NORMAL AND POSITIVE VARIATIONS:

DISCOURSES ON QUEERNESS

IN THE MENTAL HEALTHCARE STYSEM

A WOMEN'S, GENDER, AND SEXUALITY STUDIES THESIS

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BREANNA K. MCHUGH

DARTMOUTH COLLEGE

HANOVER, NEW HAMPSHIRE

To my parents, who tirelessly have tirelessly supported me through all of the identity crises and hormonal fugues of my college career;

to my friends, who have assured me that I am crazy in all the best ways;

and to Sigmund Freud, without whom I would have a lot less to complain about.

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CHAPTER ONE

INTRODUCTION

Care Under Patriarchy

Although there has been a rapid expansion of LGBT-related mental health care research in the late 20th and early 21st centuries, LGBT people continue to face healthcare disparities and disproportionately suffer from a wide range of mental and physical illnesses, including cancer, cardiovascular disease, substance-use-related illness, anxiety, and depression.[1] Furthermore, LGBT patients, especially trans patients and queer people of color, remain vulnerable to a wide range of discriminatory practices and biases within the healthcare system. Previous studies have suggested that LGBT people have higher rates of patient attrition and are less likely to access care than their straight and cisgender counterparts,[2] with many LGBT patients stating that healthcare providers have been openly transphobic or homophobic, have engaged in sexual orientation or gender-based micro-aggressions, or showed an insufficient understanding of their healthcare needs.[3]

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[1] Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, "Lesbian, Gay, Bisexual, and Transgender Populations," *Improving cultural competence to reduce health disparities,* by Mary Butler, Ellen McCreedy, Natalie Schwer, Diana Burgess, Kathleen Thiede Call, Julia Przedworski, Simon Rosser, Sheryl A. Larson, Michele Allen, Steve Fu, and Robert L. Kane (Rockville, Maryland: AHRQ, 2012), 32.

[2] Kimber Shelton and Edward A. Delgado-Romero, "Sexual Orientation Microaggressions: The Experience of Lesbian, Gay, Bisexual, and Queer Clients in Psychotherapy," *Journal of Counseling Psychiatry* 58, no. 2 (2011), accessed May 11, 2017, doi:10.1037/a0022251; Reese Kelly and Sonny Nordmarken, "Limiting Transgender Health: Administrative Violence and Microaggressions in Health Care Systems," in Health Care Disparities and the LGBT Population, ed. Vickie Harvey and Teresa Heinze Housel (Lexington, MA: Plymouth, 2014).

[3] Kelly and Nordmarken.

As a double major in psychology and women's, gender, and sexuality studies, I began to realize that the field of psychology, even when purportedly striving for equality, tends to fail queer and LGBT patients. Providers frequently fail to adhere to professionally-mandated guidelines for practice with LGBT clients,[4] and in many cases, the guidelines themselves are woefully inadequate in addressing institutionalized discrimination within the healthcare system. Current clinical models are based almost exclusively on data derived from clinical research, limiting their scope of analysis to patients that have access to therapy—typically white, affluent, cisgender people.[5] These empirical models, which look to the center to define the margins, will inevitably create a subaltern class of LGBT patient—particularly, those who are trans and TPOC, indigenous, money-poor, undocumented, disabled, and young—whose queer and trans identities are not rendered legible by hetero- and homonormative medicolegal structures. This is particularly significant as the dynamics of talk therapy itself require the patient to present a coherent narrative of self to a therapist who may not have similar lived experiences.

Further research is still required concerning clinicians' adherence to professionally-mandated standards of care.[6] However, I was far more interested in the limitations of and assumptions made by LGBT competencies and theoretical models themselves, and how their oversights and failures may be contributing to patient attrition and reluctance to access healthcare resources. I wanted to critically analyze the ways in which predominant psychological theories of human sexuality attempts to account for the lived experiences and therapeutic needs of LGBT clients. I

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[4] Rebecca Gillespie, Preparedness of Therapists to Work With Lesbian, Gay, & Bisexual (LGB) Clients: A Look at the Importance of Inclusion of LGB Issues in Graduate Level Training, PhD diss., Kean University, 2012, 37, accessed September 22, 2016, ProQuest.

[5] b. binaohan, decolonizing trans/gender 101 (Toronto, Canada: Biyuti Publishing, 2014).

[6] Gillespie 37-38.

was especially interested in the ways in which the mental healthcare system operates within a framework of epistemic (in)justice, in which queer and trans patients are (and are not) recognized as authorities on their experience both as queer people and as mentally ill people. For insight into the the ways in which these models are applied in clinical settings, I examined clinical competency materials produced by clinical researchers for use by mental health professionals working with LGBT clients. These guidelines are aspirational in nature, rather than ethically mandated. While individual practitioners may go above and beyond these recommendations, prior research has shown that, far more often, they fall behind the recommended competencies.[7] Thus, practitioners who follow these recommendations more often than not represent a best-case scenario. When the competencies themselves fail, these failures represent a failure of psychological theory to fully understand the needs of LGBT clients, rather than a failure of individual practitioners.

In order to perform an analysis of clinical competency materials within a framework of epistemic justice, I had to understand how these materials were created, and by whom. Throughout the fall and winter of the 2016-2017 academic year, I conducted exploratory research into professional psychological associations and their affiliated LGBT organizations and working groups. Ultimately, this research formed the background of a more targeted inquiry and analysis of the history of professional LGBT counseling associations in the United States, and the ways in which they have shaped modern therapeutic models of queerness. I examined the associations' capacity to act as agents of progress within their parent organizations, and also as actors in a broader medico-legal machinery that defines and shapes normative and non-normative behavior

[7] Gillespie 34-37.

and emotion. I then delved into the discourse of clinical competency itself, examining models of LGBT identity development, roadmaps for clinical success, and narratives of therapists' attempts to understand and empathize with their LGBT patients. I examined which narratives and voices were privileged within the discourse of clinical competency. My ultimate aim was to uncover the ways in which mental healthcare providers and their patients act within a larger system of social control.

A Note on Language

Selecting consistent terminology to refer to queer and trans patients was an extremely difficult task, not least because terminology was rarely consistent in psychological discourse. Furthermore, the language choices made by the source materials I was analyzing were highly intentional, and often signaled something about which identities and experiences the authors were attempting to include in their work. While I use queer and trans as umbrella terms to encapsulate all sexual and gender variant people, I recognize that the authors whose work I am analyzing often do not. By LGBT, they are most often referring to queer and trans people whose genders and sexualities fit easily within a binary Western framework, and while some intend to use LGBT as an umbrella term similar to queer, they most often are focusing on Western, "white" genders and sexualities. While they may include token references to other genders and sexualities—Two-Spirit, bakla, hijra, etc—these references are often anecdotal and tangential to their argument, which is centered on fairly rigidly defined lesbian, gay, bisexual, and (usually binary) transgender people.

When speaking about the general population of all gender and sexual minorities, I will use the terms queer and trans. However, when speaking about sources that I analyzed, I try to retain their terminology, as these terminological choices are highly political. While it is sometimes difficult to tell exactly what populations are included in a study, the acronyms used by clinical researchers do typically provide some inside into which identities and experiences they intended to focus on. For the purposes of this thesis, unless otherwise indicated, LGBT refers to lesbian, gay, bisexual, and transgender people (and not other trans and queer populations); while LGB refers exclusively to gender normative queer people who identify as either lesbian, gay, or bisexual.

Artwork

Although I was not able to directly include the voices and perspectives of LGBTQ+ clients as part of this research in any formal capacity, in order to center the voices of marginalized peoples, I have chosen to begin each chapter of this thesis with a piece of writing or art by a self-identified LGBTQ+ person who has interacted with the mental healthcare system, whether on the patient or practitioner side. These include publicly shared blog posts and artwork, as well as writings by LGBTQ+ practitioners whose work I was not able to incorporate into my research directly. They are intended to give the reader a more person-centered understanding of how discourse on sexuality, gender identity, and queerness impacts the lived realities of LGBTQ+ individuals, both practitioners and clients alike. Often, the narratives of these artists reflect the very real harms incurred by the violent aspects of the discourse I am analyzing.

LETTER TO FORMER THERAPIST #1[8]
Captain Glittertoes
5/1/14

This letter is pretty self-explanatory, but I want to give a brief introduction. I had been seeing this therapist on and off for six years, and it was only after we stopped seeing each other, mostly for reasons unrelated to the content of this letter, that I realized the full extent of what had happened in that office in terms of my gender. This is something that is still very painful for me to process, but I am sharing this (slightly edited) letter with you all because I hope that sharing my story will help other people in similar situations, or other people who are considering therapy. If any providers are reading this post, take this post to heart and consider if any of it applies to you. If it does, make changes to your practice now.

Dear [Former Therapist #1],

I have realized in the past few weeks that there is something more I need to say to you. Feeling both anger and loss, caring about and valuing much of our therapeutic time together while realizing how you hurt and utterly failed me in this way–it isn't an easy combination of feelings. When someone has both given so much and also deprived me of something so important, the emotions are not easy to navigate. I know that you have always had good intentions for me, but good intentions and positive effects are, as you must know, not the same, often. I am going to give you some feedback here that I hope you will take to heart, so that you can have a positive impact and a practice where all clients are treated equally. Although I am angry about this, and I wanted to show you that impact in this letter, I also wish you the best in implementing these changes. Please get in touch with me if you need further input, or if you otherwise want to respond.

I talked with you in one of our sessions a few months ago about my doubts and worries about us working together again. I told you that you had shot me down years ago when I had first brought up questioning my gender to you. What I didn't do then is remind you what you had said to me.

I don't remember every detail of those conversations we had when I was 18, but I do remember the traumatizing parts. I remember that, back in what must have been our first or second session, you asked if I wanted a penis. Uncomfortable, and confused as to whether this was the only measure of trans ness, I said that I didn't think so. Shortly afterwards, I think you must have concluded that I wasn't trans, or I must have concluded that I didn't want to repeat that uncomfortable conversation, because we stopped talking about it for a while.

Later, maybe months or a year later, I worked up my courage and brought it up to you again. You said that you thought I had penis envy or wanted a grab at male privilege. (At the time, I was too clueless about feminism to know what you meant, so I mentally shrugged.) You said that I wasn't trans. "But you're so feminine!" you said. (This was especially hurtful, given

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[8]Captain Glittertoes, "Letter to Former Therapist #1," Captain Glittertoes Blog, December 10, 2014, , accessed May 11, 2017, https://captainglittertoes.wordpress.com/2014/10/05/letter-to-former-therapist-1/.

my current gender identity. I don't identify with the word "feminine," but me having some characteristics that get categorized that way doesn't mean that I am a woman.)

I didn't talk with you about it again until five years later, this current year, when my internalized transphobia and gender dysphoria (among other things) was making me suicidal. (Partly, I had buried it for some time, but I found a journal entry that showed that even in the midst of that fog, I was aware of my dysphoria. Besides, a lot of why I'd buried it was because I hadn't been met with affirmation from you at all.) When I brought up my gender identity as one of my concerns about working with you again, you showed that you had evolved in some ways. You told me that you had been naive then, and that you were sorry. (But I don't think you remember what you said! At least, I hope you didn't, with that response.) You said that one of a therapist's most important jobs is to eliminate their prejudices, and now you have no personal investment in your clients' genders. You said that you understand that for people who don't fit into the binary, trying to fit them into the opposite-gender box can be just as damaging. (Here, given that I hadn't talked about my gender with you in five years, I felt you were subtly gendering me again.) Then you said, "Given all the evidence, I think it's time for a reevaluation."

This final sentence shows how much further you need to go. You do not get to evaluate my gender. You do not get to tell me who I am. Not any more than you get to tell your cis clients who they are and what genders they should be. Not only had you led me away from my true self for an extra six years, invalidated my gender identity, and used pathetic tropes to degrade who I am (trans men don't just transition for a grab at male privilege! And the words "penis envy" should never be uttered with any kind of seriousness in a gender therapist's office)–not to mention that you seemed to think inquiring about my thoughts on my genitalia was a good way to both break the ice and determine my gender–you now were judging yourself professionally fit to make those calls again! Instead of realizing the significant damage you had wrought on me (and probably many other trans clients), instead of working tirelessly to correct that damage, you simply said that I might be able to convince you, the ultimate authority on my gender, that I am trans–this time around.

As a first-year in college, I specifically sought out gender specialists so I could start exploring my gender identity. I naively thought that it was a safe space to do so, and foolishly bought into the idea that I could trust my therapist over myself. While I know that your statements don't hold complete power over me, and, of course, they don't determine my gender, your authority played a large role in squelching my shy early feelings of my true self, feelings I'd been conscious of as trans since high school, but had been waiting for a place to show. It is true, also, that especially in the early stages of gender formation, we tend to listen to others over ourselves. You have a huge responsibility!

Had I received nurturing and competent care when I was 18, I might be in a very different place today. Many of my mental health issues would at least be different, if not lessened or resolved. I might have been exposed to less or different trauma. I might even be a few inches taller, if I'd decided that testosterone was the way to go! I'd already be myself. Maybe I wouldn't have gone to the point of considering suicide to get here.

I think that you still don't understand the gravity of what you did five years ago. You still don't understand the danger of labeling yourself an expert on others' genders, or the absolute destructiveness of the gatekeeper model of trans care. In many ways, you taught me how to ad-

vocate for myself in therapy, and how to break down the barriers of authority between therapist and client. Yet you still cling to authority in this way. I shouldn't have to convince you of who I am. I am certain that you don't ask your cisgender clients to do so. I should be able to simply be, in therapy of all places. I should be supported in all ways to become more myself!

Your discouragement took away six years of my life as myself. It likely took away many others'. Please look deeply into yourself and your practice to see what amends you might be able to make with other people you have harmed through your prejudice. You have a responsibility to your current and former clients to do so. If you fail to do this, you continue to fail the trans community. Reach out to former clients and apologize, and ask if there is anything you could possibly do to connect them to resources or help now. Check in with current clients to be sure they feel affirmed. Never "evaluate" anyone's gender again. Ask for accountability and feedback from the trans community and other gender specialists (maybe them, but having met many of them, a lot of them seem as or more messed up). Please look deeply into yourself and your practice, in these ways and/or others (it is ultimately your responsibility to figure this part out) to make changes now for affirming, egalitarian care. You know the stats–lives are on the line

One more thing. I am telling you all these things, taking this time and energy, because I have seen you walk the walk of eliminating prejudice before. I hope that my trust that I have placed in you is not ill-spent. I have faith that you will take this feedback seriously and do your best to right these wrongs.

Your former client,

Still fucking known as,

*[Birth name]**

***Since this letter was written, I have started trying [current name] and using they/them pronouns.*

CHAPTER TWO

REVIEW OF THE LITERATURE

Captain Glittertoes: The Importance of Being Heard

In February 2016, a genderqueer blogger using the online pseudonym Captain Glittertoes posted an open letter to their therapist on Wordpress. The letter quickly went viral, and was eventually picked up by EverydayFeminism.com, which reposted it under the title "To My Former Therapist: Here's What It Really Means to Support My Gender Identity."[9] I chose to preface this chapter with Captain Glittertoes' letter, because it presents an intriguing case study of a seemingly well-intentioned therapist who nevertheless perpetuates the same types of oppression that contributed to Captain Glittertoes' depression.

In the letter, Captain Glittertoes explains how their therapist's frequent microaggressions related to their non-binary trans identity impeded the development of rapport between doctor and patient, and deterred them from sharing personal experiences with the therapist, whether or not these details were related to their gender identity. Although the therapist was not openly transphobic, and acknowledged that some people may not identify with a binary gender, the therapist's attempt to "evaluate" Captain Glittertoes' gender positioned them, rather then the Captain,

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[9] Captain Glittertoes, "To My Former Therapist: Here's What It Really Means to Support My Gender Identity," Everyday Feminism, February 15, 2016, , accessed May 11, 2017, http://everydayfeminism.com/2016/02/letters-to-former-therapist/.

as the ultimate authority over their gender. Thus, when the therapist reacted dismissively to suggestions that the patient may be dealing with gender dysphoria (because they were assigned female, were often read as femme/feminine, and did not wish to surgically transition), Captain Glittertoes came to began to doubt their own experience as a non-binary trans person. They fell into a deep depression, and even though they knew they needed professional support, they did not feel their therapist was willing or able to understand them, and thus was not able to effectively seek help for their suicidal ideation, something well within the purview of most counselors, because their experience of depression and social isolation was intimately connected to their non-binary trans identity.

