edited by
Misty M. Ginicola • Cheri Smith • Joel M. Filmore

Affirmative Counseling with LGBTQI+ People

American Counseling Association

WILEY

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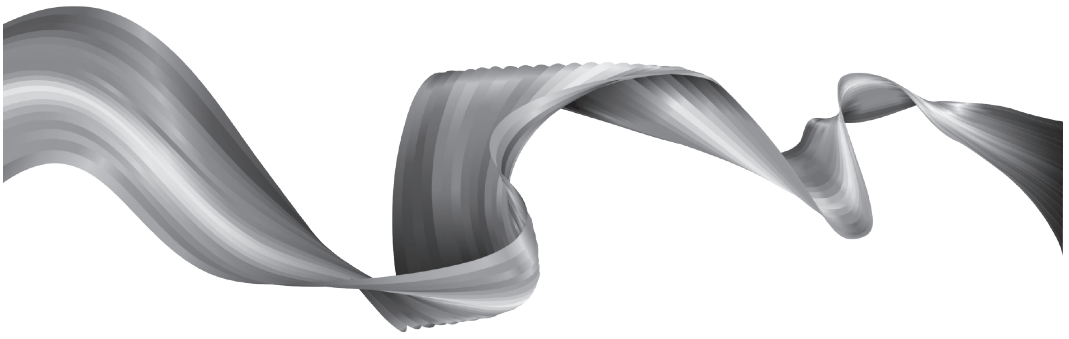

With ignorance comes fear—from fear comes bigotry.
Education is the key to acceptance.

—Kathleen Patel

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We would like to dedicate this book to all of those who are brave enough to live and love authentically as well as those who are looking for hope that it does indeed get better. We would also like to honor those counselors and helping professionals who commit their lives to learning about and helping lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, ally, pansexual/polysexual, and two-spirited people find their way, their joy, and their value.

Table of Contents

Preface

We should indeed keep calm in the face of difference and live our lives in a state of inclusion and wonder at the diversity of humanity.

—George Takei

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Possessing counseling competence in serving the lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, ally, pansexual/polysexual, and two-spirited (LGBTQQIAAP-2S, henceforth referred to as LGBTQI+) communities is important, particularly because previous research has shown that large numbers of this population seek therapy (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). If counselors are unprepared for work with this population, they could potentially do harm to these clients. Many counselors have not received adequate training to work with affectional orientation and gender minority clients; LGBTQI+ clients are aware of this deficit in the field and prescreen therapists for safety and competence in issues of affectional orientation and gender orientation (Kaufman et al., 1997; Liddle, 1997). Although many standard counseling interventions will be appropriate for work with the LGBTQI+ population, counselors need an awareness and knowledge of this population and its cultures and subcultures that extend beyond typical client concerns (Bieschke, Perez, & DeBord, 2007; Dworkin & Pope, 2012).

The needs of LGBTQI+ individuals are different from those of clients who identify as heterosexual because of variant affectional and developmental experiences that occur as well as the increased stigma and oppression that they may face in their current cultural context. A theme throughout this book is the high level of minority stress that LGBTQI+ persons experience. Without a doubt, common issues of oppression, abuse and neglect, and discrimination are threaded throughout the subgroups of the LGBTQI+ communities; however, it is both the common struggles and the unique ones that are addressed in this text.

Members of the LGBTQI+ population have frequently been lumped together as if their individual needs were exactly the same and they formed one singular community. However, there is a rich history of development, strengths, and needs in this population, both as a collective group and also in its singular subgroups (Bérubé, 1990; Faderman, 1991) that bears acknowledgment and understanding. For example, issues specific to the development of lesbian identity and culture are different from those of other subgroups (Chapman & Brannock, 1987; McCarn & Fassinger, 1996); the same can be said for identity development for gay men, bisexuals, and transgender individuals.

Another theme that is addressed in this book and is crucial for counselors to understand is that of intersectionality; stressors and difficulties are compounded for LGBTQI+ individuals when

other minority statuses, such as race and ethnicity, are also present (Chung & Katayama, 1998). Racial identity development and affectional orientation identity development are complex processes, with research suggesting that they occur concurrently (Jamil, Harper, & Fernandez, 2009). Although some assume that in LGBTQI+ communities there is more acceptance of differences, including race, there is not; in fact, there is just as much racism and prejudice in the queer community as the heterosexual community (Goode-Cross & Tager, 2011). Queer people of color (QPOC) often feel as if they are unable to identify with the predominantly White gay culture (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). They also have difficulty identifying with their racial/ethnic culture, from which they risk rejection and the loss of their only social support and cultural ties because of their affectional orientation (Diamond & Savin-Williams, 2003). The research that has focused on the intersection of race/ethnicity and affectional orientation has suggested that individuals who have to negotiate multiple identities, such as QPOC, are at an increased risk for psychosocial distress because of heterosexism and racism, which is beyond what White LGBTQI+ individuals experience (Smith, Foley, & Chaney, 2008). The discrimination suffered by QPOC is also unique based on various cultural/religious traditions and can contribute to isolation among QPOC, exacerbating psychosocial distress (Lewis, 2009). Along with these factors, one must also consider socioeconomic variables and geography, as well as other -isms that can impact a client's development, such as sexism, ageism, ableism, and the like (Smith et al., 2008).

Given these complex and specialized needs, it is imperative that counselors and other helping professionals obtain specific training on working with members of the LGBTQI+ communities; a brief class session in a multicultural course will not prepare practitioners for understanding the needs and interventions that the entirety of this population requires. As use of the LGBT acronym has increased, so too has the need to understand these complex, varied, and sometimes overlapping identities. A competent counselor needs to have an awareness of the LGBTQI+ experience and knowledge of this population and its specialized needs, as well as the skills required to work with various subcultures in the LGBTQI+ population.

This book seeks to aid in filling the gap in counselor training by providing a current and inclusive reference for developing the awareness, knowledge, and skills needed to work with the LGBTQI+ population. The intended audience is counselor educators, all counselors-in-training, and practicing counselors. This book is also appropriate for other helping professionals, such as psychologists and social workers.

By seeking out the most recent literature and including chapters by authors who serve as experts on LGBTQI+ populations in the counseling field, we have focused on making this book current and of practical importance for the clinician, student, and educator. The book is divided into four main sections: (a) Foundations, (b) Counseling Considerations and Counseling Strategies, (c) Specialized Populations, and (d) Emerging Issues.

Section I: Foundations

In Chapter 1, "Developing Competence in Working With LGBTQI+ Communities: Awareness, Knowledge, Skills, and Action," the authors review the multicultural counseling framework and multiple American Counseling Association–based competencies as well as aspects of basic competencies, including terminology and a history of oppression among the LGBTQI+ population. In Chapter 2, the author reviews the science of gender and affectional orientation.

Section II: Counseling Considerations and Counseling Strategies

In this section developmental issues for LGBTQI+ people are explored. The authors of Chapter 3 provide a conceptualization of growing up LGBTQI+ and how being an affectional

orientation and gender minority may result in additional challenges to development. In Chapter 4, the authors review what is known about LGBTQI+ youth development. Chapter 5 discusses LGBTQI+ persons in adulthood. In Chapter 6, issues surrounding identity development, coming out, and family adjustment are reviewed. It is crucial to understand the process of coming to terms with having a minority gender and/or affectional orientation as well as how the coming out process impacts both individuals and their families. Finally, in Chapter 7, the authors review issues that, because of excessive minority stress, may bring those in the LGBTQI+ population in for medical care and mental health counseling. This chapter, "Physical and Mental Health Challenges Found in the LGBTQI+ Population," provides counselors with an understanding of normative symptoms in the population due to the oppression, marginalization, and trauma surrounding being a minority. Special attention is paid to how stress may be expressed differently in the subgroups of the queer community.

