CHAPTER SAMPLER

# LGBTQ+ Mental Health

## A Chapter Sampler for Mental Health Professionals

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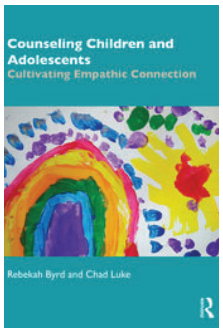
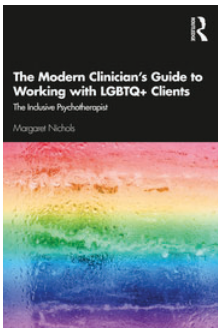
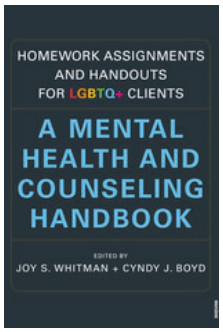
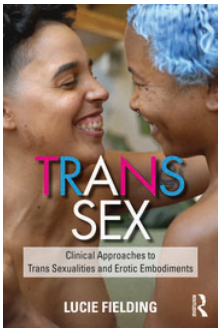
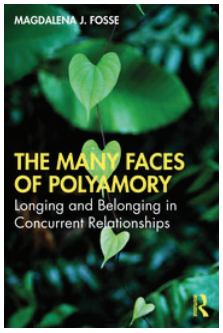
# Contents

# 1

# A CONTEXTUAL BEHAVIORAL ANALYSIS OF MINORITY STRESS

## Introduction

Minority stress theory has become one of the central lenses used to research psychological experiences of SGM populations (e.g., Graham et al., 2011). Minority stress theory began with the premise that anti-LGBTQ+ animus in society is ubiquitous and affects the well-being of SGM people in a variety of ways. No single measure, such as direct discrimination or internalized stigma (i.e., internalized homophobia, internalized biphobia, internalized transphobia), can capture the full impact of living in a biased society (Meyer, 1995). These factors are generally described as proximal to distal, and the list includes internalized stigma, rejection sensitivity, or the expectation of rejection, outness or concealment, discrimination or violence, and specific to gender minority individuals, being misgendered (e.g., referred to by an incorrect name or with incorrect pronouns; Hendricks & Testa, 2012; Meyer, 2003). More recent formulations include resilience factors, as

well, such as community connectedness and, for gender minority individuals, pride (Hendricks & Testa, 2012; Meyer, 2015). Minority stress theory provides a starting point for case conceptualization and transdiagnostic assessment, and this chapter will explore how developing a minority stress informed treatment plan can be supported through a consideration of process-based therapy and a functional contextual approach.

## The path to minority stress theory

In the first decades after the declassification of homosexuality from the DSM, most publications describing the sexual minority experience emphasized internalized stigma (i.e., internalized homophobia; e.g., Malyon, 1982). While a useful starting point as the field began to acknowledge the deleterious effects of pervasive anti-SGM bias in society, there were a number of shortcomings to this approach. First, the interpersonal and societal challenges facing SGM people were not contingent on resolving negative beliefs one was exposed to earlier in life. Familial rejection, social exclusion, and workplace discrimination all had harmful impacts, and it has been less than 20 years since the U.S. Supreme Court overturned the last sodomy laws that criminalized same-sex sexuality (for a broader discussion, see Eskridge, 2008).

This changed with the popularity of minority stress theory (Meyer, 1995). First described in *Minority Stress and Lesbian Women* in 1981 (Brooks, 1981), it was not widely adopted until subsequent promotion in the works of Ilan Meyer (1995; 2003). Based upon Brooks's grounding in systems theory, Brooks considered minority stress to be the biopsychosocial outcome of culturally sanctioned bias against SGM individuals, conveyed through both systemic bias as well as interpersonal interactions informed by anti-SGM animus (Rich et al., 2020). SGM individuals respond to the stress of living in a biased society in a number of ways, and minority stress theory offered enough flexibility to begin making sense of responses that ranged from anxiety to depression, substance use to sexual compulsivity (e.g., Lipson et al., 2019; Kerridge et al., 2017). Though initially minority stress research centered the experiences of and primarily included sexual minority individuals, the model was extended and refined to be inclusive of gender minority experiences (e.g., Testa et al., 2017).

The component parts of minority stress are internalized stigma, rejection sensitivity (or the expectation of stigma), concealment, discrimination, and violence, and in the case of gender minority stress, misgendering (Hendricks & Testa, 2012; Meyer, 2003). As noted in the introduction, it cannot be emphasized enough that minority stress is the response of SGM individuals to societal bias, and not a shortcoming of individuals (Meyer, 2019). In some cases, these may be adaptive responses to hostile environments. For example, concealment acts as a stressor, though may be an accurate response to a local context high in discrimination (Pachankis et al., 2015). Rejection sensitivity, which includes both interpersonal guardedness as well as a cognitive bias toward perceiving ambiguous responses as rejection or interpersonal submissiveness, may reduce unwanted attention in an environment in which safety is unclear (Pachankis et al., 2008). It must not be forgotten that targeting minority stress factors in psychotherapy is a means of healing individuals in societies that have not yet wholly embraced SGM people, and is not intended to supplant continued efforts to change society in ways that would allow SGM individuals to thrive (Meyer, 2019).

Research over the past decade has highlighted two major expansions of minority stress theory. First, most recent work incorporates a recognition of SGM-specific resilience factors into the model, as they mitigate the impact of bias in society (Meyer, 2015). Second, a series of studies has led to an emphasis on mediating psychological processes, with emotion dysregulation receiving the greatest attention (Hatzenbuehler, 2009). That is, the cumulative impact of minority stressors appears to diminish one's capacity for emotion regulation, which in turn increases the likelihood, varying by context, that an individual will experience adverse psychological and medical outcomes. This expanded model includes some elements not commonly listed though supported in the literature, such as experiential avoidance and shame as additional mediators, and self-compassion as a possible resilience factor (Figure 1.1; Gold et al., 2011; Leleux-Labarge et al., 2015; Mereish & Poteat, 2015; Vigna et al., 2018).

