:45 minutes

Script: In early childhood, children are egocentric, start with parallel play, engage in make-believe or fantasy play, and have a dichotomous and reductionist way of thinking. As they grow, assuming their physiological and safety needs are met, they move towards a more logical and sequential way of thinking. They begin to play cooperatively, often choosing same gender friends and gender typical roles in play and begin comparing themselves to others. At this time, some of the first indications of gender fluidity might be seen as individuals may choose opposite gender friends and roles as they play. Allowing children to explore these gender roles in play without judgement allows them to determine what feels right to them and provides a foundation of support for identity growth. Throughout their elementary school experience, they are developing their sense of self through the feedback they receive from parents, peers, and other adults. If they feel a lack of acceptance, it can lead to feelings of inferiority. Bullying for non-conformity is common and can lead to low motivation, low self-esteem, and lethargy. This type of negative experience can halt or delay other areas of development until their feelings about it can be resolved and the situation is stopped. It may cause suppression of their individual identity and withdrawal from friends and family. **(Ginicola et al, 2017).**

Slide 23



Time: 2:00 minutes

Script: In adolescence, the role of their peers becomes increasingly important. Their thinking moves toward more formal operations and abstract thinking. They begin to define themselves as unique individuals but also seek to fit in with their peers, becoming increasingly sensitive to group belonging or exclusion. This time can be particularly difficult for those who feel that their attractions or their bodies are not what they feel they should be. Gender norms and expectations are primary foundations for credibility and acceptance, with boys being lauded for athletic ability and girls for social leadership. Those who do not align with these norms often experience lower self-esteem and feelings of isolation. By middle to late adolescence, the desire for intimate emotional connections increases and a desire for romantic and/or sexual engagement begins to develop. (Ginicola et al, 2017).

How can we help?
As counselors, we should help students explore who they are internally and how they view themselves in the world, without judgement and with the Rogerian view of unconditional positive regard. We can also help parents to understand the growth and development needs of their children and the need to be allowed to explore their identities without shame or ridicule. We can help parents understand that this exploration does not definitively mean that their child is gay, lesbian, or transgender. It simply means that they are exploring their identity which is not "set in stone" and may evolve over the course of their development. (Ginicola et al, 2017).

Slide 24

Time: 2:30 minutes

Script: In early adulthood and the college years, individuals are working to overcome any negative experiences they have encountered in their high school years. This is also the time where identity and development of both platonic and romantic relationships are at the forefront. Past or current bullying, physical and emotional abuse can interfere with identity formation and authentic bonding with peers.

Coming out, if in a supportive environment, can facilitate identity development. However, if an individual comes out in a non-supportive environment, it can increase mental health concerns and reduce the ability to practice relationship skills.

While college campuses have improved their stances towards LGBTQ individuals, exclusion, ostracization, and negative attitudes still exist. For this reason, nearly 51% of LGBTQ individuals choose not to disclose their sexual orientation out of fear. This fear and inhibition cause difficulty in making other decisions as well, including those related to career paths.

Counselors need to be aware of the stigma and discrimination that young adults face in their college or career endeavors. A crucial aspect of counseling at this stage is to assist the client in learning how to develop their social supports. It is also important to have discussions on how they will deal with prejudice and discrimination in the workforce.

There are some protections against workplace discrimination, however, it is not uncommon for individuals who are openly LGBTQ to face barriers in the workforce.

Individuals who pursue a career in the miliary have even fewer supports available. It is often the attitude of military personnel that seeking help to deal with anything is a sign of weakness, so those struggling with issues related to being LGBTQ often fear reaching out for support. (Ginicola et al, 2017).

Slide 25

Time: 2:50 minutes

Script: Middle adulthood is a time when relationship issues are often the source of couples seeking counseling. LGBTQ couples face the same issues as hetero couples but have added stressors due to living in an oppressive environment or external biases that impact their relationship. Some difficulties may come from the lack of acceptance by one (or both) of the partner's families and the level of "outness" of each partner. Couples that live in smaller towns may also face community issues including feeling isolated from other LGBTQ couples.

This is also the time when marriage and family planning happen. The decision to have (or not have) children is more complex with same sex couples than for heterosexual couples. Not only do they face challenges of natural conception versus IVF versus adoption decisions, but also, whatever choices they make for having a child will often cause financial issues due to costs associated with adoption, medical costs of Invitro Fertilization, or surrogacy. Bias, adoption agency protocols, and birth parents can all impede the placement of adopted children with LGBTQ parents. It is also important for couples to understand that children will make the relationship more visible to the community due to school and other events that the child will be involved in.

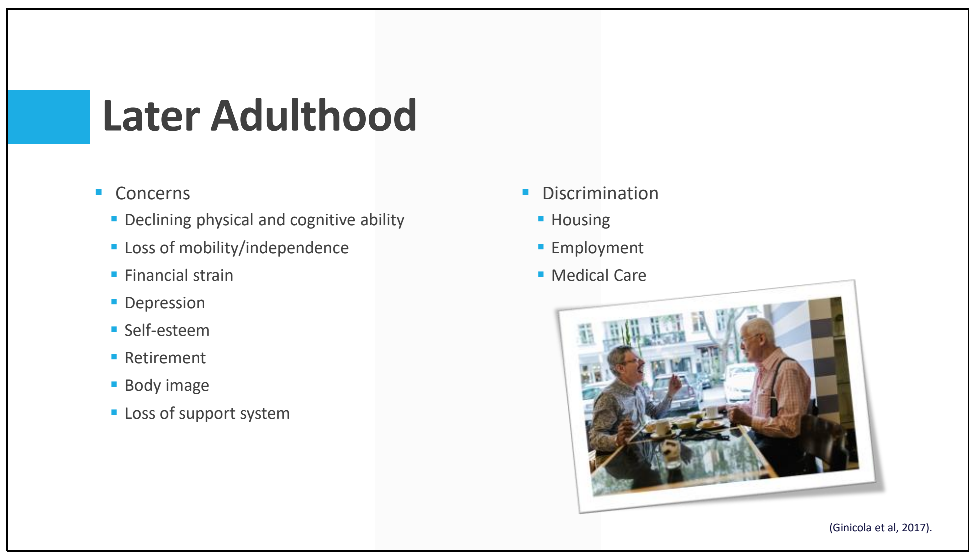
This can impact the decision on having children depending on the level of comfort each partner has with being "out."

As counselors, we must be affirming of our clients' relationships. It is also important to understand that heterosexist attitudes can cause additional strain on relationships. It is

important to know that counselors often show hetero- and mono-sexual bias which can impede the therapeutic process. It is also helpful to be aware of queer norms and parenting issues faced by LGBTQ couples.

The most important aspects of counseling LGBTQ couples are the capacity to actively listen, empathize, and to assist couples in communicating feelings and needs to each other. Having a strong therapeutic relationship that is collaborative is the means to effectively counseling LGBTQ couples at this place in their lives. (Ginicola et al, 2017).

Slide 26

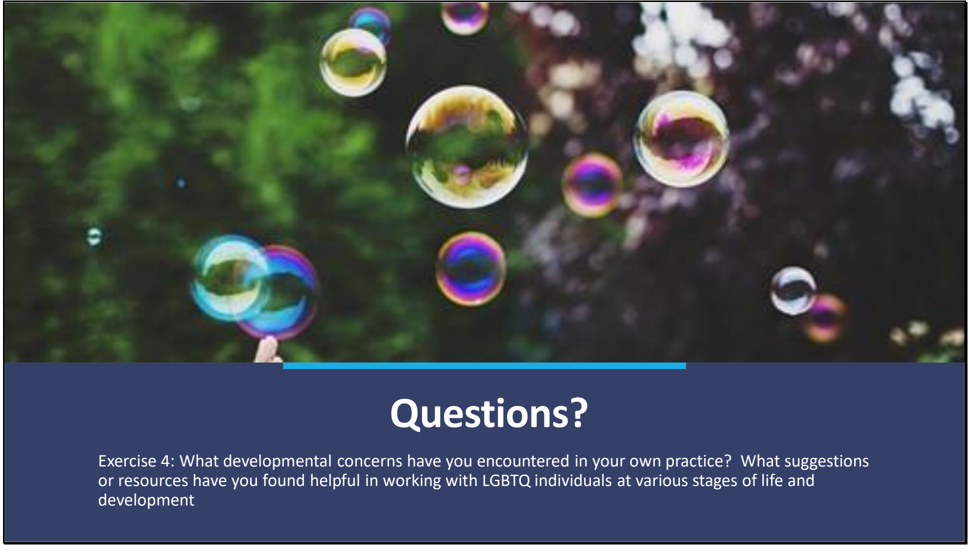


Time: 1:00 minutes

Script: In later adulthood, many of the concerns of individuals who identify as LGBTQ are very similar to those of heterosexual individuals. They have concerns about declining physical and cognitive ability, loss of mobility and independence, financial strain, depression, lowering self esteem as they face retirement, and body image.

Generational issues are currently an issue as well. Older adults have not grown up in a time where being openly LGBTQ was acceptable. They may have never come out openly to their families and may fear losing their support system. They can also face discrimination in housing, employment, and medical care. (Ginicola et al, 2017).

Slide 27



Time: 1:00 minutes + wait time (3-4 minutes)

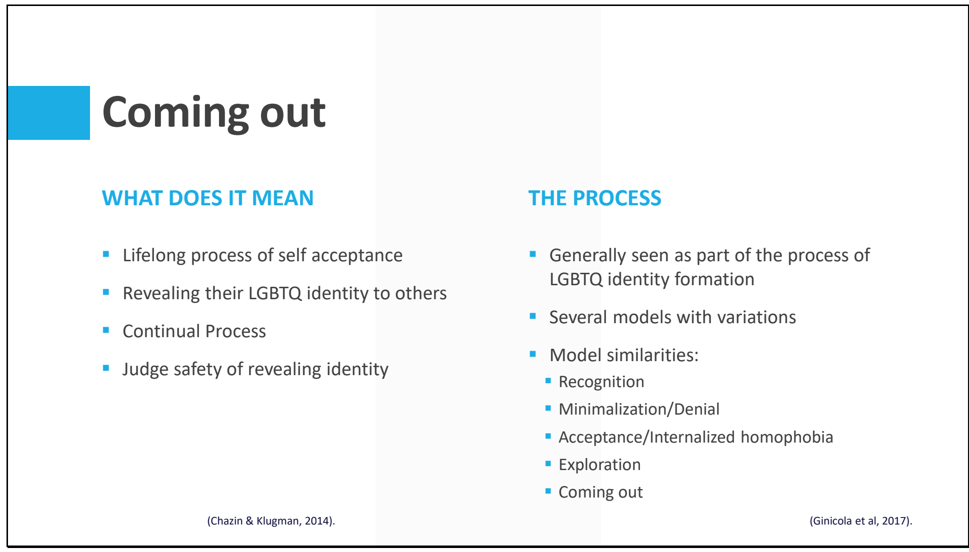
Script: Does anyone have questions at this time? <<pause to allow time for questions and answers>>

Those were great questions. Now is time for a couple of questions for you…In your workbook, on page 23 you will find exercise 4. In the space provided, please take a moment to think about and write down what developmental concerns you have encountered in your own practice and what suggestions or resources you have found helpful in working with LGBTQ individuals at various stages of life and development.

<<Give participants time to process and write answers>>

Would anyone be interested in sharing any resources or suggestions? <<give participants time to share their ideas and resources.>>

Slide 28



Time: 4:30 minutes

Script: Coming out is lifelong process of self-acceptance. People forge an LGBTQ identity first to themselves and then they may reveal it to others. Publicly sharing one's identity may or may not be part of coming out.

This is a continual process that occurs multiple times for LGBTQ persons over the course of their lifetime. Although many people think that one is either "out" or "in," this usually refers to a person's general openness with others about who he or she is. However, each time an individual encounters a new situation with new people, they must assess how safe and/or comfortable they are in sharing this information. Many times, this process can be difficult due to heterosexism, sexism, genderism, homophobia, biphobia, transphobia, and so on.

As counselors, we must be careful to not assume that LGBTQ identity development or the coming out process are factors in a client's mental health concerns. Neither of these cause mental health issues. However, the additional stressors of minority identification can contribute to them. (Chazin & Klugman, 2014).

The Process

Coming out is often seen as a part of the process of LGBTQ identity formation. There are several LGBTQ identity development models. Most of these models include an individual's recognition that their experiences of attraction do not represent the heterosexual norm. Prior to puberty,

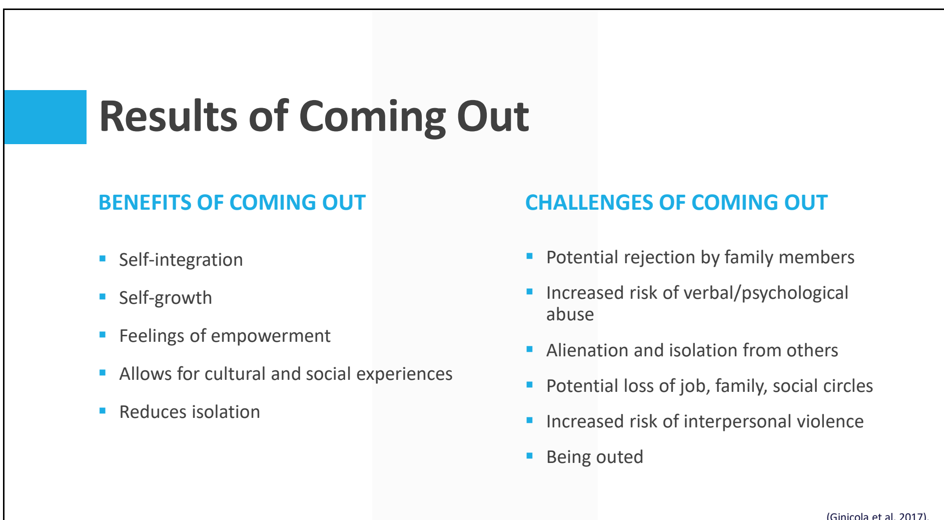
individuals are exposed to societal heteronormative beliefs as well as stereotypes associated with non-heterosexual individuals. If an individual feels that their experience may be different than the norm, they may feel confused or distressed. At this point, they may not realize that the differences are related to their sexuality, but they do recognize that their experience may be different than their same-sex peers. There is often a period of minimization, denial, and rejection of their experiences and feelings. (Ginicola et al, 2017).

Following this comes a gradual acceptance. The individual's environment plays a large role in this acceptance. If they have a supportive environment, this acceptance tends to happen more smoothly and with less internal trauma. If a child grows up in an environment where they hear homophobic talk, jokes, or religious teachings, it can contribute to a much more difficult period of personal acceptance. This can lead to feelings of shame, sinfulness, anxiety, depression, internalized homophobia, suicidality, and substance abuse.

As the individual comes to at least some level of acceptance, they may start making contacts within the LGBTQ community. This can help them to learn more about the community and fulfill various emotional, social, and sexual needs. If their experience is positive, they will generally learn greater acceptance of their own identity. If not, it can lead to increased internalized homophobia and emotional distress. (Chazin & Klugman, 2014).

At some point, individuals usually consider coming out to the people they care about. Most often, the individual will come out to a trusted friend or two before coming out to their families. Once this has taken place, they will often come out to a sibling before doing so with their parents. (Ginicola et al, 2017).

Slide 29



Time: 4:00 minutes
Script: Coming out may be a smooth process that strengthens relationships within the family and friends. However, it may also be a long process filled with stress, rejection, and prejudice.

When choosing to come out, individuals must weight the benefits and risks of doing so to each individual person they come out to. This is why they generally come out to the people they are closest to first and then to their immediate family. These initial revelations can set the stage for their own personal acceptance versus internalizing homophobic feelings.

Some of the **Benefits of Coming Out** include being able to integrate their sexuality with their personal identity, self-growth, and feelings of empowerment. By being out, at least with some people, they are more able to explore their identity as a member of the LGBTQ community and learn more about that culture. Doing so allows them to expand their social experiences and reduces the isolation that contributes to depression and other mental health issues.

There are also risks and **Challenges related to Coming Out.** Coming out to friends and family members opens them up to possible rejection by the people they value most. There is an increased risk of verbal and psychological abuse by the people they love the most and others. If they are rejected for their identity, they may face alienation and isolation from others and an increased risk of interpersonal violence.

Depending on their home situation and family acceptance or rejection, they may also end up facing homelessness. According to research statistics cited by Sellers in a 2018 study, even though LGBTQ youth make up only a fraction of the total population, they represent

approximately 40% of the homeless youth population. Of those homeless youth, a majority cite either leaving home because it became unbearable to live with the rejection of their family or they were kicked out of their homes for their identity.

Individuals who come out, or are outed, face the potential loss of their family, social circles, and in some cases, even their jobs.

Coming out is something individuals face each time they are in a new situation or meet new people. Not all individuals are out in every area of their lives due to some of the risks associated with doing so.

Some individuals are not given the choice about coming out to various people because someone to whom they have shared their identity decides to share the information with others without the express permission of the LGBTQ individual. **(Ginicola et al, 2017).**

As counselors, we need to understand that individuals may not come out to us due to fear of rejection, lack of relevance to the counseling goals, or hesitation to reveal their orientation until trust is developed. Our role is to offer support and understanding to the individual and to avoid unintentional microaggressions through heteronormative language. Should they reveal their orientation to us as part of the concerns they have about coming out, we can help them to understand their own feelings about coming out, support them throughout the process, and help them to understand that the process and extent that they come out should be their decision alone.

While the reasons for coming to therapy may not include stressors related to the coming out process, assessment should include awareness of this possibility. (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).

Slide 30

Time: 30 seconds plus writing (2-3 minutes) and sharing (2-3 minutes)

Script: Does anyone have questions? <<pause to allow time for questions and answers>>

Now is time for another question for you…In your workbook, on page 26 you will find exercise 5. In the space provided, please take a moment to think about and write down what skills and characteristics you possess that can facilitate your practice with LGBTQ clients.

<<Give participants time to process and write answers>>

Would anyone be interested in sharing your thoughts? <<give participants time to share their ideas and resources.>>

Slide 31

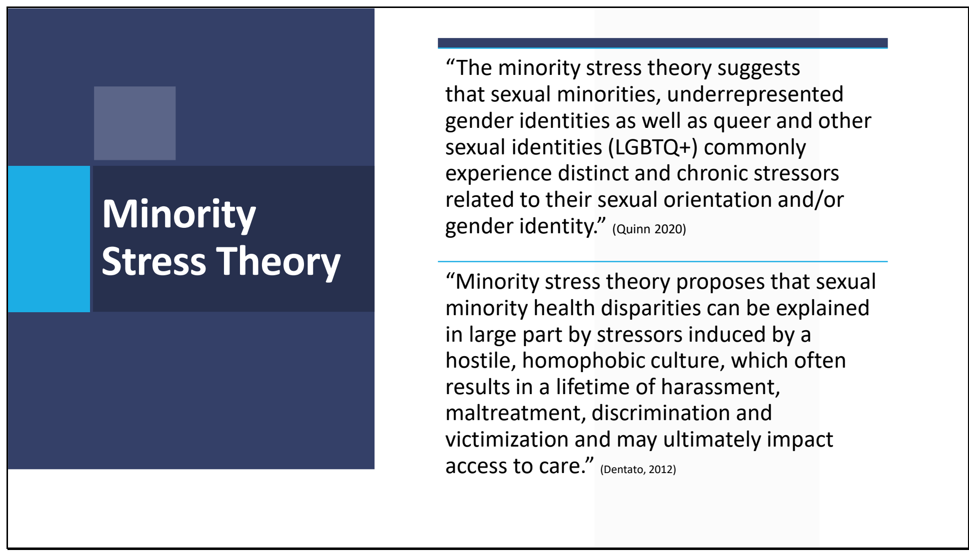
Time: 30 seconds plus time to share (1-2 minutes)

Script: How many of you have heard of the minority stress theory? What can you tell me about it?

<<Give participants time to share what they know about minority stress model/theory>>

Minority stress model states that persons from a non-dominant background encounter chronic stress due to the experiences of prejudice, discrimination, and microaggressions they face every day which, in turn, can cause greater psychological disturbances.

Slide 32



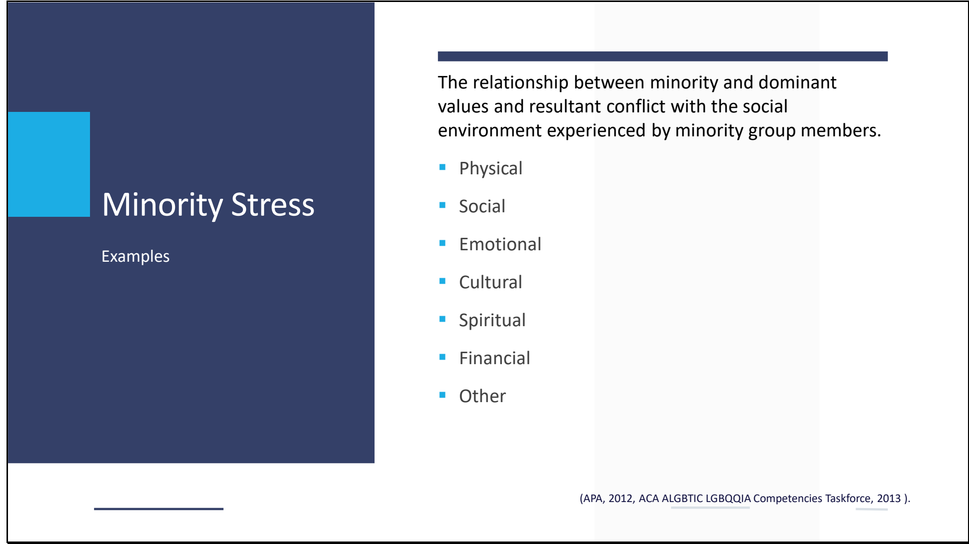
Time: 1:15 minutes

Script: Here are a couple of quotes that helped me to understand better how to articulate what this theory (or model) is as it relates to LGBTQ communities.