In addition, counseling treatment issues with LGBTQI+ clients are explored. In Chapter 8, the empirical basis of treatment strategies for these clients is reviewed in "Disaffirming Therapy: The Ascent and Descent of Sexual Orientation Change Efforts," in which the authors explore the traumatizing role that past mental health professionals and faith-based leaders played in treating affectional orientation as a curable disease. Chapter 9, "Evidence-Based Practice for Counseling the LGBTQI+ Population," provides a review of the literature as well as an introduction to the importance of using an affirmative approach with clients who are gender and affectional orientation minorities. Finally, in Chapter 10, the authors focus specifically on the affirmative approach in "Affirmative, Strengths-Based Counseling With LGBTQI+ People." The elements of an affirmative approach, as well as specific methods that can be utilized, are discussed.

Section III: Specialized Populations

In this section, the individual populations that make up the LGBTQI+ community are reviewed in order to provide the crucial counseling competence required to meet each population's specialized needs. In each chapter, authors address (a) an awareness of differences in the population, (b) knowledge of issues and problems faced by the specific population, and (c) the counseling skills and techniques appropriate for use with each specialized population.

Chapters 11 through 19 discuss issues relevant to counseling lesbian clients, gay male clients, bisexual/pansexual/polysexual clients (individuals whose relationships and bonding are not based on gender), transgender clients (individuals whose designated sex at birth and gender identity do not match), queer and genderqueer clients (individuals whose gender and affectional orientation do not fit into distinct categories), clients questioning their affectional orientation, intersex clients (those born with ambiguous or both male and female genitalia), asexual clients (those who have little or no sexual attraction to others), and two-spirit clients (individuals who are both indigenous peoples to the Americas and LGBTQI+ persons).

Section IV: Emerging Issues

The last section includes emerging issues in the field: ethnicity, religion, and advocacy needs.

The Role of Ethnicity

In Chapter 20, "Counseling an LGBTQI+ Person of Color," the intersectional issues of ethnicity and LGBTQI+ identity are discussed. In Chapter 21, "Counseling LGBTQI+ Immigrants," intersectional issues surrounding immigration and naturalization as a member of the queer community are delineated.

The Role of Religion

In Chapter 22, "The Role of Religion and Spirituality in Counseling the LGBTQI+ Client," the impact of religion on clients' identity development, numerous affirmative religions, and issues involving counselors' religious beliefs are discussed. In Chapter 23, "The GRACE Model of Counseling: Navigating Intersections of Affectional Orientation and Christian Spirituality," an established counseling model for working with religious LGBTQI+ clients is delineated. In Chapter 24, "Working With LGBTQI+ Clients Who Have Experienced Religious and Spiritual Abuse Using a Trauma-Informed Approach," the authors discuss the impact of religious trauma.

Counselor Advocacy

In Chapter 25, "Becoming an Ally: Personal, Clinical, and School-Based Social Justice Interventions," the authors discuss why it is important for counselors to identify as allies as well as how counselors can do so in their specific setting.

Glossary of Terms

The book concludes with an extensive glossary of terms that counselors working with this community should know. Problematic terms to avoid are also covered in the glossary.

Conclusion

Each chapter in this book focuses not only on the knowledge base important for practice but also on specific counseling strategies important for treatment planning. The goal of this book is to provide information that is widely needed in practice as well as in counselor training programs. Each chapter additionally has several elements to help counselors understand how to apply this knowledge as well as how to gain resources in the field. First, the "Awareness of Attitudes and Beliefs Self-Check" has three questions designed to increase counselors' cultural competence, particularly their self-awareness of marginalization and privilege. Second, each chapter contains a brief narrative and case study of a client who represents the content covered. These narratives provide a context that personalizes the information and helps the reader envision a potential client. This context is important, as it helps in the development of a practical framework of counseling strategies for a client who could present in a counselor's practice or agency. It also provides a transition into each chapter, where authors provide the essential information for counseling practice via theoretical knowledge and established research. At the end of each chapter is a list of five questions related to the original case that represents content for further discussion, which is especially useful for practicing counselors and counselor educators. Finally, online resources are provided to guide readers to more information on each topic.

When counselors have the awareness, knowledge, and skills required to work with the LGBTQI+ population, they will be much more competent providers. The key to being an effective counselor for members of these communities is truly being able to work with each client using an authentic, ethical, and affirmative approach tailored to that client's individual needs and identity. This book provides a deeper understanding of the theory and process behind counseling LGBTQI+ clients, what these clients' lives and cultures may entail, and trends in serving this population. We believe that with this information, counselors will enhance their aptitude for serving the needs of this population, which often faces

misunderstanding and rejection from others in their lives. Counselors who work with this population can then provide the understanding, acceptance, affirmation, and healing that LGBTQI+ clients so very often seek in counseling.

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About the Editors

Misty M. Ginicola, PhD, is a professor in the clinical mental health counseling program in the Counseling and School Psychology Department at Southern Connecticut State University.

Dr. Ginicola earned a bachelor's degree in psychology from State University of New York at Cortland. She earned a master's in psychology from State University of New York at New Paltz, where she received training in counseling psychology. She received two additional master's degrees (MS, MPh) from Yale University and graduated with a Doctor of Philosophy from Yale in 2006, where she completed her postdoctoral fellowship focusing on school-based mental health programming and social-emotional skills in youth.

Dr. Ginicola is of Cherokee and Celtic descent and identifies as two-spirited. Her personal experiences and professional interests have developed into specific research areas: working with diverse clients, including the lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, ally, pansexual/polysexual, and two-spirited (LGBTQI+) population; teaching multicultural competence; and teaching creative counseling strategies. Her previous and ongoing research studies address the broad definition of multicultural issues, including ethnicity, disability, women's issues, affectional orientation and gender orientation, and religion and spirituality, among others.

She additionally serves as her department's liaison for the Council for Accreditation of Counseling and Related Educational Programs and chair of the Diversity Committee. She also is currently the chair of the President's Commission of Campus Climate and Inclusion LGBTQI+ Subcommittee. In the Connecticut Counseling Association, Dr. Ginicola is a past-president of the Connecticut Association for Counseling Education and Supervision; chair of the Special Interest Group Connecticut-Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (CT-ALGBTIC); and chair of the Multicultural Counseling and Development Committee. Dr. Ginicola has served on national task forces for the American Counseling Association's ALGBTIC and is currently an editorial review board member for the *Journal of LGBT Issues in Counseling*.

In addition, she is a licensed professional counselor in the state of Connecticut and operates a private counseling practice called Walk in Balance Counseling. The name has a specific meaning attached to her cultural identity of Cherokee. Reflecting the Native saying "Walk in balance and beauty," she works with clients on a holistic level to ensure that physically, emotionally, psychologically, cognitively, and spiritually (if desired) they are caring for themselves. She also uses a person-centered existential approach to therapy, thereby helping individuals see and maintain the beauty in their lives, even in times of trauma and stress.

Her most challenging and fulfilling role has been as a mother to two sons, Wilson and Waylon. Raising her children has taught her more about teaching and modeling compassion and acceptance than she has ever learned in any textbook.

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Cheri Smith, PhD, is a professor at Southern Connecticut State University. She earned her bachelor's degree at the University of West Florida and her master's in education in school counseling and Doctor of Philosophy in educational psychology/counseling at Mississippi State University. She worked in student affairs at Mississippi State University and Florida Atlantic University. Her teaching career began at the University of Montevallo. She has also taught at St. John's University, the University of West Georgia, the New York Institute of Technology, and Troy University. In 1995, while serving as president of the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC), she participated in the first Summit on Spirituality, where the initial ASERVIC competencies were developed. In the late 1980s and 1990s, her research also included HIV/AIDS education. This connection led her to combine her research in the area of spirituality with the LGBTQ+ community.

Dr. Smith is a member of the American Counseling Association, the Connecticut and Alabama Counseling Associations, ASERVIC, ALGBTIC, the Association for Specialists in Group Work, the Association for Counselor Education and Supervision, and Chi Sigma Iota. She has served on the editorial review board for the *Alabama Counseling Association Journal*. Also, she has served as president of the Montevallo chapter of the American Association of University Women and president of the Alabama Counseling Association. In addition, for 5 years she served on the Alabama Board of Examiners in Counseling. She has served on the editorial review board for the journal *Counseling and Values*, and currently she is a site visitor for the Council for Accreditation of Counseling and Related Educational Programs.