This model is incomplete, however. For SGM individuals with intersectional identities, one's lived experience is not simply minority stress plus racism, sexism, or xenophobia (Bowleg, 2008). While there have been fledgling attempts to measure intersectional stressors, such as the

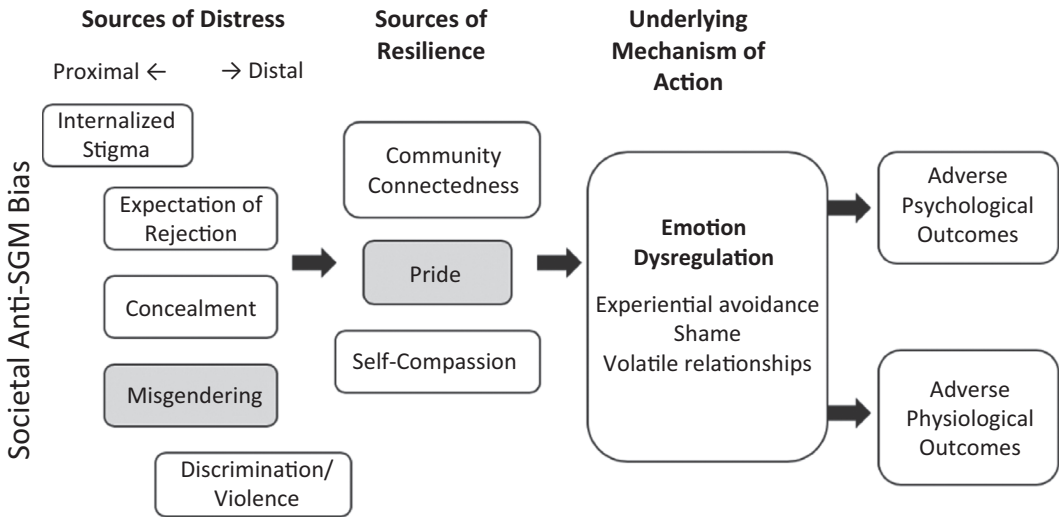



*Figure 1.1* Minority stress model with proposed resilience factors and mechanism of action. Gender minority-specific factors are shaded.

presence of racism within SGM community spaces and anti-SGM bias with a community of color, it has been more challenging to identify ways to measure or assess responses to an individual as a whole person (e.g., Balsam et al., 2011). One example can be found in the growing literature on sexual racism, which appears to be an expression of covert racism (Callander et al., 2015). Sexual racism encapsulates those attitudes and expressions of attraction that either exclude or fetishize a person of color in SGM spaces, and serve as their own unique stressor (Han & Choi, 2018). Sexual racism among sexual minority men has been associated with higher body dissatisfaction (Bhambhani et al., 2019) and psychological distress (Bhambhani et al., 2020). For a consideration of factors missing from Figure 1.1, Figure 1.2 proposes some additional considerations for work with SGM people of color.

Finally, access to SGM communities may serve as stressors of their own. This can occur through pressure to identify with a particular label in the presence of identity confusion (Gandhi et al., 2016), anti-plurisexual sentiment, and bisexual erasure (e.g., Hertlein et al., 2016), and stress to conform to particular body standards (Frederick & Essayli, 2016). Finally, the term *intraminority stress* has been adopted to refer to those stressors that arise as a result of competition and status anxiety within communities of gay men (Pachankis et al., 2020). The minority stress model, as I hope these adaptations and addendum clarify, is still undergoing revisions

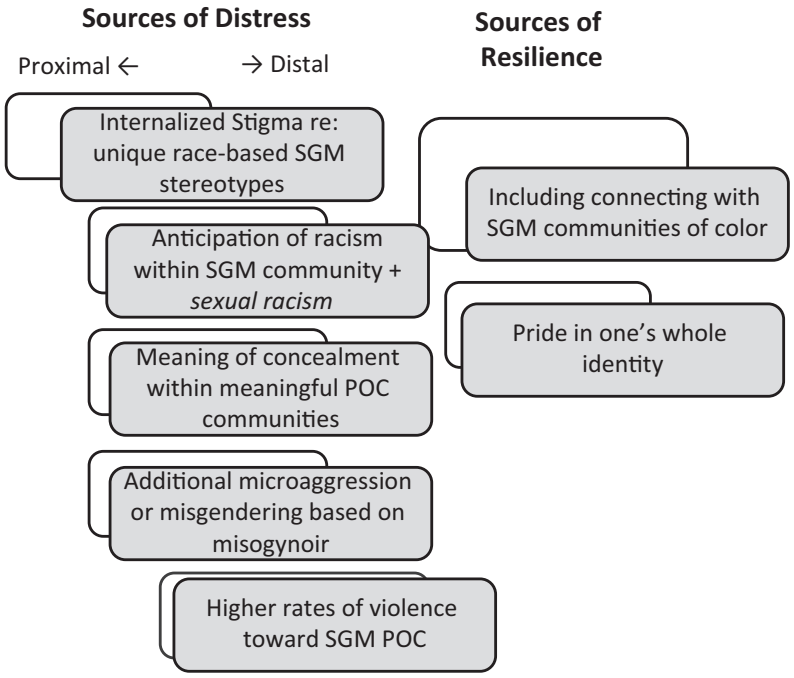



*Figure 1.2* Emphasizing just the left side of the model, these proposed factors highlight intersectional interpretations of the minority stress model.

and refinements as additional work is completed. While the minority stress model serves as a helpful signpost in developing interventions, there is an array of individual factors that may arise in treatment that should be considered in determining the course of responding therapeutically.

## Process-based therapy

In light of the recognition of common symptoms that do not correspond to specific diagnoses, and the recognition of transdiagnostic drivers of psychological diagnoses, many cognitive behavior therapists have shifted their attention toward process-based therapies (Hofmann & Hayes, 2019). Process-based CBT asks what core biopsychosocial processes presented by the client should be targeted, given their goals in their current context, and how might those be most efficiently and effectively changed (Hayes & Hofmann, 2018). In the case of minority stress, some early attempts have targeted emotion dysregulation as the underlying mechanism that may have the greatest impact, with some success in early trials with modifications of the Unified Protocol and Dialectical Behavior Therapy (e.g., Pachankis et al., 2015;

Sloan et al., 2017). While such a direction appears promising, there are additional ways to consider crafting interventions that are both mindful of minority stress theory as well as tools at the well-trained clinician's disposal. This has led to calls to develop and research interventions that emphasize SGM-specific treatment targets, such as internalized stigma, rejection sensitivity, and identity concealment (Cohen & Feinstein, 2020; Feinstein, 2019).