“The minority stress theory suggests that sexual minorities, underrepresented gender identities as well as queer and other sexual identities (LGBTQ+) commonly experience distinct and chronic stressors related to their sexual orientation and/or gender identity.” **(Quinn 2020).**

“Minority stress theory proposes that sexual minority health disparities can be explained in large part by stressors induced by a hostile, homophobic culture, which often results in a lifetime of harassment, maltreatment, discrimination and victimization and may ultimately impact access to care.” **(Dentato, 2012).**

Slide 33



Time: 4:45 minutes

Script: Minority stress is the relationship between minority and dominant values and resultant conflict with the social environment experienced by minority group members (APA, 2012).

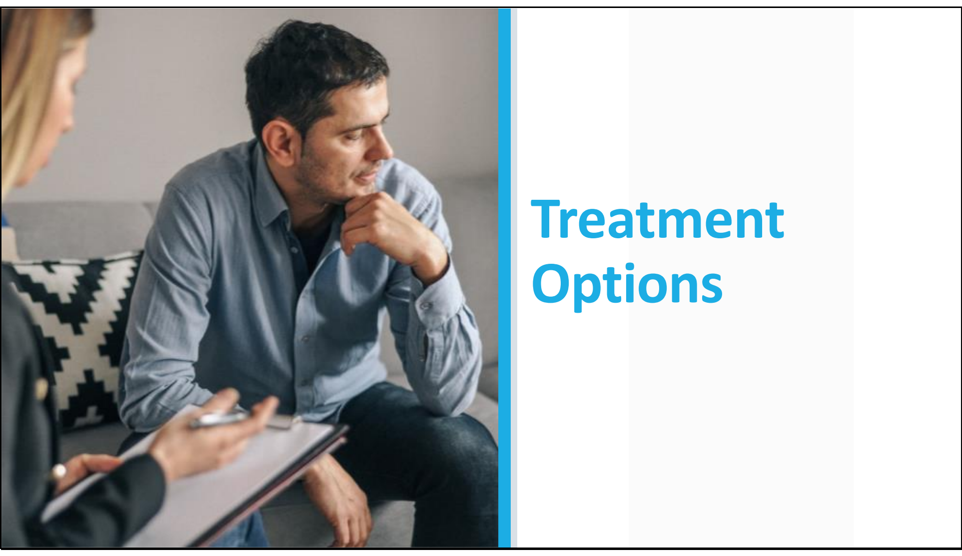
Some of the minority stressors that individuals who identify as LGBTQ may face include:

- Physical stressors
  - At times it is difficult for LGBTQ individuals to access to appropriate health care from professionals who are affirming
  - HIV – not only the risks of infection, but the stigma associated with being gay and having HIV
  - LGBTQ individuals also have a higher risk of physical assault than cis-gender, heterosexuals
- Social stress
  - They may face a lack of family support or outright rejection by their families
  - There may be additional strains on their partner relationships due to the external stressors listed here
  - They also risk losing friendships upon coming out
- Emotional stressors
  - LGBTQ individuals have an increased risk of developing Anxiety
  - Depression
  - Substance abuse and
  - Suicidality

    - We have discussed the increased risks of these already.
- Cultural stressors
    - They may face a lack of support from others in their racial or ethnic groups
    - We need to keep in mind all of the intersecting identities that can add to their minority stress on top of being LGBTQ
- Spiritual
    - Individuals may face conflicts between the spiritual teachings they were brought up with and their experience or identity and feel shame and internalized homophobia because of these conflicts.
    - There may be conflicts between their beliefs and those of their family
    - They may feel that they have to change religions or turn their back on their spiritual beliefs that were not affirming or supportive of their identities
    - It is important to note, however, that being LGBTQ does not immediately turn people away from their faith. For many, their faith can be a resiliency factor and more and more religious leaders are embracing individuals who identify as LGBTQ with a range of acceptance.
- Other Stressors they may face include
    - financial problems as a result of employment discrimination
    - or potential homelessness.
    - Youth may be kicked out of their homes by unsupportive families or forced to leave, because of the intolerable environment unsupportive family members may cause.
    - As adults, homelessness can also be a concern as a result of housing discrimination.
    - Microaggressions – Microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or not, that communicate hostile, derogatory, or negative slights or insults to ward persons of a certain cultural background. At first this definition was seen as describing what happens with non-dominant races or ethnicities. Now, however, it is understood to apply to the LGBTQ experience as well.

Affirmative counselors should understand that there is, or may be, a connection between the issues facing their client(s) and minority stress (including microaggressions) they may face on a regular basis. The client may be dealing with chronic stress related to prejudice and discrimination from not only the general public, but also from friends and family members. This type of chronic stress needs to be accounted for when assessing, diagnosing, and setting goals with clients that identify as LGBQT. (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013)

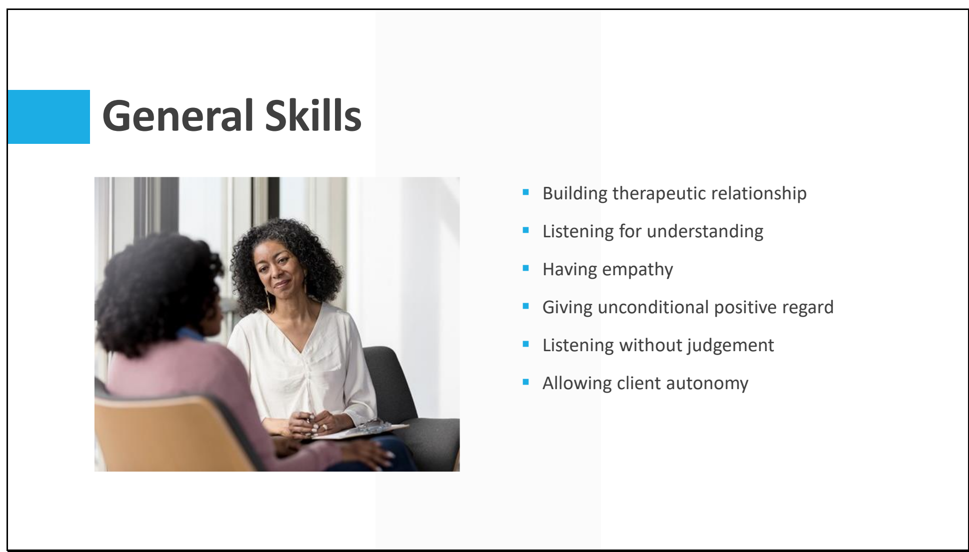
Slide 34



Time: 0:30 minutes

Script: So, now that you have more general knowledge about the LGBTQ community, history, experience, and minority stressors… let's look at what treatments are most effective in working with this community.

Slide 35



Time: 0:03 minutes

Script: As with all of our clients, building the therapeutic relationship is essential. Some our greatest skills are not based on specific theories or techniques. Instead, they are in our listening skills, empathy, and unconditional positive regard… our ability to listen without judgement and allow the client to have autonomy.

Slide 36

- Non-pathologizing of their LGBTQ identity
- Portray warmth and caring
- Non-judgmental and accepting
- Sensitive and open
- Allows for space and time to think, reflect, process, and feel
- Provides support and reassurance
- Are safe and open minded
- Facilitate open and honest discussions about LGBTQ issues

Time: 2:00 minutes plus wait time and discussion (2-3 min)

Script: Some characteristics cited as important to LGBTQ individuals include:

- Counselors who are Non-pathologizing of their identity
- Counselors who portray warmth and caring, are Non-judgmental and accepting, and Sensitive and open.
- Counselors who allow for space and time to think, reflect, process, and feel and who provide support and reassurance
- Counselors who are safe and open minded and who facilitate open and honest discussions about LGBTQ issues.

What are some other general counseling skills or characteristics that you use every day?
<<pause for responses>>

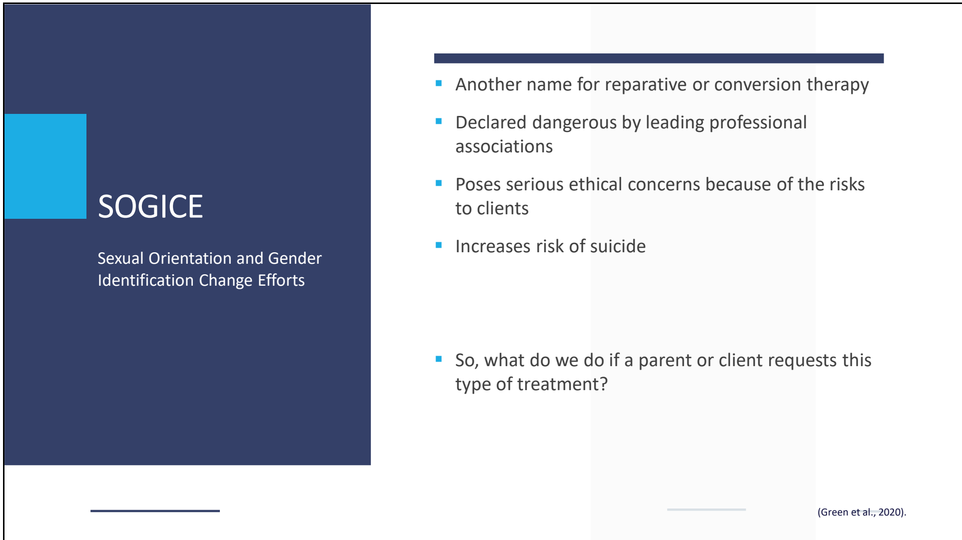
Exactly, the same skills we use every day with our clients are the skills most essential in working with LGBTQ clients. You may think, like I did, “That can’t be all there is. There has to be something specific I should know when it comes to working with this population and their needs.”

The answer to that question is both yes and no. It truly depends on the issues they are there to see you about. If they are there due to a specific mental illness, a work concern, or any other reason that is unrelated to their identification as a member of the LGBTQ community, the skills and techniques you should use are the same as they would be for anyone… keeping in mind the importance of multicultural awareness and sensitivity.

However, there are specific suggestions related to helping clients that are struggling with their gender or sexual identity.

Let's look at some of the types of therapy available…

Slide 37



Time: 4:00 minutes

Script: First, let's talk about SOGICE.

SOGICE stands for Sexual Orientation and Gender Identity Change Efforts. This is another name for reparative therapy or conversion therapy. This is the practice of attempting to change or alter the affectional orientation of an individual to being heterosexual. **(Green et al., 2020).**

Some counselors believe that clients should be allowed to seek professional help to change their sexual orientation through conversion or reparative therapies. However, counselors have an ethical obligation use evidence-based approaches that minimize the potential for harm of their client. Competent counselors understand that attempts to repair, convert, or change ones affectional or sexual orientations are detrimental and may even be life-threatening to their clients. **(Green et al., 2020).**

This practice has been uniformly declared dangerous by leading professional associations such as the World Psychiatric Association, American Medical Association, American Psychological Association, and American Counseling Association.
The ACA states specifically that "attempt alter, repair, convert, or change the affectional orientations of gender identities [or] expressions of [LGBTQ] individuals are detrimental or may even be life-threatening, are repudiated by empirical and qualitative findings and must not be undertaken." **(ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).**

Unfortunately, although it is detrimental to individuals, it is still legal in the majority of US states. Around 700,000 individuals have undergone this type of therapy, about half of which are age 13 to 17. Close to 20,000 of those adolescents will receive this therapy from a licensed counselor. The majority, however, will go through this, led by religious leaders not covered by the ethical regulations of the ACA or other professional organizations. **(Green et al., 2020).**

This type of "conversion" therapy can encompass physical and emotional abuse and rejection based on their LGBTQ identification. This is designed to induce internalized stigma. It also has a strong link to suicidality. **(Green et al., 2020).**

LGBTQ individuals have 4 times the suicide rate of heterosexual individuals. This number is even higher when exposed to conversion therapy. Those LGBTQ individuals who experience conversion attempts were 5 times more likely to report suicide attempts than those who reported no conversion attempts. They are also 3 times more likely to report multiple suicide attempts. **(Green et al., 2020).**

So, what do we do if a parent or client requests this type of treatment? <<pause for suggestions>>

According to the ACA, if a client or their parents ask about this type of therapy, counselors should advise them of the potential harm related to this type of treatment and focus on helping them to achieve a healthy, congruent affectional orientation or gender identity and expression. Counseling approaches that are affirmative of these identities are supported by empirical findings, best practices, and professional organizations such as the ACA and APA. **(Green et al., 2020).**

Just a reminder…the ACA specifically states that this type of treatment must not be undertaken.

Slide 38

Time: 0:30 minutes

Script: The alternative to "reparative" or "conversion" therapy is to provide affirmative therapy.

Affirmative therapy is defined as a type of psychotherapy used to validate and advocate for the needs of sexual and gender minority clients. Therapists use verbal and nonverbal means to demonstrate an affirming stance toward lesbian, gay, bisexual, and transgender clients.
(Hinrichs & Donaldson, 2017)

Slide 39

Time: 2:45 minutes

Script:

Many of the affirmative and evidence-based practices for working with individuals that identify as LGBTQ are the same or only slightly modified compared to what we do already with any client.

Remember, affirmative therapy is not a technique, it is a frame of reference and an attitude that can and should be utilized with all clients.

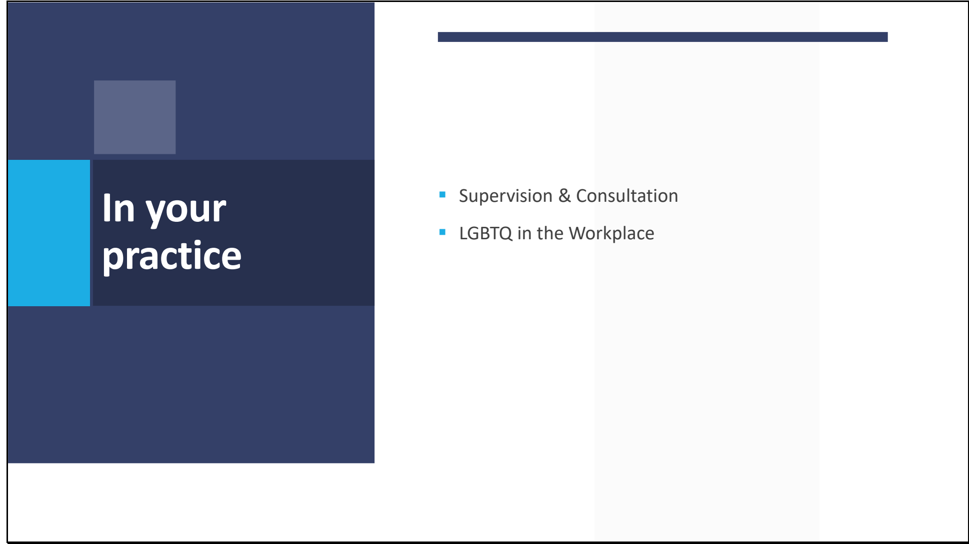
In a 2018 research article, Moradi and Budge shared some specific defining themes and best practices for working with individuals who identify as LGBTQ.

- First, it is important to no longer embrace binary attitudes towards sexual orientation or gender. Some ways to demonstrate this are, as we discussed before, updating intake paperwork with a variety of options as well as allowing clients to self-describe.
- Use of inclusive language and clients' preferred language is also important. For example, instead of saying boyfriend, girlfriend, husband, or wife using the terms partner or spouse. Remember, you can always ask what terms they prefer.
- Next it is recommended that counselors acquire accurate knowledge about their clients through genuine curiosity about their lived experiences. The LGBTQ community includes people of all ages, socioeconomic groups, races, ethnicities, genders, and a multitude of

other socio-demographics. It is important that we, as counselors, understand that not all members of the LGBTQ community are the same and not all have had the same lived experiences. These lived experiences, whether good or bad, have developed strengths and resiliency that can promote their well-being and counteract some of the minority stress they experience.

- Counselors then need to integrate their knowledge of sociopolitical oppression, understanding of resiliency, and how differences in life experiences can shape cognitive flexibility and adjust treatment plans accordingly.
- Competent counselors affirm their client's experiences of power inequities and never say "it is all in your head" or "you are being too sensitive about this."
- It is also necessary to understand that a lack of inappropriate therapy is not the same as affirmative therapy. Affirmative therapy requires positive and intentional action to utilize affirmative practices with all clients.

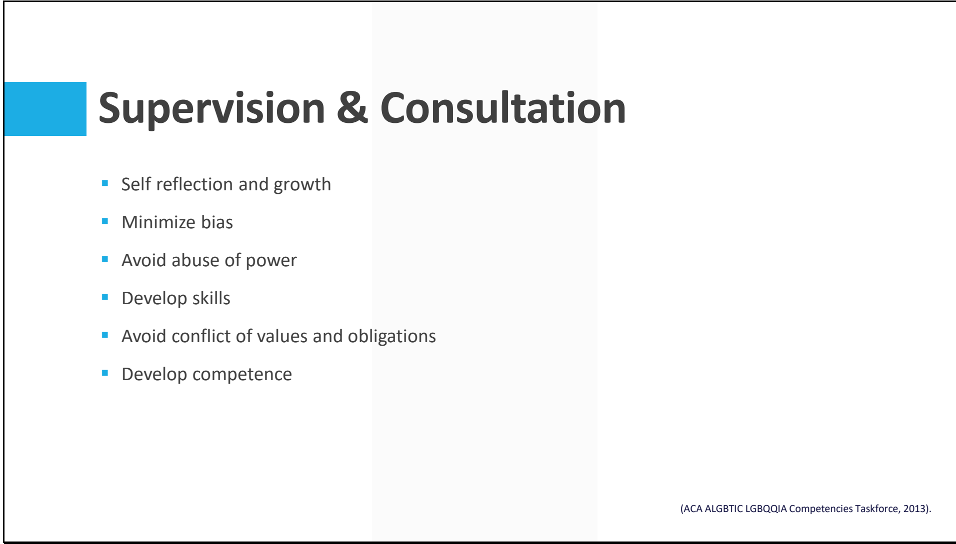
Slide 40



Time: 0:30 minutes

Script: There are some things you can do within your practice to improve overall competency in working with LGBTQ clients including utilization of supervision and consultation as well as having LGBTQ staff in your workplace.

Slide 41



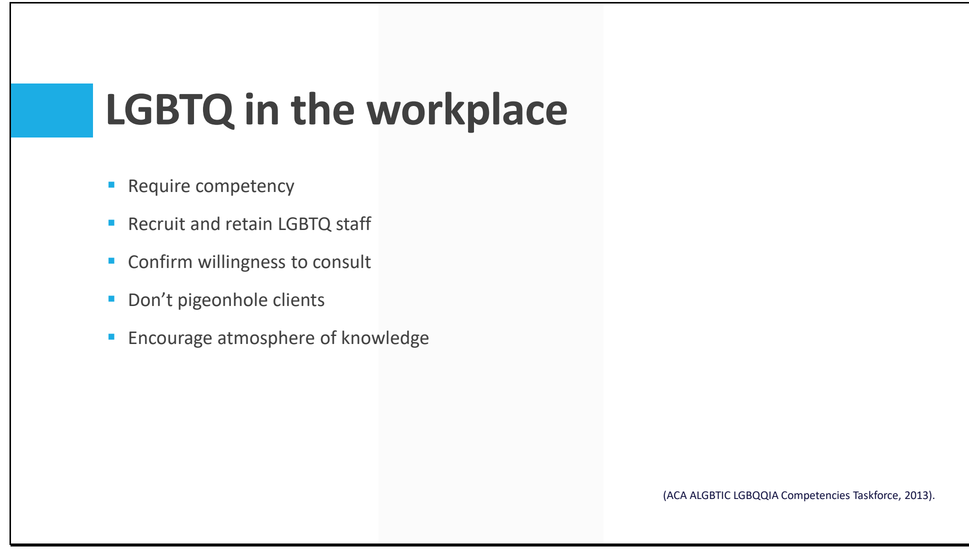
Time: 1:30 minutes

Script:
It is important to seek supervision or consultation from an individual who has knowledge, awareness and skills working with LGBTQ individuals for several reasons.
You can use consultation or supervision…

- For continued self-reflection and personal growth to ensure that one's own biases, skill, or knowledge deficits about individuals who identify as LGBTQ do not negatively affect the therapeutic relationship.
- You can use consultation and/or supervision to help recognize and minimize biases and avoid misuse or abuse of privilege and power.
- If one does not have experience working with LGBTQ individuals, to develop awareness, knowledge, and skills.
- If your personal values conflict with the professional obligations related to LGBTQ individuals, remembering that it is unethical to refer LGBTQ clients to other providers simply because of this type of values conflict.
- And to develop expertise and competence which will allow you to make adjustments in providing services as needed.

(ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).

Slide 42



Time: 1:15 minutes

Script: There are several suggestions for being a competent ally in your workplace.

It is important to advocate with administration to require competency in working with LGBTQ Individuals and to be purposeful in recruitment and retention of staff who identify as LGBTQ

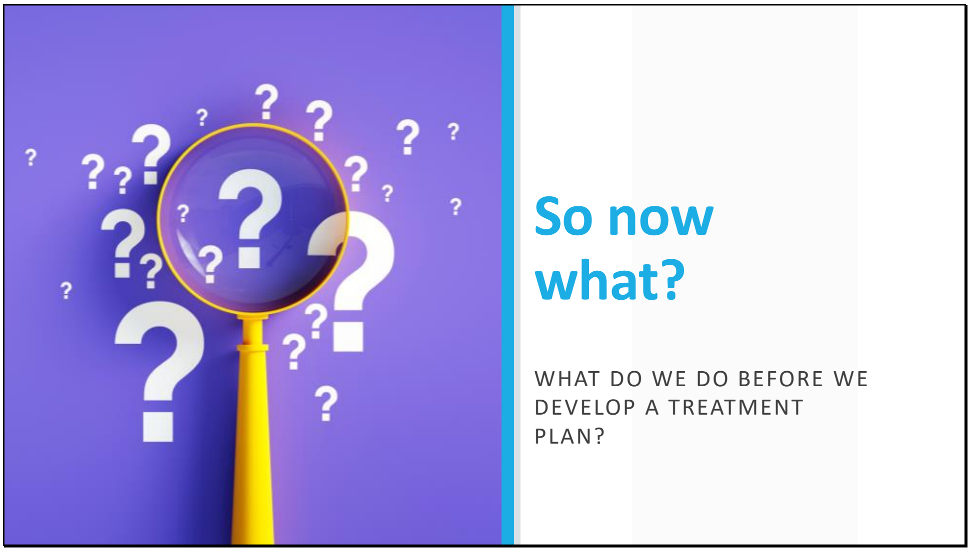
For staff that is LGBTQ, you should not assume they are the experts that should be consulted all of the time. You should confirm whether or not they are willing to consult on LGBTQ issues with other staff members

It is important not to pigeonhole all LGBTQ clients into working with the staff member that identifies as LGBTQ. That counselor may have expertise in other areas and should not be restricted to just working with LGBTQ issues.

In order to make this possible, it is essential to promote an atmosphere where all individuals are encouraged to know about LGBTQ identities.

(ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).

Slide 43



Time: 0:50 minutes plus break time (10 min

Script: So far, we have discussed treatment in terms of Reparative Therapy or Affirmative Therapy and have stated that Affirmative Therapy is the appropriate choice. However, we have also said that Affirmative therapy isn't a specific treatment technique. Affirmative therapy is a framework for all other treatment modalities to incorporate.

But we still haven't talked about specific treatments, and I assure you, we are getting there. However, what do we do before we come up with a treatment plan? <<pause for responses>>

Right, we do the intake and assess the client's needs. The ACA has developed a whole section of competencies based on Assessment of individuals that identify as LGBTQ.

Before we got into that, however, let's take a 10 min break.

Slide 44

Time: 2:15 minutes

Script: Historically, the counseling community has pathologized LGBTQ individuals and their identities. It is important to understand and appreciate the spectrum of healthy functioning within LGBTQ communities.

Counselors should be cautious in assessing clients and not just diagnose based on their presentation. At times, individuals may present more positively if they do not understand their own internalized oppression or experiences of minority stress. They may believe in the stereotypes about "people like them," feel incapable of achieving success because of stories they have heard about challenges others have faced, and have low tolerance for others that share their identity. They may even use heterosexist language without understanding how all of these things correlate with low self-esteem and low desire for partners.
Instead, counselors should account for differences in experiences and culture, just as they would for any multicultural client.

Another example to help understand this concept…presentations of paranoia, post-traumatic stress, anxiety, and depression may not be due to biological imbalances that need to be treated with medication. Instead, these may be due to environmental stress or oppression.

We must be aware of how our own biases can impact our assessment of clients as well and work toward limiting the effect they may have on diagnosis and treatment planning.
(ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).
Slide 45

Assessment Instruments

- Bias can occur through
  - Lack of appropriate norms
  - Language or terminology used
  - Content of assessment
  - Values and assumptions
- Options
  - Education and professional resources
  - Specifically adapted or created assessment tools
  - Utilize within affirmative and multicultural framework for interpretation

(ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).

Time: 1:45 minutes

Script: Bias in assessment can occur for many reasons other than those related to counselor biases.

Many of us use assessment instruments to help understand what our clients are experiencing and to assist in appropriate diagnosis. However, there have been limited attempts to develop LGBTQ norming groups for assessment instruments. Therefore, counselors must evaluate assessments for appropriateness of language, content, values, and assumptions as well as the instrument's appropriateness for use as a diagnostic tool.

Counselors should become aware of professional education and resources of assessment tools that have been adapted or created for LGBTQ clients and how they can be used with multicultural and advocacy models to address the whole person and all of their intersecting identities.

Counselors should also be aware of how assessment measurements, the DSM, and other diagnostic tools may perpetuate norms that negatively impact LGBTQ individuals and that any type of labeling that comes from these can negatively impact them, especially if the symptomology is due to oppression or minority stress.

This is not to say that all assessment instruments or results are harmful to LGBTQ individuals. Assessment instruments can still be helpful in understanding a client's experiences, however, they should be utilized within an affirmative and multicultural framework for interpretation.

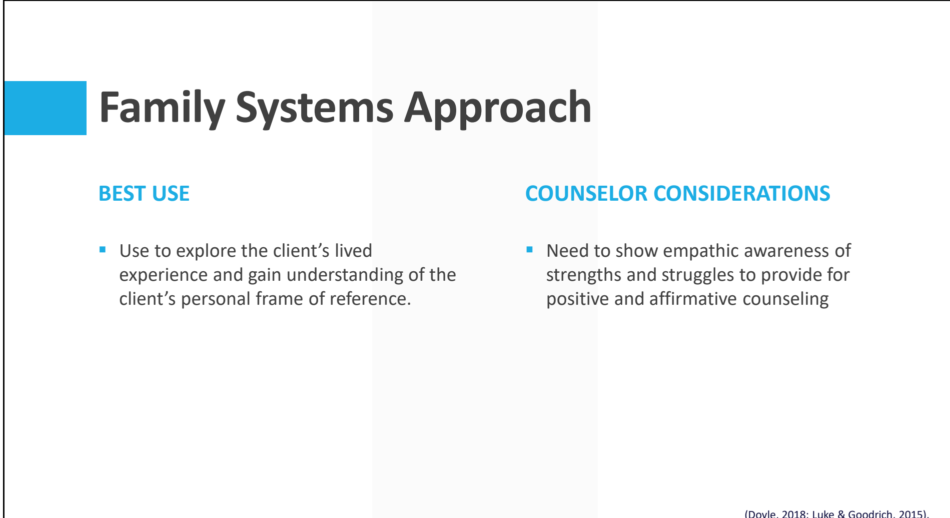
Slide 46

Time: 0:30 minutes

Script: We have covered general skills and characteristics of the affirmative counselor and important aspects of assessment related to clients who identify as LGBTQ.

Now, let's talk about specific treatments that are supported as Evidence Based Practices. Some of the EBPs for use with LGBTQ clients include the family systems approach, narrative therapy, systems theory interventions, and cognitive behavioral therapy.

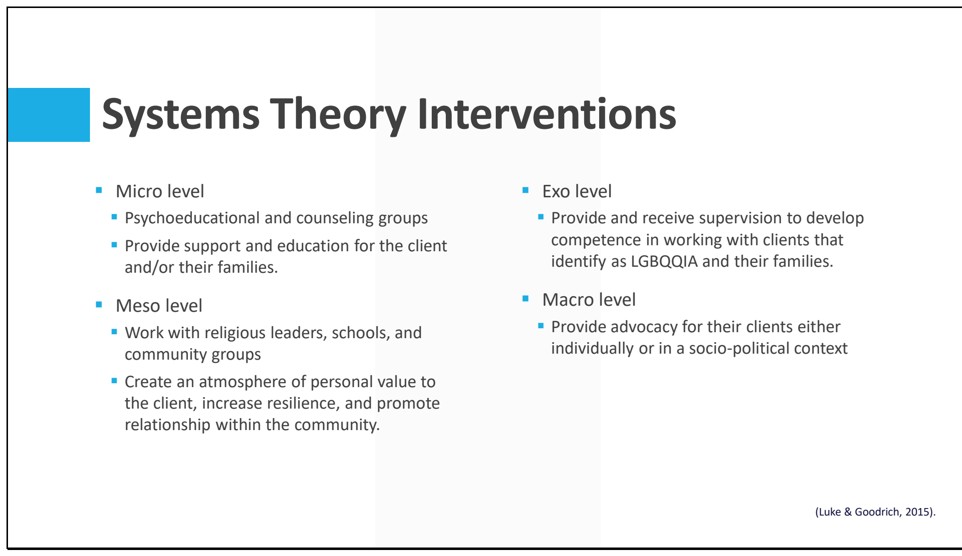
Slide 47



Time: 0:30 minutes

Script: By using family systems approach, counselors can explore the client's lived experience to gain understanding of the client's personal frame of reference. When doing so, counselors will need to show empathic awareness of strengths and struggles to provide for positive and affirmative counseling. **(Doyle, 2018; Luke & Goodrich, 2015).**

Slide 48



Time: 1:00 minutes

Script: Counselors can also use systems theory interventions. At the micro level, psychoeducational and counseling groups can provide support and education for the client and/or their families. At the meso level, counselors can work with religious leaders, schools, and community groups to create an atmosphere of personal value to the client, increase resilience, and promote relationship within the community. At the exo level, counselors can provide and receive supervision to develop competence in working with clients that identify as LGBTQ and their families. At the macro-level, counselors can provide advocacy for their clients either individually or in a socio-political context. **(Luke & Goodrich, 2015).**

Slide 49

Time: 0:20 minutes

Script: Narrative therapy can be used to assist individuals and families in reauthoring their stories from a strengths-based perspective. This can help to build the confidence of the client and improve relationships within the family.

Slide 50

Cognitive Behavioral Therapy

BEST USE

- Address dysfunctional thoughts related to being LGBTQ
- Work with the client to reframe unhelpful thoughts
- Explore the effect of actual experiences of oppression and discrimination on the client
- Help the client to externalize the blame for these experiences rather than internalizing it

COUNSELOR CONSIDERATIONS

- Determine whether or not the thoughts are dysfunctional or if they represent actual experiences of discrimination or oppression
- Question the helpfulness of thoughts rather than their validity

(Austin & Craig, 2015, Ginicola et al., 2017, Pachankis et al., 2015).

Time: 0:50 minutes

Script: CBT can be utilized to address dysfunctional thoughts related to being LGBTQ. It is important, however, to determine whether or not the thoughts are dysfunctional or if they represent actual experiences of discrimination or oppression. It is also important to question the helpfulness of thoughts rather than their validity. If the thoughts are unhelpful, it is important to work with the client to reframe them. Actual experiences of oppression and discrimination should be explored for their effect on the client and to help the client to externalize the blame rather than internalizing **(Austin & Craig, 2015, Ginicola et al., 2017, Pachankis et al., 2015).** it.

Slide 51

Adaptations of CBT for LGBTQ clients

- Psychoeducation
  - Consider role of minority stressors
  - Understand social context of homophobic/heteronormative experiences
- Cognitive Restructuring
  - Identifying automatic thoughts
  - Identifying evidence for and against thoughts
  - Identifying balanced or alternative thoughts
  - Address negative thoughts related to family and acceptance
  - Address negative thoughts related to religion/spirituality
  - Explore negative beliefs related to heterosexism and homo/bi/transphobia
- Behavioral Strategies
  - Exposure
  - Behavioral Experiments
  - Behavioral Activation
  - Discuss what is physically safe for client to participate in rather than assuming that the exposure and experiments will be safe
  - Be aware of a client's comfort and outness
    - Should be dictated by client not counselor

Time: 1:00 minutes

Script: CBT is a commonly used treatment and is the one that has the most research supporting its use with LGBTQ individuals.

Some of the common components of CBT include psychoeducation, cognitive restructuring, and use of behavioral strategies.

When utilizing psychoeducation with LGBTQ clients, counselors should consider the role of minority stressors in the client's life as well as try to understand the social context of homophobic or heteronormative experiences and incorporate that knowledge into the areas of education presented.

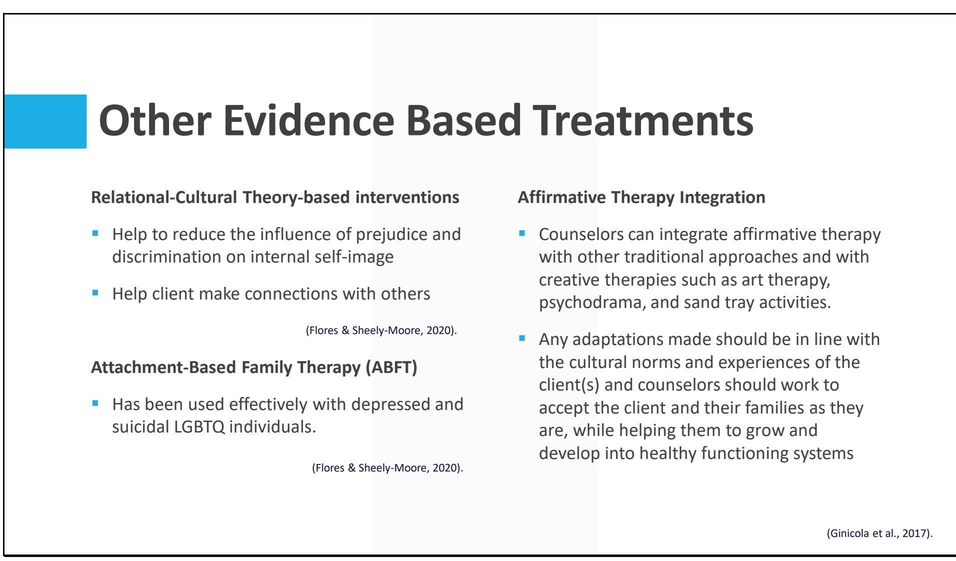
With cognitive restructuring, counselors assist clients in identifying automatic thoughts, finding evidence both for and against those thoughts, and identifying either alternative or more balanced thoughts.

With LGBTQ clients, counselors need to address negative thoughts related to family or to the acceptance of their identity by family and friends. Counselors should also explore any negative thoughts related to religion and spirituality related to their identity. Finally, counselors should explore any negative beliefs related to heterosexism and homo/bi/or transphobia.

When implementing behavioral strategies, exposure, experiments, and behavioral activation are generally used. In the case of LGBTQ clients, it is important to be aware of a client's comfort and

level of outness. Counselors should also discuss with their client what is physically safe for the participant to participate in. These should both be dictated by the client and not by the counselor.

Slide 52



Time: 1:30 minutes

Script: Flores & Sheely-Moore published a study in 2020 showing the effectiveness of Relational-Cultural Theory-based interventions in helping to reduce the influence of prejudice and discrimination on their internal self-image and help LGBTQ individuals to make connections with others.

Levy et al. (2016) report that Attachment-Based Family Therapy (ABFT) has been used effectively with depressed and suicidal LGBTQ individuals.

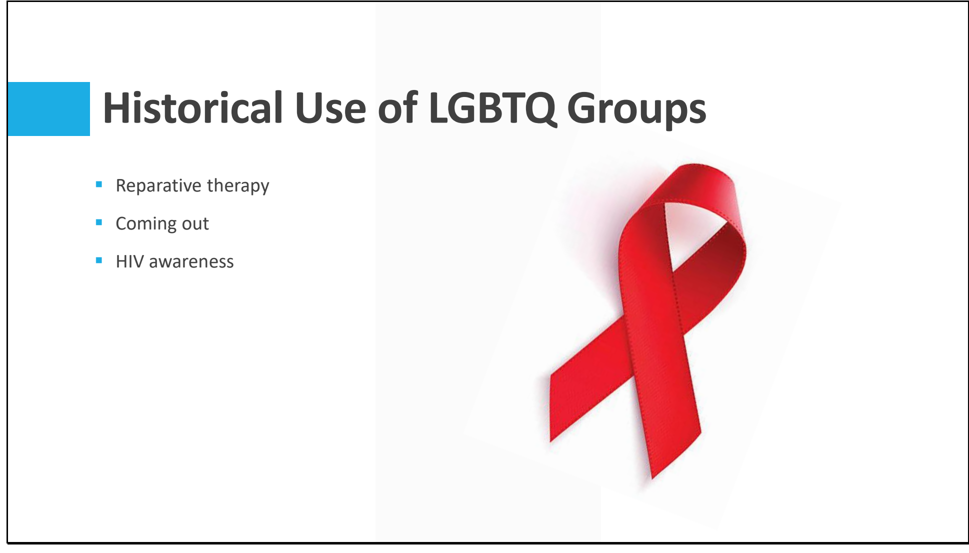
Counselors can integrate affirmative therapy with other traditional approaches and creative therapies such as art therapy, psychodrama, and sand tray activities. Any adaptations made should be in line with the cultural norms and experiences of the client(s) and counselors should work to accept the client and their families as they are, while helping them to grow and develop into healthy functioning systems.
(Ginicola et al., 2017).

Slide 53

Time: 0:20 minutes

Script: Group work can be very powerful. The benefits of group work include its efficiency, efficacy, therapeutic potential, interpersonal growth, and connection for group members.

Slide 54

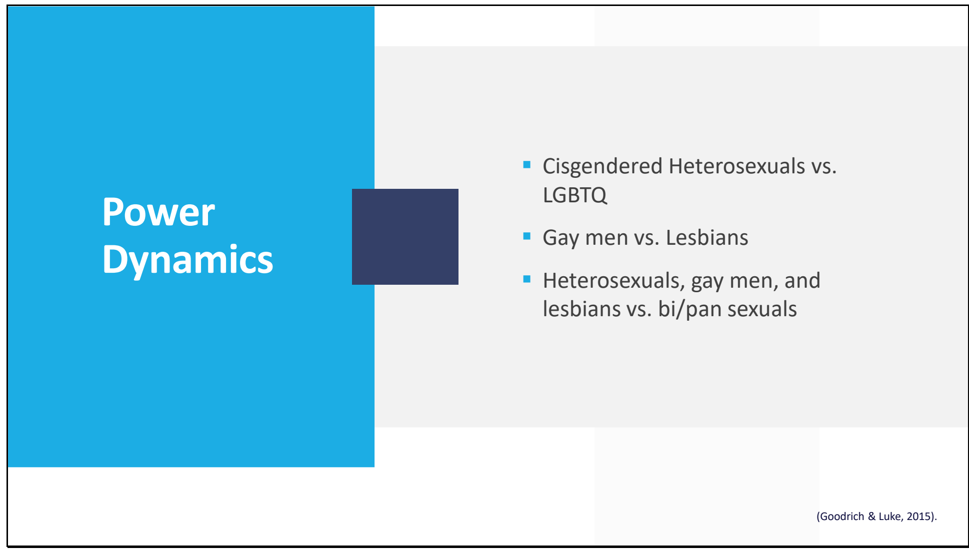


Time: 1:00 minutes

Script: Historically, groups have been used in attempts to change gender identity or sexual orientation which has led to mistrust within the LGBTQ community of the process.

In the more recent past, groups of LGBTQ individuals were focused on issues related to the coming out process and on living with HIV. However, groups can be utilized for far more as coming out is only a part of the LGBTQ experience. Further HIV is a concern for all populations, not just LGBTQ. Therefore, HIV awareness groups restricted to LGBTQ individuals adds to the stereotypes and stigma of being LGBTQ. (Goodrich & Luke, 2015).

Slide 55



Time: 1:45 minutes

Script: Power dynamics exist not only between heterosexual/cis-gender and LGBTQ communities. There are power dynamics within the LGBTQ communities as well.

Historically, lesbians were supportive of gay men when HIV/AIDS was first being discovered. Unfortunately, they did not feel that this support was returned throughout the gay rights movement. This led to increased tensions between the two communities.