She is a licensed professional counselor and supervising counselor in Alabama as well as a National Board Certified Counselor. Her proudest role has been as a parent. Along with her husband, she is raising two daughters with open hearts and open minds.

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Joel M. Filmore, EdD, is the founder, co-owner, and director of clinical services for the Lighthouse Professional Counseling Center; he is also lead faculty and program coordinator for Springfield College in Milwaukee. Dr. Filmore earned his bachelor's degree in psychology from the University of Illinois at Chicago. He earned his master's in clinical psychology from Roosevelt University in Chicago. He earned his Doctor of Education in counselor education and supervision from Northern Illinois University in DeKalb, Illinois, where he also earned a graduate certificate in quantitative research methods.

Prior to becoming a counselor educator, Dr. Filmore worked as an academic advisor in the university setting as well as a counselor in the community college setting. He also worked for more than 8 years in social services, predominantly with homeless, HIV-positive, drug-addicted, chronically mentally ill, lesbian, gay, bisexual, transgender, and other disenfranchised populations. Dr. Filmore is a biracial (African American and German/Norwegian) gay man. His personal and professional interests are in the areas of LGBTQI+ populations, multicultural issues, substance abuse/addiction, sex offender issues, sex trafficking, and trauma, as well as counselor competency.

Dr. Filmore currently serves as President-Elect for the national ALGBTIC. He also served as the cochair of the LGBTQQIA Affirmative Counseling and Social Justice

Committee 2 years running for ALGBTIC. He is past-president of the South Dakota Association for Counselor Education and Supervision as well as the cofounder and past-president of the Illinois ALGBTIC.

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We would like to thank the American Counseling Association for its unwavering support of the lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, ally, pansexual/polysexual, and two-spirited (LGBTQI+) community. We are proud to be members of an organization that always advocates for and works toward social justice for the most vulnerable populations among us.

We would also like to thank all of the authors who contributed to this book for their continual work to help those in the LGBTQI+ communities. The impact they make in education, research, and practice truly makes an immeasurable difference in the lives of the clients we serve.

Misty would like to acknowledge her brother, Steve, who taught her that being different was something to be celebrated; growing up with him as a big brother has been an honor and a blessing. She would also like to thank her husband, Mike, who loved and valued her differences from the moment he met her. She would also like to thank her sons, Wilson and Waylon, for opening up a whole new chapter of her life and identity; she works every day to make the world a more accepting place that will value their differences.

Cheri would like to thank Misty, whose hard work and desire to make a difference in the world and in the counseling profession are inspirational. She would also like to thank her fellow coeditor, Joel, and the contributing authors who helped to make this book a reality. She is also thankful to her mentors and colleagues in the Association for Spiritual, Ethical, and Religious Values in Counseling who, for the past 20+ years, have shown her the importance of religion and spirituality in the counseling profession. She would like to acknowledge her parents, who taught her to treat everyone with respect and that social justice is not optional. Cheri would also like to acknowledge Billy R. Cox, an HIV/AIDS activist whose life taught her by example how to fight for a cause with grace and whose death underscored the importance of not waiting for someone else to speak up. Mark Fitzhugh, her favorite Episcopal priest, has supported her with unconditional love and acceptance. Her children, Emma and Ella, both already activists in their own right, give her joy and hope for the future.

Joel would like to thank all of the people who, along the journey of his life, were able to see beyond his brash persona to recognize that underneath was a broken little boy who simply wanted to be loved and accepted. He acknowledges the one woman who helped forge him into the strong, determined firebrand that he is today: his grandmother, Anna Chatfield. He would especially like to thank the one person who can say he truly knows him: his husband and true love, Angel (Chino). Over the past 12 years, Angel has taught him that there really is such a thing as unconditional love.

FOUNDATIONS

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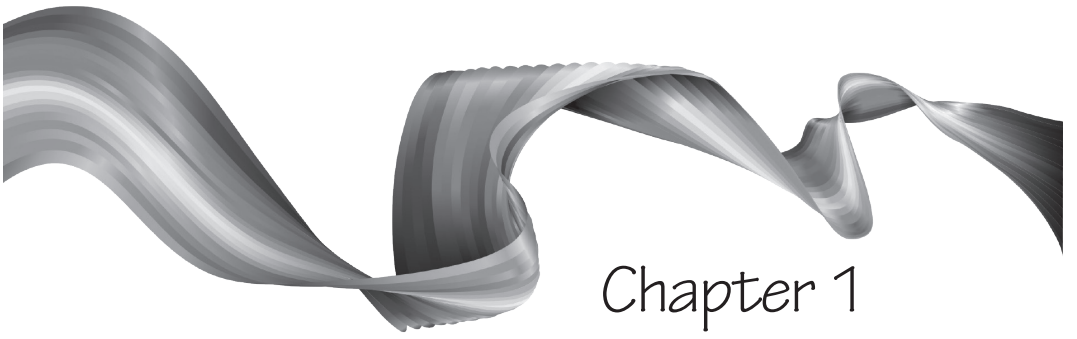
Counselors working with lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, ally, pansexual/polysexual, and two-spirited (LGBTQI+) people need a tremendous amount of information in order to serve their clients effectively. Using the framework of American Counseling Association competencies, the authors explore awareness, knowledge, and skills relevant to working with affectional orientation and gender minorities. In this section, the foundation for developing LGBTQI+ competence is addressed through an exploration of American Counseling Association competencies, terminology, history, current civil rights and social struggles, the need for advocacy, and the scientific research surrounding gender and affectional orientation variance.



Chapter 1

Developing Competence in Working With LGBTQI+ Communities: Awareness, Knowledge, Skills, and Action

Misty M. Ginicola, Joel M. Filmore, and Cheri Smith

We struggled against apartheid because we were being blamed
and made to suffer for something we could do nothing about.
It is the same with homosexuality.
The orientation is a given, not a matter of choice.
It would be crazy for someone to choose to be gay,
given the homophobia that is present.

—Desmond Tutu

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Awareness of Attitudes and Beliefs Self-Check

1. When did you first learn what being gay meant? Was it a positive or negative message?
2. What assumptions do you make about the sexual or affectional orientation of your clients? How might these assumptions emerge in your behavior?
3. What is your knowledge of the history of oppression for lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, ally, pansexual/polysexual, and two-spirited (LGBTQI+) persons?

Case Study

Martin is a 35-year-old Jamaican American gay male who has come to counseling. Martin was born in Jamaica and then moved with his family at age 10 to New York City. One of his first memories from Jamaica was watching a man be beaten to death for being gay. His father died when he was 20, and he has been responsible for caring for his family ever since. He has always known that he is gay but kept it a secret because of the extreme prejudice in his culture and family. Martin has been in a 2-year relationship with Angel, a Puerto Rican man. They have recently talked about moving forward in their relationship and moving in together. However, Martin is afraid because that will mean coming out to his deeply religious mother, who is affiliated with the Church of God.

His family lives with him in his house, so there is no way that he could keep it a secret. He has been depressed and, although not overtly suicidal, has some suicidal ideation.

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Multicultural Competence

The main purpose of this book is to assist counselors and other mental health professionals in gaining competence in working with LGBTQI+ clients such as Martin. In Martin's case, there are multiple issues that a counselor without cultural competency may miss. Martin has multiple identities: Jamaican, American, gay, male, caretaker, son, brother, and partner. These roles and identities are conflicting; they may also be something with which a counselor is unable to identify. If a counselor has never had the experience of being an ethnic minority, being an immigrant, being a gay man, growing up in a disaffirming religion and culture, or being the sole provider and caretaker for the family, the way the counselor views the world will be incredibly different from Martin's schema. This is the essential reason why counselors must enhance their cultural competency skills when working with diverse populations.