In exploring a contextual behavioral approach to treating minority stress, this volume sides with the latter argument. While a number of the skills and techniques that follow may be expected to also bolster emotion regulation skills, the emphasis is on dismantling some of the behaviors that developed as a function of internalized stigma, rejection sensitivity, and identity concealment. It is also worth recognizing that these are operationalizations that make these phenomena amenable to research, though they are not wholly discrete. For instance, cognitions about the world and other's responses to an SGM person found within internalized stigma may lead to some of the anticipated stigma that drives rejection sensitivity. Rejection sensitivity contains within the construct a number of behaviors intended to mitigate interpersonal rejection, that may be expressed through overly submissive behaviors, conflict avoidance, or interpersonal guardedness. Identity concealment, and the subsequent lack of interpersonal feedback that may undermine rejection sensitivity, are also deeply interconnected.

In this way, as the therapeutic interventions unfold in the following chapters, you may note that there are overlapping targets that are described. A mindful awareness of one's present environment may serve as a precursor to identity disclosure for some (Chapter 3), which may facilitate other vulnerable interpersonal disclosure that undermine rejection sensitivity (Chapter 6). Practicing self-compassion skills that soften the impact of situational shame may in turn lead to deeper relationships within the community (Chapter 7).

Developing a treatment that emphasizes transdiagnostic targets frees the evidence-based clinician from reliance on manualized therapies for contexts in which no clear manual exists without straying too far into the unknown. This is perhaps more important in working with SGM clients, as SGM individuals seek therapy at disproportionally high rates compared to the general population, and therapy seeking is not specifically tied to meeting criteria for a specific disorder (Cochran et al., 2003). Minority stress theory has proposed a number of specific targets that merit further attention during the course of treatment.

## Philosophy of treatment

The general approach of this book is informed by the philosophy of functional contextualism. Functionalism is a simple metaphor for understanding behavior: it is defined by its impact or effectiveness, and assumes that the same behavior may serve a different function in different situations. For instance, I may come out to a family member or friend with a goal of building trust or allowing our relationship to become mutually closer. This is different than if I were to come out while lobbying with my member of Congress, where the function may be to enforce my words as a member of a community of voters. Contextualism takes a more radical stance regarding how we define the background in which a behavior occurs. There are internal contexts, such as one's sexual orientation and gender identity, memories about close relationships, or beliefs about how the world works, that all set the stage for how an individual behaves. There are also external contexts, such as how a diagnosis shapes a medical provider's interactions with me, political debates in my state or country about SGM rights, or encounters with violence and discrimination.

A functional contextual approach assumes that there is no such thing as a behavior without this inner and outer environment shaping the desired function, and that all of our behavior is functional. A client seeking a legally required provider letter to support a gender affirming treatment who places daily calls to their therapist about the state of the letter could be acting within a context of anxiety about the outcome, responding to a history of medical providers who lacked follow-through, or a pragmatic concern about pending changes to their health insurance that may limit coverage for the desired intervention. The same behavior is uninterpretable outside of that context.

## The SORC model of case conceptualization

Each technique-focused chapter that follows incorporates the Stimulus-Organism-Response-Consequence (SORC) model for guiding a functional analysis of the client's behavior (Goldfried & Sprafkin, 1976). This provides a framework for considering both the function and context of a behavior, and draws attention to both inner and outer contexts that help to interpret, predict, or shape behaviors. This helps to fold in the range of minority stress targets, as well, so we might consider the broadest societal level of anti-SGM

animus to the most internal fears, traumatic responses, or negative thoughts about the world. We will use this model to consider where to focus in each case, and as a general framework to steer our curiosity and consider where to explore further with clients.

### *Stimulus*

The S in the model, Stimulus, refers to all of the possible antecedent factors in the past or present affecting an individual's life. This includes the place they live, their family of origin, and historical sources of trauma. My own experience as a supervisee and supervisor leads me to consider diagnoses and current medications as important pieces of a client's situation. These have social meaning when they appear on a provider's chart, both to the provider and to clients. One example is the diagnosis of *gender dysphoria* – one client may consider this a positive step toward receiving desired interventions, whereas another client may experience this diagnosis as an aversive sign of gatekeeping; their providers will have similar ranges of responses.

### *Organism*

Though it sounds strange to many in this anachronistic usage, behavioral models often use this term to refer to the individual. This is the aspect of the model that captures the internal world of a client. What thoughts, emotions, or experiences comprise the current inner world of the client? Organism factors may include an individual's experience of attraction toward other or similar genders, an inner sense of gender or lack of gender, or dysphoria within their body. If you are familiar with an "A-B-C" model of behaviorism – antecedent-behavior-consequence – both S and O may be antecedents in this approach to case conceptualization.

### *Response*

The Response refers to what a client is doing in response to the Situation and Organism factors. This can involve internal behaviors in response to their life situation, such as escaping into fantasy or ruminating, or could include behavioral responses such as not answering the phone, or evaluating the gender expression of one's outfit each morning before braving

the world. The response can involve substance use to meditation, workable solutions to those that interfere with one's life goals. For many clients, this is a mix.

### *Consequence*

This is where we consider how others in a client's environment are responding to them. This could include responses of family, colleagues, or systems that they are involved in. It can also be beneficial here to include the responses that the therapist has to client behaviors. Chapter 4 will explore in detail how to use your responses as a guide to better understanding the client as well as a place for intervention. Breaking cycles of unworkable behaviors that have been reinforced in the past is the primary goal of conceptualizing a case in this way.

Table 1.1 illustrates the types of questions or content that a therapist might assess in building a functional analysis of the client's experiences. This table will be revisited, with client-specific content, in the vignettes that appear in each therapeutic process chapter. While the names and clients are not specific to any one client, they reflect over a decade of private practice and many years of supervising SGM clients, and will illustrate common expressions of minority stress that clients may report within therapy.