This letter serves in part as a lesson in "what not to do" when working with LGBT people in a therapeutic setting. Crucially, Captain Glittertoes asserts to their therapist that the mere absence of intolerance of a patient's gender identity is not nearly enough; radically affirmative, LGBT-centered mental healthcare requires far more than a vague gesture toward tolerance. The Captain also speaks poignantly about the need for patient self-determination in therapy. Therapeutic convention often places ultimate authority squarely in the hands of the therapist, with devastating consequences for queer and trans patients just beginning to understand their own identities.

What makes Glittertoes' complaints so fascinating is that their therapists' actions fit very well within the scope of the 2012 APA Guidelines for Ethical Practice with LGBT Patients: The doctor was not overtly homophobic or transphobic, attempted to educate herself on her patients' identity, and was sympathetic to the social discrimination that they experienced.[10] However, the

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[10] American Psychological Association, "Guidelines for Practice with Lesbian, Gay, and Bisexual Clients," American Psychologist, January 2012, , accessed May 11, 2017, doi:10.1037/a0024659.

doctor's unintentional microaggressions, when paired with the perceived authority of the doctor over the patient, created a therapeutic experience that was not only invalidating, but created long-lasting repercussions for the patient's mental health. While anecdotal, the prevalence of blogs and letters expressing similar sentiments[11] demonstrate the inadequacy of current therapeutic models to adequately support queer patients, and especially trans and gender non-conforming patients of color.

Best Practices Research and Practitioner Education

Despite the rapid proliferation of best practices research in the early 2000s, research suggests that most therapists feel inadequately prepared to work with LGB clients, and many do not meet even basic recommendations for LGB patient care, partly because many mental health professionals were trained in an era in which homosexuality was still widely pathologized—ego-dystonic homosexuality remained in the DSM until 1987, and remains in the ICD-10, the DSM's international counterpart, to this day.[12] Disparities in LGBT-related competency persist even among younger practitioners, despite a proliferation of available resources designed to assist faculty teaching in mental health related programs (such as psychology, social work, and marriage

[11]ie. Ximona, "This is fun...," DeviantArt (web log), October 19, 2016, accessed May 16, 2017; Sam Dylan Finch, "What being institutionalized as a trans person made me realize," LetsQueerThingsUp.com April 3, 2016, accessed May 16, 2017; AchillesGuideToTheGalaxy, "Being transgender at the mental hospital," Youtube (video blog), November 24, 2014, , accessed May 16, 2017—to name just a few.

[12] Rebecca Gillespie, Preparedness of Therapists to Work With Lesbian, Gay, & Bisexual (LGB) Clients: A Look at the Importance of Inclusion of LGB Issues in Graduate Level Training, PhD diss., Kean University, 2012, 37, accessed September 22, 2016, ProQuest.

and family counseling) in including lesbian, gay, and bisexual content in program curricula[13] and in training and supervision.[14] While continuing education is often a requirement for mental health professionals, there is no requirement to that one fulfills continuing education requirements with coursework specific to LGBT issues, further contributing to therapists' lack of preparedness to work with LGBT clients.

To address the severity of this issue, Gillespie (2012) surveyed 74 clinical psychologists to determine their preparedness to work with LGB clients.[15] Gillespie found that although APA guidelines vis-à-vis LGB sensitivity have progressed rapidly in the past decade, therapists' training has not kept pace. 45% of clinicians reported having received very little graduate level academic training concerning LGB counseling, despite multiple research findings suggesting that LGB people seek counseling at a higher rate than their heterosexual counterparts, and that LGB sensitivity is a key factor in preventing LGB patients from discontinuing therapy.[16] Gillespie also found that when graduate programs place low importance on LGB-inclusive counseling, and when clinicians report low levels of self-training, they less more confident in their ability to effectively treat LGB patients.[17] In a similar study of couple and family therapy students, Rock et al. (2010) found that while the students generally held positive attitudes toward LGB people, less

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[13] e.g. Kathleen J. Bieschke, Parrish L. Paul, and Kelly A. Blasko, "Review of Empirical Research Focused on the Experience of Lesbian, Gay, and Bisexual Clients in Counseling and Psychotherapy.," Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients (2nd ed.)., 2007, , accessed May 11, 2017, doi: 10.1037/11482-012; Robin A. Buhrke and Louise A. Douce, "Training Issues for Counseling Psychologists in Working with Lesbian Women and Gay Men," The Counseling Psychologist 19, no. 2 (1991), accessed May 11, 2017, doi:10.1177/0011000091192006; among others.

[14] e.g. Kathleen J. Bieschke, Kelly A. Blasko, and Susan S. Woodhouse, "A comprehensive approach to competently addressing sexual minority issues in clinical supervision.," in Multiculturalism and diversity in clinical supervision: A competency-based approach.: , accessed May 11, 2017, doi:10.1037/14370-009, among others.

[15] Gillespie.

[16] Gillespie 22.

[17] Gillespie 34.

than half reported receiving any formal training on LGB-affirmative therapy, and most participants reported feeling only somewhat competent to work with LGB clients[18]. Although (once again) no LGB patients were surveyed, Rock et al. found that level of training on LGB-affirmative therapy was directly related to participants' self-reported clinical competency.[19]

Godfrey et al. (2006) also attempted to establish a consensus on components of LGBT-affirmative therapy without speaking to any LGBT patients. Therapists he interviewed highlighted the importance of continually addressing self-of-therapist issues (i.e., the need to examine one's own comfort levels, values, biases, and prejudices with regard to sex, gender, and sexual orientation); the need to educate themselves on systemic issues facing LGB clients; spending time around LGB people, in order to orient them to common struggles of this population; and ensuring that all clinical supervisors have a working knowledge of issues facing LGBT patient populations inside and outside of the clinic, whether through formal coursework, attending workshops at LGBT community centers, or engaging in volunteer work or activism with LGB people.[20] For example, a recent paper by Israel et al (2008) identified patterns that characterize therapists' descriptions of helpful and unhelpful situations with LGBT clients. A good working relationship between a therapist and their LGB client was characterized by a high degree of confidentiality, trust, and a positive and affirming attitude on the part of the therapist toward LGB issues, as well as a strong working knowledge of local LGB resources (even if LGB issues are

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[18] Monica Rock, Thomas Stone Carlson, and Christi R. McGeorge, "Does Affirmative Training Matter? Assessing CFT Students' Beliefs About Sexual Orientation and Their Level of Affirmative Training," Journal of Marital and Family Therapy 36, no. 2 (2010), doi:10.1111/j.1752-0606.2009.00172.x.

[19] Ibid.

[20]Katie Godfrey et al., "Essential Components Of Curricula For Preparing Therapists To Work Effectively With Lesbian, Gay, And Bisexual Clients: A Delphi Study," Journal of Marital and Family Therapy 32, no. 4 (2006): , accessed May 16, 2017, doi:10.1111/j.1752-0606.2006.tb01623.x.

not a primary concern).[21] It is important to note that Israel et al's study was a followup to an earlier set of interviews with LGBT clients themselves, in which the same team performed a similar content analysis on 42 interviews with LGBT patients.[22] While Israel et al. clearly recognize the importance of providing space for LGBT people to speak to their own experiences, their voice alone did not constitute sufficient authority on the subject—and Israel et al.'s second study, the one centering therapists' voices, has nearly 3 times as many citations, typically a reliable indicator that one study is more influential than another.[23]

As may be apparent by now, Godfrey et al., Gillespie, and Rock et al. are not exceptions to the norm in sidelining LGBT persons from their studies of LGBT issues in counseling. Interestingly, much of the existing best practices research focuses on the therapists' perceptions of their own preparedness to work with LGBT clients, and on self-ratings vis à vis internalized prejudices. Many papers do not include perspectives of LGBT clients, or include these perspectives only in relation to the more dominant perspectives of therapists themselves. This trend becomes even more disturbing when one considers that major professional organizations like the APA and ACA base their clinical competencies on this same set of empirical studies—meaning that guidelines for therapists working with LGBT patients are often produced in the absence of best practices research that truly centers their experiences with mental healthcare professionals.

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[21] Israel

[22] Tania Israel et al., "Helpful and unhelpful therapy experiences of LGBT clients," Psychotherapy Research 18, no. 3 (May 2008): , accessed May 16, 2017, doi:10.1080/10503300701506920.

[23] Ibid.

The Violence of Incomprehensible Stories

Emerging best practices research on LGBT clients appears to be at least vaguely aware of feminist concepts such as heteronormativity, intersectionality, and microaggressions/microinvalidations. Balsam et al. (2011) developed a metric for addressing and quantifying compounding minority stress among LGBT people of color, while Shelton and Delgado-Romero (2012) analyzed sexual orientation micro aggressions within the therapeutic environment itself, examining the ability of subtle heterosexist bias on the part of mental health practitioners to "stealthily debilitate the therapeutic environment for the purpose of continued indoctrination of systemic oppression." What is missing from many of these accounts is anything resembling a true power analysis, at least as this applies to the therapeutic setting itself. Even in LGBT-inclusive psychotherapy, when the role of the psychotherapist as the the authority on matters of the mind meets with epistemic gaps between patient and therapist, the potential for erasure and re-shaping of non-normative desires and emotions emerges. Adolescent and teen populations, whose sexual identity is still in its formative states, and whose LGBT identities are already dismissed due to their age, are particularly at risk, as are queer and trans people of color, especially those whose relationship with sexuality and gender does not fit easily within a Western framework.

The stakes of this power differential become abundantly clear when one filters this medical discourse (and lack thereof) through a lens of epistemic justice. Kristie Dotson defines two main forms of epistemic oppression in two ways: testimonial quieting and testimonial smothering. Testimonial quieting refers to the process by which certain individuals are not recognized by their audience as knowers. For example, a bisexual teen's identity may be doubted because she is

seen as too young to fully understand her own sexuality; or a trans woman of color may be denied hormone treatment because medical professionals cannot fit her experience into their model of trans-ness. Our inability to recognize marginalized people as knowers renders us incapable of understanding their needs and experiences. Testimonial smothering, conversely, is the truncating of one's own testimony in order to ensure that they only give voice to feelings and experiences for which the audience has demonstrated accurate intelligibility (the ability to understand the content of the testimony, coupled with the ability to detect a failure to understand)—for example, a pansexual transgender man may choose not to discuss his sexual identity while in therapy, because he fears that his therapist might doubt his trans identity if she knew that he was interested in men as well as women. Both testimonial quieting and testimonial smothering are necessarily informed by micro-aggressions and micro-invalidations, and, in the context of psychotherapy, have very real treatment implications.[24]

Miranda Fricker's testimonial injustice occurs when an audience does not grant credibility to a speaker due to their own prejudices; this is similar to Dotson's model of testimonial quieting. Hermeneutical injustice, in addition to the failure to render oneself communicatively intelligible to another, can occur when a hermeneutically marginalized person, due to their membership in a group that does not have equal access to participation in the generation of social meanings, is unable to make sense of their own experiences—for example, a queer patient who has difficulty fitting their experiences and desires into a narrow, identitarian framework. A hermeneutically marginalized person may be able to communicate their experience with ease to

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[24] Kristie Dotson, "Conceptualizing Epistemic Oppression," Social Epistemology 28, no. 2 (2014), doi: 10.1080/02691728.2013.782585; Kristie Dotson, "A Cautionary Tale: On Limiting Epistemic Oppression," Frontiers: A Journal of Women Studies 33, no. 1 (2012): , doi:10.5250/fronjwomestud.33.1.0024.

members of their own social group, but may not be able to bridge the hermeneutical gap between their in-group and the wider society, make themselves understood to the relevant institutional bodies. They may also be so hermeneutically oppressed that they are radically incapable of certain forms of self-expression, even internally.[25]

The profoundly racialized and gendered aspects of epistemic injustice within dominant medical discourse become clear when examining the diagnostic criteria for gender dysphoria. In *decolonizing trans/gender 101,* b. binaohan, a Filipino *bakla,* describes the ways in which the Western model of gender—one where sex, gender, and sexuality are discrete, unconnected entities, with an "almost obsessive focus on the body as the locus of gender"—when deployed by the medicolegal system, become very violent toward indigenous peoples and other people of color.[26] According to binaohan, the localization and medicalization of gender within the body "participates in the pathologizing of indigenous genders" by "shift[ing] the focus from how a person's gender is embedded within a socio-spiritual community, to a focus on their body"[27]—an emphasis that becomes abundantly clear when reading the DSM-5's guidelines for diagnosis of gender dysphoria, the first three of which are strongly tied to bodily incongruence:

> "A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics; A strong desire to be rid of one's primary and/or secondary sex characteristics; A strong desire for the primary and/or secondary sex characteristics of the other gender."[28]

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[25] Miranda Fricker, Epistemic injustice: power and the ethics of knowing (Oxford: Oxford University Press, 2011).

[26] b. binaohan, decolonizing trans/gender 101 (Toronto, Canada: Biyuti Publishing, 2014), 61.

[27] Ibid 62.

[28] American Psychiatric Association, (2013), Gender Dysphoria, *Diagnostic and statistical manual of mental disorders (5th ed.)*. Arlington, VA: American Psychiatric Publishing.

Compare this neatly separated sex/gender/sexuality model with the nuanced identities of many queer people elucidated by the work of sociologists like Carla Pfeffer, who explores queer negotiations of identity and social group membership among lesbian women and trans men (2016).[29] Through analysis of her interviews with 50 queer, cisgender women in relationships with trans men, Pfeffer argues for the necessity of examining the ways in which gender and sexual orientation are co-constitutive, and defined relationally. In *Imagining Transgender: An Ethnology of a Category,* David Valentine explores the ways in which the modern sexual/gender distinction emerged in the 1970s through a discursive move within the field of psychiatry to depathologize homosexuality by depicting it as internal, private, and invisible, and therefore non-pathological. While Valentine acknowledges that this rhetorical shift in psychiatric nosology echoed sentiments shared by gender/sexual subcultures of the 1970s, who were increasingly naming and experiencing distinctions between butch lesbians and trans men, gay men and trans women, and a host of other gender variant categorizations, often in racially-coded and class-inflicted ways. That many queer and trans activists accept this current sexual/gender distinction almost without question is a testament to its insidiousness. In the span of a few decades, the clear division between sexual orientation, sex, and gender identity has become completely naturalized, at the same time that LGBT advocates have embraced a "born this way" mantra that further cements these categories as innate, biological, and immutable.[30]

Public acceptance of LGBT/queer people has increased alongside claims of biological determinism, particularly in the medical and psychotherapeutic fields (where evidence for the

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[29] Carla A. Pfeffer, "Identity Shifts, Recognition, and Intersectionality in Trans Partnerships and Families," Queering Families, 2017, , accessed May 11, 2017, doi:10.1093/acprof:oso/9780199908059.003.0002.

[30] Michael Bronski, Ann Pellegrini, and Michael Amico, "Myth 7: Homosexuals are Born That Way," "*You Can Tell Just By Looking'"and 20 Other Myths About LGBT Life and People,* (Boston: Beacon Press, 2013), 53.

biological and immutable nature of homosexuality played a key role in the removal of homosexuality from the DSM and ICD).[31] However, an analysis of the ways in which cis women in relationships with trans men are (mis)recognized as queer or heterosexual reveals the interactive social processes that determine inclusion and exclusion across gender and sexual identity categories.[32] Furthermore, these dynamic social processes have social and material consequences, such as (lack of) access to heterosexual and queer-coded spaces, social support from family and peers, and exposure and vulnerability to queer and transphobic violence. Pfeffer's work reveals that sexual identity is a much more relational and context-dependent process than most psychologists recognize; stable definitions often do not encompass the complex and messy lived realities of LGBT patients. Further, our current sexual/gender model has its roots in a trans-exclusive and race/class-inflected system that has historically located pathology in Black, brown, and visibly queer bodies.