The American Counseling Association (ACA) *Code of Ethics* has established several standards that apply to counseling LGBTQI+ people (ACA, 2014). ACA ethical standards require counselors to be developmentally and culturally sensitive in all stages of counseling with all clients as well as in counselor education and supervision (Standards A.2.c., B.1.a., E.5.b., E.8., F.2.b., F.7.c., F.11.c., H.5.d.). The *ACA Code of Ethics* also requires counselors to be aware of historical prejudices in diagnosis (Standard E.5.c.); this directly applies to work with LGBTQI+ persons, as they were pathologized as mentally ill through much of history. Standard A.4.b. requires counselors to be aware of personal values; counselors working with LGBTQI+ clients must be aware of their own values related to gender and affectional orientation in order not to impose these attitudes in their work with clients. This is very important, as Standard A.11.b. maintains that counselors cannot refer clients based on value conflicts. Standard C.2.a. specifically requires counselors to develop multicultural counseling competence in order to work appropriately with diverse clients; counselors should also receive continuing education to improve their multicultural competence (Standard C.2.f.).

Several sets of specific competencies developed by groups in ACA can be helpful in guiding counselor learning. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) competencies for counseling with lesbian, gay, bisexual, transgender, queer, questioning, intersex, and ally individuals (Harper et al., 2013) is the quintessential standard for counselors who serve LGBTQI+ clients (see http://www.algbtic.org/competencies.html). Organized along Council for Accreditation of Counseling and Related Educational Programs areas, it provides a framework for understanding all that is needed to be a positive influence in a counseling environment with this minority population. ALGBTIC (2010) also has a set of competencies for working with transgender clients (also available at http://www.algbtic.org/competencies.html).

Beyond the specific ALGBTIC competencies, another important framework to utilize is the Association for Multicultural Counseling and Development competencies. The *Multicultural and Social Justice Counseling Competencies* (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015) model addresses a variety of cultures through counselor self-awareness, client worldview, counseling relationship, as well as counseling and advocacy interventions (see Figure 1.1). An important focus in achieving multicultural competence is understanding the perspectives of a privileged or marginalized counselor as well as a privileged or marginalized client. The dynamics between marginalization and privilege impact a counselor's perspective and behavior. Each minority status carries marginaliza-

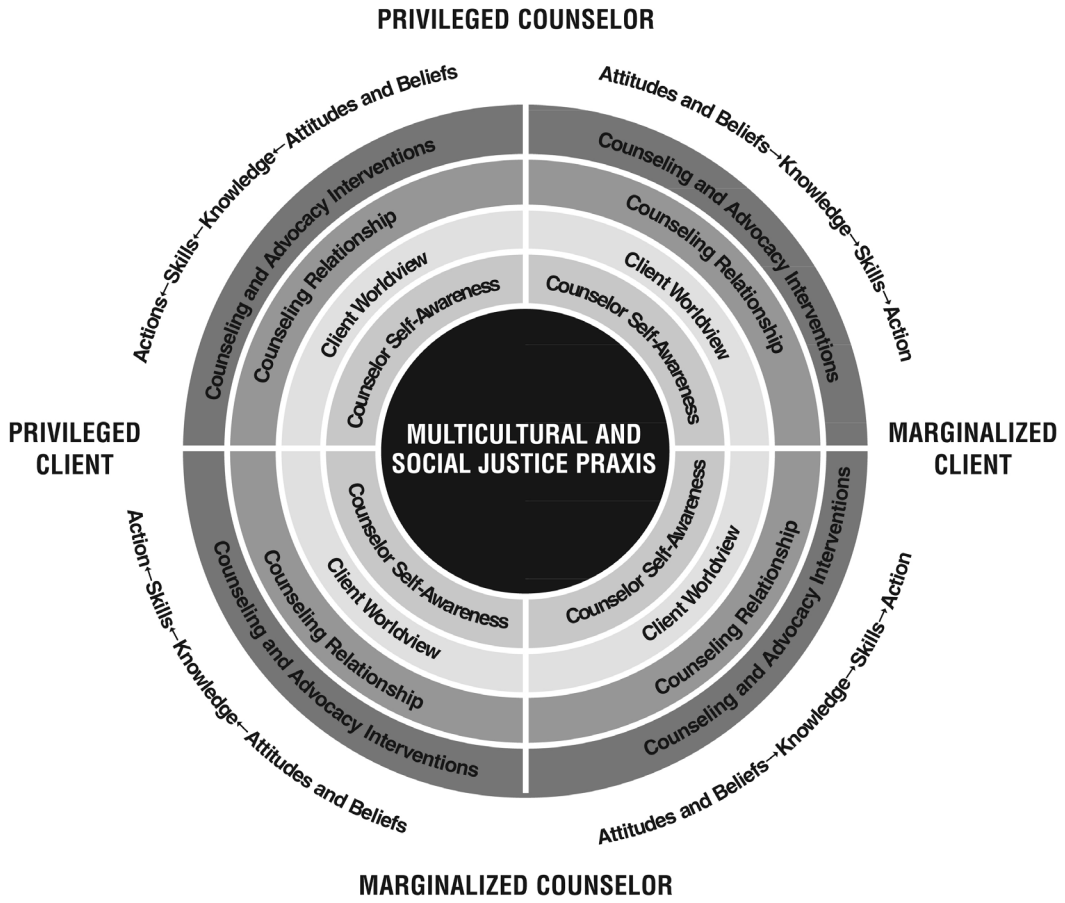

FIGURE 1.1

Multicultural and Social Justice Counseling Competencies

Note. From *Multicultural and Social Justice Counseling Competencies* (p. 4), by M. J. Ratts, A. A. Singh, S. Nassar-McMillan, S. K. Butler, and J. R. McCullough, 2015. Retrieved from https://www.counseling.org/docs/default-source/competencies/multicultural-and-social-justice-counseling-competencies.pdf?sfvrsn=20. Copyright 2015 by M. J. Ratts, A. A. Singh, S. Nassar-McMillan, S. K. Butler, and J. R. McCullough. Reprinted with permission.

tion; each majority status carries privilege. However, every person carries a series of complex identities and backgrounds (age, gender, ability status, religion/spirituality, socioeconomic level, race/ethnicity, affectional orientation and gender orientation, immigrant status, indigenous heritage, mental health status, etc.) that form multiple perspectives of both privilege and marginalization, as one person can be a minority in some statuses and in the majority in others. This complex interconnection of social identities is called *intersectionality* (Harper et al., 2013). For counselors, understanding the impact of discrimination, power, stereotypes, privilege, and oppression is central to serving any population but is particularly important with the LGBTQI+ population.

In considering their own privilege and marginalization, counselors must consider their intersectional identities, as they will very likely experience privilege in some areas and marginalization in others. Kocet (2008) adapted a checklist from Operation Concern to represent an activity to fully explore power and privilege (see Figure 1.2). In this activity, counselors can identify where they have more power, enjoy less stigma, and have an

NORM (Have Privilege)		OTHER (Less Privileged)	
Men	❑	Women	❑
White	❑	People of color	❑
Heterosexual	❑	Lesbian, gay, bisexual	❑
Non-transgender	❑	Transgender	❑
Wealthy	❑	Poor	❑
Adult	❑	Child	❑
Traditionally educated	❑	Self-educated	❑
Society's definition of sane	❑	Other than society's definition of sane	❑
Temporarily able bodied	❑	Differently abled	❑
Society's definition of attractive	❑	Other than society's definition of attractive	❑
Society's definition of emotionally stable	❑	Other than society's definition of emotionally stable	❑
Young adult or middle aged	❑	Older	❑
English speaking	❑	Other language speaking	❑
Average size	❑	Other sized	❑
White collar	❑	Blue collar	❑
Noninstitutionalized	❑	Institutionalized	❑
Nonvictim	❑	Survivor	❑
Christian	❑	Those with other religious/spiritual beliefs	❑
North American	❑	The rest of the world	❑
Two heterosexual parents per family	❑	Other family compositions	❑
Healthy	❑	Less healthy	❑
Land owners	❑	Tenants	❑

FIGURE 1.2

Kocet's (2008) Adapted Power and Privilege Checklist

Note. Adapted from "My Personal Privileges Handout," by M. Kocet, 2008, at http://vc.bridgew.edu/cgi/viewcontent.cgi?filename=2&article=1003&context=change&type=additional. Originally adapted from National Centers of Excellence in Women's Health Cultural Competence Curriculum, originally from Operation Concern, Department of Social Work Education, San Francisco State University, San Francisco, CA. Copyright 1993 by B. G. Gordon and H. B. Hogue. Adapted with permission.

opportunity to serve as allies for the less privileged or marginalized group. Both privilege and marginalization will shape a counselor's attitudes and beliefs, which can potentially interfere with counseling clients, if one is unaware of them.