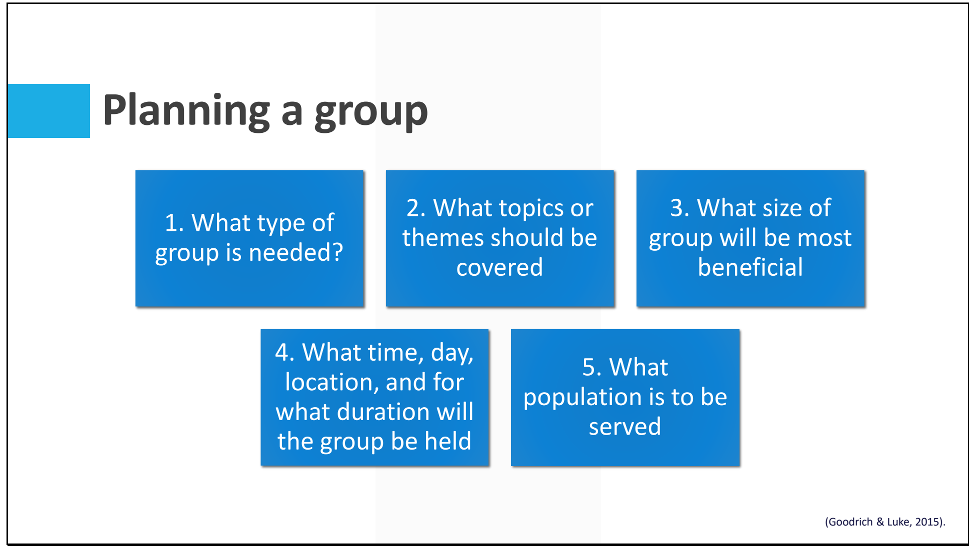
Additionally, those who identify as bi- or pan-sexual have long been overlooked within the larger LGBTQ community. Some individuals report that they are made to feel "not gay enough" to understand what gay men and lesbians experience. They also face being "not straight enough" to fit in with heterosexual groups. There are feelings of exclusion from all sides.

This may also be tied to fears associated within both communities related to partner choice by these individuals.

Because of these dynamics, counselors need to be aware of potential discomfort or distress that can arise with in groups that are heterogenous in nature.

Society tends to group LGBTQ individuals under one umbrella. However, this community is actually comprised of many different communities, cultures, and experiences. (Goodrich & Luke, 2015).

Slide 56



Time: 1:15 minutes

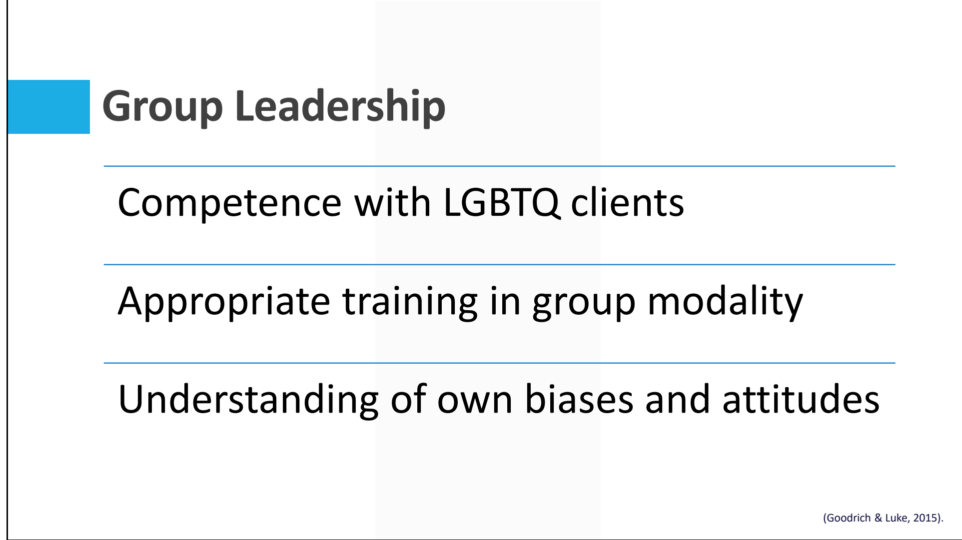
Script: When starting any group, there are many factors to consider in the planning stages.

1. What type of group is needed
2. What topics or themes will be covered
3. What size of group will be most beneficial
4. What time, day, and location will the group be held and for how long
5. What population will be served

Number 5 is a key element when planning an LGBTQ group. Based on the answers to the other questions, this can vary. Is the group specifically for LGBTQ individuals or is it a group that includes LGBTQ and potentially heterosexual individuals as well?

Group leaders need to decide, based on their intended outcomes, if a homogenous or heterogenous group will be most beneficial to group members. In some cases, the support and encouragement of heterosexual allies in a group may be beneficial. In others, the shared experience of a homogenous group can be better. (Goodrich & Luke, 2015).

Slide 57

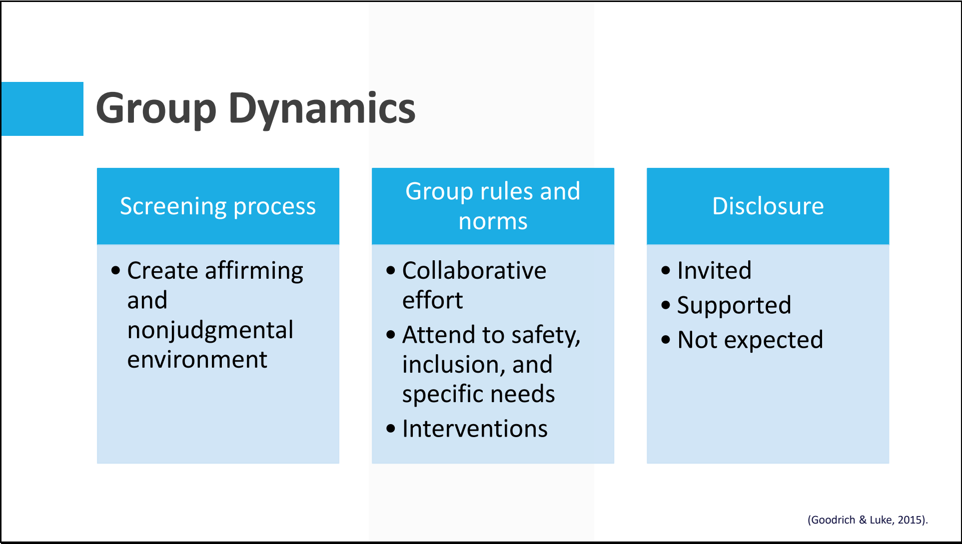


Time: 0:30 minutes

Script: Group leaders must be competent not only in counseling LGBTQ individuals, but also have appropriate training in the group modality offered. For example, counselors should not offer a group for LGBTQ individuals who struggle with drug or alcohol addiction if they have no training in Drug and Alcohol Addictions Therapy.

Leaders must also face their own biases and experiences that may affect their views and attitudes towards their group members.
(Goodrich & Luke, 2015).

Slide 58



Time: 1:30 minutes

Script: Once the planning has been completed, the comes the screening process.

It is essential to create an environment that is affirming and nonjudgmental during the screening process. This is the foundation for having an affirming environment throughout the group process.

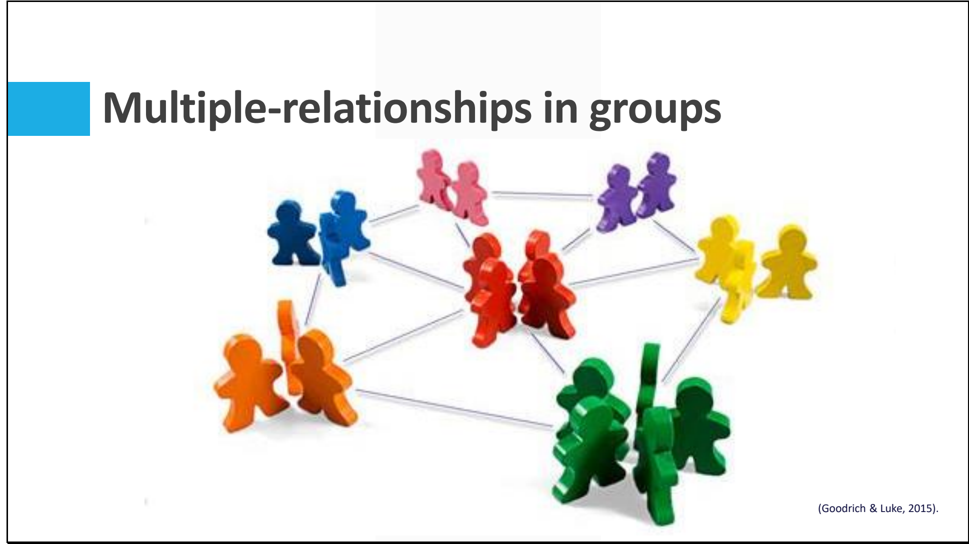
Once the group has been planned and members selected, it is generally beneficial for the group members to be involved in a collaborative effort to develop group rules and norms.

These rules and norms should attend to the safety, inclusion, and specific needs of group members. The group leader should actively intervene if any actions, either overt or covert, threaten a member's safety, group cohesion, or the integrity of the group process.

It is important to create a group environment where disclosure of sexual or affectional orientation is invited and supported but is not required or expected.

Groups are microcosms of society. Even in groups specific to LGBTQ members, some members may not feel safe in this type of disclosure due to experiences of prejudice, discrimination, and oppression.

Slide 59

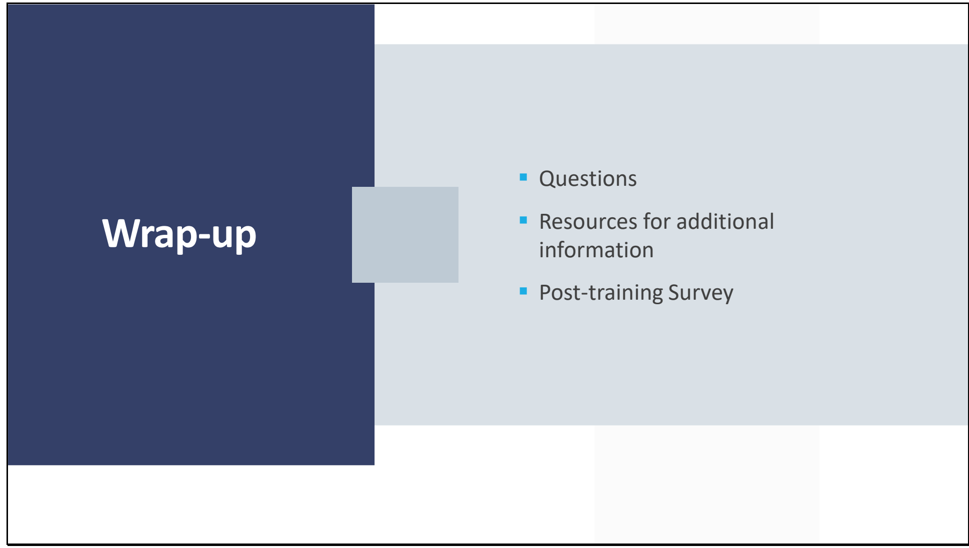


Time: 0:45 minutes

Script: Leaders also need to be aware that because of the close-knit nature of LGBTQ communities, group members and leaders may know one another outside of the group. This may impact group dynamics. Leaders should seek supervision and/or continuing education to understand best practices and foster ethical practices when working with LGBTQ groups and managing dual relationship concerns.

A key factor is to determine if these relationships will cause any harm. If there is a possibility of harm, the leader needs to take action in the best interest of the clients. (Goodrich & Luke, 2015).

Slide 60



Time: 1:20 minute plus question-and-answer time (1-2 minutes) and time to complete survey (3-5 minutes)

Script: We have covered a lot of information during this training. Do you have any questions before we wrap things up?

<<wait for questions and provide any answers you can>>

At the end of your training manual, you will find a list of resources that you may find helpful.

Immediately following the resources page, you will find a Post-training survey. Please take a few moments before you leave to complete this survey and include your name or participant ID.

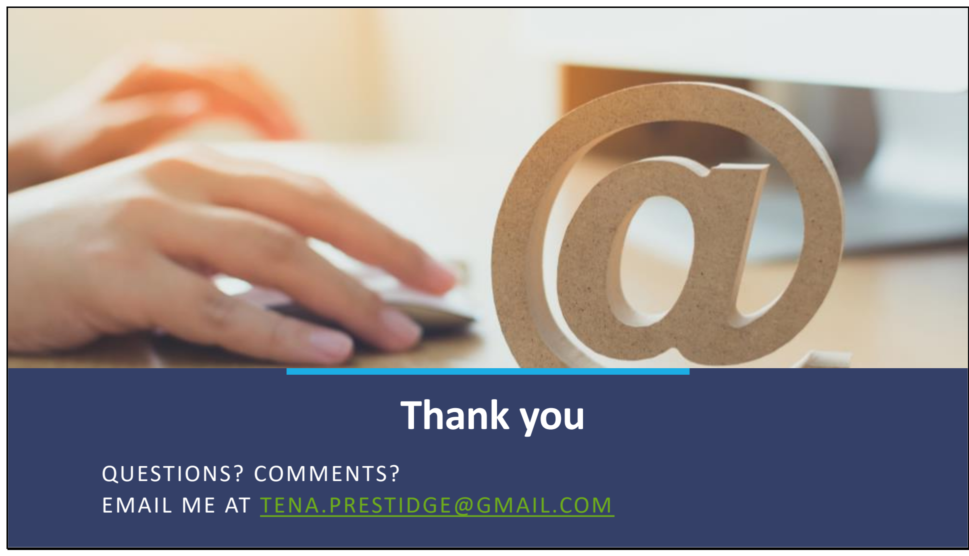
While you are completing that survey, I want to say thank you for attending this training. We covered a lot of material in a relatively short period of time.

As stated at the beginning of this training, the intent of this training has been to lay the foundation for greater confidence and competence in working with clients who identify as LGBTQ.

I hope you have learned some new things and feel more ready for your role as a counselor of LGBTQ individuals.

The ACA has additional trainings related to affirmative therapy and working with LGBTQ clients including career and lifestyle development for LGBTQ individuals, counseling allies, and counseling intersex individuals. Additional information and competencies are also available for working with Transgender and Genderqueer individuals.

Slide 61



Time: 0:15 minutes

Script: If you have any questions about this training or would like to schedule a training for others in your workplace, feel free to contact me at tena.prestidge@gmail.com.

I will remain here after we are done if anyone would like to stay and ask questions.

Tena Prestidge

Email: tena.prestidge@gmail.com

Affirmative Counseling with LGBQQIA Individuals

A Training and Resource Manual for Mental Health Counselors

Spring 2022

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Confidence and Competency Questionnaire

Please mark the most accurate box

Values and Beliefs					
Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	
					I feel comfortable working with LGBTQ clients.
					If I see a person wearing a wedding ring, I assume they are heterosexual.
					I am comfortable discussing sexual and affectional orientation with my clients
					I am comfortable discussing gender identity/expression with my clients.
					I do not assume a person's presentation for counseling is related to their sexual orientation or gender identity/expression.
					I advocate for an LGBTQ inclusive environment
Communication					
Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	
					I use language that reflects that of my LBGTQ patients so I can communicate effectively with them.
					When working with transgender patients, I use their name of choice and preferred gender pronoun.
					When taking a social history, I ask about a person's relationship history and if they have a partner (not if they are married.)
					I advocate for the use of LGBTQ inclusive language in my organization and among my colleagues.
Knowledge					
Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	
					I am aware of resources and community referrals for LGBTQ patients.
					I keep abreast of clinical best practices for LGBTQ patients.

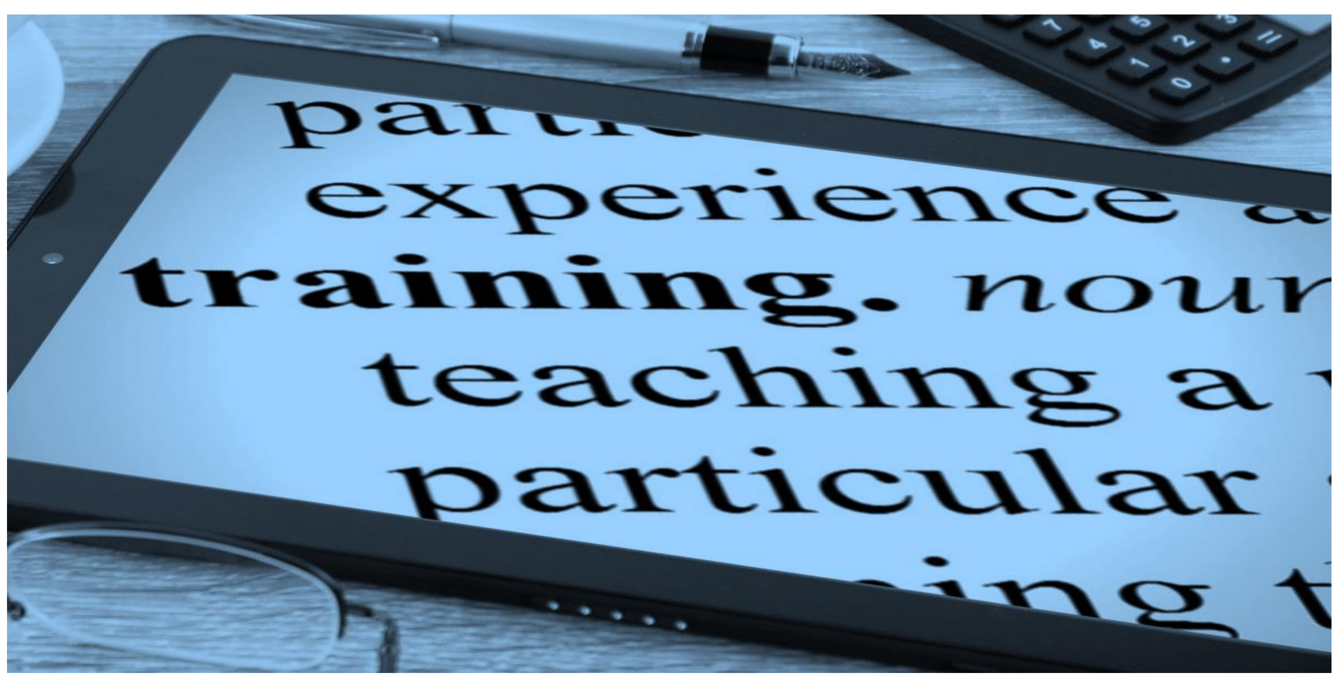
*** Adapted from LGBT-Cultural-Competency-Training-Questionnaire-Post-Test** https://www.communitycatalyst.org/blog/text/LGBT-Cultural-Competency-Training-Questionnaire-Post-Test.pdf

Introduction

What brings us to this training?

Many counselors do not feel qualified or comfortable treating members of the LGBTQ community (Rutherford et al., 2012). The desire for competence and confidence in counseling individuals that identify as LGBTQ is what this training is all about.

This manual, along with the on-line training, has been prepared utilizing current evidence-based practices and is guided by the ACA Code of Ethics and the ACA's ALGBTIC LGBQIQA Competencies.



"The aim… is to provide a framework for creating safe, supportive, and caring relationships with LGBQIQA individuals, groups, and communities that foster self-acceptance and personal, social, emotional, and relational development."

-ALGBTIC Competencies for Counseling LGBQIQA
(ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013)

Language & Acronyms

I don't know what terms to use!

(LGBQQIA Competencies B.1, B.2, C.2, E.5, I.11)

Knowing what terms to use can be confusing and they can vary by state, region, and person. The best way to know which terms to use with an individual in counseling is to ask them what they prefer. For example, during intake you can make it routine to ask all of your clients "What are your preferred pronouns?" If you ask this of all clients, it becomes easier as you get more comfortable with the idea that what you perceive may not be their reality.

At the end of this booklet is a list of commonly used terms and definitions based on the author's local community, the GLADD Media Reference Guide (n.d.), and the ALGBTIC Competencies for Counseling LGBQIQA (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013). Language is subject to change over time and sometimes this happens fairly quickly, so don't be afraid to ask if you are unsure! To get started though, the terms listed at the end of this booklet are generally safe to use. If a client prefers a different term than you use, they will likely tell you and you can adjust accordingly.

Welcome to the alphabet soup.

Some terms encountered frequently in this book include:

LGBTQ – Lesbian, Gay, Bisexual, Transgender, and Queer – an inclusive acronym for all individuals who identify as other than cisgender and heterosexual. – Used in this training when referring to all individuals of this community.

LGBQIQA – Lesbian, Gay, Bisexual, Queer, Intersex, Questioning, and Ally – Used in this training when including all individuals of the LGBTQ community other than Transgender or Genderqueer. This training focuses on the needs of the LGBQIQA community specifically, as the needs and experiences of Transgender and Genderqueer are unique and are outside of the scope of this training. Some guidelines and suggestions are relevant to all LGBTQ individuals, including the Trans/Genderqueer community, so in those situations, LGBTQ will be used.

ALGBTIC – Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. This is a part of the American Counseling Association and is the name of the group who developed these competencies. However, this group has now revised its name to be more inclusive and is now known as SAIGE (Society for Sexual, Affectional, Intersex, and Gender Expansive Identities.)

Notes:

Areas of competency

The ACA/ALGBTIC Competencies are broken down into 10 different areas of competence. This training will cover the six of the competencies listed in the ALBTIC Competencies for Counseling LGBQIQA. Each section of the training will include a list of competencies covered in that section. This training is not designed to give you everything you need to know, but to give an overview and a starting place for developing your own comfort, confidence, and competence in working with the LGBTQ communities. (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013)

Areas of Competence

- Human Growth and Development
- Social and Cultural Diversity
- Helping Relationships
- Professional Orientation
- Career and Lifestyle Development
- Assessment
- Research and Program Evaluation
- Being a Competent Ally

Other areas of competence not addressed in this training:

- Counseling Allies
- Counseling People who are Intersex

Allies & Affirmative Counseling

Awareness

(LGBQQIA Competencies A.17, C.6, G.4, I.10, I.4)

- **What does it mean to be aware?**
  Awareness is knowing one's own identity and biases and how that identity is both different from and similar to individuals that identify as LGBTQ.