You may begin to see how experiences flow from a client's history and inner experiences to behavioral responses, and what factors within the environment may be maintaining those patterns. Most therapeutic interventions target the client's responses to their own history and inner experiences. In some cases, such as through advocating for a more affirming setting in a medical office, situational factors may be directly acted upon (see Chapter 8). Changing the consequences of interpersonal behaviors most often arises within the therapeutic relationship, however. While we will explore the ingredients of an effective relationship in Chapter 2, Chapter 6 will describe specific principles to guide the therapist in order to reinforce under-rehearsed new interpersonal behaviors. This could range from providing a warm context for coming out to responding genuinely and authentically to disclosures of microaggressions or experiences of loss that the client has not previously had the context to voice. More than one intervention strategy may be appropriate for any given treatment target, so

*Table 1.1* A Prospective SORC for Conceptualizing a Client's Minority Stress-Related Experiences

| *Stimuli* | *Organism* | *Response* | *Consequence* |
|---|---|---|---|
| How did the family respond to the client coming out?<br>What is the current socio-political climate?<br>Has the client experienced discrimination or violence due to their identity? | What are the client's negative beliefs about their sexual orientation or gender identity, including what it means about them or what it means for their life?<br>Does the client interpret unclear responses as signs of rejection?<br>Does the client report shame, or feelings of something wrong with the self?<br>Is the client affected by trauma memories? | Does the client actively work to conceal their gender identity or sexual orientation?<br>Does the client avoid unknown environments or people?<br>Does the client engage in behaviors to distract from unwanted internal experiences?<br>Does the client disconnect from meaningful relationships (either out of fear of rejection, or painful associations)? | How do others respond to the client's responses?<br>What do the client's responses elicit in you, as the therapist?<br>How do systems, including healthcare, employers, or schools, respond to the client's responses?<br>Are the client's responses workable for them, in terms of reaching their stated goals? |

as you explore, consider that many of the approaches may be done in tandem, and none are mutually exclusive.

## Summary

- Sexual and Gender Minority Stress is a model that elucidates how societal bias harms SGM people, and does not reflect any inherent shortcomings among SGM individuals.
- Sexual and Gender Minority Stress models offer a helpful guide in identifying SGM-specific, transdiagnostic targets for intervention.
- Process-based therapy suggests a framework for considering how to approach transdiagnostic, non-specific targets in therapy using existing tools in a flexible way.

- A functional contextual model can facilitate identifying treatment targets while remaining mindful of the societal context in which a client's behaviors are occurring.

## Recommended reading

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# 13 LGB Children and Adolescents

*Rebekah Byrd, Christian Chan, and Chad Luke*
Christian Chan as guest contributor

## Objectives

- Describe and define many key terms from this chapter associated with LGB children and adolescents.
- Understand the many alarming statistics associated with LGB individuals.
- Examine appropriate principles for creating and supporting safe spaces.
- Understand legal and ethical issues that apply to LGB children and adolescents.
- Evaluate ways counselors can work with schools and community settings to make spaces more affirming and supportive.
- Examine ways to empower and encourage LGB children and adolescents.

## Reflective Questions

- What are my own experiences surrounding sexual, affectional, and gender diversity?
- In what ways will I work to understand the importance of language?
- Throughout my life, what messages did I receive from family, school, work, and society about LGB communities and sexual, affectional, and gender diversity?
- How can I continue to work on my biases and gaps in culturally responsive practices toward LGB children and adolescents?
- How can I advocate for our LGB children and adolescents in varying settings?
- What ways can I work to empower and encourage LGB children and adolescents?

## Concepts and Terms

Chapter 12 of this volume included many terms associated with LGBTGEQIAP+ individuals and discussed the importance of language. Counselors should understand that affectional/sexual identity and orientation does not just exist on a binary; LGB individuals need skilled clinicians who understand how to advocate and promote health for all children and adolescents. You will notice the term used previously, affectional/sexual orientation. This term is used to underscore the meaningful relationship that exists between people instead of focusing on the term "sexual" which often diminishes, minimizes, and "others" the relationship to something less than that of heteronormative relationships. If we must use a term, we prefer to use affectional orientation. Reiterated below are a few terms we will discuss most in this chapter. Taken from GLSEN (2020) the following are definitions:

> *Bisexual:* A person who is emotionally and/or physically attracted to two or more genders, often used to describe people attracted to "genders like theirs" and "other genders."

*Gay:* Someone, who can be transgender or cisgender, who is attracted to someone of the same gender.

*Lesbian:* Someone, who can be transgender or cisgender, who generally considers themselves a woman or femme who is attracted to other women and/or femmes.

*LGBTQ:* An umbrella term referring to people who identify as lesbian, gay, bisexual and/or transgender. The acronym can also include additional letters, in reference to other identities that do not conform to dominant societal norms.

As previously mentioned, language is important. Counselors should be comfortable using appropriate language and terms with clients (Ginicola, Smith, & Rhoades, 2016; Ginicola, Smith, & Filmore, 2017). This creates a safe atmosphere for the client. To also broaden the counselors' vocabulary with LGBTGEQIAP+-affirming interventions, we recommend reviewing several guiding documents, such as the ALGBTIC Competencies for Counseling Transgender Clients (ALGBTIC, 2009); ALGBTIC Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals (Harper et al., 2012); ALGBTIC Standards of Care in Assessment of Lesbian, Gay, Bisexual, Transgender, Gender Expansive, and Queer/Questioning (LGBTGEQ+) Persons (Goodrich et al., 2017); and ALGBTIC Standards of Care for Research with Participants Who Identify as LGBTQ+ (Griffith et al., 2017).

## LGB Youth and Adolescents in the United States

It is beyond troubling that a 2019 national survey reported that nearly 7 in 10 (69.8%) school mental health professionals (this includes school counselors, school-based counselors, social workers, and psychologists) reported that they received little to no graduate training in working with LGB individuals (GLSEN, ASCA, ACSSW, & SSWAA, 2019). In this same national survey, 64.3% of school mental health professionals gave their graduate training programs a score of fair or poor in preparing them for working with LGB students in the school setting. We know that not all readers will work in a school setting, but it is important to understand how to work with this system, as most all of the children and adolescents you will work with will likely be in a school somewhere. Working with the school is important in providing best practice for clients, even if you are in an agency, private practice, or other setting, since children and adolescents spend most of their time in schools. This chapter provides an essential place to start when learning how to advocate, support, and affirm LGB children and adolescents in many settings.