Models of Identity Development

Previously, I have discussed some of the limitations and covert violence of current psychological sexual/gender frameworks without explicitly discussing how these frameworks inform psychological models of LGBT identity development. Here, I will flesh out a few of the common therapeutic models in greater detail, and discuss how these models inform psychological practice with queer and trans patients. Bilodeau and Renn (2005) group models of LGBT

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[31] Ibid.

[32] Ibid.

identity development employed by mental healthcare practitioners into four main categories: stage models of sexual orientation and identity development, lifespan and nonlinear models, diverse persepectives, and medical and psychiatric perspectives.[33]

The most widely used LGBT identity development models in current psychosexual theory is between lifespan and nonlinear models and older, stage models of LGBT identity models. These models are usually linear, focusing on the resolution of internal conflict related to same-sex desire or gender-variant feelings. These typically begin with a denial phase, in which individuals employ defense strategies to repress and deny recognition of same-sex attraction. Individuals may then experience a crisis of identity when they can no longer block feelings of same-sex attraction. Gradually, through a process of emotional and behavioral experimentation, the individual recognizes and accepts their sexual orientation, though the individual is prone to relapse, with some stage models emphasizing the end of the first same-sex relationship as a time of intense vulnerability.[34]

Stage Models

The earliest, and perhaps most famous, stage model of sexual identity development is the Cass Model, developed by Vivienne Cass in 1979. In the identity confusion stage, individuals feel that they are different from peers, but despite a growing sense of alienation from others, remains largely in denial. The identity comparison stage is similar to the bargaining stage in the

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[33] Brent L. Bilodeau and Kristen A. Renn, "Analysis of LGBT identity development models and implications for practice," New Directions for Student Services 2005, no. 111 (2005): 34, accessed May 11, 2017, doi:10.1002/ss.171.

[34] Ibid 25-27.

Kubler-Ross model of grief—the individual may conceive of their same sex attraction as a phase, a crush as an exception to their dominant heterosexual orientation, or may identify as bisexual rather than gay (that the Cass model implies that bisexuality is usually a phase has made it quite controversial among bisexuals). In the identity tolerance stage, the individual explores LGBT identity and may attempt to enter into LGBT communities, but does not fully accept their identity; in the identity acceptance stage, they forge deeper connections with other LGBT people, and in the identity pride stage, the individual exhibits strong feelings of adhesion to the LGBT community, and may feel anger toward heterosexuals. The identity pride stage is associated with a strong us/them dichotomy. Ritter and Terndrup's *Handbook of Affirmative Psychotherapy with Lesbians and Gay Men* makes Cass's tacit pathologization of activist consciousness painstakingly (yet obliviously) clear: "For some at this stage, the combination of anger and pride energizes the person into action against perceived homophobia, producing an "activist."[35]

A more modern stage model put forth by Robertson aims for a less essentialist view of sexual orientation, with an increased emphasis on the ways in which identities are created relationally.[36] Drawing on ethnographic research with adolescent males at an LGBT youth center, Robertson theorizes that sexuality is constructed through four processes: violating compulsory sexuality, seeking an explanation, exploring sexuality, and negotiating identity. Robertson views sexuality as a socially constructed category, and her paper explores the processes by which adolescent males give meaning to their affects and desires, as well as "how the adoption of a sexual

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[35] Kathleen Ritter and Anthony I. Terndrup, Handbook of affirmative psychotherapy with lesbians and gay men (New York: Guilford Press, 2002), 96.

[36] Mary Anna Robertson, ""How Do I Know I Am Gay?": Understanding Sexual Orientation, Identity and Behavior Among Adolescents in an LGBT Youth Center," Sexuality & Culture 18, no. 2 (2013): , doi:10.1007/s12119-013-9203-4.

identity is often more pragmatic than romantic."[37] When youths violate the rigid boundaries around femininity and masculinity, they are often labeled by others as sexually deviant; the boys and young men in Robertson's study likewise recount stories of being marked by others for violating gender-normative behavior and/or straying from heteronormative sexual scripts during adolescence. When adolescents are marked as "different," they seek an explanation and name for their difference, and become complicit in marking themselves as outside the norm. After self-recognition comes exploring sexuality, in which they pursue relationships with other queer people in order to learn how to appropriately "be" queer. In the final, "negotiation" phase, young people become comfortable in their sexual identity.[38]

Although Robertson attempts to account at least in part for sexual fluidity and views sexuality as a process informed as much by socialization as by biology, her model does not account for the fluidity of sexuality over time. Her approach also does not consider how the experience and memory of sexual identity can be retroactively created though attempts to render one's own experience legible within a homonormative script that views sexuality as a static identity category (largely during what she refers to as phase three, exploring sexuality).

Lifespan Models

Lifespan models of LGBT identity development involve many similar processes to stage models, but rather than existing in strict sequence, staged models view identity development as a

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[37] Ibid. 369.

[38] Ibid 370-371.

series of overlapping identity formation processes, some of which can happen in any order, or even simultaneously.[39] One of the most prevalent lifespan models, the D'Augelli framework, attempts to account for the fact that LGBT identity is context dependent, an emphasizes the multiple components of one's identities, both personal and relational. The D'Augelli model contains 6 main processes: exiting heterosexuality, developing a personal LGB identity, developing an LGB social identity, becoming an LGB offspring, developing an LGB intimacy status, and entering an LGB community.[40]

In reality, most clinical competency literature makes use of a blended model; very few are explicitly loyal to only Cass, Robertson, Drescher, D'Augelli, or any other model, and some put forth their own paradigm altogether. There is often some slippage between staged and lifespan models, as most psychologists now recognize that one may not move through all the stages of a staged model in order, or may not even go through all the stages at all (I have a strong suspicion that Vivienne Cass would consider my personal development to have stalled out somewhere in Stage 5 for years. I'm hopefully a hopeless case).

Diverse Models

Feminist, postmodern, and queer perspectives on gender identity are considered largely irrelevant by most clinical researchers, including Bilodeau and Renn, who claim that these mod-

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[39] Bilodeau and Renn 28.

[40] Anthony R. D'Augelli, "Identity Development and Sexual Orientation: Toward a Model of Lesbian, Gay, and Bisexual Development.," in Human diversity: perspectives on people in context, by Edison J. Trickett, Roderick J. Watts, and Dina Birman (San Francisco: Jossey-Bass, 1994).

els "do not provide theoretical background on identity development per se,"[41] an intriguing premise given that most queer and feminist theorists do indeed consider themselves just that—theorists. However, Bilodeau and Renn hit on an important point, which will be referenced throughout this thesis: psychology is an empirical science; thus, only theories of psychosexual identity development are constrained to those parts of identity which can be directly observed and quantified. Even diversity-based models of LGBT identity development are often overlooked by clinical researchers due to insufficient empirical data (although, to be fair, some researchers, including Bilodeau and Renn, reject diversity-based models because they are too essentialist; they dislike that many assume "fixed notions o socially constructed categories (gender, race, class…) and universality of LGBT people within those categories."[42]

Medical Models

Perhaps the most dangerous model, from an epistemic justice standpoint, is the medical/psychiatric model, which posits that "normal" identities are cisgender and heterosexual, and that homosexuality and transgender identities are clinical disorders with a set list of empirically defined and diagnosable symptoms. These models make LGBT people into a clinical population, although not all medical models assert that LGBT persons ought to be cured—simply that queerness is an unnatural, pathological state. In current psychological practice, a medical model exists explicitly for trans and gender-variant identities only—and for that matter, only those "dis-

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[41] Bilodeau and Renn.

[42] Bilodeau and Renn 34.

tressed" by the discrepancy between their sex and gender (of course, this assumes that sex and gender are discrete, meaningful categories—a distinction which, again, emerged in the 1970s with the explicit intention of shifting the locus of pathology from sexual desire to gender expression).[43] A shift in psychiatric nosology from the explicitly pathologizing internal states to external expressions of non-normativity precipitated the depathologizing of homosexuality and the invention of new ways to medicalize gender. While I will later discuss traces of pathologizing language and rhetoric embedded in clinical competencies and the DSM itself, for the most part, this model exists in the background, unspoken, and obscured by plausible deniability—at least for whitenormative LGB people. For trans people and queer people of color, whose bodies are not rendered comprehensible by our current sexual/gender model, the medical model of queerness is alive and well. The gatekeeper model of healthcare naturalizes white, binary trans identities even while medicalizing them, and the hermeneutical oppression inherent in this system is disproportionately violent to queer and trans people of color.[44]

The Covert Violence of Accepted Truths

If there is one theme tying together current best practices research and models of sexual/gender development, it is the covert violence of deeply held truths—truths that seem natural and logical, and which taken on their own, outside of the sociopolitical context that created them, often seem quite innocuous. The sorting out of gay, straight, and bisexual, of cis and trans, closeted

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[43] Diagnostic and statistical manual of mental disorders, 5th ed.

[44] b. binaohan, *decolonizing trans/gender 101,* (Toronto: Biyuti Press, 2014), 61-62.

and out, and of integrated and ill, all *seem* fairly straightforward until one considers the ways in which these categorizations were developed and naturalized by people with a stake in maintaining a system of social control over certain kinds of queer bodies. Tracing echoes of the medical model, which views homosexuality and gender variance as inherently pathological, into more innocuous-seeming stage-based and lifespan models, reveals the insidious ways in which these paradigms regulate gender and sexuality in the modern era by covertly (and in some cases, quite overtly) locking LGBTQ+ and gender variant people out of the creation of social meanings.

I have just recently come out as a gay trans man, and so I decided to speak with a counselor at my college. They didn't understand why I was worried that the loans I have to take out to pay for my education will make my transition harder because it will leave me unable to afford trans surgery. Regarding the surgery, they even asked, "Aren't you a little young to be mutilating your body? There's nothing wrong with being butch or a lesbian."

I am not butch, female, lesbian, or too young. I am a 19 year old gay trans man in North Carolina.

~Anonymous Submission, microaggressions.tumblr.com

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Self-portrait from a mental institution

Anonymous Genderqueer Teen
April 4, 2016 - dev.queermentalhealth.org

CHAPTER THREE

METHODS

This chapter describes the methodological approaches I followed in this research project, as well as the process through which I selected them, and the implications of these methods for the types of conclusions I was able to draw from my research.

Research Design

Given that a review of the literature exposed a systematic privileging of certain voices over others—namely, empirical researchers over queer individuals, and white, homonormative LGB people over gender variant queer and trans people of color—I wanted to see how the pervasiveness of these voices impacted professional counseling associations' recommendations practitioners working with queer patients on the ground. My goal was to analyze discourses of queerness in clinical competency materials produced by and for mental health practitioners working with LGBTQ+ populations. I was particularly interested in the ways in which the mental healthcare system deploys, shapes, and reifies hegemonic discourses of normality, and how the therapist/patient dyad operates as a site for the production and reification of social meanings around sexuality and gender. Further, I was interested in which experiences and embodiments of queerness are privileged and othered by these discourses.

Analysis 1: Organizations

My first task in conducting this research was to determine how best practices findings were collected, synthesized, and used to create widely accepted clinical competency guides for practitioners in the first place—who produced these guides, how, and why? As I intended to analyze the power dynamics at work in discourses of queerness, understanding the positionality of the authors and situating the guides in a broader social and political context was absolutely critical. This first phase of research, which took place mainly between July 2016 and February 2017, was highly exploratory. As I read and collected clinical competency materials, I searched for information on which groups had funded and published them, and what role the authors played in these organizations (if any).

As I examined groups that produce clinical competency guides and other educational resources for mental health clinicians working with LGBTQ+ clients, I found that a wide range of organizations are currently working to improve mental healthcare for LGBTQ+ people. However, in order to narrow the scope of this project, I limited my analysis to organizations affiliated with national counseling and mental health associations, such as American Psychological Association, the American Psychiatric Association, the American Counseling Association, the American School Counselors' Association, the Association of Mental Health Counseling, and the American Association of Marriage and Family Counselors. Affiliate organizations include national LGBTQ+ organizations affiliated with one of these national organizations (for example, the Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling is a national organization affiliated with the ACA); the state chapters of these affiliate organizations, and

LGBTQ+ working groups within professional organizations that do not operate independently. While these organizations may not be doing the most radical work, their association with mainstream counseling associations grants them legitimacy within the field; therefore, therapists look to clinical competency guides and other educational resources and research produced by these organizations represent that any therapists as voices of authority on working with LGBT patients. Since my goal was to look at competencies that are currently accepted the "gold standard" within the field, restricting my research to works produced by these organizations made the most sense.

Once I had narrowed my purview, I conducted broad contextual research on all organizations with therapy of the history of clinical organizations for LGBTQ+ issues in therapy, and examined them in the broader context of evolving ethical standards for practice with LGBTQ+ people. This section of data is meant to provide background information on the organizational/social context in which clinical competency guides for working with LGBTQ+ patients are created. I wanted to understand how these organizations operate, and what their institutional goals are. I then conducted a more targeted analysis of these organizations' websites' contents—my full coding sheet is enclosed at the end of this chapter. This analysis provided insight into the intended audiences of these sites—in some cases, exclusively mental health professionals; in others, LGBTQ+ community members and their loved ones. I wanted to understand who is accessing these organizational resources, and why.how much of the content hosted on the sites publicly accessible (that is, accessible without an ACA, ALGBTIC, or similar member login), what types of information are public vs private, whether the site intended primarily for mental health professionals or LGBTQ+ community members, and whether they producing their own regionally specific information or reposting national resources.

Analysis 2: Discourses on Queerness in Clinical Competency Materials

In the second phase (which overlapped slightly with the first), between January 2017 and April 2017, I performed a content analysis on the clinical competency materials themselves, with an intent to determine how these guides conceive of an LGBT-affirmative model of healthcare.

A second coding sheet was used to analyze national and state clinical competency guides and handbooks (and, in the case of a few states, transcriptions of educational podcasts produced by the ACA). The bulk of my data was gathered from educational information freely available from organizational websites. Many guides were hosted online in .pdf or podcast form. Other sites hosted bibliographies with key titles for self-education. In these cases, documents were typically requested directly from the author (in the case of journal articles, presentation notes, or other short publications), or through BorrowDirect, DartDoc, or ResearchGate. In cases where clinical competency resources were not freely available through the organizational sites, I requested information from members of the organization via email, along with a brief description of my research goals (sample email included in appendices). Most requests were fulfilled, though lack of access to some materials that were not made publicly available, or for which no permanent record existed (i.e. training seminars that were not recorded), was a limitation of the study.

I performed a content analysis on the 14 national and 25 state/local clinical competency guides that I was able to obtain (*see* Appendix II for a full listing). I began my analysis with open-coding procedures, making extensive notes on repeating concepts and themes across the first several guides. I then moved through guides using a more targeted coding method (see end of chapter for full coding sheet). I broke my analysis into five main subsections. In the first, I

made note of the target population (children/adolescents or adults, school setting or clinical, in-patient vs outpatient, etc) and the gender and sexual identities covered by the guide, as well as general information, such as year of creation and number of pages. In the second section, the first true analysis section, I explored the ways in which the guides call for therapist self-reflection. This section explores therapist self-directives and affective transformations: unlearning biases, examining beliefs about LGBTQ+ individuals, etc. In the third section, I explore what the authors consider salient issues in therapy with LGBTQ+ clients, including the centrality (or lack thereof) of LGBTQ+ identity to therapeutic discourse and treatment plans, and the ways in which LGBTQ+ clients are seen as similar and distinct from other patient populations. The fourth section examines psychological models of sexuality and gender deployed by the text, such as closet narratives, paradigms of LGBTQ+ identity formation, (non)pathology, normativity, and multiculturalism. The final section addresses overarching knowledge systems not specifically addressed by earlier subsections: historical, scientific, and sociocultural.

Limitations and Further Research

My research did not examine to what extent psychologists follow, or are even aware of, the recommendations of the educational materials put forth by the APA, ACA, and affiliated LGBTQ and allied therapists' organizations. While other researchers have chosen to focus on the degree to which therapists acquire, or attempt to acquire, clinical competency (*see* Gillespie et al. and Godrey et al.), I instead chose to focus on the discourses around LGBTQ+ identity within the mental healthcare system. While individual practitioners may go above and beyond the recom-

mended competencies (although prior research shows that the reverse is more often true, particularly among older practitioners), by analyzing the clinical competencies themselves, I was able to explore the ways in which psychological theory, rather than individual therapists, contributes to ongoing violence against LGBTQ+ patients.