The multicultural competence model also requires counselors to develop an awareness of attitudes and beliefs, requisite knowledge, skills, and actions to take in the areas of counselor self-awareness, client worldview, and the counseling relationship. These areas culminate in establishing competency with counseling and advocacy interventions with and on behalf of clients at multiple levels.

Two other sets of competencies can be valuable for counselors who work with LGBTQI+ clients: the Association for Specialists in Group Work *Multicultural and Social Justice Competence Principles for Group Workers* (Singh, Merchant, Skudrzyk, & Ingene, 2012) and the Spiritual Competencies of the Association for Spiritual, Ethical, and Religious Values in

Counseling (2009). Each of these sets of competencies can help counselors develop skills for working on the wide variety of issues that may present in counseling with clients in LGBTQI+ communities.

Awareness of Attitudes and Beliefs

When working with an LGBTQI+ client, it is crucial that counselors be aware of their own attitudes and beliefs to ensure that they maintain an awareness of their own privilege, marginalization, and potential biases, which could negatively impact the client. These include issues surrounding gender, affectional orientation, and sexuality. Counselors should understand the attitudes and beliefs of their LGBTQI+ clients as well as how these clients' identity development and experiences of oppression, privilege, and marginalization impact their worldviews, attitudes, beliefs, behavior, and physical and mental health. Counselors should be aware of how external cultures, stereotypes, marginalization, power, and privilege will impact the counseling relationship. For example, Martin may be reluctant to seek counseling because of a mistrust of the mental health field resulting from previous experiences of oppression and discrimination. He may be reticent to connect with the counselor for fear that the counselor will be rejecting or might not understand his Jamaican culture. If the counselor is heterosexual and Caucasian, this mistrust may be compounded and Martin may present as resistant. The goal for both heterosexual and LGBTQI+ counselors is to become *allies,* which are people who are supportive of individuals in the LGBTQI+ communities who may also face discrimination themselves (Harper et al., 2013).

There are several constructs to be aware of in understanding attitudes and beliefs surrounding this population. The overarching acronym that represents this community varies depending on the focus (e.g., LGBQQ is typical for work on affectional orientation), organization (e.g., many use LGBT or LGBTQ as their main acronym), or inclusiveness (ALGBTIC uses LGBQQIA in its competencies). However, there are currently 11 recognized identities under the affectional orientation and gender minority umbrella, including allies. The entire population is referred to (in several iterations with different orders) as *LGBTQQIAAP-2S* (lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, ally, pansexual/polysexual, and two-spirited). As the complete acronym is quite unwieldy, two umbrella terms are commonly used to refer to this population without compromising inclusiveness: *queer community* (which refers to queer theory and includes both affectional orientation and gender minorities) and *LGBTQI+* populations or communities. Although *queer* was once, and sometimes still is, utilized as a pejorative term, many in the LGBTQI+ community have reclaimed the term as an indicator of strength and unity (Harper et al., 2013). It is important to note that in this book, the acronym may be LGBTQ or LGBQQ when discussing research studies of limited populations.

In relation to specific terminology, there are several terms to be aware of in the LGBTQI+ population. One is *affectional orientation,* which refers to "the direction an individual is predisposed to bond with and share affection emotionally, physically, spiritually, and/or mentally" (Harper et al., 2013, p. 38). It is meant to replace *sexual orientation* as an outdated term; these constructs are similar, in that they refer to both the nature of an individual's romantic attractions and the identity surrounding those attractions (VandenBos, 2015). However, *affectional orientation* highlights the full spectrum of relationships rather than just the sexuality aspect (Harper et al., 2013). Although these concepts are similar, shifting to using the term *affectional orientation* rather than *sexual orientation* can purposely broaden the focus of discussion of LGBTQI+ people to their relationships rather than just their sexual behavior (Crethar & Vargas, 2007; Klein, 1993). In the realm of affectional identity, there are *lesbians,* or women who bond romantically with other women, and *gay men,* or men who

bond romantically with other men (Harper et al., 2013). *Bisexual, pansexual,* and *polysexual* individuals bond based on a wider range of gender identities, which may include male, female, genderqueer, and transgender. *Queer* refers to individuals who specifically identify as such because the other categories do not capture the complexity of their identity; this could be because of their identified nonbinary gender identity, relationship status (e.g., polyamory), or political reasons (Harper et al., 2013). *Questioning* individuals are those who identify with the LGBTQI+ communities but are unsure of the nature of their emotional, physical, mental, and/or spiritual attractions (Harper et al., 2013). *Asexual* individuals are those who may experience a romantic bonding attraction but not sexual or physical attractions; when present, their romantic attractions can vary from none to heterosexual or gay, lesbian, or bisexual (Bogaert, 2004).

Another characteristic in these communities is *gender identity,* or the personal identity surrounding masculinity or femininity (Harper et al., 2013; VandenBos, 2015). Gender identity and affectional orientation are not *binary,* or two separate concepts: male/female, gay/heterosexual. Rather, they both appear to be on a continuum. Gender and affectional orientation are not finite, fixed concepts; they are *fluid,* meaning that they develop, shift, and evolve throughout the life span. These developmental issues are further delineated in Chapters 3 through 6. In terms of gender identity, persons may identify as *genderqueer,* or someone who experiences a blending of genders, or as a gender minority. Gender minorities, who may also identify as *transgender,* experience a mismatch between their physical assigned sex and their gender identity. These individuals present as *gender nonconforming,* an umbrella term that indicates a child who at a young age does not exhibit gender-stereotyped play or interests. Some gender-conforming individuals may certainly be LGBTQI+; however, heterosexual individuals can also be gender nonconforming. Transgender persons who experience significant distress and/or impairment may be diagnosed as having *gender dysphoria* according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, 2013). Another related term in the gender identity category is *cisgender,* which describes someone whose sex and gender identity align: in other words, non-transgender. Some individuals are also born *intersex,* with male and female or ambiguous genitalia; such individuals were formerly known as *hermaphrodites,* but the new term is less pejorative and not associated with the negative aspects with which *hermaphrodite* was once associated (Harper et al., 2013). *Two-spirit* individuals are those who have an indigenous heritage and who identify with traditional Native concepts of variant gender and affectional orientation as having spiritual and social value (Jacobs, Thomas, & Lang, 1997).

Some confuse affectional orientation with *relationship systems.* For example, one might believe that bisexuals have multiple romantic partners at one time. However, this is not the case; relationship systems include monogamy (romantic involvement with one partner) and polyamory (multiple partners). These relationship systems are discussed and are consensual in nature, whether it is to only be involved with each other as romantic partners or to have multiple partners in some constellation or formation (i.e., an open relationship to date anyone, three partners, a partner who bonds with only one individual in a couple, etc.). These relationship systems are present in all affectional orientation identities, most commonly heterosexual partnerships. However, even in a heterosexual context, consensually non-monogamous relationships are severely stigmatized in society and seen as negative or doomed to fail, despite evidence to the contrary (Conley, Moors, Matsick, & Ziegler, 2013).

A key component of being multiculturally aware is understanding how a personal experience may be different from a minority experience in terms of both marginalization and privilege. The majority culture experiences a privilege that those in the LGBTQI+ communities do not, and that is having a gender and affectional orientation that is the norm for and reinforced by society. There are several constructs to be aware of in this regard.

Heteronormativity is the view that people's assigned sex, gender identity, gender roles, and affectional identity are immutable, binary (male vs. female), and heterosexual in nature (VandenBos, 2015). This norm or standard is expressed in human societies, leading those who do not meet this norm to feel abnormal or in violation of society's standards.