Important to understand is that LGB children and adolescents do not face these concerns as a result of their identity status. The concerns they deal with have to do directly with how society accepts them, issues they deal with at home and at school, and these concerns are a result of living in a heterosexist society. It is important to understand that LGB individuals are not just inherently at risk; their risk is from having to navigate unsupportive and unsafe spaces often on a daily basis. Providing support early and often is crucial to aid in the prevention of the development of health disparities later in the life of an LGB person (Calzo et al., 2017; Luke, Harper, Goodrich, & Singh, 2017).

In 2017, suicide was the second leading cause of death among children and youth ages 10–14 and also the second leading cause of death among youth and adults ages 15–34, according to the Centers for Disease Control and Prevention *WISQARS Leading Cause of Death Reports* (CDC 2017). In the 2016 CDC report on *Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9–12* (YRBS), LGB youth

reported attempting suicide one or more times during last 12 months at a rate almost 5 times higher than their heterosexual peers (CDC 2016). LGB youth were also 5 times more likely to need medical treatment after a suicide attempt. This same report also noted that LGB youth are also 3 times as likely to seriously consider suicide and 3 times as likely to make a suicide plan as heterosexual youth.

This CDC report in 2016 was the agency's first national study of health of LGB students in grades 9–12. In this study, the following were also noted:

- 17.8% of LGB students were physically forced to have sexual intercourse. That is a rate more than 3 times higher than heterosexual students.
- 22.7% of LGB students experienced dating violence of a sexual nature. That is a rate more than 2 times higher than heterosexual students.
- 17.5% of LGB students experienced dating violence of a physical nature. That is a rate more than 2 times higher than heterosexual students.
- 34.2% of LGB students experienced being bullied on school property. This rate is 2 times higher than heterosexual students.
- 28% of LGB students experienced being bullied electronically. This rate is 2 times higher than heterosexual students.
- 12.5% of LGB students did not attend school due to feeling unsafe at school or on their travels to and from school. This rate is more than 2 times higher than heterosexual students.
- 60.4% of LGB students reported feeling hopeless or sad. This rate is more than 2 times higher than heterosexual students.
- 42.8% of LGB students reported suicidal ideation. This rate is 3 times higher than heterosexual students.
- 29.4% reported attempting suicide. This rate is more than 4 times higher than heterosexual students.

Other statistics from this CDC report (2016) were also alarming.

- 11.5% of LGB students reported having ever used hallucinogenic drugs. This is a rate more than 2 times higher than heterosexual students.
- 10.1% of LGB students reported having ever used ecstasy. This is a rate more than 2 times higher than heterosexual students.
- 6% of LGB students reported ever having used heroin. This is a rate more than 4 times higher than heterosexual students.
- 8.2% of LGB students reported having ever used methamphetamines. This rate is 4 times higher than heterosexual students.
- 9.7% of LGB students reported having taken steroids without a prescription. This is a rate more than 3 times higher than heterosexual students.
- 17.3% of LGB students reported having ever used inhalants. This is a rate more than 3 times higher than heterosexual students.
- 5.4% of LGB students reported having ever injected an illegal drug. This rate is 5 times higher than heterosexual students.

Counselors should be aware that the chief reason an LGB child or adolescent is kicked out or removed from home is due to conflict related to an adolescent's sexual or gender identity (Ryan, Huebner, Diaz, & Sanchez, 2009). Berberet (2006) conducted a needs assessment of LGBTQ youth living in out-of-home care in San Diego and found that of the youth surveyed, 65% had been in either foster care or a residential group home facility and 39%

reported being "kicked out" of their own home due to their gender identity or their sexual orientation. Further, Berberet noted that 90% of the LGTBQ youth in this assessment reported surviving on the streets by dealing drugs; "trading drugs for money, food, and a place to sleep" (p. 374). Additionally, LGBTQ-identifying youth are overrepresented in the child welfare system and experience poor educational outcomes, probation, and homelessness at higher rates than peers (Martain, Down, & Earney, 2016). Martain et al. further posited that these disparities are even worse for LGBTQ youth of color and represent alarming and bleak outcomes about their experiences.

Many county and state estimates in the child welfare system note that the proportion of gender and sexual minority youth are much higher than the general youth statistics (Detlaff, Washburn, Carr, & Vogel, 2018). Some evidence suggest that this rate is about 15.5% – or 146,000 youth in the welfare system identify specifically as LGB (Detlaff et al., 2018). This estimate does not take into account those youth who are not openly out or who may be questioning. Further, Detlaff et al. also found that LGB youth of color are overrepresented in the welfare systems and that LGB youth were much more likely to meet criteria for adverse mental health concerns. This study found substantial differences between LGB youth and heterosexual youth in regard to diagnostic criteria for trauma, depression, and substance abuse, and also in overall mental health and behavioral issues. Prevention and early intervention efforts aimed at teaching parents, caregivers, and families about the deleterious effects of rejecting behaviors is imperative to assist with keeping these LGB youth in their homes (Ryan et al., 2009).

### *Experiences in School*

One study found that higher levels of school connectedness predicted less suicidal ideation among LGB youth supporting evidence that school connectedness (factors included safety concerns, school relationships, and school bonding/belongingness) may in fact serve as a protective factor against suicide for LGB individuals (Whitaker, Shapiro, & Shields, 2016). In the most recent *National School Climate Survey* conducted by GLSEN (Gay, Lesbian, and Straight Educators Network), researchers confirmed that schools are still very hostile places for LGBTQ children and adolescents (Kosciw, Greytak, Zongrone, Clark, & Truong, 2018). Researchers found that:

- Almost every LGBTQ person (98.5%) surveyed reported hearing discriminatory and anti-LGBTQ language at school.
- 56.6% of students surveyed reported hearing discriminatory and/or anti-LGBTQ language from teachers and school staff.
- 59.5% of LGBTQ students in the schools reported feeling unsafe at school due to their affectional/sexual orientation.
- 34.8% missed an entire day of school in the past month due to feeling uncomfortable or unsafe in school while 10.5% of LGBTQ students miss four or more days due to feeling uncomfortable or unsafe – in the last month.
- 75.4% of LGBTQ students reported that they avoided school functions due to feeling uncomfortable or unsafe.
- 70.5% of LGBTQ students reported that they avoided extracurricular activities due to feeling unsafe or uncomfortable.
- Almost a fifth of LGBTQ students surveyed reported having had to change schools due to feeling unsafe or uncomfortable.
- 70.1% of LGBTQ students were verbally harassed at school based on affectional/sexual orientation.