Examining educational resources produced by and for therapists provides a wealth of information on how therapists are thinking about clinical competency with LGBTQ+ patients, and allows me to analyze relevant models of LGBTQ+ identity, development, and clinical demographics. My research includes the voices of many LGBTQ+ healthcare practitioners (some of whom may have accessed mental health resources at some point in their lives), but did not allow me to access the experiences of LGBTQ+ patients in a direct way. Thus, my results are limited to analyzing the clinical discourse itself, and I cannot comment on the effects of this discourse on the lived experiences of LGBTQ+ patients, or the effects of this discourse on individuals outside of the therapeutic context—ie. the ways in which discursive moves within therapy affect broader social perceptions of LGBTQ+ people.

Furthermore, many sites contain information beyond clinical competency information for practitioners. The sheer diversity of types of information hosted on these sites makes a deeper analysis of the content of these resources difficult to accomplish—there is simply too much variation in the sample to draw any meaningful results about the utility or perspective of these resources, and community-based resources strayed a bit too far afield from my research on the conceptual models deployed by mental health practitioners working with LGBT people. Some sites contain information on the legal status of LGBT persons in the state. Several states, including Texas and Tennessee, published white pages condemning religious freedom acts and repara-

tive therapy. (While Tennessee's ALGBTIC chapter's website is relatively simple, its parent organization, the Tennessee Counselor's Association, posted a video on its homepage in which one of the executives of the TCA speaks out against RFAs.)

Most sites, at a bare minimum, contain contact information for local LGBT-friendly therapists; although their minimum guidelines for LGBT competency are less clear. They further often include lists of local resources—local LGBT support groups and community events, as well as resources around coming out, and supporting LGBT children and family members. Despite the difficulties in conducting a formal content analysis on these resources, given that professional counseling associations are considered by many people—both mental health professionals and laypeople—to be authorities on LGBT mental health, analysis on the ways in which these materials further contribute to the kinds of cultural productions analyzed in the next chapters may very well be a fruitful endeavor.

Full Listing of Guides By State

National Associations

American Association for Marriage and Family Therapy (AAMFT) Queer-Affirmative Caucus
- Therapeutic Issues for Same-Sex Couples
- LGBT Affirmative Therapy: Tips for creating a more lesbian, gay, bisexual, transgender, & queer inclusive practice from the AAMFT Queer Affirmative Caucus

American Counseling Association (ACA)
- Casebook for Counseling Lesbian, Gay, Bisexual, and Transgender Persons and Their Families. Sari H. Dworkin and Mark Pope.

American Mental Health Counseling Association
- An Affirmative Approach to Supervision: Working With LGBQ+ Supervisees and Clients

American Psychiatric Association (APA)—ALGP
- (Repost: American Psychological Association) Appropriate Therapeutic Responses to Sexual Orientation
- (Repost: American Psychological Association): The LGBT Casebook. Petros Levounis, Jack Drescher and Mary E. Barber. (2012).
- (Repost: American Counseling Association): Casebook for Counseling Lesbian, Gay, Bisexual and Transgender Persons and Their Families. Sari H. Dworkin and Mark Pope. (2012).
- (Repost: World Professional Organization for Transgender Health): WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People

American Psychological Association (APA)—Division 44
- Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients
- Guidelines for Psychological Practice With Transgender and Gender Nonconforming People
- Lesbian, Gay, Bisexual and Transgender Aging
- The LGBT Casebook. Petros Levounis, Jack Drescher and Mary E. Barber. (2012).

American School Counselor Association
- The School Counselor and LGBTQ Youth

Association for Child and Adolescent Counseling
- Position Statement on LGBTQQIAA Individuals

Association for Lesbian, Gay, Bisexual, and Transgender Issues In Counseling (ALGBTIC)
- ALGBTIC Clinical Competencies for Counseling with LGBQQIA Individuals
- ALGBTIC Clinical Competencies for Counseling with Transgender Individuals

Substance Abuse and Mental Health Services Association
- A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

State Associations

Alabama
Association of LGBT Issues in Counseling—Alabama (ALGBTICAL)
- Gay, Lesbian, Bisexual, and Transgender Issues in Counselor Education and Supervision: A Call to Advocacy
- When Values and Ethics Conflict: The Counselor's Role and Responsibility

California
California Association of Marriage and Family Therapists
- Becoming Culturally Competent with LGBT Clients

Psychologists for Social Justice—California
- Evaluating the Ally Role: Contributions, Limitations, and the Activist Position in Counseling and Psychology (2016).

California Faculty Association (CFA) Lesbian, Gay, Bisexual, Transgender Caucus
- SafeZone Manual (2015)

Georgia
Association of LGBT Issues in Counseling—Georgia
- Anneliese Singh, "Counseling Queer Youth" (2008)

Iowa
Iowa Association of School Counselors
- (Repost): CFA LGBT Caucus SafeZone Manual
- Creating Supportive School Environments for LGBT Families: Strategies for School Counselors

Illinois
Illinois Association of LGBT Issues in Counseling (IALGBTIC)
- (Repost: American Psychological Association): The LGBT Casebook. Petros Levounis, Jack Drescher and Mary E. Barber. (2012).
- (Repost: American Counseling Association): Casebook for Counseling Lesbian, Gay, Bisexual and Transgender Persons and Their Families. Sari H. Dworkin and Mark Pope. (2012).

- Mindfulness and Acceptance for Gender and Sexual Minorities: A Clinician's Guide to Fostering Compassion, Connection, and Equality Using Contexual Strategies. Matthew Skinta and Aisling Curtin. (2016)
- Cognitive-Behavioral Therapies with Lesbian, Gay, and Bisexual Clients. Christopher R. Martell, Steven A. Safren, and Stacey E. Prince. (2003)

Kansas
LGBT-Affirmative Therapists' Guild of Greater Kansas City
- The Impact of Sexual and Gender Microaggressions on LGBT Accessibility to Healthcare

Maryland
Maryland Department of Health and Mental Hygiene
- Providing Safe Spaces For Transgender and Gender Non-Conforming Youth: Guidelines for Gender Identity Non-Discrimination
- (Repost: PFLAG MetroDC) LGBTQ Mental Health

Nebraska
Nebraska Association of LGBT Issues in Counseling (Nebraska ALGBTIC)
- From Awareness to Action: Becoming a LGBT Advocate in a Conservative Rural Community

New Mexico
Association of LGBT Issues in Counseling—New Mexico (ALGBTIC-NM)
- Kristopher Goodrich and Melissa Luke, "Group Counseling with LGBTQI Persons" (2015).

New York
Association for LGBT Issues in Counseling—New York (ALGBTIC-NY)
- School Counselors and Social Justice Advocacy for Lesbian, Gay, Bisexual, Transgender, and Questioning Students
- An Interdisciplinary Approach to Lesbian, Gay, Bisexual, and Transgender Clinical Competence, Professional Training, and Ethical Care

South Carolina
Association for LGBT Issues in Counseling—South Carolina (ALGBTIC-SC)
- Moving Beyond CACREP Standards: Training Counselors to Work Competently with LGBT Clients

Tennessee
Tennessee Counseling Association LGBTQ Working Group (TCN-LGBTQ)
- LGBTQ Training for School Counselors

Texas
ALGBTIC-Texas
- White Paper on Sexual Orientation Change Efforts

- Counseling LGBTQ Youth: Social, Ethical, and Therapeutic Implications

Utah

LGBT-Affirmative Therapists' Guild of Utah

- (Repost: American Psychological Association): The LGBT Casebook. Petros Levounis, Jack Drescher and Mary E. Barber. (2012).
- (Repost: American Counseling Association): Casebook for Counseling Lesbian, Gay, Bisexual and Transgender Persons and Their Families. Sari H. Dworkin and Mark Pope. (2012).

Table 1: Organizational Website Coding Sheet

State:	
Name of Organization	
Parent Organization(s)	Usually ACA, ALGBTIC, and/or state counseling association
Year founded	
Site purpose	
Community Support and Advocacy	(usually a combination of these three)
Networking	
Clinical Competency	
Site contents	(elaborate on resources present…not just yes/no)
On-site Resources	
Public/Private	elaboration therein (ex. public community resources, private practitioner resources)
Self-produced materials	self-authored clinical competency info
Community oriented info*	links to local LGBT orgs, information for queer/questioning youth, etc
Practitioner oriented info*	Clinical competency guides, professional networking info, etc
Contact Info	
Conference Participation	
Journal	
Other notable:	

Table 2: Clinical Competency Guide Coding Sheet

Basic Information:	
Guide Title:	
State of Origin (or National):	
Year of Publication:	
Length (pages):	
Patient population:	*(ex. children/adolescents, adults, medical/therapeutic setting)*
Breadth of guide:	
LGB or trans specific? If yes, is there a complementary guide for LGB or trans patients? Identities specifically mentioned in the guide (list):	
Main focus of guide:	
Therapist Self-Reflection	
Assumptions about therapist	
Assumption that the therapist is straight/cisgender Assumption that the therapist is unfamiliar with LGBT people Assumption that the therapist is anxious/uncomfortable working with LGBT clients	
Appeal to therapist as compassionate	
Appeal to therapist as tolerant	
References to therapist needing to educate themselves	
about LGBT issues	
about intersectional perspectives	
Discussion of relative privilege	
Salient Issues in Therapy	

Explicit condemnation of conversion therapy
Discussion of how to build trust/empathy with LGBT patient
Coming out
Passing
Stigma and microaggressions
STDs and medical issues
Interpersonal relationships
Family members Friends/peers Authority figures Coworkers Cultural group (ie. religious or ethnic community)
Sociolegal issues
Marriage Adoption Access to facilities Job security
Intersections
STDs Sexual abuse Drug use Gender/Gender variance Race Religion SES Ability status/chronic illness Other

Models of LGBT Identity
Explicit focus on normality
Non-pathology Morality

Coming out/closet narratives

reifies closeted/out binary
views being “out” as dynamic/situational
views being “out” as an ideal end state

Views sexuality as fluid/dynamic

Recognizes patients may identify outside of LGBT (no label, different label, distinguishes between practice and identity, etc.)

Models of LGBT identity development (ie. Roberts, Cass)

Overarching Knowledge Systems

Historical

Where does the history start?
Key researchers/studies
Key LGBT milestones
References to history of homophobia and queerantagonism in the medical field

Cultural

Appeals to normality/sameness (i.e. LGBT people are just like us)
Appeals to empathy/compassion
Popular opinion
Political discourse

Scientific

Emphasis on objectivity
Emphasis on empirical research in determining successfulness of therapeutic interventions
Appeals to scientific authority (ie. DSM, APA policy, etc)

Other notes:

Three Women, mixed media (2014)

Anonymous

"I enjoy using pill bottles and Saphis casings as frames for my mixed media oil paintings. Stockpiling and creating from the detritus of my illness makes me feel as if I am doing something positive and healing. In so openly declaring my illness in visual art, owning it, I feel I am working towards destigmatization."

CHAPTER FOUR

ANALYSIS 1: LGBT COUNSELING ASSOCIATIONS

This chapter explores the emergence, development, and current sociopolitical context of LGBT counseling organizations. An analysis of discourse around counseling queer and trans individuals would not be complete without an understanding of the conditions under which this discourse is produced. As clinical researchers conduct best practices research and channel these findings into educational materials for other mental health professionals, they are necessarily influenced by the prevailing ideology of their own institutions. Understanding the sociopolitical context in which these guides were produced, as well as the dynamics of the organizations producing them, helps us to locate these researchers within a broader system of social control, and helps explain how and why advocates within professional counseling associations have failed to produce radical change.

The Beginning: The Emergence of LGB Counseling Organizations

Because for many years, gay and lesbian mental health professionals could not organize openly, much early organizing is likely lost to history. However, the Association of LGBTQ Psychiatrists and the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, affiliates of the APA and ACA respectively, have kept relatively detailed archival information.

According to the Association of LGBTQ Psychiatrists, gay and lesbian mental health professionals began organizing in the late 1960s and early-to-mid 1970s.[45] Propelled by the momentum of the Gay Liberation movement, gay and lesbian mental health professionals began meeting in secret at annual professional conventions to discuss ways they might pursue more equitable treatment for themselves and their gay and lesbian clients.[46] Meeting publicly, at least at first, was extremely dangerous, as homosexuality was still considered a mental disorder. If outed, they would be considered mentally unfit to practice, and their ethical boards would likely strip them of their licenses, perhaps permanently. Although they could not meet openly, these gay mental health practitioners played an instrumental role in removing homosexuality from the Diagnostic and Statistical Manual of Mental Disorders, and in 1973, after years of meeting in secret, a group of psychiatrists shocked the American Psychiatric Association by coming out publicly at their annual convention to create the Association of Lesbian and Gay Psychiatrists.[47]

Other professional organizations soon followed suit. At the 1975 convention of the American Personnel and Guidance Association—now the American Counseling Association—a group of gay and lesbian practitioners split from their parent organization to form the Caucus of Gay and Lesbian Counselors.[48] This association would later become the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, a national organization affiliated with the ACA with branches in 25 U.S. states and counting.[49]

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[45] "AGLP History," Association of Gay and Lesbian Psychiatrists, accessed May 17, 2017. http://www.aglp.org/pages/AGLPHistory.php.

[46] "AGLP History."

[47] Bob Rhode, "ALGBTIC History," ALGBTIC-NY, November 28, 2016, accessed May 17, 2017, https://algbtic-ny.org/history/.

[48] Ibid.

[49] Ibid.

While the remarkable bravery of these pioneering gay and lesbian practitioners cannot be understated, their early work was also marred by their attempts to create space for themselves without questioning existing systems of social control. These gay mental health professionals, who were keen to establish that their sexuality was not socially deviant, fought against the medical field's attempts to codify visible signs of homosexuality in the body. This discursive move could not have been more perfectly timed. Affluent and largely white gay males increasingly sought to distinguish themselves from the Black, brown, and visibly queer drag queens, trans women, and gender non-conforming lesbian feminists. Meanwhile, a psychological field seeking to distance itself from the pseudoscience of the early 20th century began to shift its emphasis from the invisible and unconscious to overt, visible signs of pathology, creating an opportunity for accommodationist gay advocates to create a sharp distinction between highly visible gender variance and largely invisible same-sex desire.[50] Both psychiatry and 1970s sexual/gender subcultures began to consolidate a sharp distinction between gender and sexual orientation, and the time was ripe for the institution of a new, more sustainable model of gendered, sexual, and racial normality.[51]

Gay and lesbian mental health professionals, eager to present themselves as upright, respectable, and mentally healthy, wholeheartedly embraced a new sexual/gender system that defined homosexuality against that which was visible, creating a new pathological category of racialized and class-inflected gender deviants.[52] In 1980, Gender Identity Disorder entered into

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[50] Ibid 54-55.

[51] Ibid 54-55.

[52] Ibid 56.

the DSM-III, and the institutionalization of a new sex/gender system was complete.[53] The repercussions of this decision continue to cause disproportionate violence to trans and gender non-conforming patients to this day.

Reincorporation by Mainstream Professional Associations and Emergence of State-Level Organizing

Despite early success in the 1970s, partially fueled by the progress of the Gay Liberation movement, ALGBTIC fell into disarray in the 1980s as AIDS became an international epidemic.[54] ALGP faired slightly better, and even managed to lobby its parent organization, the APA, to create a standing committee on LGB concerns in 1985,[55] and a committee for AIDS research in 1986.[56] However, funding and institutional support for LGBT counseling organizations has always been in flux. Sponsoring LGBT-related research and organizing was for many years politically dangerous for large professional organizations, especially for groups receiving federal funding.[57]

However, a resurgence of the LGBT rights movement in the late 90s and early 2000s sparked a new wave of psychological research on LGBT people. As public acceptance of LGBT people (or at least, the homonormative and respectable among us) has increased, close affiliation

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[53] Ibid 55.