Heterosexism is a prejudice against any individuals who do not meet heteronormative expectations, which include binary male versus female gender expression and identity, as well as heterosexual attractions (VandenBos, 2015). These prejudices can lead to *homophobia,* which is fear associated with same-sex relationships, which can also be internalized into one's own self, or *internalized homophobia.* Sometimes termed *homoprejudice,* these prejudices can result in acts of violence and discrimination in employment, housing, and personal relationships.

Knowledge

Having advanced knowledge related to multicultural counseling is important not only to understanding behavior in the counseling process but also to increasing positive outcomes in a multicultural context (LeBeauf, Smaby, & Maddux, 2009). Although counseling programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (2015) are required to infuse multicultural counseling across the eight domains into their curricula, there are no required methods for how to do so. As long as a counseling program discusses multicultural issues and assesses student learning in social and cultural diversity, that can suffice as having met the requirements.

Unfortunately, the truth is that even if counselors were to take a semester-long course on multicultural counseling, they would not necessarily be considered competent or knowledgeable, as such classes are most often introductory. Regardless, the onus is on individual counselors to increase and maintain their knowledge after graduating and engage in a process of learning that continues throughout their professional development.

Counselors who work with LGBTQI+ clients should have knowledge of history and cultural events that have shaped their own privileges and marginalized statuses as well as their clients' intersectional backgrounds and identity development. Counselors should also be knowledgeable about international and global affairs. For example, the counselor working with Martin should understand his Jamaican culture, how his experience of trauma in his childhood impacts his own identity development, and what he is risking by coming out to his family and community.

Multicultural counseling has been called the *fourth force* in the helping professions (Pedersen, 2001) and as such connotes the importance of having a strong knowledge base from which to draw when working with clients who are *other than* the majority population. Providing counseling services to minority populations has become increasingly commonplace in professional counseling. Although the United States has never been so diverse, when it comes to racial, gender, and affectional orientation differences, the populace struggles with divisiveness brought on by incendiary rhetoric, both political and social.

A History of Oppression and Bias

Throughout ancient history, there were records of same-sex relations, both monogamous and polyamorous bisexual and gay or lesbian relationships, just as there were heterosexual ones (Greenberg, 1988; Hubbard, 2003; Mussi, 2002; Talalay, 2005; Wilhelm, 2008). There is also evidence of transgender and third-gender persons in virtually every civilization across recorded history (Greenberg, 1988). This evidence can be found in Africa, the Americas, Assyria, China, Egypt, Europe, India, Israel, Japan, the Middle East, Persia, and the South

Pacific. Although the cultural beliefs and practices differed in each context, the existence of gender and affectional orientation variance was seen as normative, often valued in the civilization (Greenberg, 1988; Hubbard, 2003; Mussi, 2002; Talalay, 2005; Wilhelm, 2008). There is also some evidence that many great leaders, notably Alexander the Great, had same-sex relationships and were highly valued in their time (Green, 2007).

Starting in the fourth century, these previously sanctioned relationships began to be seen as immoral (Fone, 2000). The apparent precedent for the massive change in attitude against acceptance of gender and affectional orientation variance was the advent of Westernized religion, specifically the Roman Catholic Church. Although there is some evidence that the Roman Catholic Church originally accepted same-sex relationships, at some point gender roles associated with natural law (e.g., intercourse for purposes of procreation) became standard teaching, and "homosexuality" and sodomy were condemned in Europe. In 390, sodomy was made illegal by Christian emperors and became punishable by death. From the fifth to the 17th centuries, these laws began to spread to virtually every government around the world where Europeans emigrated and the Catholic Church spread. During the Spanish Inquisition, more than 1,600 individuals were stoned, castrated, and burned at the stake for being sodomites. As the religion spread, so did the negative attitudes regarding sexuality in general as well as affectional orientation and gender variance in particular. During the Renaissance, same-sex acts were punished by assault (e.g., flogging), genital mutilation, and/or death.

In the 18th and 19th centuries, civil rights groups began forming in Europe and countries began to decriminalize "homosexuality" (Fone, 2000). France became the first to decriminalize sodomy between consenting adults, and several other countries followed, including Prussia, The Netherlands, Indonesia, Brazil, and Japan. However, this viewpoint was not accepted globally; during the same period of time, sodomy laws were enacted in the United States, Poland, Guatemala, and Mexico. Subsequently, several countries, including Russia, Panama, Paraguay, Peru, Iceland, Switzerland, Sweden, Portugal, Greece, England, Wales, and Thailand, to name a few, repealed sodomy laws. Although LGBTQI+ individuals were gaining more acceptance, many people around the world were still commonly arrested and detained for same-sex sexual activity; during World War II, gay men, along with other minorities, were persecuted and executed in Nazi concentration camps, with the pink triangle being used to label them in the camps.

The field of psychiatry was partially responsible for the movement to decriminalize same-sex sexual activity; theorists and psychiatrists coined the term *homosexual* and argued that it was a clinical disorder (Bayer, 1987; Drescher & Merlino, 2007; Krajeski, 1996). The origin of *homosexuality* as a pathological term is one reason why it is no longer used in the LGBTQI+ community. With the advent of seeing "homosexuality" as a disorder, psychiatrists advocated for the removal of criminal penalties while simultaneously pathologizing those in LGBTQI+ communities. Psychiatric theories regarding the origin of affectional orientation variance at the time ranged from a congenital disorder to degenerative neurological conditions to serious mental illness. Some theorists argued that "homosexuality" was a sexual inversion, which was a variation, not a disease. However, even some of these theorists believed that it could be reversed or cured. One theorist who agreed with the ideas surrounding sexual inversion but disagreed with the idea of a cure was Sigmund Freud. Freud theorized about the role of the oedipal conflict in creating affectional orientation variance but also stipulated that sexual inversion could be completely natural; he particularly believed that bisexuality was universal but sublimated in heterosexuals. Unfortunately, most psychiatrists who practiced after Freud supported the belief that "homosexuality" was pathological and needed to be cured.

In America, the history of LGBTQI+ treatment can be split into pre-Stonewall and post-Stonewall, which refers to the revolt in New York City that began the American LGBTQI+

civil rights movement (Edsall, 2003; Fone, 2000; Foster, 2007; Godbeer, 2002). Before Stonewall, Europeans interpreted the Native gender and affectional orientation variance (now known as *two-spirit*) as sinful and derogatory. Derived from the laws from the English versions of buggery, sodomy remained a taboo and illegal act that would result in genital mutilation and death. Although in the late 1700s states began removing the death penalty for sodomy, it remained an illegal act. The Federal Bureau of Investigation and local police departments kept lists of gay and lesbian persons, the bars and bathhouses they patronized, as well as their friends; sweeps on cities, parks, bars, and beaches were regularly performed to rid cities of LGBTQI+ persons. The mafia, which sometimes blackmailed the wealthier customers, commonly ran the bars that served LGBTQI+ persons in New York City; some historians theorize that local police were receiving kickbacks from this blackmail that kept the bars open. Wearing opposite-gender clothing had been outlawed in some states; educational organizations fired teachers and professors who were suspected of being lesbian, gay, or bisexual. As a result, a multitude of LGBTQI+ persons were exposed, were harassed, lost their jobs, were placed in mental institutions, and/or were jailed. Therefore, it was necessary to be closeted during this time. There had been some LGBTQI+ civil rights organizations and social justice activism in the 1950s and 1960s, but little had changed. A small riot in response to police harassment occurred in Los Angeles in 1959; another occurred in San Francisco in 1966 at Compton's Cafeteria, when police attempted to arrest transgender women and drag queens for dressing in women's clothing.