- 28.9% of LGBTQ students experienced being physically harassed based on affectional/sexual orientation – in the past year.
- 48.7% of LGBTQ students reported being harassed electronically (social media or text messaging) in the past year.
- 57.3% of LGBTQ students reported being sexually harassed at school in the past year.
- 55.3% of the LGBTQ students who experienced assault or harassment did not report it to school staff or administration due to fearing the situation would get worse or due to having little faith that an intervention would occur.
- 60.4% of the students who reported that they did notify school staff or administration about an incident stated that school staff did not respond to said reported incident or told the student to ignore the situation.

Though the statistics are alarming, they are important for understanding how to create a safe school environment. Advocating for all students is both an ethical and legal obligation for counselors (ACA, 2014, ASCA, 2012). Specifically, the ASCA's *The Professional Counselor and LGBTQ Youth* (2016b) position statement advocated:

> School counselors promote equal opportunity and respect for all individuals regardless of sexual orientation, gender identity or gender expression. School counselors recognize the school experience can be significantly more difficult for students with marginalized identities. School counselors work to eliminate barriers impeding LGBTQ student development and achievement.
>
> (p. 1)

This position statement has also been updated to include specific areas in which school counselors provide support and advocacy in school from working in individual sessions to advocating for equitable extracurricular and educational opportunities. This position statement also addressed the need for counselors to advocate for gender-neutral facilities in the school, supporting an inclusive curriculum at every grade level, advocating and adopting policies at school that directly address discrimination prevention, encouraging staff training, and supporting families and communities to be affirming and inclusive. These are not merely suggestions. These are ethical imperatives and necessary safety measures for all of our LGBTGEQIAP+ children and adolescents. Both ACA (2014) and ASCA (2016a) ethical codes outline the importance of social justice, multicultural competency, and advocacy efforts specific to LGBTGEQIAP+ individuals.

It has also been noted in this text multiple times the role that supportive adults play in the lives of children and adolescents. LGBTQ students who report feeling supported and safe at school report better experiences in school and increased academic success (Kosciw et al., 2018). Kosciw et al. (2018) also "found that LGBTQ students whose parents engaged in advocacy with their school, overall, had better well-being, including higher levels of self-esteem and lower levels of depression" (p. 25).

It is clear that there still exists great need for creating affirming, supportive, and caring schools for all students. Counselors working with children and adolescents should be at the forefront of this movement as we seek to advocate for all of our students. This essential work from GLSEN regarding school climate makes excellent recommendations and suggestions that still need attention. GLSEN suggests the following recommendations (Kosciw et al., 2018):

- Increasing student access to appropriate and accurate information regarding LGBTQ people, history, and events through inclusive curricula, and library and internet resources;

- Supporting student clubs, such as GSAs, that provide support for LGBTQ students and address LGBTQ issues in education;
- Providing professional development for school staff to improve rates of intervention and increase the number of supportive teachers and other staff available to students;
- Ensuring that school policies and practices, such as those related to dress codes and school dances, do not discriminate against LGBTQ students;
- Enacting school policies that provide transgender and gender-nonconforming students equal access to school facilities and activities and specify appropriate educational practices to support these students; and
- Adopting and implementing comprehensive anti-bullying/harassment policies that specifically enumerate sexual orientation, gender identity, and gender expression in individual schools and districts, with clear and effective systems for reporting and addressing incidents that students experience.

(xxviii)

School counselors, school-based counselors, and anyone working with children and adolescents can also take part in, promote, and even provide safe space trainings, as research has shown that safe space training specific to counselors increased counselor levels of knowledge, awareness, and skills related to the LGBTGEQIAP+ competency (Byrd & Hays, 2013).

### *Experience at Home*

Familial rejection of LGB children and adolescents can lead to many negative outcomes. Ryan et al. (2009) noted that LGB young adults who indicated higher levels of familial rejection during their adolescence were 8.4 times more likely to have attempted suicide, 3.4 times more likely to have used substances, 5.9 times more likely to experience higher levels of depression, and 3.4 times more likely to disclose having unprotected sex compared to LGB peers reporting no familiar rejection or low levels of familial rejection related to sexual orientation or identity when an adolescent. Additionally, "negative parental responses to sexual orientation or gender are associated with young people's psychological distress; however, parent-child relationships characterized by closeness and support, however, are an important correlate of mental well-being" (SAMHSA, 2015, p. 21). The Trevor Project (2019a) research brief on accepting adults report noted that LGBTQ youth who had at least one accepting and supportive adult were 40% less likely to attempt suicide in the last year.

Ryan et al. have provided research that clearly shows a link between parental/caregiver rejection and rejective behaviors when children and adolescents were growing up and adverse health outcomes in LGB individuals into young adulthood. When working with LGB children and adolescents, counselors must evaluate, assess, and educate parents, caregivers, and families about the negative and far-reaching impact of rejecting behaviors (Chan, 2018; Estrada, Singh, & Harper, 2017; Ryan et al., 2009). Counseling families can provide the needed support, safe space, and help necessary to increase well-being of LGB children and adolescents (Harper et al., 2012; Mills-Koonce, Rehder, & McCurdy, 2018; Ryan et al., 2009). Ryan and colleagues (2009), in particular, further recommended that those working with children and adolescents can start increasing support for LGB and decrease family rejection by doing the following:

1. Ask LGB adolescents about family reactions to their sexual orientation and gender expression and refer to LGB community support programs and for supportive counseling as needed.

2. Identify LGB support programs in the community and online resources to educate parents about how to help their LGB children. Parents need access to positive parental role models to help decrease rejection and increase family support for their LGB children.
3. Advise parents that negative reactions to their adolescent's LGB identity may negatively influence their child's health and mental health.
4. Recommend that parents and caregivers modify highly rejecting behaviors that have the most negative influence on health concerns, such as suicidality.
5. Expand anticipatory guidance to include information on the need for support and the link between family rejection and negative health problems in LGB young people.

(p. 351)

## Creating Safe Spaces

Counselors must advocate for safe spaces for all. Due to discrimination, harassment, prejudice, and lack of legal protections, many LGBTGEQIAP+ individuals feel unsafe in many environments. Unfortunately, our schools and counseling offices are often no different. We must make our environments safe spaces. Many resources and ideas exist for how to create safe spaces for all. This section discusses some ideas.