- **What is included in one's identity?**
  One's identity is defined by race, ethnicity, indigeneity, socioeconomic status, religion or spirituality, gender identity, sexual orientation, age, abilities, immigration/refugee status, language, education, appearance, profession, and many other intersecting parts.

- **What does intersectionality mean?**
  Intersectionality is a framework for conceptualizing a person, group of people, or social problem affected by a number of discriminations and disadvantages. It takes into account people's overlapping identities and experiences in order to understand the complexity of prejudices they face based on their self-identification. (DEI, 2021)

  To understand intersectionality is to understand and acknowledge that everyone has their own unique experiences of discrimination, oppression, and marginalization . (Taylor, 2019)

- **What are biases?**
  Biases are inclinations or prejudices for or against someone or something. To have personal biases is to be human. We all hold our own subjective world views and are influenced and shaped by our experiences, beliefs, values, education, family, friends, peers and others. As counselors, we need to be aware of how our biases and/or privileges may influence our assessments, choice of treatments, and/or may cause us to overlook challenges faced by an individual. (Psychology Today, n.d.)

- **Bias exploration website:**
  https://implicit.harvard.edu/implicit/selectatest.html

Exercise 1

What are ways that you identify yourself?

____

____

____

____

____

What biases have you encountered?

____

____

____

____

"Counselors who are allies will demonstrate behaviors and attitudes that may be outside their role as counselors."

-ALGBTIC Competencies for Counseling LGBQIQA (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013)

What does it mean to be an ally?

(LGBQQIA Competencies I.1 - I.23)

Being an ally is more than just being professionally competent in working with individuals from the LGBTQ community. Being an "ally" is taking the next step beyond competence in your counseling sessions and stand up against marginalization and prejudice in your home, workplace, and community.

Competent allies will:

- Have awareness of how their own identity is similar to and different from individuals who identify as LGBTQ.
- Know and understand issues both past and present that have affected the LGBTQ community, including socio-cultural, political, and economic climates and their effect on institutional practices, laws, and policies.
- Support individual's decisions about coming out.
- Facilitate supportive environments in their practice and their community. (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013)

Exercise 2

What are some things that people can do to show that they are an ally?

____

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____

What are some things that you would feel comfortable doing to become a better ally?

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____

✔ **Competence Check:** *Close your eyes and imagine someone who is gay or lesbian. What do you see? What biases are present in your image?*

Now imagine a same sex couple holding hands as they shop in a local retail store. What do you see? What biases are present in your image? What is your first reaction?

If you have any concerns about your thoughts or reactions, you can discuss how to work on these things with your supervisor, your personal counselor, and/or in consultation with a trusted colleague.

Homophobia

(LGBQQIA Competencies B.7, C.4)

Concepts like homophobia can be tricky. The word homophobia brings to mind extreme situations like Matthew Shepard, who was murdered in 1998 for being gay, or the 49 people who were killed and 53 who were injured at a nightclub in Orlando that was known to be a "gay bar" in 2016, or the 44 LGBTQ who were murdered in 2020 (History.com, 2021). But what about the more subtle forms of homophobia? Where individuals see two same-sex individuals holding hands and feel uncomfortable or look away. Where individuals find out someone is gay, and curiosity causes them to ask inappropriate questions about their sex life. Where people use the word "gay" to mean something negative.

Homophobia can be seen in both large and small scale on a day-to-day basis. Our society has a prevalent mindset of cis-gendered, heteronormativity.

The Riddle Homophobia Scale was developed to help us more clearly understand the various levels of homophobia. It was developed by Dr. Dorothy Riddle, a psychologist from Tucson, Arizona (Betterbeing, 2018).

Listed on the following page are the four negative and four positive "levels of attitude" toward lesbians and gay men as developed by Dr. Riddle.

HOMOPHOBIC LEVELS OF ATTITUDE

NEGATIVE LEVELS OF ATTITUDE

1. Repulsion: Same gender sexuality is seen as a ‘crime against nature.” Lesbians and gay men are sick, crazy, immoral, sinful, wicked, etc. Anything is justified to change them: imprisonment, hospitalization, aversion therapy, electroshock, etc.

2. Pity: Heterosexual chauvinism. Heterosexuality is seen as preferable. Any possibility of “becoming straight” should be reinforced, and those who seem to be “born that way” should be pitied.

3. Tolerance: Same gender sexuality is considered just a phase of adolescent development that many people go through and most people “grow out of.” Thus, lesbians and gay men are less mature than heterosexuals and should be treated with the protectiveness and indulgence one uses with a child. Lesbians and gay men should not be given positions of authority because they are still working through their adolescent behavior.

4. Acceptance: Still implies that there is something to accept. It is characterized by such statements as “You’re not a lesbian to me, you’re a person!”, “What you do in bed is your own business,” or “That’s fine with me as long as you don’t flaunt it!”

POSITIVE LEVELS OF ATTITUDE

1. Support: The basic civil liberties position. People at this level may be uncomfortable themselves, but they are aware that homophobia is wrong and work to safeguard the rights of lesbians and gay men.

2. Admiration: Acknowledge that being lesbian and gay in our society takes strength. People at this level are willing to truly examine their homophobic attitudes, values, and behaviors.

3. Appreciation: Value the diversity of individuals and see lesbians and gay men as a valid part of that diversity. People at this level are willing to combat homophobia in themselves and others.

4. Nurturance: Assume that lesbians and gay men are indispensable in our society. People at this level view lesbians and gay men with genuine affection and delight and are willing to be allies and advocates.

(Adapted from Dorothy Riddle, psychologist. @betterbeing, 2018)

Exercise 3

Where do you fall on the scale? ________________________________

Have your attitudes changed over time? ________________________________

If your attitudes have changed, what caused them to do so? ____________________________

____

____

____

____

____

Has anything about this surprised to you? ____

____

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____

Myth Buster

(LGBQQIA Competencies C.3)

- **T / F** Bisexuality is a term for individuals who have not made up their mind yet. (Cleveland State University. n.d.)
- **T / F** Many pedophiles are gay men. (Schlatter & Steinback, 2011)
- **T / F** Most lesbians have been molested or had bad experiences with men. (Case Western Reserve University, n.d.)
- **T / F** Gays have an agenda to convert people to their way of life. (Granderson, 2012)
- **T / F** People become gay because they were sexually abused as children or there was a deficiency in sex- role modeling by their parents. (Schlatter & Steinback, 2011)
- **T / F** Lesbian, gay, and bisexual people can be identified by certain mannerisms or physical characteristics (Case Western Reserve University, n.d.)

Getting Started

Where do I start?

(LGBQQIA Competencies C.12, C.17, C.18, E.7, G.14, I.1, I.2, I.13, I.14, I 15, I.19 I.23)

You are already making the first step towards becoming a competent counselor for LGBTQ individuals by participating in this training. Gaining knowledge and participating in trainings related to working with LGBTQ provides an excellent foundation for developing confidence and competence.

Another step is to review your office's paperwork and your office itself. Slight changes can make a significant difference.

The Office

Making your office a place that feels safe and supportive of all individuals is an important part of counseling. One way to do this is to be aware of what they will see when they walk in the door.

- **Literature and Posters.** If you have literature or posters in your waiting area or office, include items that are LGBTQ inclusive. This can include LGBTQ supportive periodicals, books, posters, or take-home LGBTQ-oriented literature (Hinrichs & Donaldson, 2017).
- **Irrelevant or offensive comments related to gender or sexuality.** Object to and eliminate jokes or humor that puts down or portrays individuals in stereotypical ways. Further, counter or object to statements about gender identity or sexual orientation which are not relevant to decisions, evaluations, or treatment of individuals (Hinrichs & Donaldson, 2017).

- **Education and professional development.** Encourage education and professional development related to intersectional identities. Include affectional/sexual orientation and gender identity/expression as a part of embracing a multiculturally diverse workplace (Hinrichs & Donaldson, 2017).

The Paperwork

The use of inclusive language on your intake paperwork helps to provide a safe and comfortable environment for members of the LGBTQ community. Following are some ideas for inclusive language on intake paperwork:

- **Gender.** Any document that asks for gender should include not only male and female options, but also a place for those who do not identify as either. One way to be inclusive and to have affirmative language when it comes to self-identification, is to have gender be a fill-in-the-blank option so the client is free to indicate how they identify. Another option is to include Female, Male, Non-binary, Trans Female, Trans Male, and Other: _______, with the option to write in what “Other” means to them. Previously, simply having male, female, or other was seen as a step in the right direction. However, having only male and female listed while anything else is “other” also shows a form of bias, giving the impression that anything other than male or female is a lesser option (Hinrichs & Donaldson, 2017).

- **Sexual/Affectional Orientation questions.** Like gender, affectional (or sexual) orientations are not binary. In the past, people were labeled as either straight or gay. For some individuals, these terms are adequate. However, there are many labels to describe one’s sexual and/or affectional orientation. Having questions of this nature be open to self-identification is by far the most inclusive option. Another option is to list several of the more common orientations, with the option of “other,” is again acceptable. For example: Asexual, Bi/Pansexual, Heterosexual, Homosexual, Other: _______. Notice that this list is arranged alphabetically. By alphabetizing, it avoids the impression of being arranged hierarchically and thus, avoiding the perception of heterosexism (Hinrichs & Donaldson, 2017).

- **Marital Status.** With the legalization of same-sex marriage, this is somewhat less antagonizing than it has been historically. However, when thinking of inclusion, we need to think of other possible answers than “Single” or “Married.” Having other options, such as Divorced, Married, Partnered, Single, Widowed, and Other: _______, allows for individuals to identify their current status. It can also allow for individuals to share additional information such as living in a poly-family or that they are engaged. Each of these options can make a difference in one’s support system and in some of the issues they may face. By allowing multiple or different options, we allow individuals to share information that can be an important part of their treatment (Hinrichs & Donaldson, 2017).

Historical Viewpoint

What's next?

(LGBQQIA Competencies B.3, C.15, E.8, I.3)

Setting the stage for a comfortable and safe place for individuals that identify as LGBTQ is a positive move towards making your practice more affirmative. However, just LOOKING like a place that offers affirmative counseling does not mean that you are quite there yet…but it is a good start.

Members of the LGBTQ community have historically been pathologized by the mental health community. This has led to a general feeling of mistrust towards mental health practitioners. In order to overcome that history, we need to know a little bit about it and the history of the LGBTQ movement.

Ancient History

Prior to the 3rd century, homosexuality, transgender, and third gendered were considered normal and even celebrated in certain societies (Anderson, 2018, Ginicola et al., 2017).

In the 4th centuries, with the rise of Christianity, homosexuality started to be seen as immoral. Laws were passed to outlaw same-sex marriage and eventually, same-sex sexual acts became punishable by death (Ginicola et al., 2017).

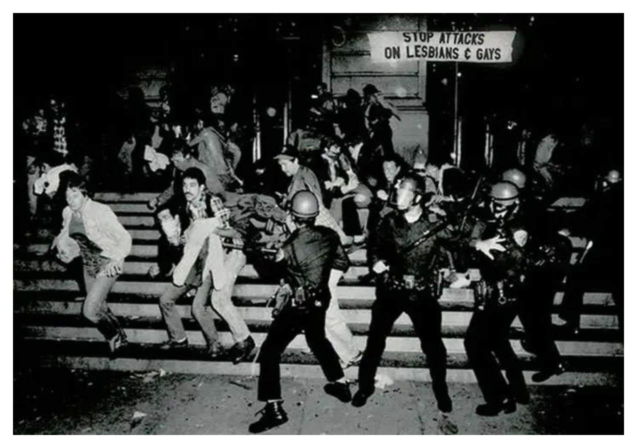
In the following centuries, many laws were passed that outlawed homosexuality. In 1483, during the Spanish Inquisition, over 1,600 individuals were stoned, castrated, and burned for being "sodomites." (Ginicola, n.d.)

Niankh-khnum & Khnum-hotep of Ancient Egypt, 25th century BC (Anderson, 2018)

In the 1700-1800s, some countries began decriminalizing homosexuality. However, in America, laws against homosexuality were enacted (Ginicola et al., 2017).

But that is ancient history…isn't it?

Recent History



(Suson, 2015)

As recently as the mid-20th century, police raids on bathhouses and gay bars were common. In 1969, police raided a mafia-run "gay" bar. This time was different, instead of the patrons being arrested or fleeing, they resisted. This was the start of the Stonewall Riots which lasted 6 days and became a turning point in the gay civil rights movement. (An interesting documentary about the Stonewall Riots was produced by PBS and can be found at https://www.pbs.org/wgbh/americanexperience/films/stonewall/.) (PBS.com, 2020)

Following the Stonewall uprising, the LGBTQ civil rights movement became more prominent. In **1973**, the APA removed homosexuality from the DSM. Until this time, homosexuality was perceived to be a mental disorder. (CNN.com, n.d.)

1978 – Harvey Milk, a leading political activist for the gay community and one of the country's first openly gay elected officials, was murdered. *(For more information about Harvey Milk, see https://www.history.com/topics/gay-rights/harvey-milk.)* (History.com, 2018)

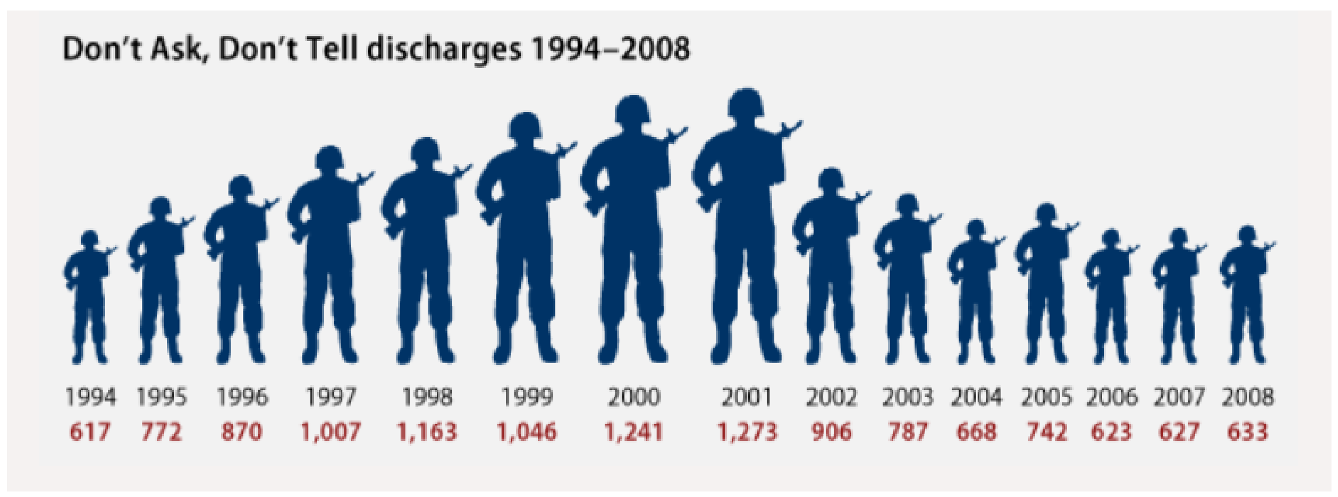
1992 – World Health Organization removes homosexuality from its list of illnesses (Ginicola, n.d.).

1993 - Defense Directive 1304.26 issued, which directed that military applicants were not to be asked about their sexual orientation. This policy is now known as "Don't Ask, Don't Tell." This was adopted in 1994 as the official federal policy on military service, requiring sexuality be kept in the closet and if it weren't, consequences could follow, including discharge from service. During the time, this policy was in effect over 12,000 individuals were discharged from service due to their sexual orientation being discovered. (Encyclopaedia Britannica, n.d.).

1996 – Defense of Marriage Act (DOMA) passed into law. This law defined marriage as between one man and one woman. It also instructed that states that banned same-sex marriage and the federal government were not required to recognize same-sex marriages performed in other states. (Defense of Marriage Act, 1996).

2009 – Hate Crimes Act – expanded the 1969 United States federal hate-crime law to include crimes motivated by a victim's actual or perceived gender, sexual orientation, gender identity, or disability (CNN.com, n.d.).

2011 - September 20, 2011 - End to Don't Ask, Don't Tell – Service members previously discharged for their LGBTQ+ status were offered re-enrollment and future recruits were advised that they would no longer face discrimination when trying to serve their country. (CNN.com, n.d.)



(CAP Action, 2010)

2013 – Supreme Court ruled that Section 3 of DOMA was unconstitutional. This meant that the federal government had to recognize the legal marriages of same-sex couples. Because of Section 2 of DOMA, the ruling did not require any state to legalize or recognize these marriages (CNN.com, n.d.).

2015 – Nation-wide Marriage Equality – Supreme Court ruled that states cannot keep same-sex couples from marrying and must recognize their unions, thereby granting the right to same sex marriages in all 50 states (History.com, 2018).

2016 – Service of Transgender Military Members reinstated (with conditions) after originally being banned in 1960. In 2017, the US President wrote and executive order reinstituting this ban (Diamond, 2017).

2021 – Military service by transgender individuals allowed with no restrictions (Biden, 2021).

2022 – Texas governor attempts to take trans youth away from supportive parents and states that gender affirming medical services for trans youth is "child abuse." (More information on ACLU's web site: https://www.aclu.org/cases/doe-v-abbott) Several other states have cases pending for denial of coverage for treatment for trans youth (ACLU.org, 2022).

What does this all mean for us…and them?

To boil it down, the socio-political environment in America is improving for LGBTQ individuals…but there are still groups in this country that, while some mean well, marginalize, terrorize, and otherwise try to invalidate the value of these individuals as human beings. From hate crimes to microaggressions, these can build up to a terrifying existence for some members of the LGBTQ community.

One thing to remember is that people are more than their sexual or gender identity. There are also intersecting parts of that identity that make each person's experience unique.

Review Questions: *What are intersecting identities? How has bias and prejudice such as trans-phobia and homophobia impacted legislation?*

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Human Development

(LGBQQIA Competencies A.1, A.2, A.5, A.6, A.7, A.8, A.9, A.10, A.11, A.19, B.4, B.5, B.6, B.8, B.9)

Most of us have heard of Maslow's hierarchy of needs. In this theory, Maslow states that as needs are met at lower levels, needs from higher levels emerge (McLeod, 2007).

In short, this diagram helps us to understand that all individuals need safety, belonging, love, and respect to grow and develop in a healthy way.

(Plateresa, 2020)

Childhood

In early childhood, children are egocentric, start with parallel play, engage in make-believe or fantasy play, and have a dichotomous and reductionist way of thinking. As they grow, assuming their physiological and safety needs are met, they move towards a more logical and sequential way of thinking. They begin to play cooperatively, often choosing same gender friends and gender typical roles in play. They also begin comparing themselves to others.

At this time, some of the first indications of gender fluidity might be seen as individuals may choose opposite gender friends and roles as they play. Allowing children to explore these gender roles in play without judgement allows them to figure out what feels right to them and provides a foundation of support for identity growth.

Throughout their elementary school experience, they are developing their sense of self through the feedback they receive from parents, peers, and other adults. If they feel a lack of acceptance, it can lead to feelings of inferiority. Bullying for non-conformity is common and can lead to low motivation,

low self-esteem, and lethargy. This type of negative experience can halt or delay other areas of development until their feelings about it can be resolved and the situation is stopped. It may cause suppression of their individual identity and withdrawal from friends and family (Ginicola et al, 2017).

Adolescence

In adolescence, the role of peers becomes increasingly important. Thinking moves toward more formal operations and abstract thinking. Individuals begin to define themselves as unique but also seek to fit in with their peers, becoming increasingly sensitive to group belonging or exclusion. This time can be particularly difficult for those who feel that their attractions or their bodies are not what they are told they should be.

Gender norms and expectations are primary foundations for credibility and acceptance at this age, with boys being lauded for athletic ability and girls for social leadership. Those who do not align with these norms often experience lower self-esteem and feelings of isolation.

By middle to late adolescence, the desire for intimate emotional connections increases and a desire for romantic and/or sexual engagement begins to develop. These desires and conflicting emotions about the acceptability of the directions these attractions lie can further affect the mental health and self-esteem of adolescents. Other factors such as culture, religion, race, family education levels, and family make-up can greatly influence the development of these individuals (Ginicola et al, 2017).

Lesbian, gay, and bisexual youth attempt suicide at 4 times the rate of their heterosexual peers.

Nearly 75% of LGBTQ youth report verbal and physical (36%) harassment at school. Nearly 17% report being assaulted. Most do not report it because they do not believe school staff will do anything.

(Ginicola et al, 2017)

How can we help?

As counselors, we should help students explore who they are internally and how they view themselves in the world, without judgement and with the Rogerian view of unconditional positive regard.

We can help parents to understand the growth and development needs of their children and the need to be allowed to explore their identities without shame or ridicule. We can help parents understand that this exploration does not definitively mean that their child is gay, lesbian, or

transgender. It simply means that they are exploring their identity which is not “set in stone” and may evolve over the course of their development.