The landscape of American culture changed with one major event: the Stonewall riots (Carter, 2004; Duberman, 1993; Edsall, 2003). In the 20th century, police raids on bathhouses and bars were common; the police would commonly arrest gay men, lesbians, transgender persons, and drag queens for simply being present in such an establishment. On June 28, 1969, a police raid occurred at the Stonewall Inn in Greenwich Village, New York City. Greenwich Village was known to have a large LGBTQI+ population, making it a frequent target for police harassment. At 1:20 a.m., four plainclothes police officers attempted to arrest any men dressed as women (all individuals dressed as women were asked to go with female police officers to the bathroom to verify their sex) from among the approximately 200 persons in the bar. Patrons refused to comply, and a crowd began to form outside. The crowd became irate as police became aggressive with a male dressed as a woman, and a lesbian was hit on the head with a police baton. The crowd began to overturn the police vehicles, yell, and throw things at the now 10 police officers, who retreated into the bar for safety. The impact of the oppression and discrimination from every angle reached its boiling point in the crowd that night; the anger and outrage were palpable. The Tactical Police Force eventually arrived and cleared the street, but it took close to 3 hours, with injuries to police as well as those in the crowd. Standing up to the oppression empowered the community, which reported the riot to several media outlets. The next night, another riot broke out, indicating a shift in the community's willingness to actively confront oppression as well as in the number of allies who were on board with joining the fight. Following this, several LGBTQI+ advocacy groups formed and became active in protesting and mobilizing the community. The first gay pride parades were held in three cities across America on the 1-year anniversary of the Stonewall riot, which came to represent the LGBTQI+ civil rights movement, empowerment, pride, and the communities' willingness to fight for equal rights.

Following Stonewall, major political movements fighting for LGBTQI+ rights sprang up across the globe, with the repeal of sodomy laws in many countries (Deitcher, 1995; Marcus, 2002). As a result of LGBTQI+ activism, the Kinsey sexuality studies (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953), and Evelyn Hooker's (1956) research showing no differences between heterosexual and "homosexual" men, the American Psychiatric Association voted to remove "homosexuality" from the *Diagnostic and Statistical*

Manual of Mental Disorders (*DSM*) in 1973 (Bayer, 1987; Drescher & Merlino, 2007; Krajeski, 1996). However, the *DSM* included sexual orientation disturbance to represent clients who were unhappy with their affectional orientation variance, which continued to legitimize sexual orientation change efforts (Drescher & Merlino, 2007). The mental health field continued to have a strained relationship with the LGBTQI+ community, as reparative and curative therapies were still espoused (Bayer, 1987; Drescher & Merlino, 2007; Krajeski, 1996). Also in 1973, Gerry Eastman Studds became the first openly gay individual to serve as a congressperson (Deitcher, 1995; Marcus, 2002). Another noteworthy event occurred when Harvey Milk, a well-admired and openly gay politician in San Francisco, was assassinated (Deitcher, 1995; Marcus, 2002). In 1987, the *DSM* removed all references to "homosexuality" as a mental illness; the World Health Organization followed suit in 1992, as did the American Medical Association in 1994 (Deitcher, 1995; Marcus, 2002).

Another formidable historical event in the LGBTQI+ communities was the HIV and AIDS epidemic in the 1980s (Cohen, 2012; Shilts, 1987). When the illness was first noted in 1981, it was thought to be a rare form of cancer. Although the virus impacted intravenous drug users and those with hemophilia as well, it predominantly spread in the gay male community; in 1992, it was termed *gay-related immune deficiency.* In 1985, more than 20,000 cases of HIV/AIDS were reported globally. By 1989, there were more than 100,000 cases in the United States alone, with approximately 10 million people living with HIV globally. The impact of this epidemic on the queer community was devastating. The number of gay males who died caused a panic among the LGBTQI+ community; immense grief as many watched all of their friends die; and outrage at the lack of support from the government, which saw this as an isolated gay problem. Because LGBTQI+ persons, particularly gay males, were so devalued, there was a very long delay in any type of attention or public health response. In addition, many heterosexual persons became fearful of LGBTQI+ people, who began to carry the stigma of being diseased. Discrimination against gay men and those living with HIV/AIDS was palpable throughout these decades. Although these tragic events decimated the LGBTQI+ communities in many ways, they also mobilized LGBTQI+ persons and allies to engage in activism. In 1999, it was estimated that 14 million people had died from AIDS around the globe. Because of the tremendous public health initiatives promoting safe sex, the activism of the LGBTQI+ communities and allies, and programs to eliminate the sharing of needles by drug users, the spread of the virus began to slow. With the advent of medication used to treat HIV, the diagnosis was no longer a death sentence. The prevalence of HIV/AIDS peaked in 2005 but then began to decrease; in 2013, it was estimated that 35 million people currently had a diagnosis of HIV. The activism in response to the AIDS crisis became a template for later social justice work, including the development of allies. It also brought about the beginnings of the LGBTQI+ community by building solidarity between gay men and lesbians surrounding HIV/AIDS.

Although civil unions were being accepted in many countries globally, in the mid-1990s America passed the Defense of Marriage Act of 1996 defining marriage as between a man and a woman. LGBTQI+ civil rights issues began to be addressed at a fast pace under the Barack Obama administration. In 2009, definitions of federal hate crime regulations were expanded to include affectional and gender orientation as a minority group. In 2010, Don't Ask, Don't Tell, which required members of the military to be closeted about their minority affectional orientation status or face discharge, was repealed (Don't Ask, Don't Tell Repeal Act of 2010). In 2013, the Defense of Marriage Act was repealed (*United States v. Windsor et al.,* 2013), and the Supreme Court granted marriage equality in 2015 (*Obergefell et al. v. Hodges et al.,* 2015). In 2016, state bans on same-sex couple adoptions were ruled to be unconstitutional (*Campaign for Southern Equality et al. v. Mississippi Department of Human Services et al*., 2016). In 2016, the Pentagon also ended the ban on transgender persons serving in the U.S. military; this now

paves a path for existing military personnel to openly transition while enrolled, for already transitioning transgender persons to join the military, and for medical coverage important for such a transition identified by doctors (Rizzo & Cohen, 2016). In 2016, an Oregon court also ruled that a citizen could identify as third gender, a landmark ruling rendering Jamie Shupe the first legally nonbinary person in the United States (Foden-Vencil, 2016).

Current Oppression and Bias

Despite great strides in the social justice movement for affectional minority equality, there has been an equal and opposite reaction from the religious right. Following the string of positive LGBTQI+ civil rights legislation, there has been a backlash that can be seen in the rise of religious liberty bills or, as some refer to them, *anti-LGBT legislation* (Macgillivray, 2008). Although these laws are on a myriad of different topics, the basic tenet of all proposed legislation stipulates that the government does not have the right to force religious individuals to support or provide services to LGBTQI+ individuals. Proponents of the *liberty* laws do not see that the laws are allowing discrimination while taking liberty and freedom away from others; they only believe that these laws will allow them not to act in a way that goes against their religious beliefs. These same arguments were used to support discrimination against African Americans, from the abolition of slavery laws to the advent of civil rights legislation.

North Carolina passed a law in April 2016 that makes it illegal for people to use a public bathroom that does not match the sex designated on their birth certificate ("Session Law 2016-3, House Bill 2," 2016). It also prevents anyone from suing based on discrimination, in direct violation of an antidiscrimination law that has been in effect since 1985. This law is currently considered one of the most anti-LGBT laws in the country.

Likewise, on April 27, 2016, Tennessee's governor signed into law a bill that gives counselors the right to refuse service to anyone based on the counselors' sincerely held *principles* ("Tennessee Senate Bill 1556," 2016). This is a shift from legislation that previously used the term "sincerely held *religious beliefs."* Many other states are also in the process of proposing similar bills. What these laws seek to do is to circumvent the *ACA Code of Ethics,* which explicitly states that no counseling professional may discriminate against a client based on the counselor's value conflicts with the client (ACA, 2014, Standard C.5.). On May 12, 2016, President Obama's administration issued a sweeping directive that interpreted Title IX requirements of public schools to grant transgender students access to bathrooms that match their gender identity, which reflects the specific update to Title IX by the U.S. Department of Education (U.S. Department of Justice, 2016). Although it may seem unnecessary for the federal government to become involved so that children can have access to bathroom facilities, this merely highlights the degree and level to which people will go to discriminate, oppress, and ostracize those in the LGBTQI+ community.