### *Safe Schools*

GLSEN's most recent *National School Climate Survey* (Kosciw et al., 2018) provided helpful information for making schools safer for all of our LGBTGEQIAP+ youth. These recommendations are specific to school systems yet should also include such general ideas as making paperwork inclusive, providing examples of LGBTGEQIAP+ individuals on bulletin boards and historical celebrations/holidays, rules against bullying and heterosexist speak, and challenging heterosexist biases on a daily basis. GLSEN's recommendations for schools specifically are:

- Faculty and staff need to support clubs such as Gay-Straight Alliances or Gender and Sexuality Alliances (GSAs). These student clubs are supportive for LGBTGEQIAP+ students and help to address LGBTGEQIAP+ issues in education.
- Trainings for school staff are necessary. These trainings help educate all and have been shown to improve rates of knowledge, awareness, and interventions, while increasing the number of supportive teachers and staff accessible to students.
- Provide and have available appropriate and accurate information and resources concerning LGBTGEQIAP+ individuals, history, and occurrences through curricula that are inclusive and updated library and internet resources.
- Confirm that school protection policies and practices exist and are followed. These can include dress code policies and/or school dance policies that do not discriminate against LGBTGEQIAP+ students.
- Endorse and implement policies and practices that do not discriminate against transgender and gender-expansive students and their equal access to education.
- Approve and implement comprehensive and inclusive school and district anti-bullying/harassment policies that specifically discuss affectional/sexual orientation, gender identity, and gender expression as protected categories along with race, ability status, and religion. These policies need to include definitive and operative procedures for reporting and addressing occurrences that students experience.

## Safe Community Agencies

While the previous information focused on the school setting specifically, counselors in a variety of settings across communities and agencies must also advocate for creating safe spaces. Counselors are housed in hospitals, mental health clinics, government buildings, private practices, substance abuse facilities, outpatient counseling agencies, prison systems, and assisted living facilities. The following recommendations can be essential places to start in making all of our spaces more supportive and affirming.

- Review, develop, and enforce workplace policies based on non-discrimination and anti-bullying/harassment that explicitly protect LGBTGEQIAP+ individuals.
- Examine forms to ensure that they are inclusive of all identities (e.g., intake forms could include multiple options for gender or a blank to fill in, instead of a forced choice male/female option).
- Conduct and provide continuing education on LGBTGEQIAP+-relevant information.
- Have gender-neutral restrooms.
- Include resources, references, and community supports that display and are inclusive of LGBTGEQIAP+ individuals (books, brochures, movies, articles, pictures, magazines, community resources, etc.).
- Conduct events, presentations, and programming that are supportive, safe, and affirming for LGBTGEQIAP+ individuals.
- Disseminate newsletters that include LGBTGEQIAP+ concerns and are inclusive of all clients.
- *Listen!*
- Educate yourself and others.
- *Advocate!*
- Be supportive of employees in their various stages of development while challenging heterosexist and heteronormative ideas and concepts.

## Legal and Ethical Implications

Counselors should also be aware that most LGB individuals reside in states with no legal protection against discrimination based on sexual orientation, gender identity, and expression (SOGIE) (Detlaff et al., 2018). Further, Detlaff et al. state:

> because no overarching federal protections exist to protect LGBTQ+ individuals from discrimination, system involved youth in these states are left vulnerable to inequitable treatment in schools or within human services agencies, and also in public spaces related to housing and placement.
>
> (p. 192)

There has been recent discriminatory legislation passed allowing those in the helping profession to refuse services to individuals that would go against the provider's religious beliefs (Tennessee being one of them). Tennessee state House Bill (HB 1840, 2016), also referred to as the Counselor's Bill, states:

> Mental Health & Substance Abuse Services, Dept. of – As enacted, declares that no person providing counseling or therapy services will be required to counsel or serve a client as to goals, outcomes, or behaviors that conflict with the sincerely held principles

> of the counselor or therapist; requires such counselor or therapist to refer the client to another counselor or therapist; creates immunity for such action; maintains liability for counselors who will not counsel a client based on the counselor's religious beliefs when the individual seeking or undergoing the counseling is in imminent danger of harming themselves or others.
>
> Amends TCA Title 4; Title 49 and Title 63

Although some of this legislation is vague, the origin was specifically discriminating against LGBTGEQIAP+ individuals. The Family Action Council of Tennessee, Inc. (2019) stated that the bill provides both criminal and civil protections to Tennessee counselors (in private practice) who decide to refer clients if the client's goals are in conflict with the counselor's "sincerely held principles or religious beliefs" (para 1) and that this bill "deletes the new provision of the ACA code of ethics that prohibits referrals in such instances" (para 3). This provision they are referring to was added and clarified to the newest version of the ACA *Code of Ethics* (ACA 2014) and states:

> A.11.b. Values Within Termination and Referral: Counselors refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs and behaviors. Counselors respect the diversity of clients and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

The Mississippi state Religious Liberty Accommodations Act (HB 1523), also called the Protecting Freedom of Conscience from Government Discrimination Act, is another similar law. CNN Wire stated that

> under the law, religious organizations will be able to deny LGBT people marriage, adoption and foster care services; fire or refuse to employ them; and decline to rent or sell them property. Medical professionals will be permitted to refuse to participate in treatments, counseling and surgery related to "sex reassignment or gender identity transitioning".
>
> (2016, para 9)

These types of legislation will lead to further limiting access to services for LGB individuals, limiting placement options or those in the welfare system, and will also perpetuate the harmful and damaging belief that these individuals do not deserve, need, or require affirming, loving, supportive, and safe households (Detlaff et al., 2018). Under such bills, members of the LGBT community could also be denied counseling, medical treatment, suicide hotline services, and could even be forced into "conversion therapy" (Bolles, 2016).