We can also work with or within schools to promote a supportive school climate with staff and teachers who have been trained in affirmative practices (Ginicola et al, 2017).

Early Adulthood

In early adulthood and the college years, individuals are working to overcome any negative experiences they have encountered in their high school years. This is also the time where identity and development of both platonic and romantic relationships are at the forefront. Past or current bullying, physical and emotional abuse can interfere with identity formation and authentic bonding with peers.

Coming out, if in a supportive environment, can facilitate identity development. However, if an individual comes out in a non-supportive environment, it can increase mental health concerns and reduce the ability to practice relationship skills.

While college campuses have improved their stances towards LGBTQ individuals, exclusion, ostracization, and negative attitudes still exist. For this reason, nearly 51% of LGBTQ individuals choose not to disclose their sexual orientation out of fear. This fear and inhibition cause difficulty in making other decisions as well, including those related to career paths.

Counselors need to be aware of the stigma and discrimination that young adults face in their college or career endeavors. A crucial aspect of counseling at this stage is to assist the client in learning how to develop social supports. It is also important to have discussions on how they will deal with prejudice and discrimination in the workforce. There are some protections against workplace discrimination; however, it is not uncommon for individuals who are openly LGBTQ to face barriers in the workforce.

Individuals who pursue a career in the miliary have even fewer supports available. It is often the attitude of military personnel that seeking help to deal with anything is a sign of weakness, so those struggling with issues related to being LGBTQ often fear reaching out for support (Ginicola, et al, 2017).

Middle Adulthood

Middle adulthood is a time when relationship issues are often the source of couples seeking counseling. LGBTQ couples face the same issues as hetero couples but have added stressors due to living in an oppressive environment or external biases that impact their relationship. Some difficulties may come from the lack of acceptance by one (or both) of the partner's families and the level of "outness" of each partner. Couples that live in smaller towns may also face community issues including feeling isolated from other LGBTQ couples.

This is also the time when marriage and family planning happen. The decision to have (or not have) children is more complex with same sex couples than for heterosexual couples. Not only do they face challenges of natural conception versus IVF versus adoption decisions, but also, whatever choices they make for having a child will often cause financial issues. Bias, adoption agency protocols, and birth parents can all impede the placement of adopted children with LGBTQ parents. It is also important for couples to understand that children will make the relationship more visible to the community due to school and other events. This can impact the decision on having children depending on the level of comfort each partner has with being "out."

As counselors, we must be affirming of our clients' relationships. It is also important to understand that heterosexist attitudes can cause additional strain on relationships. It is important to know that counselors often show hetero- and mono-sexual bias which can impede the therapeutic process. It is also helpful to be aware of queer norms and parenting issues faced by LGBTQ couples.

The most important aspects of counseling LGBTQ couples are the ability to actively listen, empathize, and to assist couples in communicating feelings and needs to each other. Having a strong therapeutic relationship that is collaborative is the means to effectively counseling LGBTQ couples at this phase of their lives (Ginicola et al, 2017).

Later Adulthood

In later adulthood, many of the concerns of individuals who identify as LGBTQ are similar to those of heterosexual individuals. They have concerns about declining physical and cognitive ability, loss of mobility and independence, financial strain, depression, lowering self-esteem as they face retirement, and body image.

Generational issues are an issue as well. Older adults have not grown up in a time where being openly LGBTQ was acceptable. They may have never come out openly to their families and may fear losing their support system. They can also face discrimination in housing, employment, and medical care as well as increasing social isolation and invisibility (Ginicola et al, 2017).

Exercise 4

What developmental concerns have you seen in your own practices? ________________

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What suggestions or resources have you found helpful in working with LGBTQ individuals at various stages of life and development? ____

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Coming Out

Coming Out: What does it mean?

(LGBQQIA Competencies A.18, C.13)

Coming out is lifelong process of self-acceptance. People forge an LGBTQ identity first to themselves and then they may reveal it to others. Publicly sharing one's identity may or may not be part of coming out.

This is a continual process that occurs multiple times for LGBTQ persons over the course of their lifetimes. Although many people think that one is either “out” or “in,” this usually refers to a person’s general openness with others about who he or she is. However, each time an individual encounters a new situation with new people, they must assess how safe and/or comfortable they are in sharing this information. Many times, this process can be difficult due to heterosexism, sexism, genderism, homophobia, biphobia, transphobia, and so on.

As counselors, we must be careful to not assume that LGBTQ identity development or the coming out process are factors in a client’s mental health concerns. Neither of these cause mental health issues. However, the added stressors of minority identification can contribute to them (Chazin & Klugman, 2014).

The Process

(LGBQQIA Competencies A.13, A.14, A.15, A.16, A.19, C.16, I.5, I.6, I.7)

Coming out is often seen as a part of the process of LGBTQ identity formation. There are several LGBTQ identity development models. Most of these models include an individual’s recognition that their experiences of attraction do not represent the heterosexual norm. Prior to puberty, individuals are exposed to societal heteronormative beliefs as well of stereotypes associated with non-heterosexual individuals. If an individual feels that their experience may be different than the norm, they may feel confused or distressed. At this point, they may not realize that the differences are related to their sexuality, but they do recognize that their experience may be different than their same-sex peers. There is often a period of minimization, denial, and rejection of their experiences and feelings. (Ginicola et al, 2017).

Following this comes a gradual acceptance. The individual's environment plays an influential role in this acceptance. If they have a supportive environment, this acceptance tends to happen more smoothly and with less internal trauma. If a child grows up in an environment where they hear homophobic talk, jokes, or religious teachings, it can contribute to a much more difficult period of personal acceptance. This can lead to feelings of shame, sinfulness, anxiety, depression, suicidality, and substance abuse.

As the individual comes to at least some level of acceptance, they may start making contacts within the LGBTQ community. This can help them to learn more about the community and fulfill various emotional, social, and sexual needs. If their experience is positive, they will generally learn greater acceptance of their own identity. If not, it can lead to increased internalized homophobia and emotional distress (Chazin & Klugman, 2014).

At some point, individuals usually consider coming out to the people they care about. Most often, the individual will come out to a trusted friend or two before coming out to their families. Once this has taken place, they will often come out to a sibling before doing so with their parents (Ginicola, et al, 2017).

Benefits of Coming Out

- Self-integration
- Self-growth
- Feelings of empowerment
- Allows for cultural and social experiences
- Reduces isolation

Challenges of Coming Out

- Potential rejection by family members
- Increased risk of verbal/psychological abuse
- Alienation and isolation from others
- Potential loss of job, family, social circles
- Increased risk of interpersonal violence

Coming out is something individuals face each time they are in a new situation or meet new people. Not all individuals are out in every area of their lives due to some of the risks associated with doing so.

Some individuals are not given the choice about coming out to various people because someone to whom they have shared their identity decides to share the information with others without the express permission of the LGBTQ individual (Ginicola et al, 2017).

As counselors, we need to understand that individuals may not come out to us due to fear of rejection, lack of relevance to the counseling goals, or hesitation to reveal their orientation until trust is developed. Our role is to offer support and understanding to the individual and to avoid unintentional microaggressions through heteronormative language. Should they reveal their orientation to us as part of the concerns they have about coming out, we can help them to understand their own feelings about coming out, support them throughout the process, and help them to understand that the process and extent that they come out should be their decision alone (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).

Exercise 5

What skills and characteristics do you possess that can facilitate your practice with LGBTQ clients?

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Minority Stress

Minority Stress Theory

"The minority stress theory suggests that sexual minorities, underrepresented gender identities as well as queer and other sexual identities (LGBTQ+) commonly experience distinct and chronic stressors related to their sexual orientation and/or gender identity." (Quinn 2020).

"Minority stress theory proposes that sexual minority health disparities can be explained in large part by stressors induced by a hostile, homophobic culture, which often results in a lifetime of harassment, maltreatment, discrimination and victimization and may ultimately impact access to care." (Dentato, 2012).

Minority Stressors

Minority stress is the relationship between minority and dominant values and resultant conflict with the social environment experienced by minority group members (APA, 2012).

- Physical
  - Access to appropriate health care
  - HIV
  - Assault
- Social
  - Lack of family support
  - Partner relationships
  - Friendships
- Emotional
  - Anxiety
  - Depression
  - Substance abuse
  - Suicidality
- Cultural
  - Lack of support from others in their racial or ethnic groups
- Spiritual
  - Possible conflicts between spiritual teachings and their experience/identity
  - Possible conflicts between their beliefs and those of their family
- Other
  - Financial problems as a result of employment discrimination
  - Homelessness due to being kicked out as a youth
  - Homelessness as a result of housing discrimination

(ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013)

General skills and characteristics for working with LGBTQ clients

- Building therapeutic relationship
- Listening for understanding
- Having empathy
- Giving unconditional positive regard
- Listening without judgement
- Allowing client autonomy
- Non-pathologizing of their LGBTQ identity
- Portray warmth and caring
- Non-judgmental and accepting
- Sensitive and open
- Allows for space and time to think, reflect, process, and feel
- Provides support and reassurance
- Are safe and open minded
- Facilitate open and honest discussions about LGBTQ issues
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✔ **Competence Check:** *What other skills and characteristics do you demonstrate every day in your counseling practice?*

Reparative Therapy

(LGBQQIA Competencies C.10, E.6)

SOGICE stands for Sexual Orientation and Gender Identity Change Efforts. This is another name for reparative therapy or conversion therapy and the practice of attempting to change or alter the affectional orientation of an individual to heterosexual (Green et al., 2020).

This practice has been uniformly declared dangerous by leading professional associations such as the World Psychiatric Association, American Medical Association, American Psychological Association, and American Counseling Association. The ACA states specifically that "attempt alter, repair, convert, or change the affectional orientations of gender identities [or] expressions of [LGBTQ] individuals are detrimental or may even be life-threatening, are repudiated by empirical and qualitative findings and must not be undertaken." (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).

Unfortunately, although it is detrimental to individuals, it is still legal in the majority of US states. Around 700,000 individuals have undergone this type of therapy, about half of which are age 13 to 17. Close to 20,000 of those adolescents will receive this therapy from a licensed counselor. The majority, however, will go through this led by religious leaders not covered by the ethical regulations of the ACA or other professional organizations (Green et al., 2020).

This type of "conversion" therapy can encompass physical and emotional abuse and rejection based on their LGBTQ identification which is designed to induce internalized stigma. It also has a strong link to suicidality (Green et al., 2020)

LGBTQ individuals have 4 times the suicide rate of heterosexual individuals. This number is even higher when exposed to conversion therapy. Those LGBTQ individuals who experience conversion attempts were 5 times more likely to report suicide attempts than those who reported no conversion attempts. They are also 3 times more likely to report multiple suicide attempts (Green et al., 2020).

If a client or their parents ask about this type of therapy, counselors should advise them of the potential harm related to this type of treatment and focus on helping them to achieve a healthy, congruent affectional orientation or gender identity and expression. Counseling approaches that are affirmative of these identities are supported by empirical findings, best practices, and professional organizations such as the ACA and APA (Green et al., 2020).

Reminder the ACA specifically states that conversion therapy must not be undertaken.

Affirmative Therapy

(LGBQQIA Competencies C.1, C.3, C.5, C.8, C.9, C.11, C.12, E.9, E.10, E.12, E.13, I.12)

"Affirmative therapy is defined as a type of psychotherapy used to validate and advocate for the needs of sexual and gender minority clients. Therapists use verbal and nonverbal means to demonstrate an affirming stance toward lesbian, gay, bisexual, and transgender (LGBT) clients."

(Hinrichs & Donaldson, 2017)

Affirmative Therapy Best Practices

- Eschew binaries
  - Have intake forms with options for people to self-describe
    - Assess sexual orientation identity, sexual attraction, and sexual behaviors
    - Assess sex assigned at birth, gender identity, intersex
  - Use affirmative language
- Acquire accurate knowledge about life experiences
  - Not all members of the LGBTQ community are the same
- Integrate knowledge
- Engage in and affirm challenges to power inequities
- Understand that the lack of inappropriate therapies does not equal affirmative therapy (Moradi and Budge, 2018)

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Supervision & Consultation

(LGBQQIA Competencies C.7, D.8, E.3, E.4, G.5, I.8)

It is important to seek supervision or consultation from an individual who has knowledge, awareness and skills working with LGBTQ individuals.

- For continued self-reflection and personal growth to ensure that one's own biases, skill, or knowledge deficits about individuals who identify as LGBTQ do not negatively affect the therapeutic relationship.
- To help recognize and minimize biases and avoid misuse/abuse of privilege and power.
- If one does not have experience working with LGBTQ individuals to develop awareness, knowledge, and skills.
- If one's personal values conflict with professional obligations related to LGBTQ individuals.
- To develop expertise and competence and to make adjustments in providing services as needed. (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).

LGBTQ in the workplace

(LGBQQIA Competencies I.16, I.17, I.18)

There are several suggestions for being a competent ally in your workplace.

- Advocate with administration to require competency in working with LGBTQ Individuals
- Be purposeful in recruitment and retention of staff who identify as LGBTQ
- Confirm with LGBTQ staff whether or not they are willing to consult on LGBTQ issues with other staff members
- Refrain from referring all LGBTQ clients to LGBTQ staff. They may have expertise in other areas and should not be restricted to just working with LGBTQ issues.
- Promote an atmosphere where all individuals are encouraged to know about LGBTQ identities. (ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).

Assessment

General Assessment Information

(LGBQQIA Competencies G.1, G.3, G.4, G.6)

Historically, the counseling community has pathologized LGBTQ individuals and their identities. It is important to understand and appreciate the spectrum of healthy functioning within LGBTQ communities.

Counselors should be cautious in assessing clients and not just diagnose based on their presentation. At times, individuals may present more positively if they do not understand their own internalized oppression or experiences of minority stress. They may believe in the stereotypes about "people like them," feel incapable of achieving success because of stories they have heard about challenges others have faced and have low tolerance for others that share their identity. They may even use heterosexist language without understanding how all these things correlate with low self-esteem and low desire for partners.

Instead, counselors should account for differences in experiences and culture, just as they would for any multicultural client. For example, presentations of paranoia, post-traumatic stress, anxiety, and depression may not be due to biological imbalances that need to be treated with medication. Instead, these may be due to environmental stress or oppression.

Counselors need to be aware of how their own biases can impact their assessment of clients and work toward limiting the effect that those biases may have on diagnosis and treatment planning.

Assessment Instruments

(LGBQQIA Competencies G.6, G.7, G.8, G.10, G.11, G.13, G.16, G.17)

Bias in assessment can occur for many reasons other than those related to counselor biases.

Many counselors use assessment instruments to help understand what their clients are experiencing and to assist in appropriate diagnosis. However, there have been limited attempts to develop LGBTQ norming groups for assessment instruments. Therefore, counselors must evaluate assessments for

appropriateness of language, content, values, and assumptions as well as the instrument's appropriateness for use as a diagnostic tool.

Counselors should become aware of professional education and resources of assessment tools that have been adapted or created for LGBTQ clients and how they can be used with multicultural and advocacy models to address the whole person and all of their intersecting identities.

Counselors should also be aware of how assessment measurements, the DSM, and other diagnostic tools may perpetuate norms that negatively impact LGBTQ individuals and that any type of labeling that comes from these can negatively impact LGBTQ individuals, especially if the symptomology is due to oppression or minority stress.

This is not to say that all assessment instruments or results are harmful to LGBTQ individuals. Assessment instruments can still be helpful in understanding a client's experiences. However, they should be utilized within an affirmative and multicultural framework for interpretation.

(ACA ALGBTIC LGBQQIA Competencies Taskforce, 2013).

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Evidence Based Treatments

Family Systems Approach

- Used to explore the client's lived experience and gain understanding of the client's personal frame of reference.
- Counselors will need to show empathic awareness of strengths and struggles to provide for positive and affirmative counseling (Doyle, 2018; Luke & Goodrich, 2015).

Systems Theory Interventions

- At the micro level, psychoeducational and counseling groups can provide support and education for the client and/or their families.
- At the meso level, counselors can collaborate with religious leaders, schools, and community groups to create an atmosphere of personal value to the client, increase resilience, and promote relationship within the community.
- At the exo level, counselors can provide and receive supervision to develop competence in working with clients that identify as LGBQQIA and their families.
- At the macro-level, counselors can provide advocacy for their clients either individually or in a socio-political context (Luke & Goodrich, 2015).

Narrative Therapy

- Used to assist individuals and families in reauthoring their stories from a strengths-based perspective.
- This can help to build the confidence of the client and improve relationships within the family (Luke & Goodrich, 2015).

CBT (Cognitive Behavioral Therapy)

- Used to address dysfunctional thoughts related to being LGBQQIA (Austin & Craig, 2015, Ginicola et al., 2017, Pachankis et al., 2015).
- Determine whether or not the thoughts are dysfunctional or if they represent actual experiences of discrimination or oppression.
- Question the helpfulness of thoughts rather than their validity.
- If the thoughts are unhelpful work with the client to reframe them.
- Actual experiences of oppression and discrimination should be explored for their effect on the client and to help the client to externalize the blame rather than internalizing it (Ginicola et al., 2017).
- Assess for safety, comfort, and level of outness prior to implementing behavioral strategies.

Other Evidence Based Practices

Relational-Cultural Theory-based interventions

- Help to reduce the influence of prejudice and discrimination on internal self-image
- Help LGBTQ individuals to make connections with others (Flores & Sheely-Moore, 2020).

Attachment-Based Family Therapy (ABFT)

- Used effectively with depressed and suicidal LGBQQIA individuals (Levy et al., 2016).

Affirmative Therapy Integration

- Counselors can integrate affirmative therapy with other traditional approaches and with creative therapies such as art therapy, psychodrama, and sand tray activities.
- Any adaptations made should be in line with the cultural norms and experiences of the client(s) and counselors should work to accept the client and their families as they are, while helping them to grow and develop into healthy functioning systems (Ginicola et al., 2017).

Group Work

Benefits

- Efficiency
- Efficacy
- Therapeutic potential
- Interpersonal growth
- Connection

Historical View

- Change gender identity
- Change sexual orientation
- Mistrust within the LGBTQ community

In the more recent past

- Issues related to the coming out process
- Living with HIV

However, groups can be utilized for far more as coming out is only a part of the LGBTQ experience. Further HIV is a concern for all populations, not just LGBTQ. Therefore, HIV awareness groups restricted to LGBTQ individuals adds to the stereotypes and stigma of being LGBTQ (Goodrich & Luke, 2015).

(LGBQQIA Competencies D.2, D.3, D.4, D.5, D.6, D.7, D.9, D.10, D.11, D.12, D.13, D.14, D.14, D.16, D.17, D.18, D.19, D.20, D.21)

Power Dynamics

Power dynamics exist not only between heterosexual/cis-gender and LGBTQ communities. There are power dynamics within the LGBTQ communities as well.

Historically, lesbians were supportive of gay men when HIV/AIDS was first being discovered. Unfortunately, they did not feel that this support was not returned throughout the gay rights movement. This led to increased tensions between the two communities. (Goodrich & Luke, 2015)

Additionally, those who identify as bi- or pan-sexual have long been overlooked within the larger LGBTQ community. Some individuals report that they are made to feel “not gay enough” to understand what gay men and lesbians experience. They also face being “not straight enough” to fit in with heterosexual groups. There are feelings of exclusion from all sides.

This may also be tied to fears associated within both communities related to partner choice by these individuals (Goodrich & Luke, 2015).

Because of these dynamics, counselors need to be aware of potential discomfort or distress that can arise with in groups that are heterogenous in nature.

Society tends to group LGBTQ individuals under one umbrella. However, this community is actually comprised of many different communities, cultures, and experiences (Goodrich & Luke, 2015)
.

Planning a group

When starting any group, there are many factors to consider in the planning stages.

1. What type of group is needed?
2. What topics or themes will be covered?
3. What size of group will be most beneficial?
4. What time, day, and location will the group be held and for how long?
5. What population will be served?

Number 5 is a key element when planning an LGBTQ group. Based on the answers to the other questions, this can vary. Is the group specifically for LGBTQ individuals or is it a group that includes LGBTQ and potentially heterosexual individuals as well?

Group leaders need to decide, based on their intended outcomes, if a homogenous or heterogenous group will be most beneficial to group members. In some cases, the support and encouragement of heterosexual allies in a group may be beneficial. In others, the shared experience of a homogenous group can be better.

Group leadership

Group leaders must be competent not only in counseling LGBTQ individuals, but also have appropriate training in the group modality offered. For example, counselors should not offer a group for LGBTQ individuals who struggle with drug or alcohol addiction if they have no training in Drug and Alcohol Addictions Therapy (Goodrich & Luke, 2015).

Leaders must also face their own biases and experiences that may affect their views and attitudes towards their group members.

Screening process

Once the planning has been completed, the comes the screening process.

It is essential to create an environment that is affirming and nonjudgmental during the screening process. This is the foundation for having an affirming environment throughout the group process.

Once the group has been planned and members selected, it is generally beneficial for the group members to be involved in a collaborative effort to develop group rules and norms.

These rules and norms should address the safety, inclusion, and specific needs of group members. The group leader should actively intervene if any actions, either overt or covert, threaten a member's safety, group cohesion, or the integrity of the group process.