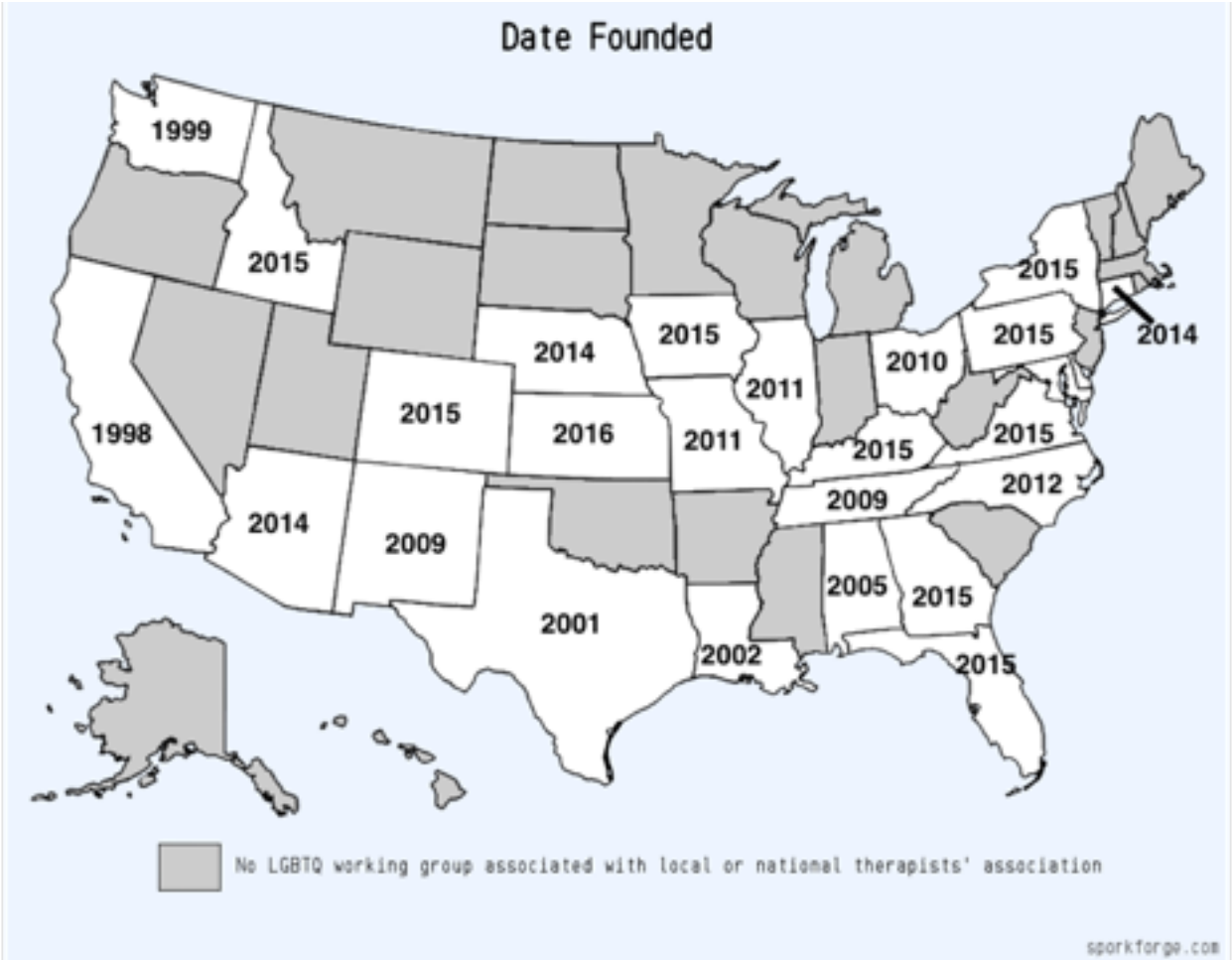
[54] Rhode.

[55] "About the Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues," American Psychological Association, accessed May 18, 2017, http://www.apadivisions.org/division-44/about/index.aspx.

[56] "HIV/AIDS Programs." American Psychological Association. Accessed May 18, 2017. http://www.apa.org/pi/aids/index.aspx.

[57] Rhode.

Figure 1: Emergence of State-Level LGBT Counseling Associations



between professional organizations ands their LGBT working groups and offshoots has become more advantageous for mainstream professional organizations.[58] Throughout the 90s and 2000s, we see a proliferation of LGBT working groups within national organizations. Further, large LGBT counseling associations like ALGBTIC begin to organize at a state level to better address local concerns.

From the map on the next page, we can see two clear waves of creation of state-level working groups on LGBT issues in counseling: one in the late 1990s through the early 2000s, and a second in the late 2000s through the mid-2010s. Although I was initially surprised that

[58] Rhode.

many states that are traditionally conservative—for instance, Texas, Louisiana, and Alabama—were among the first to create state-level LGBT working groups, upon analyzing the political context in which these organizations have historically been created, this pattern makes a great deal of sense. As noted earlier, the first LGBT counseling associations affiliated with major professional organizations emerged soon after the introduction of new policy from the American Psychiatric Association and the American Psychological Association that depathologized homosexuality.[59] Around the same time, the criminal status of persons engaging in same-sex sexual behavior began to shift, amidst strong political pressure from Gay Liberation groups.[60] Prior to 1962, sodomy was a criminal offense in every U.S. state. Many states—Colorado, Oregon, Delaware, Hawaii, North Dakota, Massachusetts, Ohio, New Hampshire, New Mexico, California, Indiana, Maine, Washington, West Virginia, South Dakota, Vermont, Wyoming, Iowa, Nebraska, and New Jersey—decriminalized anal sodomy during the 70s.[61] Here, we see cultural shifts impacting the ways in which queer bodies are pathologized and criminalized, and vice versa, creating shockwaves through the entire system of state and social control of sexuality. (Of course, several states re-criminalized sodomy, or selectively decriminalized sodomy among heterosexual couples while retaining laws against same-sex intercourse, in the conservative backlash of the years to follow).[62] While a few states did decriminalize sodomy in the 80s, the next cascade occurred between 1992 and 2003, with Kentucky, Washington, DC., Nevada, Tennessee, Montana, Georgia, Rhode Island, Maryland, Missouri, Arizona, and Minnesota striking down their bans

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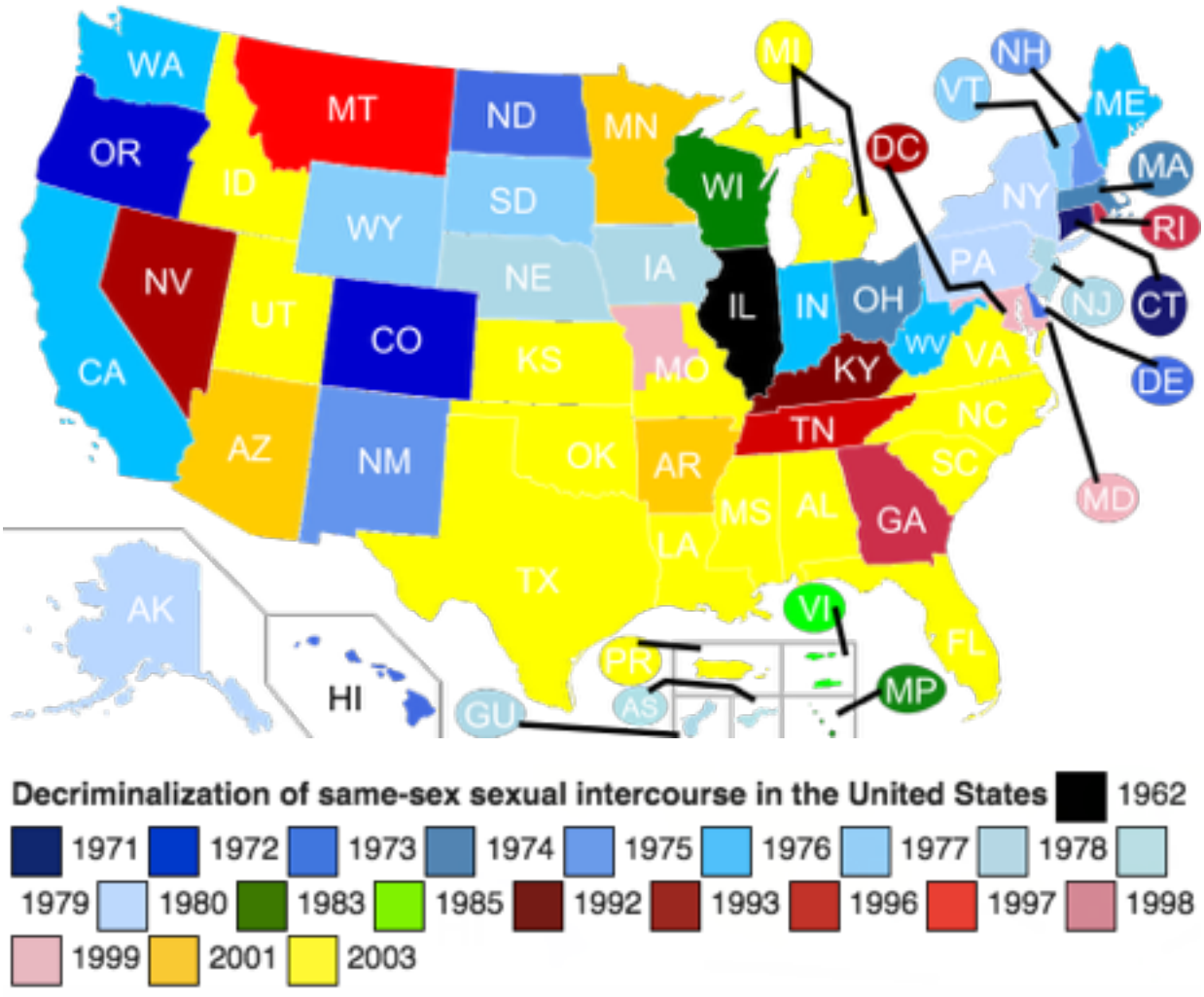
[59] Rhode; "ALGP History."

[60] "The History of Sodomy Laws in the United States - Introduction," GLAPN, , accessed May 18, 2017, https://www.glapn.org/sodomylaws/sensibilities/introduction.htm.

[61] Ibid.

[62] Ibid.

Figure 2: Decriminalization of same-sex sexual intercourse in the United States



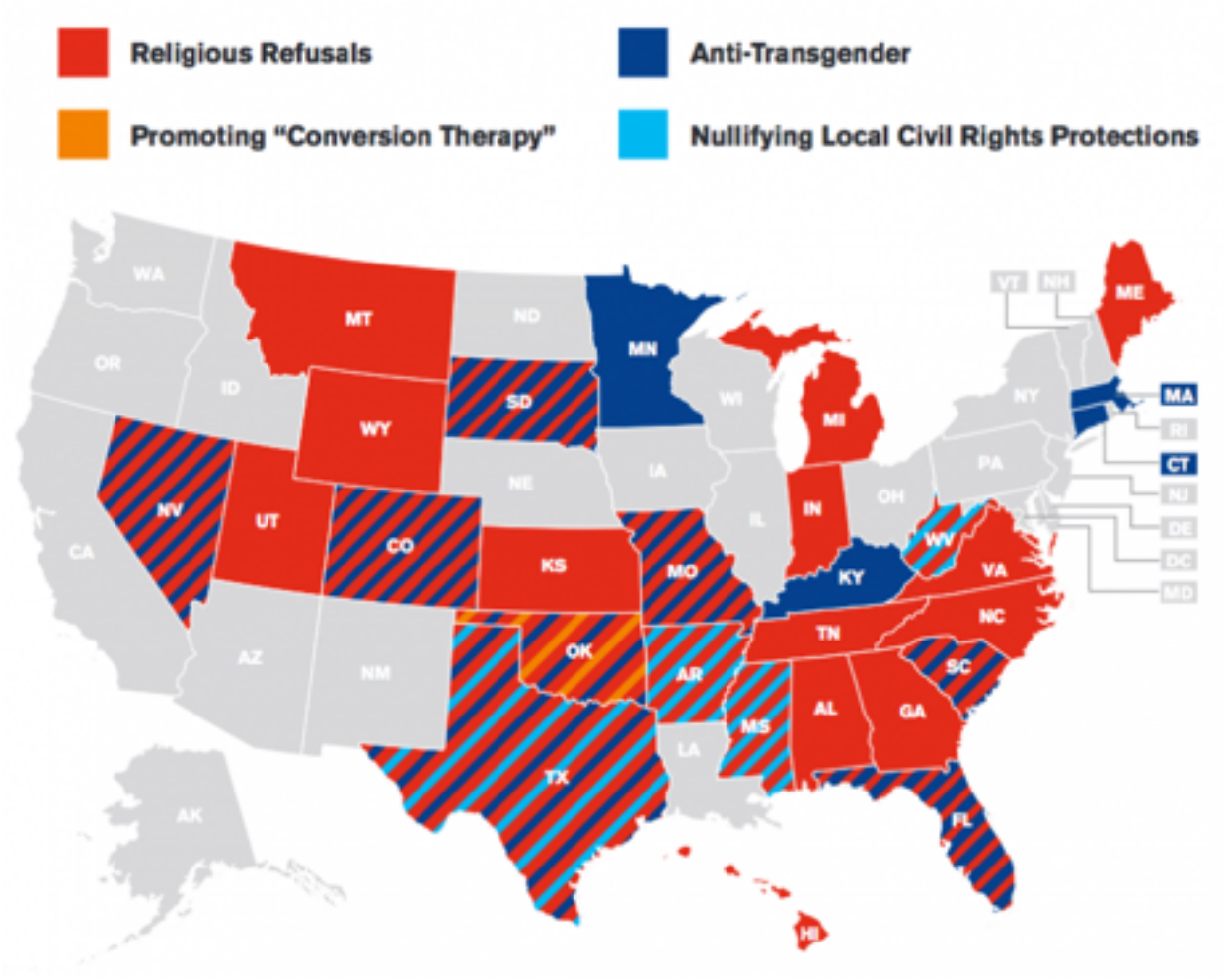
either via legislative repeal or through the court of appeals.[63] In 2003, all remaining anti-sodomy laws were invalidated by Lawrence v. Texas.[64]

Comparison between Figures 1 and 2 shows that the revitalization of working groups for LGBT issues in counseling within mainstream professional organizations in the late 90s and early 2000s was contemporaneous with a climate of increased political debate around the social and legal status of LGBT people. This trend is visible in the revitalization of ALGBTIC and other

[63] Ibid.

[64] Ibid.

Fig. 3: Map of Religious Freedom Restoration Acts by State as of March 2015—the same year as Obergefell v. Hodges, and the year that 9 state ACA branches introduced ALGBTIC affiliates (Source: Human Rights Campaign)



ACA working groups dedicated to LGBT issues, and in the beginnings of state-level organization. This trend continues with the wave of marriage equality rulings and religious freedom acts in the early-to-mid 2010s, before the 2015 Obergefell v. Hodges ruling.

Professional counseling associations' sponsorship of LGBTQ working groups and affiliates appears to correlate not only with shifting political opinion, but with contention—examination of Figure 2 reveals that the states least likely to have local chapters with dedicated LGBT working groups and affiliates are those that are solidly blue or solidly red. This may partly ex-

plain why some dependably liberal states, like Massachusetts and Vermont, do not have dedicated LGBT working groups within their chapters of national professional organizations—in such solidly blue territory, LGBT mental health advocacy is perhaps more easily handled by grassroots activist organizations and dedicated government agencies—after all, contributing time and energy to a political cause (at least on the part of large professional organizations like the ACA and APA) isn't much use if the battle is already lost, or if it could be won without you. While I cannot comment directly on how this impacts the mental wellbeing of queer individuals directly, it is nevertheless important to understand that the activity of LGBT counseling associations is integrally connected with our shifting sociopolitical realities, and, as we saw in the 1970s, what is politically advantageous for LGBT advocates within professional counseling associations—or even mainstream LGBT activists—-may not be what is most beneficial for queer and trans people interacting with the mental healthcare system.