In November 2016, results of the U.S. presidential election revealed that the country elected a candidate who had espoused numerous prejudices, including those toward the LGBTQI+ population. Reactions following the election were quite profound, with a clear division on the importance of human rights for minority groups. At the time of this book's printing, the impact of this election is unclear. However, it seems unlikely that the pace of progress in LGBTQI+ rights will be maintained; many of the protections achieved thus far may indeed be at risk. Although only time will tell, it seems very unlikely that federal protections for LGBTQI+ persons will be reached in the next 4 years (Stack, 2016).

In the absence of a federal law or mandate, these battles for equal protection and rights under the law are occurring at the state level (Human Rights Campaign, 2016). Nondiscrimination issues include adoption laws, employment, housing, and public accommodations (e.g., restaurants, movie theaters, shops). For those who identify as transgender, current

political movements include fighting the multiple statewide legislative proposals for bathroom laws, working toward gender marker change laws for identification documents, and working toward laws that allow for the inclusion of transgender issues in health care and insurance. Although the federal government now includes gender and affectional orientation as protected categories for hate crimes, many individual states do not. In terms of protection in schools, there is much work to be done on school nondiscrimination laws and policies. Although all states have antibullying laws, some states do not have protection for LGBTQI+ youth in them; some states go a step further to state that LGBTQI+ students are excluded from protection, and others restrict the inclusion of LGBTQI+ topics in schools.

These exclusionary and oppressive laws reflect the level of marginalization and bias toward LGBTQI+ persons. These attitudes and biases often result in verbal or physical harassment, bullying, and assault. LGBTQI+ youth report facing a hostile climate in schools as well as frequent harassment, bullying, and abuse (Kosciw, Greytak, Palmer, & Boesen, 2014). Twenty percent of all victims of hate crimes are affectional orientation and gender minorities (Federal Bureau of Investigation, 2014). Males, ethnic minorities, those who have a variant gender, and youth living in a rural areas are at the greatest risk for bullying, harassment, and hate crimes (Diaz & Kosciw, 2009; Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Much more subtle, yet still incredibly damaging, are microaggressions, which are daily indignities, slights, and insults reflecting discrimination and bias toward minorities that are, most often, unconscious (Sue et al., 2007). Microaggressions leave individuals questioning whether they are being too sensitive because microaggressions are not blatant discrimination but rather marginalization. Yet the outcomes of microaggressions are a heightened sense of awareness (hypervigilance) and low-level stress that research shows over time have the same impact as posttraumatic stress disorder (Robinson & Rubin, 2016).

Continuing Career and Health Care Disparities

Research shows that discrimination in the workplace based on affectional orientation is also a substantial problem. LGBTQI+ individuals who are out at work have a 40% chance of being discriminated against based solely on their affectional orientation, which is 4 times as much as LGBT individuals who are not out at work (Pizer, Sears, Mallory, & Hunter, 2012). Most commonly, LGBT individuals reported experiencing harassment, with many having lost their jobs following the harassment (Pizer et al., 2012). The situation is more severe for transgender employees: Their experience of discrimination increases dramatically (Sears & Mallory, 2011). Although research supports the fact that LGBT individuals experience discrimination at work, very little research has looked at intersectional identities, such as the greater bias that queer people of color might experience. One could argue, anecdotally speaking, that the intersectionality of these two identities creates discriminatory experiences at an exponential rate.

The Role of Media

In 1998, Ellen DeGeneres came out on national television, making history and paving the way for increased representation on television and in cinema of LGBTQI+ individuals and characters (Gomillion & Giuliano, 2011). Research suggests that the media may influence psychological domains, including individuals' self-perceptions (Hammack, 2005). Ochman (1996) found a link between self-esteem and storybook characters, as affectional minority children who were exposed to stories with strong, positive, same-sex characters exhibited increased self-concepts. Ochman was able to demonstrate that the positive examples, or portrayals, in the media of characters with whom the children shared qualities helped to increase the children's self-concepts. More contemporary research has found that people are more likely to have high self-esteem if they believe that they have more characteristics in common with their role models (Wohlford, Lochman, & Barry, 2004). This research supports

the importance of how minority populations, both racial and sexual, are portrayed in the media, as the media is a powerful tool in crafting a dominant narrative. If research supports the idea that positive portrayals of characteristics in role models have the effect of increasing one's self-esteem, then it stands to reason that negative portrayals of characteristics in role models can have a deleterious effect on self-esteem. The portrayal of LGBTQI+ individuals in the news, on television, and in movies likewise paints a less than accurate picture of what it means to be an affectional minority (Houseman, 2010). The increase in television shows related to this population has been seen as a cause for celebration. Shows such as *Queer as Folk, The L Word, Queer Eye for the Straight Guy, RuPaul's Drag Race, Glee,* and *Orange Is the New Black* bring attention to LGBTQI+ persons in mainstream media. However, they may also sometimes give an unrealistic or skewed portrayal of LGBTQI+ life as hypersexual and feed into certain stereotypes of the LGBTQI+ communities. In reality, the truth of affectional orientation and gender minority life is substantially more mundane.

Skills

Culturally competent counselors also have skills in gaining self-awareness, communicating, and understanding how to assess their own biases and their impact. They also know how to adequately assess clients' cultures, privilege, and marginalization as well as use appropriate cross-cultural conceptualization and communication skills. These counselors know how to apply knowledge, theories, and research to connect with and enhance the counseling relationship with their clients. Counselors should be able to skillfully provide counseling interventions, which for LGBTQI+ clients are affirmative, strengths based, and designed to build empowerment and identity development. For example, the counselor working with Martin should provide a safe and warm environment; be prepared to discuss and feel comfortable discussing the differences in their experiences; and understand how to help him consider the influences in his life and develop strength, resilience, and coping skills in meeting his counseling goals.

Action

It is important that multiculturally competent counselors also take action to continually develop and maintain self-awareness; stay up to date on cultural variance and multicultural counseling skills; and actively explore issues of race, privilege, identity, and understanding. Counselors should also understand when and how to take advocacy action, as many states are in the process of proposing anti-LGBTQI+ bills. Advocacy and its role in counseling are discussed in Chapter 25. Counselors should additionally be aware of how to promote equity and remove barriers at institutional, community, and public policy levels.

Conclusion

When serving as a counselor for an LGBTQI+ client, a counselor must have multiple sets of skills. Although having competence in counseling is required, counselors also need the ability to understand which techniques work best for these populations, when they should be utilized, and how they should be modified for each client. As all clients have, in addition to their affectional orientation and gender identity, multiple intersectional identities of sex, ethnicity, socioeconomic status, religion/spirituality, age, and generation, to name a few, all must be considered when working with clients. Developing cultural competence for working with LGBTQI+ clients involves being aware of the overarching cultural bias against affectional orientation and gender variance as well as how these messages have impacted the

counselor. Being LGBTQI+ culturally competent also involves gaining knowledge regarding how internal experiences of being LGBTQI+ and external treatment as an affectional orientation or gender minority have shaped the client's strengths and challenges. Counselors must be familiar with a wide variety of techniques that are empirically supported or, when there is a lack of empirical research, based on preliminary findings in the literature and sure not to cause harm. Internalizing all of these skills will lead the counselor to the important role of being an ally; advocating for social justice and equality for affectional orientation and gender minorities is also an important role for the counselor, client, and the counseling field.

Questions for Further Discussion

1. What precursory factors could be impacting Martin's reticence to come out as well as his depressive symptoms?
2. If you were Martin's counselor, what attitudes and beliefs would you need to be aware of that could impact Martin or the counseling relationship?
3. How would you gain knowledge about the Jamaican culture? About Church of God beliefs? About being a gay man in Jamaica?
4. What would be some appropriate counseling goals and strategies for Martin?
5. What type of advocacy might be helpful for Martin?

Resources

1. Develop your awareness of your biases by taking the Implicit Association Test with the sexuality and gender subtests at https://implicit.harvard.edu/implicit/takeatest.html.
2. Take the LGBTQI+ course created by ACA and the Human Rights Campaign at http://aca.digitellinc.com/aca/lessons/1.
3. Review the resources available through the ALGBTIC website at http://www.algbtic.org.
4. Be familiar with continuing education offered by ACA in order to stay up to date with your cultural knowledge. Visit https://www.counseling.org/continuing-education/overview for more information.

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