It is important to create a group environment where disclosure of sexual or affectional orientation is invited and supported but is not required or expected.

Groups are microcosms of society. Even in groups specific to LGBTQ members, some members may not feel safe in this type of disclosure to due experiences of prejudice, discrimination, and oppression.

Multiple relationships within a group

Leaders need to be aware that because of the close-knit nature of LGBTQ communities, group members may know one another outside of the group. This may impact group dynamics. Leaders should seek supervision and/or continuing education to understand best practices and foster ethical practices when working with LGBTQ groups and managing dual relationship concerns.

A key factor is to determine if these relationships will cause any harm. If there is a possibility of harm, the leader needs to take action in the best interest of the clients (Goodrich & Luke, 2015).

Wrap Up

Thank you for attending this training. We covered a lot of material in a relatively brief period of time.

As stated at the beginning of this training, the intent of this training has been to lay the foundation for greater confidence and competence in working with clients who identify as LGBTQ.

I hope you have learned some new things and feel more ready for your role as a counselor of LGBTQ individuals.

The ACA has additional trainings related to affirmative therapy and working with LGBTQ clients including career and lifestyle development for LGBTQ individuals, counseling allies, and counseling intersex individuals. Additional information and competencies are also available for working with Transgender and Genderqueer individuals.

If you have any questions about this training or would like to schedule a training for others in your workplace, feel free to contact me at tena.prestidge@gmail.com.

Thank you,

Tena Prestidge

Additional Resources

GLAAD Media Reference Guide
https://www.glaad.org/reference/lgbtq

ACA Code of Ethics
http://www.counseling.org/knowledgecenter

ALGBTIC Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals
http://dx.doi.org/10.1080/15538605.2013.755444

PBS Documentary on Stonewall Riots
https://www.pbs.org/wgbh/americanexperience/films/stonewall/

SAIGE website
https://saigecounseling.org/

ACA Continuing Education
https://www.counseling.org/continuing-education

LGBTQ Youth Resources
http://www.glesen.org/
https://community.pflag.org
http://www.cdc.gov/lgbthealth/youth-resources.htm

Trevor Project
http://www.thetrevorproject.org

Human Rights Campaign on Reparative Therapy
http://wwww.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy

APA report on appropriate therapeutic responses to affectional orientation
http://www.apa.org/pi/lgbt/resources/sexual-orientation.aspx

Information for and about Lesbians
http://www.lesbian.com
http://www.lesbianherstoryarchives.org/
http://www.nclrights.org/
http://womeninthelife.com/

Information for and about Gay Men
http://www.cdc.gov/msmhealth/professional-resources.htm
http://www.gmad.org

Information for and about Bi-/Pansexuals
http://www.biresource.net
http://everydayfeminism.com/2014/11/pansexuality-101/

Information for and about Questioning Individuals
http://thetrevorproject.org/pages/spectrum
http://www.yoursexualorientation.info/
http://www.glbthotline.org/
http://www.itgetsbetter.org

Affirmative Religious Supports
http://www.gaychurch.org
http://www.hrc.org/resources/faith-positions
http://believeoutloud.com/background/christianity-and-lgbt-equality

Post Test

Confidence and Competency Questionnaire

Please mark the most appropriate box

Values and Beliefs					
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	
					I feel comfortable working with LGBTQ clients.
					If I see a person wearing a wedding ring, I assume they are straight.
					I am comfortable discussing sexual and affectional orientation with my clients.
					I am comfortable discussing gender identity/expression with my clients.
					I do not assume a person's presentation for counseling is related to their sexual orientation or gender identity/expression.
					I advocate for an LGBTQ inclusive environment at work.
Communication					
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	
					I will use language that reflects that of my LBGTQ patients so I can communicate effectively with them.
					When working with transgender patients, I will use their name of choice and preferred gender pronoun.
					When taking a social history, I will ask about a person's relationship history and if they have a partner (not if they are married.)
					I will advocate for the use of LGBTQ inclusive language in my organization and among my colleagues.
Knowledge					
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	
					I am aware of resources and community referrals for LGBTQ patients.
					I keep abreast of clinical best practices for LGBTQ patients.

What is the most useful thing you heard today? ____

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What is the least useful thing you heard today? ____

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Will you incorporate what you learned today in your practice? ☐ Yes ☐ No

If yes, what will you incorporate? ____

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If you will not incorporate what you learned, why not? ____

____

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____

____

*** Adapted from LGBT-Cultural-Competency-Training-Questionnaire-Post-Test** https://www.communitycatalyst.org/blog/text/LGBT-Cultural-Competency-Training-Questionnaire-Post-Test.pdf

Glossary

Terms and Definitions

Following are some commonly used terms based on the presenter's local community and the GLAAD Media Reference Guide.

Affectional Orientation: The direction (sex, gender identity/expression) an individual is predisposed to bond with and share affection emotionally, physically, spiritually, and/or mentally. This is used in place of sexual orientation to de-emphasize sexual behavior as the sole basis of understanding identity.

Ally: Anyone, whether cis-gendered and heterosexual or members of the LGBTQ communities, who provides personal support to a person or persons who self-identify as LGBTQ.

Asexual: An adjective used to describe people who do not experience sexual attraction (e.g., asexual person). A person can also be aromantic, meaning they do not experience romantic attraction.

Bisexual: A person who has the capacity to form enduring physical, romantic, and/ or emotional attractions to those of the same gender or to those of another gender. People may experience this attraction in differing ways and degrees over their lifetime. Bisexual people need not have had specific sexual experiences to be bisexual; in fact, they need not have had any sexual experience at all to identify as bisexual. (Often used interchangeably with pansexual.)

Cisgender: Individuals who gender identity aligns with the sex they were assigned at birth.

Coming Out: A lifelong process of self-acceptance. People forge a LGBTQ identity first to themselves and then they may reveal it to others. Publicly sharing one's identity may or may not be part of coming out.

This is a continual process that occurs multiple times for LGBTQ persons over the course of their lifetimes. Although many people think that one is either "out" or "in," this usually refers to a person's general openness with others about who he or she is. However, each time an individual encounters a new situation with new people, they must assess how safe and/or comfortable they are in sharing this information. Many times, this process can be difficult due to heterosexism, sexism, genderism, homophobia, biphobia, transphobia, and so on.

Gay: People whose enduring physical, romantic, and/ or emotional attractions are to people of the same sex (e.g., *gay man*, *gay people*). Sometimes *lesbian* (n. or adj.) is the preferred term for women. Avoid identifying gay people as "homosexuals" an outdated term considered derogatory and offensive to many lesbian and gay people.

Gender expression: The outward manifestation of one's gender identity, through clothing, hairstyle, mannerisms, and other characteristics. Social constructions are made within each culture for what is deemed appropriate for one's gender identity and expression, however, sometimes a person's gender identity expression does not fit traditional socially constructed categories.

Gender identity: The inner sense of being a man, woman, both, or neither.

Heterosexual: An adjective used to describe people whose enduring physical, romantic, and/ or emotional attraction is to people of the opposite sex.

Homosexual: Outdated clinical term considered derogatory and offensive.

Homophobia: An aversion, fear, hatred, or intolerance of individuals who are lesbian, gay, bisexual, queer, or questioning or of things associated with their culture or way of being. Intolerance, bias, or prejudice is often a more accurate description of antipathy toward LGBTQ people.

Homophobia also can be internalized, which is seen when lesbian, gay, bisexual, queer, or questioning individuals believe they are indeed deserving of ill treatment because of their identity.

Intersex: An individual who was born with male and female characteristics in their internal/external sex organs, hormones, chromosomes, and/or secondary sex characteristics, formerly termed hermaphrodite. Although the term hermaphrodite is still used by some members of the Intersex community, it has gone out of favor with many people who are intersex due to its pejorative use.

Lesbian: A woman whose enduring physical, romantic, and/or emotional attraction is to other women. Some lesbians may prefer to identify as gay (adj.) or as gay women.

LGBTQ: Acronym for lesbian, gay, bisexual, transgender, and queer. Sometimes, when the Q is seen at the end of LGBT, it can also mean questioning. LGBT and/or GLBT are also acceptable. The term "gay community" should be avoided, as it does not accurately reflect the diversity of the community. Rather, LGBTQ community is preferred.

LGBQIQA: Acronym used for lesbian, gay, bisexual, queer, intersex, questioning, and asexual. This is used when referring to those who do not consider themselves heterosexual and/or transgender. LGB or LGBQ can also be used as shortened versions of this acronym.

Queer: An adjective used by some people, particularly younger people, whose sexual orientation is not exclusively heterosexual. Typically, for those who identify as queer, the terms lesbian, gay, and bisexual are perceived to be too limiting and/or fraught with cultural or political connotations they feel do not apply to them. Some people may use queer, genderqueer, or nonbinary to describe their gender identity and/or gender expression. Once considered a pejorative term, queer has been reclaimed by some LGBT people to describe

themselves; however, it is not a universally accepted term even within the LGBT community.

Questioning: Individuals who are unsure if they are emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with men, women, or both.

Sex: The sex one is assigned at birth is intended to identify a person as female, intersex, or male and is determined by the words society have used to denote a person's sexual anatomy, chromosomes, and hormones. Because many transgender people do not resonate with words like "biological sex," it is preferable to use the words *sex* and *assignment* when discussing these constructs

Critical Analysis

Areas of Strength

After reviewing the training, the author feels that a lot of information is provided in a concise and informative manner. The scope of the project is broad and provides solid foundational information in the six areas of competency addressed. The training provides multiple opportunities for participants to reflect on their own practice as well as how their biases and intersecting identities may impact treatment and perceptions of their clients.

The goal of this training is to provide a foundation for competence and increased confidence in counseling individuals that identify as LGBTQ. By doing so, the training prepares participants to create safe, supportive, and caring relationships with LGBTQ individuals, groups, and communities that foster self-acceptance and personal, social, emotional and relational development. The training is based on current evidence-based practices and is guided by the ACA Code of Ethics and the ACA's ALGBTIC Competencies for Counseling LGBQIQA.

Areas for Growth

While this training is fairly comprehensive in covering the ACA's ALGBTIC Competencies for Counseling LGBQIQA, there are areas of competency that were not included including Research and Program Evaluation and Career and Lifespan Development. The author felt that including those areas would become cumbersome and overwhelming to participants by trying to cover too many areas. Other areas that were not included are the competencies for counseling individuals who identify as intersex and the competencies for counseling allies for the same reasons. Additional segments covering each of these areas would make the training more comprehensive.

Another aspect of training that would be beneficial is more in-depth discussion of each of the evidence-based treatments presented. Again, the author chose breadth of coverage over depth in order to provide a broader foundation for competency; however, some participants may feel that more specific information on these treatments would be beneficial.

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Appendix I

Terminology

Affectional Orientation: The direction (sex, gender identity/expression) an individual is predisposed to bond with and share affection emotionally, physically, spiritually, and/or mentally. This is used in place of sexual orientation to de-emphasize sexual behavior as the sole basis of understanding identity**.**

Ally: Anyone, whether cis-gendered and heterosexual or members of the LGBTQ communities, who provides personal support to a person or persons who self-identify as LGBTQ.

Asexual: An adjective used to describe people who do not experience sexual attraction (e.g., asexual person). A person can also be aromantic, meaning they do not experience romantic attraction.

Bisexual: A person who has the capacity to form enduring physical, romantic, and/ or emotional attractions to those of the same gender or to those of another gender. People may experience this attraction in differing ways and degrees over their lifetime. Bisexual people need not have had specific sexual experiences to be bisexual; in fact, they need not have had any sexual experience at all to identify as bisexual.

Cisgender: Individuals who gender identity aligns with the gender they were assigned at birth.

Coming Out: A lifelong process of self-acceptance. People forge a LGBTQ identity first to themselves and then they may reveal it to others. Publicly sharing one's identity may or may not be part of coming out.

Gay: People whose enduring physical, romantic, and/ or emotional attractions are to people of the same sex (e.g., *gay man*, *gay people*). Sometimes *lesbian* (n. or adj.) is the preferred

term for women. Avoid identifying gay people as "homosexuals" an outdated term considered derogatory and offensive to many lesbian and gay people.

Gender expression: The outward manifestation of one's gender identity, through clothing, hairstyle, mannerisms, and other characteristics**.**

Gender identity: The inner sense of being a man, woman, both, or neither.

Heterosexual: An adjective used to describe people whose enduring physical, romantic, and/ or emotional attraction is to people of the opposite sex.

Homosexual: Outdated clinical term considered derogatory and offensive. The Associated Press, New York Times and Washington Post restrict usage of the term.

Homophobia: Fear of people attracted to the same sex. Intolerance, bias, or prejudice is usually a more accurate description of antipathy toward LGBTQ people.

Lesbian: A woman whose enduring physical, romantic, and/or emotional attraction is to other women. Some lesbians may prefer to identify as gay (adj.) or as gay women.

LGBTQ: Acronym for lesbian, gay, bisexual, transgender, and queer. Sometimes, when the Q is seen at the end of LGBT, it can also mean questioning. LGBT and/or GLBT are also often used. The term "gay community" should be avoided, as it does not accurately reflect the diversity of the community. Rather, LGBTQ community is preferred.

LGBQQIA: Acronym used for lesbian, gay, bisexual, queer, questioning, intersex, and asexual. This is used when referring only to those who do not consider themselves heterosexual and/or transgender.

Queer: An adjective used by some people, particularly younger people, whose sexual orientation is not exclusively heterosexual (e.g. queer person, queer woman). Typically, for those who identify as queer, the terms lesbian, gay, and bisexual are perceived to be too

limiting and/or fraught with cultural connotations they feel don't apply to them. Some people may use queer, or more commonly genderqueer, to describe their gender identity and/or gender expression (see non-binary and/or genderqueer below). Once considered a pejorative term, queer has been reclaimed by some LGBT people to describe themselves; however, it is not a universally accepted term even within the LGBT community. When Q is seen at the end of LGBT, it typically means queer and, less often, questioning.

Questioning: Individuals who are unsure if they are emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with men, women, or both.

* Term definitions from LGBTQ individuals as well as from GLAAD Media Reference Guide - Lesbian / Gay / Bisexual Glossary of Terms (GLAAD, n.d.)

Appendix II

ALGBTIC Competencies for Counseling Lesbian, Gay, Bisexual, Queer, and Questioning Individuals

A. Human Growth and Development

Competent counselors will:

A. 1. Understand that biological, familial, cultural, socio-economic, and psychosocial factors influence the course of development of affectional orientations and gender identity/expressions.

A. 2. Affirm that LGBQQ persons have the potential to integrate their affectional orientations and gender identity into fully functioning and emotionally healthy lives and relationships.

A. 3. Identify the heterosexism, biphobia, transphobia, homophobia, and homoprejudice inherent in current lifespan development theories and account for this bias in assessment procedures and counseling practices.

A. 4. Be aware of the effects internalized homophobia/biphobia/transphobia may have on individuals and their mental health.

A. 5. Notice that developmental periods throughout the lifespan (e.g., youth, adolescence, young adults, middle adults, older adults) may affect the concerns that LGBQQ clients present in counseling.

A. 6. Recognize how stigma, prejudice, discrimination and pressures to be heterosexual may affect developmental decisions and milestones in the lives of individuals regardless of the resiliency of the LGBQQ individual.

A. 7. Know that the normative developmental tasks of LGBQQ youth, adolescence, young adults, middle adults, older adults, may be complicated, delayed, or compromised by identity confusion, anxiety and depression, suicidal ideation and behavior, academic failure, substance abuse, physical, sexual, and verbal abuse, homelessness, prostitution, and STD/HIV infection.

A. 8. Understand that the typical developmental tasks of LGBQQ older adults often are complicated or compromised by social isolation and invisibility.

A. 9. Understand that affectional orientation is not necessarily solid, it is or “can be” fluid, and may change over the course of an individual’s life span.

A. 10. Recognize the influence of other contextual factors and social determinants of health (i.e. race, education, ethnicity, religion and spirituality, socioeconomic status, role in the family, peer group, geographical region, age, size, gender identity/expression, etc.) on the course of development of LGBQQ identities.

A. 11. Understand that LGBQQ individuals family structures may vary (e.g. multiple coupled parenting families, polyamorous families), and they may belong to more than one group they consider their family.

A. 12. Understand that an LGBQQ individual’s family of origin group and/or structure may change over time, especially as it relates to the family’s acceptance/rejection of the LGBQQ member, and acknowledge the impact that being rejected from one’s family may have on the individual. If problems exist in the “family of origin,” the individual may create a “family of choice,” among supportive friends and relatives.

A. 13. Understand the individual, throughout the lifespan, may or may not be “out” about their affectional orientation in any or all aspects of their life. Recognize reasons for disclosing or not disclosing an affectional orientation may vary.

A. 14. Recognize that the coming “out” process may impact individuals return to earlier stages of development that may or may not be congruent with individual’s chronological age.

A. 15. Acknowledge the limitations of current coming “out” identity development models and recognizes that such models are not to be approached in a linear fashion, but appreciate the fluidity of such models.

A. 16. Work to integrate coming out identity development models with other models of identity when appropriate (i.e. racial, gender, spirituality identity models). Counselors validate the multifaceted nature of identity and help clients to achieve identity synthesis and integration.

A. 17. Recognize, acknowledge, and understand the intersecting identities of LGBQQ individuals (e.g., affectional orientation, race, ethnicity, nationality, gender identity and expression, religion/spirituality, class, ability, etc.) and their accompanying developmental tasks. This should include attention to the formation and integration of the multiple identity statuses of LGBQQ individuals.

A. 18. Understand that coming out is an on-going and multi-layered process for LGBQQ individuals and that coming out may not be the goal for all individuals. While coming out may have positive results for a person’s ability to integrate their identity into their lives thus relieving the stress of hiding, for many individuals coming out can have high

personal and emotional costs (e.g., being rejected from one's family of origin, losing a job/career, losing one's support system).

A. 19. Understand LGBQQ group members have the resiliency to live fully functioning, healthy lives despite experiences with prejudice, discrimination, and oppression.

B. Social and Cultural Diversity

Competent counselors will:

B. 1. Understand the importance of appropriate use of language for LGBQQ individuals and how certain labels (such as gay or queer) require contextualization to be utilized in a positive and affirming manner.

B. 2. Be aware that language is ever-evolving and varies from person to person; honor labels and terms preferred by the client; recognize that language has historically been used and continues to be used to oppress and discriminate against LGBQQ individuals; understand that the counselor is in a position of power and should model respect for the individual's declared vocabulary.

B. 3. Understand the history, contributions of diverse participants, and points of pride for the LGBTQIQA community (e.g., the LGBTQIQA rights movements). Be aware of current issues/struggles/victories for the LGBTQIQA community (e.g., ENDA, Marriage equality, Don't Ask Don't Tell, Hate Crimes Legislation, suicides related to anti-LGBT bullying) as well as current events within the profession (e.g., students/ practitioner refusing services to LGBQQ individuals, resolutions on reparative therapy, etc.).

B. 4. Be aware of the social and cultural underpinnings to mental health issues (e.g. high suicide rate of LGBQQ children and adolescents, particularly in response to anti-

LGBTQIQA bullying. Also be aware of how antigay bullying impacts children and adolescents from all communities, not just LGBTQIQA communities).

B. 5. Acknowledge that heterosexism and sexism are worldviews as well as value-systems that may undermine the healthy functioning of the affectional orientations, gender identities, and behaviors of LGBQQ persons.

B. 6. Understand that heterosexism and sexism pervade the social and cultural foundations of many institutions and traditions and may foster negative attitudes, overt hostility, and violence toward LGBQQ persons.

B. 7. Recognize how internalized prejudice, including heterosexism, racism, classism, religious/spiritual discrimination, ableism, adultism, ageism, and sexism may influence the counselor's own attitudes as well as those of LGBQQ individuals, resulting in negative attitudes and/or feelings towards LGBQQ individuals.

B. 8. Recognize, acknowledge, and understand the intersecting identities of LGBQQ individuals (e.g., affectional orientation, race, ethnicity, nationality, gender identity and expression, religion/spirituality, class, ability, etc.) and their accompanying developmental tasks. This should include attention to the formation and integration of the multiple identity statuses of LGBQQ individuals.

B. 9. Understand how the intersection of oppressions such as racism, homophobia, biphobia, classism, or sexism may affect the lives of LGBQQ individuals (e.g., Queer People of Color may be marginalized within their LGBTQIQA communities, which means they may lack a type of support that could operate as a protective factor, homelessness rates, access to healthcare services, etc.).

B. 10. Familiarize themselves with the cultural traditions, rituals, and rites of passage specific to LGBTQIQA populations.

B. 11. Use empowerment and advocacy interventions to navigate situations where LGBQQ clients encounter systemic barriers (see the ACA Advocacy Competencies) when appropriate and/or requested.

B. 12. Recognize that spiritual development and religious practices may be important for LGBQQ individuals, yet it may also present a particular challenge given the limited LGBQQ positive religious institutions that may be present in a given community, and that many LGBQQ individuals may face personal struggles related to their faith and their identity.

C. Helping Relationships

Competent counselors will:

C. 1. Acknowledge that affectional orientations are unique to individuals and they can vary greatly among and across different populations of LGBQQ people. Further, acknowledge an LGBQQ individual's affectional orientation may evolve across their lifespan.