Current State of the Field

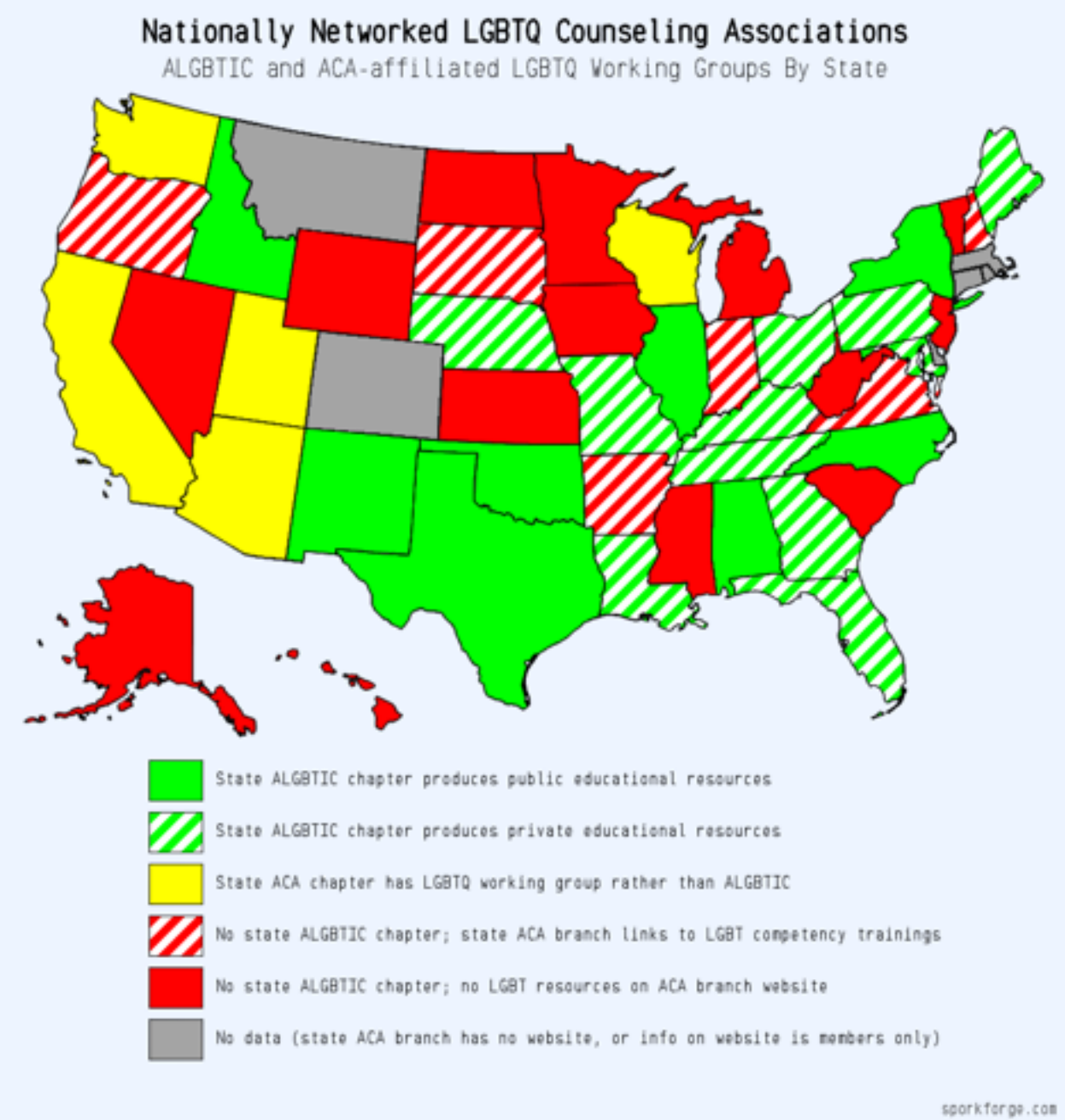
Most national counseling associations maintain LGBT working groups or affiliate organizations, as do several government agencies involved in mental healthcare policy (for a full listing of national and state organizations and their clinical competency materials, *see* Appendix II). However, the majority of state-level organizations producing clinical competency information are ultimately affiliated with the American Counseling Association—partly because the ACA organizes on a state level already. In the past two decades, state ALGBTIC chapters have proliferated rapidly. In most cases, because ALGBTIC is a division of the ACA, state ALGBTIC chap-

ters are affiliated with their local ACA chapter, and receive funding from both their state ACA branch and ALGBTIC national. In some cases, state branches of the ACA maintain LGBTQ working groups that are not affiliated with ALGBTIC; however, this is much less common. In addition, because many clinicians belong to multiple professional organizations, there is a large degree of fluidity in terms of membership between these interlinked organizations. Many ALGBTIC executives have presided over state-level LGBT working groups, local ALGBTIC chapters, and ALGBTIC national. (*See* Figure 4 on the next page. Note that the map accounts only for state chapters of national organizations—national networks with LGBT working groups headquartered in a state, but without an official state chapter.)

Clinical Competency Resources

Of states that have either a local ACA-run LGBTQ working group or a state ALGBTIC chapter, about half of them produce publicly accessible educational materials targeted at clinicians, and the rest host private educational resources that can be accessed through a member login or by joining a ACA-run listserv. Accessing these private materials usually requires a substantial annual fee (between $50-$200), and membership is only available to practicing physicians and students in a related field. For states that did not have a nationally-affiliated LGBT working group, I made a note of whether any of their state ACA chapters had LGBT working groups. In many states, obtaining locally-produced information on LGBT clinical competencies still poses an enormous challenge. Alaska, Hawaii, Nevada, North Dakota, Minnesota, Michigan, Vermont, West Virginia, and Mississippi all lack a both an LGBT working group within their ACA branch, a state ALGBTIC chapter, and their state ACA chapter provides no resources on

Fig. 4: Practitioner Resources Provided by State-Level Organizations. Organizations that provide resources for community members but not for practitioners are not considered to provide educational resources for the purpose of this study.



working with LGBT clients. Of course, these practitioners may be part of other professional organizations, such as the APA and AAMFT, but because these organizations do not break down along state lines in the same way as the ACA, the materials that they provide are typically not as

attentive to the state-level issues as other organizations with state chapters may be—for example, while the APA released a statement condemning the Tennessee Religious Freedom Restoration Act of 2016, the Tennessee chapter of the ACA released a statement explaining its significance for practitioners in the field, and its potential repercussions for persons working within the mental health industry and their clients.

Figure 4 shows the breakdown of each therapy organization in terms of whether or not they publish educational resources for practitioners. These resources may take the form of webinars, podcasts, a suggested reading list, self-produced guides, and other best practices trainings for practitioners. To be considered an educational resource, it must be intended to impart practical knowledge to a mental health practitioner—either providing background information on LGBT clients, outlining skills and therapeutic interventions, or some combination of the two. As state organizations have begun producing their own clinical competency materials, mental health professionals are able to produce better-targeted materials for their local population; however, like their national and historical counterparts, they can easily fall prey to the same sorts of omissions and covert injustices that have characterized LGBT-affirmative psychology since its inception.

"A pair of photosets I took during a hospital stay (self-portraits)."

Self Image *(upper);* Voices *(lower)*
Faye Knox (queer)

~*~

STIGMA: a mark or sign of disgrace or discredit.

MENTAL ILLNESS: disordered functioning of the mind…

…I love the definitions of stigma and mental illness. They complement each other so well, don't you think? Kind of like a cocktail, a drink made by mixing various spirits and/or fruit juices… and any hybrid mixture…and any number of different drugs used together to treat a condition. I personally like 1 part stigma to 2 parts mental illness: it has a nice little kick to it. Combine the three and well, whew, you have a real drink here. I – a person – can only be facetious about this. If I wasn't I'd be blubbering all over this keyboard.

excerpt from The Human Condition
Anonymous trans woman

Posted on *queermentalhealth.org*, 04/04/2012

CHAPTER FIVE

ANALYSIS 2: CONTENT ANALYSIS OF CLINICAL COMPETENCY MATERIALS

Overall Findings

As this excerpt from "The Human Condition" makes abundantly clear, pathology and stigma are deeply, almost inextricably intertwined. Covert moral judgments lurk beneath the surface of our supposedly empirically-based and morally agnostic psychiatric nosology. As this anonymous poet comments, being stigmatized means that your thoughts and experiences are deprived of credibility. In much the same way, she sees her autonomy and authority over her own identity stripped away by a medical system that pathologizes her gender expression. The way in which transphobia and hermeneutical injustice lurk beneath the surface in this woman's poem rings very true to the sorts of willful oversights and covert biases I found when analyzing a set of 14 national and 25 local clinical competency guides.

While I expected to see a great deal of regional variation, there were striking similarities across the board. Even guides exclusively targeted at addressing a local concern (for example, the ALGBTIC-Texas's brief to the Texas Counseling Association condemning conversion therapy and instructing counselors on how to approach the topic with their clients and coworkers) exhibited some of the same frameworks. Overall, guides focused on practical concerns for therapists on the ground, and were highly morally agnostic. Very few made appeals to the morality of LGBT identity or behavior, or even about the immorality of homophobic social systems, prefer-

ring instead to deploy language around non-pathology and statistical normality. These omissions were in their own way very productive, and in many cases helped reinforce existing systems of social control, as I will explore below.

Therapist Transformations

Clinical competency guides also function as tools of transformation of therapeutic consciousness that enable therapists to take on a tolerant, allied identity with respect to their LGBT clients. Most guides assume that the therapist is straight and cisgender, at least implicitly. Through a series of rhetorical moves, the guides describe a prototypical process of affective and practical transformation, in which the therapist emerges from an initial apprehension and lack of knowledge into a competent, tolerant, and knowledgable professional, though the process of knowledge gathering itself is more often hinted at than explicitly discussed, or in many cases may be de-emphasized in exchange for a deeper focus on the therapists' willingness to relinquish their preconceptions about LGBT people and, in the words of Skinta and Curtin, "connect with the common humanity of sexual minority clients."[65] Regardless of the clinicians actual familiarity with issues facing queer and gender non-conforming people, and with their clients' lived experiences in particular, the most crucial thing, as many guides emphasize, is "to remain open"[66] and

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[65]Mindfulness and Acceptance for Gender and Sexual Minorities: a Clinician's Guide to Fostering Compassion, Connection, and Equality Using Contextual Strategies, ed. Matthew Skinta & Aisling Curtin (Context Press, 2016).

[66] Kristopher Goodrich et al., "Group Counseling with LGBTQI Persons," interview, ACA Speaker's Profile: Kristopher Goodrich (audio blog), 2015, accessed March 23, 2017, http://www.prolibraries.com/counseling/?select=speaker&speakerID=34344.

to engage in "open dialogue with a patient about their gender identity/expression, sexual orientation, and/or sexual practices."[67]

While clinical competency texts do provide clinically useful information on issues facing (an often narrow subset of) LGBT clients, as materials produced by and for therapists, they also operate to protect the therapists' sense of themselves as tolerant neoliberal progressives, often without requiring a full transformation of affect, fully formed knowledge of systemic social issues effecting LGBT populations, or active unlearning of culturally ingrained queerphobia. An excerpt from a 2008 ACA podcast series hosted by ALGBTIC-Georgia initially primes clinicians' sense of themselves as distinct from and unfamiliar with LGBT people: "often, when we're working with queer youth…many times we feel lost," then deploys a hypothetical counselor who is likewise naïve: "say…there is a counselor…that has very little consciousness about this group at all, and there isn't a lot of advocacy in their community, they perhaps don't have friends or relatives who have come out…it's just a new thing for them, you know?"[68] In *The LGBT Casebook,* a book listed on many state sites as an essential tool for developing clinical competency with LGBT populations, Levounis et al. again invoke this shadow therapist: "for the clinician less familiar with the issues common to lesbian, gay, bisexual, and transgender (LGBT) people, a presenting patient may induce particular anxiety."[69] Once again, the queer client is presented as a source of stress for the psychologist, and the client's sexuality, rather than psychology's overwhelming heteronormativity, is at issue. The therapist's lack of knowledge, however, is

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[67] "GUIDELINES FOR CARE OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PATIENTS." Gay and Lesbian Medical Association, 2010. Reposted on American Psychiatric Association Website.

[68] "Group Counseling with LGBTQI Persons."

[69] Mary E. Barber, Jack Drescher, and Petros Levounis, The LGBT Casebook (Lesbian, Gay, Bisexual, and Transgender Casebook) (American Psychiatric Publishing, Inc, 2012), xvii.

not only forgivable, but to be expected; after all, their incipient affective transformation occurs within an epistemic space that views white heterosexuality as prototypical for both therapist and client. The therapist's initial trepidation is a psychological state which might be transformed, through a bit of effort, into an openminded and compassionate outlook on non-normative clients —clients who are, after all "just like everyone else."[70] This identification with the LGBT client facilitates the therapists' affective shift from a bewildered state to a confident and knowledgable one, often by highlighting the LGBT client's normality—as in the previous example—or their vulnerability, as in the Georgia podcast, in which Singh states that the first thing clinicians should recognize about their LGBT clients is that "this is an extremely vulnerable group of people" that "experience a pretty horrendous amount of discrimination" and whose rates of suicide are far higher than those of their heterosexual and cisgender peers. In fact, the emphasis on the normality of LGBT people themselves—and the appeal to their basic humanity—functions *as an explicit appeal to the therapists' sense of themselves as compassionate caretakers*.

One danger of such a model is that it privileges the therapists' affective transformation over the needs of the client. This approach forces the client to take on the emotional labor of educating the therapist and giving them space to work through their own hangups regarding gender and sexuality. While many guides do recommend that therapists conduct their own research, this discussion still takes place in the absence of a discussion of the relative privilege of therapist relative to client. SAMHSA and Goodrich and Luke note that many clients, especially those who have just come out, prefer to work with a counselor who also identifies as LGBT; however, these points are incidental to the narrative and never fully explored; power and authority in particular

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[70] Levounis et al. xv.

are never mentioned. From Goodrich et al.: "There's also, I mean, there are some LGBT individuals for whom it's incredibly important that their counselor--whether individual or group--is also a member of that population and so in that sense identity is significant and powerful aspect of our experience and so those, I don't necessarily have a universal answer for for everyone, I think it's something to find the right fit for the right person."[71] This incidental mention of LGBT therapists is almost an afterthought—and is the only acknowledgement by either text that therapists who are not straight and cisgender exist. The prototypical therapist remains heterosexual, implicitly coded white and male, and innocently unaware of LGBT clients, ready to achieve affective transformation through an illuminating relationship with a hypothetical LGBT client.

However, as clinical competency resources are by definition intended for use by therapists, it is hardly surprising that the thoughts and feelings of these prototypical clinicians are so central to clinical competency discourse. What is more surprising, however, is the ways in which the LGBT client serves as an object onto which the therapist can project thoughts and feelings about LGBT people. While the therapeutic model typically positions the client as a subject, and the therapist as a passive, mirror-like object onto whom the client projects and works through unresolved desires and conflicts (a process known as transference, first described by Sigmund Freud in *Studies on Hysteria*),[72] here, the object of transference is the patient, rather than the therapist. The patient's subjectivity is de-centralized, while the therapists' affective transforma-

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[71] Kristopher Goodrich et al., "Group Counseling with LGBTQI Persons," interview, ACA Speaker's Profile: Kristopher Goodrich (audio blog), 2015, , accessed March 23, 2017, http://www.prolibraries.com/counseling/?select=speaker&speakerID=34344.

[72] For a deeper discussion of transference, *see* GoodTherapy.org's article: "Transference," GoodTherapy.org, August 28, 2015, http://www.goodtherapy.org/blog/psychpedia/transference.

tion, rather than the patient's healing, becomes the driving force in the discourse around LGBT issues in therapy.

Given that clinical competency guides for working with LGBT clients largely serve as roadmaps for therapists' own affective transformations, perhaps it makes sense that so many guides assume that LGBT identity is central to the client's presenting mental health concern, and that still others encourage practitioners to follow sexuality-based lines of inquiry when working with LGBT people, despite claiming that for many people, sexuality and gender-related issues are related only tangentially to their mental health. These questions are not intended to diagnose or treat the patient; rather, they are necessary for the therapist's own countertransference and subsequent affective transformation.

Client Transformations and the Paradox of Normality

Although psychological literature has in recent years become more aware that linear models of coming out do not represent the lived realities of many LGBT clients, coming out and closet narratives remain central to discourse around sexual and gender minorities in therapy. However, the term "coming out" is itself fraught, and there is some disagreement among clinicians about what exactly is meant by the term. For the Substance Abuse and Mental Health Services Association, coming out refers to "the individual and personal process of accepting one's homosexual or bisexual orientation and transforming it from a negative to a positive attribute,"[73] while other organizations, such as the American School Counselors' Association, coming out

[73] A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals, publication, LGBTQ Working Group, Substance Abuse and Mental Health Services Association (2007).

(though never explicitly defined) seems to refer to the process of disclosing one's sexual or gender identity publicly;[74] and still others, like the *LGBT Casebook* used by Illinois and Arizona define several types of coming out: to self, to other LGBT individuals, and to society at large.[75] However, despite these inconsistencies in terminology, strong thematic commonalities emerge when examining the coming out process in the broader context of psychological models of LGBT identity development. Further, while many clinical competency guides state that coming out (however that term is understood) should not be seen as an end goal for all patients, nearly all center discourses around ways that therapists can facilitate clients' coming out.

First and foremost, sexual identity is seen as an absolute; while people may initially be confused about their sexual identity, and may even move between several identities while undergoing a transformation of attitude toward one's same-sex desires, the patient's "true" sexual orientation is seen as static; SAMHSA and Levounis, for instance, mentions that some individuals may identify as bisexual as a stepping stone before coming out as gay or lesbian.[76] Furthermore, certainty and stability of one's LGBT identity is explicitly linked to a positive affective transformation: "the coming out process transforms a negative self-identity into a positive one,"[77] while the closeted state is characterized as one of deep denial, negative self-attribution, and unhappiness.[78] Though many clinical competency guides urge therapists that asserting forcing a client to come to terms with their identity before they are ready is rarely helpful (which sounds reasonable

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[74] ASCA guide.

[75] Levounis et al.

[76] SAMHSA 2007.

[77] Ibid.

[78] Levounis et al.; Christopher R. Martell, Steven A. Safren, and Stacey Ellen Prince, Cognitive-behavioral therapies with lesbian, gay, and bisexual clients (New York: The Guilford Press, 2004); APA Guidelines for Psychological Practice With Gay, Lesbian, and Bisexual Clients (2011).

enough), the implication is that one cannot have a healthy relationship with one's sexuality or gender without following a coming out process that (while potentially influenced by a variety of factors such as age, ethnicity, religion, and cultural background) almost inevitably ends with the client accepting their own identity. The further, more subtle assumption is that the therapist, who must "assess the client's stage of coming out," and be careful not to force a client into identifying as LGBT[79] before they are ready, is positioned as the ultimate authority on a client's sexual identity.

Necessary to this attitudinal shift is the reformation of queer identity development as a process of grief. Melissa Luke describes the tangible and intangible losses facing LGBT people who come out—both the potential and actual loss of familial and peer relationships, and the client's grieving for a lost, heterosexual fantasy self, or what she terms "the loss of what might have been."[80] This conceptualization of coming out as a process of grief and catharsis is reflected in the Cass model of homosexual identity development, a paradigm developed by Vivienne Cass based on studies of gay and lesbian Australians in the late seventies. Cass's paradigm is cited in guides authored by SAMHSA, Skinta and Curtin, Martell et al., and AGLBTIC national, the Tennessee LGBTQ working group, ALGBTIC-Texas, the California Association of Marriage and Family Therapists Working Group, ALGBTIC-Iowa, and the Texas Counseling Association. The Cass model, like many staged models of LGBT identity development, bears a eerie resemblance to the Kübler-Ross model of grief: in each, the participants progress through a finite series of affective and attitudinal stages, characterized by a dependable set of behaviors, in a semi-sequen-

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[79] The SAMHSA guides are intended for use with all LGBT clients, but their language frequently focuses on lesbian, gay, and bisexual clients to the exclusion of transgender clients. I decided to retain the original wording of the SAMHSA guides, but note this discrepancy, in order to present the guide as accurately as possible.

[80] "Group Counseling with LGBTQI Persons."

tial order (most modern theorists agree that clients may pass through stages non-linearly, may skip some stages, and may linger in some stages longer than others) until finally reaching a cohesive end state. Perhaps the best example of the type of affective transformation negotiated in these staged models is articulated by Levounis et al. (2012), based upon the work of Jack Drescher (the text's second author): "[coming out] involves recapturing disavowed experiences through a continuing process of linguistic coding that gives previously unacceptable feelings new meanings."[81]

The Cass model makes explicit the connection between certainty, fixed identity, and a fully integrated sense of self. In the first stage of the Cass model, Identity Comparison, individuals begin to question their same sex attractions, experience "painful feelings, such as anxiety and shame," and may employ a variety of coping mechanisms to block unwanted same-sex attraction or non-normative gender identification.[82] From there, LGBT persons enter the identity comparison stage, in which they consider the possibility that they may not be straight/cisgender, but this identification is still a source of intense emotional pain; in the identity tolerance stage, LGBT persons begin to have greater commitment to LGBT identity and may seek out other LGBT people, but may waver in terms of their preferred label (some guides, such as SAMHSA, reiterate here that lesbian and gay individuals in this stage may identify as gay; ASCA references transgender students who first identify as gay males or drag queens); in the euphoric identity acceptance stage and embittered identity pride stage, LGBT persons become more aware of the divides between LGBT persons and mainstream society; finally, in the identity synthesis stage, LGBT

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[81] Levounis et al. 13.

[82] SAMHSA 2007.

identity becomes less central and more fully integrated into consciousness and LGBT persons become aware that the us/them dichotomy between LGBT and straight/cisgender persons is not valid.[83] Levounis et al.'s updated model follows a similar paradigm, citing the following developmental milestones: feeling different, experiencing same sex attractions, questioning assumed heterosexuality, same-sex behavior, self-identification, disclosure, romantic relationships, and self-acceptance and synthesis.[84] While Levounis et al. preface this model with a reminder that "such linear and idealized portraits are not empirically substantiated,"[85] the order in which they are presented is telling. In many ways, this updated model (cited by no less than the APA Guidelines for Practice with LGBT Youth—many of the clinical competency resources cross-reference each other) is more conservative than Cass's 1979 model; it situates a fully formed LGBT identity not only as a non-salient, "synthesized" identity, but also within the context of a romantic relationship, situating monogamy as a precursor to self-acceptance and psychological integration.[86]

In the staged models of coming out preferred by a majority of guides, coming out is seen the inevitable end goal of a potentially very messy journey of grief and catharsis. Furthermore, anger toward mainstream, heteronormative society, as well as "aggressive"[87] feelings of pride or over-identification with LGBT peers, are viewed as pathological—less highly developed LGBT identities. Necessary for the adoption of a fully formed, adult homosexuality or transgender identity is the ability to adapt to mainstream society, while combative and anti-assimilationist behav-

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[83] SAMHSA 2007.

[84] Levounis et al. 18-27.

[85] Ibid 19.

[86] Ibid. 26-27.

[87] SAMHSA 2007. (Yes, it does really refer to intense feelings of LGBT Pride as "aggressive.")

iors are to be considered immature, transitional identities. (The importance of the historical context in which Cass's guide was created—in 1979, at the tail end of Gay Liberation and the same year that 100,000 people marched on Washington for Lesbian and Gay Rights[88]—cannot be understated here). Singh (ALGBTIC-Georgia, 2008) goes even farther than Cass, Drescher, and Levounis and explicitly links static, culturally coherent identity to development, stating that for many LGBT people, their gender or sexual development may not match their chronological age. Through this, Singh elucidates, albeit unintentionally, one of the most profound dangers of a staged-developmental framework of LGBT identity development—this model views queer genders and sexualities, especially those that explicitly question an identitarian, Westernized, and binary model of queerness, as developmentally delayed, a discursive move that not only pathologizes queerness but opens those who are questioning their sexuality (or those whose sexuality and/or gender are not readily understandable to the practitioner) to condescension and ableism. By positing that a queer person's 50 years of experience with their gender and sexuality are somehow different from a cisgender straight person's, and therefore less developmentally mature, she positions queer patients in an inescapable hermeneutical trap, in which their experiences of gender will never been seen as as advanced, as valid, or as reliable as a straight and cisgender person's, despite queer of color critiques that suggest that it is in fact white, straight and cisgender persons—those whose gender and sexuality have always been accepted and unquestioned by those around them—who may in fact have a less highly developed relationship with their gender and sexuality, simply because it is never something they have much cause to think about or question.

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[88] mallhistory.org (Though Vivienne Cass was Australian, the Gay Liberation movement in the mid-70s in Australia largely paralleled US-based Gay Lib.— https://collections.museumvictoria.com.au/articles/2832).

The medicalization of the coming-out process becomes even more violent when applied to trans populations. Because access to trans-related health care often rests upon medical practitioners' capacity to read them as "authentically" trans, the types of psychodevelopmental gatekeeping, in which practitioners act as gatekeepers to fully formed, mature LGBT consciousness, become even more explicit. The WPATH model of mental healthcare, endorsed by the American Psychiatric Association and the American Psychological Association, requires assessment of the patient's gender and relationship to gender, regardless of the patient's presenting mental health concern.[89] Several trans guides, including WPATH and ASCA,[90] mention that one should always be very clear with children who identify as trans that there is a "way back"—that changes to gender, outside of surgical intervention, are always reversible. Thus, transgender children must continually assert and defend their gender at every step of the transition process, regardless of whether the mental health treatment that they seek is even related to their trans identity. One can see how this would be particularly violent for trans youth who do not identify with a gender easily understood by cisgender practitioners—that is, patients whose gender identity fits easily within a binary, Western construction of gender; youth who are white or white passing; heterosexual; and whose gender expression aligns closely with their gender identity. This all further assumes that these concepts have some degree of validity for this hypothetical patient at all (see b. binaohan).

The pathologization of LGBT identification has very real treatment applications for practitioners working with sexual and gender minority clients. In Skinta and Curtin's *Mindfulness*

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[89] WPATH 2011.

[90] ASCA 2015; ASCA blog.

and Acceptance for Gender and Sexual Minorities, an introductory mindfulness meditation encourages sexual minorities to let their experiences of stigma and discrimination, and the saliency of their minority identities, fade into the background:

> Shift the spotlight of your attention to acknowledge times when you've felt invalidated or stigmatized for being a sexual minority…allow yourself to notice the unwanted emotion this brings up.
>
> And now broaden your awareness to acknowledge other sexual minorities who have felt similar invalidation and stigmatization, acknowledging a thread of common humanity that runs between you. The aim of this part of the exercise is not to minimize your pain in any way, but rather to acknowledge that others also know and share the pain of your experience.
>
> Now, broadening out once more, acknowledge the wider community of humanity across all sexual orientations. Do they also know something of being invalidated and victimized? Of course, their story lines might be different than yours. The things they've been invalidated or stigmatized about may be different, yet is there something in their underlying values and vulnerabilities that you can relate to? As best you can, see if you can acknowledge a thread of common humanity that links us all, regardless of sexual orientation, gender identity, race, color, or nationality. Again, the aim is not to minimize your pain in any way. The aim is to situate you, here and now, within the context of the world at large—a place where the vast majority of people know the pain of not being accepted by others.[91]

This meditation, which aims to move LGBT persons into the final, identity synthesis stage of Cass's model, in which LGBT identity, now fully integrated into one's sense of self, can lose salience and fade into the background, is premised on the idea that LGBT persons, in order to be psychologically healthy, must cultivate sympathy for their oppressors. While the authors are careful to note that the exercise is not meant to minimize the patient's trauma,[92] their careful word choice—replacing terms such as "discrimination" and "oppression" with "invalidation" and

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[91] Matthew Skinta and Aisling Curtin, Mindfulness and Acceptance for Gender and Sexual Minorities: a Clinician's Guide to Fostering Compassion, Connection, and Equality Using Contextual Strategies (Context Press, 2016), 23-24.

[92] Skinta and Curtin, 23.

"victimization," and then "victimization" with "pain,"—*is* intended to minimize their experience as uniquely oppressed persons within a heteronormative and queerantagonistic culture.

Becoming "just like everybody else" does not require one to become heterosexual, and does not even require one to repress their experience of trauma, per se—it merely requires that one repress one's experience of queerantagonism; a fully developed LGBT consciousness is one that views traumatic experiences as incidental and unconnected to larger power structures. To threaten the status quo is to be pathological; to sympathize with one's oppressor and erase one's experiences of queerness as an axis of oppression is to become a fully integrated, normative, and psychologically healthy individual. It is no coincidence of language that to fully "integrate" one's LGBT identity into consciousness, one must also integrate into heteronormative society, and erase the parts of oneself—one's sense of injustice—that threaten the status quo. Only the immature remain angry.

This sort of testimonial quieting posits that individuals with a fluid sexual identity are developmentally delayed (with all the ableist baggage that term entails), and removes their agency as knowers from the equation, at least until such a time as they can travel further down the culturally sanctioned path of coming-out. SAHMSA's guide places LGBT addicts in a psychological bind, in which coming out "is especially important to LGBT people trying to recover from substance abuse, for whom feeling positive about themselves is important to their recovery," but that LGBT people "with a long substance abuse history may have difficulty attaining this [the final] level of synthesis" within the Cass model.[93] Here, the therapist is posited as the authority on the patient's coming out experience, (and is even seen as the ultimate authori-

[93] SAMHSA 2007.

ty over "gays and lesbians" who "choose not to come out," despite their sexual experiences with people of the same gender), and further implies that coming out may require a clean bill of psychological health, and that the sexualities and genders of *all* addicts may be to some extent up for debate.[94]

This paradox may seem initially confusing—if one is to correctly understand SAMHSA, queer addicts, because their sense of self is impacted by their substance use, do not have access to a fully developed (and therefore psychologically sound) LGBT identity. By extension, LGBT persons who have any mental health condition that affects their sense of self (and you'd be hard pressed to find a psychological diagnosis that *doesn't* in some way impact one's sense of self) are *all* cut off from access to a fully formed LGBT identity. This paradox of normality links directly to the standard set by the APA in 1973 that when homosexuality was first depathologized: "homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities," and that "no burden of proof of such judgment, capacity, or reliability shall be placed on these individuals greater than imposed on any other persons." This statement, which has been echoed in the APA's Policy Statement on Gay and Lesbian Teachers (1981); in their Policy Statement on LGB individuals in the military (2005); and in their Guidelines for Practice With Gay, Lesbian, and Bisexual Clients (2002, 2012).[95] This "burden of proof" model is dangerous because, to state the obvious, it still requires a burden of proof. That is, it does not instruct practitioners *not* to question whether their patient is reliable, only that they question

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[94] SAMHSA 2007.

[95] APA Guidelines for Practice with Lesbian, Gay, and Bisexual Clients (2002; 2012); APA Policy Statement on Gay and Lesbian Teachers (1981); APA Policy Statement on LGBT Persons in the Military (2005).

them *only as much* as a straight person—a rhetorical move explicitly determines a queer patient's credibility based on their proximity to straightness.

The slippage from a patient's lack of desire (or ability) to conform to an idealized, homonormative model to their mental instability and pathology is such that guides frequently have to include caveats asserting that this is not, in fact, the case (at least, not this time). Martel et al., for example, take great pains to remind the reader that Amelia, a promiscuous bisexual woman, "did have an unstable sense of self, but this was indicated not by her bisexuality, but by the persistent belief that she would "cease to exist" without a meaningful love relationship."[96] When combined with an earlier argument that practitioners (implicitly or explicitly) code queer genders and sexualities as "less developed" than those of cisgender and straight peers with the same chronological age, the burden of proof argument provides a logical escape route for practitioners who argue that it is not LGBT identity per se that makes them unreliable, with unstable senses of self—it is a patient's mental illness that makes them unreliable, a mental illness that renders their non-normativity pathological and incomprehensible. Since presumably most LGBT persons entering therapy are to some extent grappling with mental illness—and since experiencing queerantagonism in itself can be quite traumatic[97]—this argument in reality perpetuates systemic testimonial silencing of *all queer patients,* especially the most marginalized within the LGBT community. The APA's claim that queer persons represent "normal and positive variations" of human sexuality cements the APA's position on LGBT clients in an appeal to normality—an appeal to normality which by its very nature necessitates the erasure of less-normative queer people, and are par-

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[96] Martel et al. 177.