C. 2. Acknowledge and affirm identities as determined by the individual, including preferred labels, reference terms for partners, and level of outness.

C. 3. Be aware of misconceptions and/or myths regarding affectional orientations and/or gender identity/ expression (e.g., that bisexuality is a "phase" or "stage", that the majority of pedophiles are gay men, lesbians were molested or have had bad experiences with men).

C. 4. Acknowledge the societal prejudice and discrimination experienced by LGBQQ persons (e.g., homophobia, biphobia, sexism, etc.) and collaborate with individuals in overcoming internalized negative attitudes toward their affectional orientations and/or gender identities/expressions.

C. 5. Acknowledge the physical (e.g., access to health care, HIV, and other health issues), social (e.g., family/ partner relationships), emotional (e.g., anxiety, depression, substance abuse), cultural (e.g., lack of support from others in their racial/ethnic group), spiritual (e.g., possible conflict between their spiritual values and those of their family's), and/or other stressors (e.g., financial problems as a result of employment discrimination) that may interfere with LGBQQ individuals ability to achieve their goals.

C. 6. Recognize that the counselor's own affectional orientation and gender identity/expression are relevant to the helping relationship and influence the counseling process. Use self-disclosure about the counselor's own affectional orientation and gender identity/expression judiciously and only when it is for the LGBQQ individual's benefit.

C. 7. Seek consultation and supervision from an individual who has knowledge, awareness, and skills working with LGBQQ individuals for continued self-reflection and personal growth to ensure that their own biases, skill, or knowledge deficits about LGBQQ persons do not negatively impact the helping relationships.

C. 8. If affectional orientation and/or gender identity/expression concerns are the reason for seeking treatment, counselors acknowledge experience, training, and expertise in working with individuals with affectional orientation and/or gender identity/expression concerns at the initial visit while discussing informed consent and seek supervision and/or consultation as necessary.

C. 9. Understand that due to the close-knit nature of LGBTQIQA communities, multiple relationships with LGBQQ individuals are not always avoidable or unethical and may impact the helping relationship. Counselors should seek appropriate supervision and/or consultation in order to foster ethical practices.

C. 10. Recognize the emotional, psychological and sometimes physical harm that can come from engaging clients in approaches which attempt to alter, "repair" or "convert" individuals' affectional orientation/ gender identity/expression. These approaches, known as reparative or conversion therapy lack acceptable support from research or evidence and are not supported by the American Counseling Association or the American Psychological Association. When individuals inquire about these above noted techniques, counselors should advise individuals of the potential harm related to these interventions and focus on helping clients achieve a healthy, congruent affectional orientation/gender identity/expression.

C. 11. Understand the unique experiences of bisexuals and that biphobia is experienced by bisexuals in both the LGBTQIQA and heterosexual communities.

C. 12. Ensure that all clinical-related paperwork and intake processes are inclusive and affirmative of LGBQQ individuals (e.g., including "partnered" in relationship status question, allowing individual to write in gender as opposed to checking male or female).

C. 13. Recognize that the individual's LGBQQ identity may or may not relate to their presenting concerns.

C. 14. Conduct routine process monitoring and evaluation of the counselor's service delivery (treatment progress, conceptualization, therapeutic relationship) and, if necessary, re-evaluate their theoretical approach for working with LGBQQ individuals

given the paucity of research on efficacious theoretical approaches for working with LGBQQ individuals.

C. 15. Recognize and acknowledge that, historically, counseling and other helping professions have compounded the discrimination of LGBQQ individuals by being insensitive, inattentive, uninformed, and inadequately trained and supervised to provide culturally proficient services to LGBQQ individuals and their loved ones. This may contribute to a mistrust of the counseling profession.

C. 16. Understand the coming out process for LGBQQ individuals and do not assume an individual is heterosexual and/or cisgender just because they have not stated otherwise. Individuals may not come out to their counselors until they feel that they are safe and can trust them, they may not be out to themselves, and this information may or may not emerge during the process of counseling. A person's coming out process is her/hir/his own, and it is not up to the counselor to move this process forward or backward, but should be the decision of the individual. The counselor can help the individual understand her/hir/his feelings about coming out and offer support throughout the individual's process.

C. 17. Demonstrate the skills to create LGBQQ affirmative therapeutic environments where disclosure of affectional orientation is invited and supported, yet there are not expectations that individuals must disclose their affectional orientation.

C.18. Continue to seek awareness, knowledge, and skills with attending to LGBQQ issues in counseling. Continued education in this area is a necessity for competent counseling due to the rapid development of research and growing knowledge base related

to LGBQQ experience, community, and life within our diverse, heterocentric, and ever-changing society

D. Group Work

Competent counselors will:

D. 1. Understand LGBQQ group members have the resiliency to live fully functioning, healthy lives despite experiences with prejudice, discrimination, and oppression.

D. 2. Recognize the power the group process has for LGBQQ members in affirming identity, community development, and connection during all group modalities (e.g., psychoeducation, task, counseling, psychotherapy, etc.).

D. 3. Recognize within-group power differentials and oppression among LGBQIQA members may occur, and counselors should be able to use their knowledge of group process and social justice to address such oppression.

D. 4. Demonstrate an awareness of their own affectional orientation, the fluidity of sexuality, and how stereotypes, prejudice, and societal discrimination may have influenced group counselor attitudes towards LGBQQ members.

D. 5. Integrate current research and best practices into group work with LGBQQ individuals, recognizing the paucity of research on group work with LGBQQ individuals, and utilizing supervision and consultation as needed.

D. 6. Acknowledge the challenges and opportunities related to voluntary disclosure of affectional orientation by group members and group leaders.

D. 7. Demonstrate the skills to create group environments where disclosure of affectional orientation is invited and supported, yet there are not expectations that group members must disclose their affectional orientation.

D. 8. Recognize the emotional, psychological and sometimes physical harm that can come from engaging clients in approaches which attempt to alter, “repair” or “convert” individuals’ affectional orientation/ gender identity/expression. These approaches, known as reparative or conversion therapy lack acceptable support from research or evidence and are not supported by the American Counseling Association or the American Psychological Association. When individuals inquire about these above noted techniques, counselors should advise individuals of the potential harm related to these interventions and focus on helping clients achieve a healthy, congruent affectional orientation/gender identity/expression.

D. 9. Acknowledge that group work has been used in the past by mental health professionals to attempt to change a member’s affectional orientation/gender identity/expression and that group members may have valid reasons for mistrust in group settings.

D. 10. Communicate and create a non-judgmental, LGBQQ-affirming environment when conducting group screening.

D. 11. Demonstrate the skills necessary to create a LGBQQ-affirming group environment throughout the group developmental process.

D. 12. Understand that due to the close-knit nature of LGBTQIQA communities, multiple relationships with group members are not always avoidable or unethical and may impact the group process. Counselors should seek appropriate supervision and/or consultation in order to foster ethical practices.

D. 13. Understand the potential benefits of flexibility and collaboration with group members in establishing group rules. For example, a group rule that members do not

socialize outside of group may be limiting or impossible for LGBQQ individuals given the close-knit nature of LGBTQIQA communities.

D. 14. Understand how intersecting identities and oppressions impact group members' lived experiences and may impact group process, member roles, and experiences in the group.

D. 15. Understand that groups are a microcosm of society and that group settings may feel unsafe for LGBQQ clients according to their experiences with prejudice, discrimination, and oppression. Competent group leaders will employ a strength-based approach to work with these potentially vulnerable group members.

D. 16. Work collaboratively with LGBQQ group members in both heterogeneous and homogeneous group settings to ensure group treatment plan expectations and goals attend to the safety, inclusion, and needs of LGBQQ members.

D. 17. Intervene actively when either overt or covert disapproval of LGBQQ members threatens member safety, group cohesion and integrity.

D. 18. Utilize consultation and supervision with mental health professionals who are competent and experienced in working with LGBQQ issues if they do not have previous counseling experience working with LGBQQ individuals in both LGBQQ specific and non- specific groups to help them to develop awareness, knowledge, and skills.

D. 19. Continue to seek awareness, knowledge, and skills with attending to LGBQQ issues in group work. Continued education in this area is a necessity for competent counseling and group work due to the rapid development of research and growing knowledge base related to LGBQQ experience, community, and life within our diverse, heterocentric, and ever- changing society.

D. 20. Understand how group counseling theories may not take into account the unique barriers and challenges LGBQQ individuals face. Understand that the use of particular group counseling theories may not have been normed for LGBQQ individuals, and that group counselors should keep this in mind so that interventions based on such theories are assessed for their efficacy.

D. 21. Be aware of the important role that Heterosexual Allies may have in heterogenous groups to provide support and encouragement to LGBQQ members.

E. Professional Orientation and Ethical Practice

Competent counselors will:

E. 1. Utilize an ethical decision-making model that takes into consideration the needs and concerns of the LGBQQ individual when facing an ethical dilemma.

E. 2. Utilize a collaborative approach with LGBQQ individuals to work through ethical dilemmas that impact the professional relationship when appropriate.

E. 3. Consult with supervisors/colleagues when their personal values conflict with counselors' professional obligations related to LGBQQ individuals about creating a course of action that promotes the dignity and welfare of LGBQQ individuals.

E. 4. Seek consultation and supervision from an individual who has knowledge, awareness, and skills working with LGBQQ individuals for continued self-reflection and personal growth to ensure that their own biases, skill, or knowledge deficits about LGBQQ persons do not negatively impact the helping relationships.

E. 5. Use language, techniques and interventions which affirm, accept, and support the autonomy of intersecting identities and communities for LGBQQ individuals.

E. 6. Recognize the emotional, psychological, and sometimes physical harm that can come from engaging clients in approaches which attempt to alter, "repair" or "convert" individuals' affectional orientation/ gender identity/expression. These approaches, known as reparative or conversion therapy lack acceptable support from research or evidence and are not supported by the American Counseling Association or the American Psychological Association. When individuals inquire about these above noted techniques, counselors should advise individuals of the potential harm related to these interventions and focus on helping clients achieve a healthy, congruent affectional orientation/gender identity/expression. Reparative therapy has been formally repudiated as ineffective and even harmful through policies adopted by numerous organization and associations including the following:

- American Association of School Administrators
- American Academy of Pediatrics
- American Counseling Association
- American Federation of Teachers
- American Medical Association
- American Psychiatric Association
- American Psychoanalytic Association
- American Psychological Association
- Council on Child and Adolescent Health
- The Interfaith Alliance Foundation
- National Academy of Social Workers
- National Education Association
- World Health Organization

E. 7. Continue gaining specialized training/education through professional workshops, reading relevant research, and staying up to date on current events for LGBQQ individuals and the LGBTQIQA community.

E. 8. Recognize and acknowledge that, historically, counseling, and other helping professions have compounded the discrimination of LGBQQ individuals by being insensitive, inattentive, uninformed, and inadequately trained and supervised to provide culturally proficient services to LGBQQ individuals and their loved ones. This may contribute to a mistrust of the counseling profession.

E. 9. Recognize the resiliency of LGBQQ individuals and their unique ability to overcome obstacles.

E. 10. Advocate with/for LGBQQ individuals to provide affirming, accepting and supportive counseling services when divergent viewpoints exist between supervisors and supervisees.

E. 11. Advocate with and for LGBQQ individuals on various ecological levels of community systems (e.g., micro, meso and macro) to provide affirming, accepting and supportive counseling services (e.g., educating the community and promoting changes in institutional policies and/or laws as the mental health of LGBQQ individuals is often impacted by stigma and oppression).

E. 12. Be aware of and share relevant LGBTQIQA affirmative community resources with LGBQQ individuals when appropriate.

E. 13. Understand that due to the close-knit nature of LGBTQIQA communities, multiple relationships with LGBQQ individuals are not always avoidable or unethical and may impact the helping relationship. Counselors should seek appropriate supervision and/or consultation in order to foster ethical practices.

F. Career and Lifestyle Development

Competent counselors will:

F. 1. Assist LGBQQ individuals in making career choices that facilitate both identity acceptance and job satisfaction.

F. 2. Understand how current career theories may not take into account the unique barriers and challenges that LGBQQ individuals face in their career paths and integrate the use of career theories in ways that are affirming of the needs of LGBQQ individuals. Understand that the use of particular career theories may not have been normed for LGBQQ individuals, and that interventions based on such theories will need to be assessed for their efficacy.

F. 3. Understand that career assessment instruments may not have been normed for LGBQQ individuals, and therefore the interpretation of their results and subsequent interventions will need to be adjusted to take this into account.

F. 4. Understand how systemic and institutionalized oppression against LGBQQ individuals may adversely affect career performance and/or result in negative evaluation of job performance, and thus may limit career options resulting in underemployment, less access to financial resources, and over-representation/ under-representation in certain careers.

F. 5. Be aware and share information with LGBQQ individuals the degree to which government (i.e., federal, state, and/or local) statutes, union contracts, and business policies perpetuate employment discrimination based on affectional orientation and gender expression and gender identity and advocate with LGBQQ individuals for the promotion of inclusive and equitable policies.

F. 6. Understand how experiences of discrimination, oppression, and/or violence may create additional inter/ intrapersonal barriers for LGBQQ individuals at work (e.g. decreased career/job satisfaction, lack of safety and comfort, interpersonal conflict, etc.).

F. 7. Understand how experiences of discrimination and oppression related to affectional orientation and/or gender identity/expression at work may be compounded when other experiences of discrimination or oppression are also experienced (e.g. racism, classism, ableism, ageism, religious discrimination, lookism, nationalism, etc.).

F. 8. Advocate for and with LGBQQ individuals and support the empowerment of LGBQQ individuals to advocate on their own behalf to promote inclusive policies and practices in the workplace as they are applicable on a micro-level (e.g. training on LGBQQ issues in the workplace), meso-level (in local communities) and macro-levels (e.g. in the larger communities with policies, legislations, and institutional reform).

F. 9. Demonstrate awareness of the challenges and safety concerns involved with coming "out" to co-workers and supervisors and how that may affect other life areas (e.g. housing, self-esteem, family support, upward employment opportunities).

F. 10. Maintain and ensure confidentiality of LGBQQ identities when advocating for an individual in the workplace even though individuals may be out in their community or in other personal areas.

F. 11. Link individuals with LGBQQ mentors, role models and resources that increase their awareness of viable career options, when appropriate.

F. 12. Increase knowledge and accumulate resources for LGBQQ individuals of workplaces that have a reputation of being safe, inclusive, and embracing environments.

G. Assessment

Competent counselors will:

G.1. Become informed (via empirical and theoretical literature and supervision/consultation with LGBTQIQA communities' resources) of the spectrum of healthy functioning within LGBTQIQA communities. Appreciate that differences should not be interpreted as psychopathology, yet they often have been interpreted in harmful ways to LGBTQIQA individuals/couples/families (e.g. the history of support and use of reparative/conversion therapy within the mental health field).

G.2. Acknowledge that affectional identity, gender identity, and other intersecting identities (race, ethnicity, class, ability, age, etc.) may or may not be the presenting concern for LGBQQ individuals, but that experiences of oppression may impact presenting issue(s).

G.3. Understand that at times individuals may present more positively to counseling than their actual experiences if they have not identified the oppressions or identity-stresses they may have experienced or if they have high levels of internalized oppression. Internalized oppression presents in a variety of ways and can sometimes be difficult to identify. Some examples are: an individual who uses heterosexist language while not understanding how this correlates to low self-esteem, low desire for partners, and/ or low tolerance for people of the same community; an individual believes that the stereotypes they hear about their identity are indeed true of all people of that identity; individuals feel incapable of success because they have heard so many negative things about people whose identity they share.

G.4. Be aware of how their own biases and/or privileges may influence their assessment with each LGBQQ individual, for example, promoting a particular course of treatment and/or overlooking individual's challenges.

G.5. Utilize supervision and consultation (from an individual who has knowledge, awareness, and skills in working with LGBQQ individuals) as a tool to help counselors recognize and minimize biases and avoid misuse/abuse of privilege and power.

G.6. Understand and be aware of the historical and social/cultural context regarding the practice of assessment, particularly in relation to underserved populations, such as LGBQQ individuals/couples/ families.

G.7. Recognize that assessment procedures can be potentially helpful as well as potentially harmful to individuals/families and be cognizant of the legal and ethical guidelines regarding best-practice standards for assessment with LGBQQ individuals/couples/families, (e.g. ACA Code of Ethics and Standards for Multicultural Assessment). Also be aware that legal codes and ethical guidelines may conflict, especially where LGBQQ individuals do not have equal rights and protections.

G.8. Understand the standard features of assessment: test development/item development, normative samples, psychometric properties (validity, reliability) and demonstrate knowledge of diversity issues impacting the development, norming, administration, scoring, interpretation, and report writing dimensions of the assessment process.

G.9. Seek out the perspectives and personal narratives of LGBQQ individuals and communities as essential components in order to more fully understand appropriate assessment of LGBQQ people.

G.10. Understand that bias in assessment can occur at several levels (i.e., theoretical considerations, content of items, language and meaning of items, values/assumptions of items, normative samples, referral question, and examiner-examinee dynamics). Thus, competent counselors must critically evaluate assessment procedures and instruments with attention to appropriateness of language usage in referral questions, diagnostic considerations, individual's personal identity, and practice settings.

G.11. Recognize that there have been very limited attempts, to date, to develop LGBTQIQA norm groups for counseling assessment instruments. This lack of norm groups should prompt significant caution regarding the interpretation of assessment results across any and all domains of functioning (e.g., cognitive, personality, aptitude, occupational/career, substance abuse, and couple/family relationships).

G.13. Become aware of professional education and resources of assessments tools adapted and/or created for LGBQQ individuals/couples/families and how those may be used in conjunction with multicultural and advocacy models to address the whole person and all of their intersecting identities.

G.14. Review intake paperwork, intake forms, interview methods, initial interventions, screening in the assessment measures to ensure use of inclusive language, which would allow for the fluidity of affectional orientation and gender identities and how those labels (or lack thereof) vary by individual. (For example, allowing space to self-identify gender and affectional orientation and to include intersecting identities such as class, race, ethnicity, ability, etc.)

G.15. Develop awareness of how technology has impacted the counseling profession in regards to appropriate assessment and treatment planning for LGBQIQ individuals (e.g.

increased accessibility of LGBQQ communities to information, confidentiality and anonymity of online counseling, and the dangers of dual relationships with the advent of the use of social networking services).

G.16. Understand how assessment measurements, the Diagnostic and Statistical Manual of Mental Disorders, and other diagnostic tools may perpetuate heterosexist, genderist, and sexist norms that negatively impact LGBQQ Individuals.

G.17. Understand any type of labeling that results from assessments may negatively impact LGBQQ individuals, especially labeling of symptomology due to oppression and/or minority stress.

H. Research and Program Evaluation

Competent counselors will:

H.1. Be aware that the counseling field has a history of pathologizing LGBQQ individuals and communities (e.g., studies of homosexuality as a "disorder" and research agendas that seek to "prove" that affectional orientation and/or gender identity/expression can be "changed"). Understand that these approaches to research and program evaluation have been deemed harmful and unethical in their research goals by professional organizations in the field (see Introduction).

H.2. Be aware of existing LGBQQ research and literature regarding social and emotional well-being and challenges to identity formation, resilience and coping with oppression, as well as ethical and empirically supported treatment options.

H.3. Have knowledge of the gaps in scholarship and program evaluations regarding understanding the experiences of LGBQQ individuals, families, and communities (e.g., research on couples may not include the experiences of LGBQQ partners or relationship

configurations). Understand how this gap widens when other marginalized identities are considered (e.g. LGBQQ People of Color, LGBQQ People who are Differently Abled, etc.)

H.4. Understand how to critically consume research and program evaluations with LGBQQ individuals and communities so that future research endeavors may assist with understanding needs, improving quality of life, empowering LGBQQ individuals, and enhancing counseling effectiveness for LGBQQ individuals.

H.5. Be current and well-informed on the most recent scholarship (e.g., research studies, conceptual work, program evaluation) with LGBQQ individuals and communities.

H.6. Understand limitations of existing literature and research methods regarding LGBQQ individuals with regard to sampling (e.g., racial/religious diversity), confidentiality issues (e.g., LGBQQ youth who are not "out" to their parents and cannot seek parental consent for participating in studies), data collection (e.g., accessing samples who are not "out"), and generalizability across the distinct identities within LGBQQ identities and experiences (e.g., research on gay men may not be generalizable across lesbians or bisexual men).

H.7. Seek to be intentional when sampling LGBQQ individuals and communities so that participant samples represent a wide range of diversity (e.g., race/ethnicity, gender, ability status, social class, geographic region, national origin, etc.) and note in limitations when it is not possible to generalize to particular populations.

H.8. Have knowledge of qualitative, quantitative, and mixed-methods research processes, the application of these methods in potential future research areas such as individual experiences of LGBQQ people, counselor awareness and training on LGBQQ concerns,

reduction of discrimination towards LGBQQ individuals, advocacy opportunities for positive social change in the lives of LGBQQ individuals, and strengths of LGBQQ families and parenting.

H.9. Understand how to utilize research and program evaluation participation incentives to provide valuable resources to LGBQQ individuals, communities, and those that serve these populations