[97] D Szymanski, S Kashubeck-West, & J Meyer (2008a), Internalized heterosexism: A historical and theoretical overview, *The Counseling Psychologist, 36,* 510–524.

ticularly violent to queer and trans people of color and money-poor, undocumented, disabled, non-monogamous queer people, and other queer people who are further marginalized.

Empiricism and Willful Forgetting

Perhaps the clearest danger of the type of amoral arguments allowed by an emphasis on empiricism and scientific objectivity is in the discourse within counseling organizations around conversion therapy. Within the mental healthcare system, the official term for ex-LGBT therapy is SOCE, short for "Sexual Orientation Change Efforts," a benign sounding term that masks the reality of conversion therapy: that is, that vulnerable LGBT persons are tortured in what often amounts to sexual abuse (i.e. the pairing of sexual stimuli and shock or medications that induce illness or vomiting)—scenes that sound more as though they belong in outtakes from *A Clockwork Orange* than in therapeutic practice. However, it is not the use of therapeutic practices that are often cruel and unusual that, according to the APA, make conversion therapy "controversial"—it is the "tensions between the values held by some faith based organizations, on the one hand, and those held by lesbian, gay, and bisexual rights organizations and professional and scientific organizations, on the other."

In keeping with many practitioners who oppose legislation banning conversion therapy on the grounds that it would be an imposition on the best judgment of clients (or the free will of the client) while maintaining some degree of moral agnosticism about conversion therapy itself, the APA does not take a moral stand for or against conversion therapy per se, choosing to rely on APA regulations against fraud, rather than the harm principle: "The ethics, efficacy, benefits, and

potential for harm of therapies that seek to reduce or eliminate same-gender sexual orientation are under extensive debate in the professional literature and the popular media," and while "psychology, as a science, and various faith traditions, as theological traditions, can acknowledge and respect their profoundly different methodological and philosophical viewpoints," the APA "must rely on proven methods of scientific inquiry based on empirical data" in making a decision about conversion therapy.

This limits discourse to empirical research; there is nothing immoral about therapists encouraging "change efforts" per se; and the language itself cloaks the violent nature of these therapies. The APA frames SOCE prohibitions in terms of fraud, not acceptance of queer and trans people or even opposition to prejudice.[98] The harms are proven though. In the first APA guide released in 2001 around LGBT psychotherapy, the guide contained guidelines on how to properly care for patients traumatized by conversion therapy—although it would not be until nine years later, in 2010, when the APA released an explicit condemnation of conversion therapy. They still have not stated that conversion therapy is morally wrong—merely that it is not proven to be efficacious—an argument that is doubly dangerous not only in its reluctance to challenge homophobia within its own ranks, but by its use of language that implies that conversion therapy might be acceptable therapeutic practice *if it were empirically proven;* the problem is that under some circumstances, conversion therapy actually does inhibit same-gender sexual behavior, which the APA admits in its own condemnation of conversion therapy: claiming that "while sexual orientation (i.e. erotic attractions and sexual arousal oriented to one sex or the other, or both) was unlikely to change…some individuals appeared to learn how to ignore or limit their attraction."

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[98] APA Policy Statements on LGBT Individuals.

Meanwhile, despite describing particular challenges that may present in therapy with patients who were traumatized by conversion therapy in their Guidelines for Practice With LGBT Patients, their SOCE white pages claim that "sound data on the safety of SOCE are extremely limited," although they concede that "some individuals reported being harmed by SOCE."[99]

In most cases, the potential harms of an exclusively (or near-exclusively) empirical model of LGBT mental health are far more insidious. However, an exclusive reliance on data-driven treatment methods—which, because of their basis in clinical research that often caters to wealthy white LGB people to the exclusion of queer and trans people of color—can often veil practices that serve the status quo more than they serve LGBT clients at large. Therapists are encouraged to learn to talk the talk—in other words, to learn the vocabulary around certain social and legal issues while lived experience is decentralized. GLMA, for instance, recommends that practitioners "post a rainbow flag, pink triangle, unisex bathroom signs, or other LGBT-friendly symbols or stickers"[100] in their offices to create a welcoming environment; similarly, the American School Counselors' Association recommends that school counselors prominently display queer-friendly imagery,[101] while the APA guidelines encourage practitioners to become familiar with gay subculture and deploy this vocabulary while working with LGBT people.[102]

While certainly creating a visibly welcoming environment and using terminology consistent with a patient's preferences can be an important part of establishing rapport with a client (all clinical competency guides, remember, are grounded in empirical research), they do not require

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[99] APA Policy Statement on Conversion Therapy, 2010.

[100] GLMA guide.

[101] ASCA 2015.

[102] APA Guidelines for Practice With Lesbian, Gay, and Bisexual Clients (2016).

the practitioner to shift their perception of the world in any significant way. Of course, this trend is not exclusive to counseling with LGBT persons—Levitt et al. (2006) recommends that practitioners attempt to mirror their patients' language choices and interests in order to build rapport with clients on a moment to moment basis[103]—but this approach comes across as particularly insufficient when considering the power relations involved, a concern which is largely glossed over by psychological literature around clinician/client similarity, and becomes even more problematic when one considers that many patients face multiple axes of oppression, and the power differential—and, therefore, the epistemic gap—between these clients and their counselor may loom very large indeed.

The crux of the issue is that these superficial methods, while empirically sound, make only a superficial attempt to bridge the epistemic gap between doctor and patient. Rather this approach minimizes only the *perception* of a gap, which may limit testimonial smothering (the tendency of the LGBT person to truncate their own testimony to include only parts they believe the practitioner will understand), but still allows for a good deal of epistemic violence. Here, we see again that an empirically valid approach—marketing oneself as LGBT-friendly does indeed make LGBT persons more willing to believe that one actually is LGBT-friendly,[104] and may even improve client outcomes—is deployed to obscure the impact of power relations on the patient/therapist dyad, and obscuring the fact that creating truly anti-heteronormative (not merely LGBT-inclusive or LGBT-affirming) therapy would require deep structural changes not just to clinical procedures but to existing models of the therapist/patient dyad.

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[103] Heidi Levitt, Mike Butler, and Travis Hill, "What Clients Find Helpful in Psychotherapy: Developing Principles for Facilitating Moment-to-Moment Change.," Journal of Counseling Psychology 53, no. 3 (Fall 2006): , accessed May 18, 2017, doi:10.1037/0022-0167.53.3.314.

[104] GLMA 2004.

If most mental health practitioners are aware of the long and troubled history of homophobia in the field of psychology, one would not know it from reading clinical competency guides. Guides that take the longest view begin with Alfred Kinsey and Evelyn Hooker, both of whom helped to demystify and depathologize homosexuality, to the exclusion of their contemporaries, who did the opposite. The vast majority of guides however, begin with the 1973 declaration by the APA that "homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities," starting the history of the APA's relationship to queer clients at the precise moment that they became the "good guys" in the narrative—a move that is most often made with no discussion of the social context in which this decision was made (except, perhaps, a passing mention of Gay Liberation.)

Of course, for practitioners on the ground working with LGBT patients, a working knowledge of how medical and psychological discourse on human sexuality has evolved over time does not directly contribute to the hard skills required to understand their patients issues in the same way as, say, a working knowledge of current insurance codes that will allow a transgender patient access to hormone therapy, or awareness of the potential legal repercussions for a bisexual woman who is unsure whether she should come out to her boss.

However, what is lost by this ahistorical perspective is an understanding of how and why current models of psychosexual development have developed and prevailed. Let us return briefly to our discussion of Vivienne Cass, a psychologist working with gay and lesbian Australians in the late 70s. Does it make a difference to consider that these studies took place as gay and lesbian activists themselves centered coming out in their narratives of self, and at a time when an emerging gay rights movement, more concerned than its predecessors with respectability politics,

sought to divide queers who could blend into normative society from those that could not?[105] Or, consider the fact that Gender Identity Disorder, which has since been replaced by the slightly more palatable Gender Dysphoria, was added the same year as the 1973 statement that homosexuality was not a mental disorder—shifting the lines of normativity, but ultimately still ensuring that the DSM continued to function as a tool to pathologize and diagnose difference. The production and naturalization of our current sexual/gender system—the one supported by most LGBT-affirmative therapists and accepted as natural and logical by much of the general public, many queer people included—was explicitly created and institutionalized to shift the focus of socio-medical control of queer bodies from private expressions of sexuality to public expressions of gender.[106] Whitenormative gay men became non-pathological explicitly and intentionally at the expense of queer and trans people of color. This ahistorical perspective is willful and productive; it allows practitioners to operate blind—some with more intentionality than others than others—to the coding of queerness, brownness, and gender variance as pathological, further weaponizing scientific research on sexuality through the intentional forgetting of the social context that produced it.

Tying it all Together

An analysis of clinical competency materials reveals the ways in which current psychomedical discourse on queerness serves a dual purpose—to be overtly tolerant, and to covertly

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[105] "Gay Liberation Movement," Museums Victoria Collections, accessed May 18, 2017, https://collections.museumvictoria.com.au/articles/2832.

[106] Valentine 54-56.

maintain social control over certain kinds of queer bodies. As distillations of empirical best practices research that often privileges the perspective of the counselor over the patient, clinical competencies are somewhat paternalistic. Their recommendations are based what therapists believe works best for their clients, rather than the clients' self-determination (and, as distillations of clinical research, they can only draw data from a subset of queer people that have access to therapy.) They also function as tools of transformation of therapeutic consciousness that enable therapists to take on a tolerant, allied identity with respect to their LGBT clients, often without requiring a full transformation of affect or unlearning of culturally ingrained (and scientifically ingrained) queerphobia. Practitioners act as gatekeepers to "developed" LGBT consciousness, with an emphasis on the patient moving from a closeted, anxious, dystonic state to an empowered, open, out state. Scientific objectivity allows the therapist to perpetuate certain systems of power and knowledge control while an ahistorical perspective on psychological treatment of human sexuality allows this scientific objectivity to become further weaponized, as it further obscures the origins of covert pathologization of queerness and gender non-conformity within the DSM. Combined, these factors lead to the unsettling conclusion that even LGBT-affirmative therapy perpetuates and shapes epistemically violent knowledge systems that disproportionately target queer and trans people of color for social control.

CHAPTER 6

CONCLUSION

The official de-pathologization of homosexuality by the American Psychiatric Association in 1973 and American Counseling Association in 1975 kicked off a wave of organizing and advocacy by LGBT practitioners within mainstream professional counseling associations. However, since their creation, these organizations have been dependent on the shifting politics and financial constraints of their parent organizations, with interest in maintaining close ties with LGBT working groups waning and waxing with the tide of political interest in the welfare of LGBT people. While initially operating somewhat independently of their parent organizations (both financially and organizationally), LGBT working groups have increasingly become integrated into large, mainstream professional associations, allowing them access to greater funding and institutional support, but decreasing their agency and narrowing their political impact.

Given their position within hegemonic counseling organizations, it is perhaps not surprising that their ability to critique these same structures and reevaluate longstanding therapeutic practices is somewhat restricted. These LGBT organizations and working groups fail LGBT patients by advocating surface-level changes without questioning the systemic violence hidden within longstanding psychological conventions. At times, such basic scientific protocols as empiricism can be weaponized against LGBT persons. Clinical competency resources, as distillations of empirical best practices research, often fail to speak to the experiences of the most mar-

ginalized members of queer and trans community, especially QTPOC, indigenous people, people of low socioeconomic classes, and those with multiple marginalized identities. Because these groups face large healthcare disparities and are often uninsured or underinsured, they are less likely than more privileged LGBT people to gain access to therapy, and thus are sidelined from research on LGBT people. Thus, only the most privileged LGBT people—typically highly educated and white—have access to the system of psychological knowledge production, one which, for the most part, attempts to incorporate LGBT persons into existing models of human development, and thus preferentially caters to LGBT persons who are the closest proxy for straight white affluent persons. Scientific objectivity allows counseling as a discipline to perpetuate certain systems of power and knowledge control, while an ahistorical perspective on psychological treatment of human sexuality allows this scientific objectivity to become further weaponized, as it obscures the origins of covert pathologization of queerness and gender non-conformity within the DSM.

As tools produced by and for therapists, clinical competency guides cater to the subjectivity of the practitioner. They are designed to enable practitioners to take on a tolerant, allied identity with respect to their LGBT clients, often without requiring a full transformation of affect or unlearning of culturally and scientifically ingrained queerphobia. By privileging the therapist's affective transformation over the emotional growth of the client, the current models of LGBT therapy consistently fail to center the patient in its portrayal of an effective patient/practitioner dyad. Further, practitioners act as gatekeepers to "developed" LGBT consciousness, with an emphasis on the patient moving from a closeted, anxious, dystonic state to an empowered, open, out state. LGBT patients, especially those who are closeted, questioning, or sexually fluid, are con-

sidered to be in an infantile state, from which only the most privileged and mentally healthy individuals are able to effectively assert their autonomy and credibility. The sexualities and genders of mentally ill persons are particularly suspect—a finding which is particularly concerning given that most people who seek treatment for a mental health concern do so because they are *not* in perfect mental health. But a queer person need not actually have a mental illness to be perceived as pathological. Within current models of LGBT development, achieving a fully integrated, mature LGBT identity necessitates a "letting go" of one's experience as an oppressed person within a heteronormative and queerantagonistic culture, further pathologizing alternative modes of conceptualizing queer empowerment and self-identification.

Current clinical models delineate a new classification system for pathological and non-pathological queer identities and modes of being. While they may provide guidelines for care that benefit some LBGT patients, they represent further iterations of a medico-legal model that shapes and preserves the status quo. Reconceptualizing LGBT-affirmative therapy is not easy—in many ways, it requires a radical upheaval of the scientific system of knowledge production itself, within a discipline that is still recovering from its very unscientific (and still profoundly racist, sexist, and homophobic) past. A truly queer-centered therapy would not look to queer patients as exceptions to the norm, or as variations of human nature that must be worked into existing theories of human development. Rather, psychological theory must look to marginalized peoples as effective authorities on their own experience, and center these voices in the creation of new theories that properly account for the role of the medicolegal system itself in the institutionalized violence perpetrated against these populations. Educational resources for counselors, too, must center the voices of marginalized peoples. Therapy, a space designed for emotional

healing, cannot be yet another space where marginalized peoples are forced to expend emotional labor in educating and defending their lived experiences to practitioners who are not prepared to work with them. Further, effective queer counseling must accept that the mental healthcare system has historically operated as an agent of social control that has exacted state-sanctioned violence against those it deemed pathological—namely, those it deemed too Black, too brown, too queer, and too female.

Lastly, queer-centered counseling is useless to queer people if they cannot access it. Hundreds of thousands of people are turned away by therapists every year because they lack health insurance or their insurance does not adequately cover mental healthcare. Even more are denied care because no therapists in their area accept their insurance, because they cannot afford co-pays, because they are undocumented, or because patients with white-sounding names are far more likely to get a call back from a counselor than patients with Black or Hispanic-sounding names. Still others cannot access therapy because the long hours they work at low-wage jobs do not afford them enough time to access care. While I did not focus on these populations in my thesis, it is important to note that queer-centered therapy will not be complete without structural changes that make healthcare truly accessible to all people. A true queer-centered mental healthcare system must account for epistemic injustice within its own body of work, *and* address systemic injustices that have ensured that mental healthcare remains out of reach for many who are in desperate need of compassionate care.

Until we are able to create a mental healthcare system that is truly queer-inclusive—one in which all queer people have access to a qualified, competent practitioner whose practice is grounded in psychological literature that centers the voices of marginalized people—only the

most privileged LGBT people will ever represent the “normal and positive variations” delineated by the APA in their *Guidelines For Practice with LGBT Clients*. Until then, the token inclusion of these select few will continue to obscure the ongoing oppression of those deemed too Black, too brown, too queer, too poor, too sick, and too radical to be sane.

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