### *"Conversion Therapy"*

It is also important for us to say a bit about what is known as "conversion therapy". We have put this phrase in quotation marks because this is actually not therapy at all. This practice is extremely dangerous and has long lasting harmful and damaging outcomes. "Conversion therapy refers to attempts to change a person's sexual orientation or gender identity through a variety of methods, including induced vomiting and electric shock" (Equality Federation, n.d.). The Trevor Project (2019b) *National Survey on LGBTQ Mental Health* reported that youth who had been subjected to conversion therapy were more

than twice as likely to attempt suicide as LGBTGEQIAP+ youth who were not subjected to conversion therapy. This is on top of their already increased levels of suicide. Mallory, Brown, and Conron (2018) estimate that:

- 20,000 LGBT youth (ages 13–17) will receive conversion therapy from a licensed healthcare professional before they reach the age of 18 in the 41 states that currently do not ban the practice.
- 6,000 LGBT youth (ages 13–17) who live in states that ban conversion therapy would have received such therapy from a licensed healthcare professional before age 18 if their state had not banned the practice.
- 57,000 youth (ages 13–17) across all states will receive conversion therapy from religious or spiritual advisors before they reach the age of 18.
- 698,000 LGBT adults (ages 18–59) in the United States have received conversion therapy, including about 350,000 LGBT adults who received treatment as adolescents.

(p. 1)

The Substance Abuse and Mental Health Services Administration (2015) notes that conversion therapy "is a practice that is not supported by credible evidence and has been disavowed by behavioral health experts and associations" (p. 1). Equality Federation (n.d.) further emphasizes that "all of the nation's leading professional medical and mental health associations condemn conversion therapy as unnecessary, ineffective, and dangerous". Take a moment to think about that. *All* of the leading professional mental health organizations in the United States not only oppose this despicable practice, but believe it to be dangerous. So why then is this still being not only practiced, but mental health professionals are actually still referring individuals to this perilous practice?! Additionally, if helping professionals are ethically obligated to adhere to best practice procedures and utilize empirically based strategies (ACA, 2014), how could an ethical counselor ever refer for "conversion therapy" when "none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation" (SAMHSA, 2015, p. 1), and why would ethical counselors want to? With the previously stated estimations indicating that this is still happening at alarming rates, counselors have an ethical and legal obligation to not only refrain from such referrals, but to actively advocate against such practices.

## Working With Family Members of LGB Children and Adolescents

In addition to several of the contextual, social, and political factors to consider for LGB children and adolescents, professional counselors can strongly consider partnerships and collaboration with family members and parents/caregivers to sustain allyship (Estrada et al., 2017; Harper et al., 2012). According to Chan (2018), families can serve as meaningful and transformative allies for LGB children and adolescents, given the lack of legal and environmental support for children and adolescents within several community systems. Vital to a comprehensive set of supports, parents/caregivers and family members can often use their own privileges and safety to advocate in collaboration with LGB children and adolescents (Chan, 2017, 2018). Since numerous LGB children and adolescents spend the majority of their time at home and in schools, it would be pertinent for counselors to consider how they might leverage school/community/family partnerships to facilitate potential forms of advocacy. Additionally, stronger relationships with parents/caregivers for LGB children can decrease interpersonal and systemic forms of minority stress and discrimination (Meyer, 2010, 2014; Ryan et al., 2009). In particular, Magette, Durtschi,

and Love (2018) noted that adolescents and emerging adults with strong relationships with parents/caregivers can reduce substance use and improve coping strategies. Watson, Rose, Doull, Adjei, and Saewyc (2019) supported this notion by highlighting the vital role of fathers in support and connectedness of LGB adolescents. Substantiating the relationship of families to LGB children and adolescents, LGB children and adolescents are primarily exposed to the family system as an immediate source of support and can transfer this experience to other systems (e.g., community supports, school, church; Chan, 2017, 2018; Estrada et al., 2017; Mills-Koonce et al., 2018).

Counselors in a diversity of work settings (e.g., community agencies, schools) play a pivotal role in connecting with children and adolescent clients, particularly school counselors (Byrd & Hays, 2013). In the context of LGB children and adolescents, school counselors can have a profound impact on their academic achievement, climate of safety, and social and emotional well-being (Byrd & Hays, 2013; Luke et al., 2017). This point operates in tandem with the findings developed by several researchers to augment an understanding of affirmative practices (see Farmer, 2017; Farmer, Welfare, & Burge, 2013). To bolster the inclusion and collaboration of families in developing more affirming environments for LGB children and adolescents, counselors can use a variety of considerations and tools to initiate interpersonal and systemic changes (Luke et al., 2017).

When counselors provide their services in multiple work settings, they have an opportunity to develop a number of tools for assisting families with connecting to experiences of an LGB child or adolescent. Namely, counselors assess for affirmative knowledge and environments within families, where families may have misconceptions or underlying ideologies about sexual and affectional diversity. In assessing for knowledge, it is important for counselors to capitalize on the strengths of family members who may already carry significant empathy with LGBTGEQIAP+ communities; participate in community and legislative advocacy for LGBTGEQIAP+ communities; or hold extensive knowledge about LGBTGEQIAP+ affirming practices. Given these possibilities, counselors cannot necessarily assume that families of LGB adolescents are not affirming. Rather, counselors can more so consider the level of development and knowledge of family members to enhance their support, allyship, and solidarity with another LGB family member.

In working with family members, counselors can also draw from broaching behaviors in their counseling practice (see Day-Vines et al., 2007; Day-Vines, Ammah, Steen, & Arnold, 2018). As a vital component of culturally responsive practices, broaching behaviors alludes to explicit discussions of cultural factors in counseling practice, where counselors thereby validate discussions of culture and provide a safer space for clients and students (Day-Vines et al., 2007). With the intention to enhance the counseling relationship and to empower the client or student, initiating broaching behaviors requires key ingredients from the Multicultural and Social Justice Counseling Competencies (MSJCC) along the domains of knowledge, attitudes and beliefs, skills, and advocacy (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015). A distinct connection between the model of broaching and the MSJCC entails increased attention to the attitudes and beliefs, which would ultimately bolster a counselor's awareness of their own relationships, power, and privilege with clients. For instance, a counselor using the infusing behavior on the continuum of broaching would incorporate culturally sensitive interpersonal responses with family members of LGB children and adolescents while infusing discussions on systems and power (Day-Vines et al., 2018). Moving intentionally toward the infusing behavior can serve as a meaningful experience for working with families of LGB children and adolescents to transfer the relationship as a teachable moment, where family members can feel empowered to examine their own privilege, systemic factors, and cultural sensitivity to an LGB child or adolescent.

Adding to the practice of broaching, counselors can primarily build the knowledge of parents/caregivers and family members to form affirming spaces and environments for their LGB children and adolescents (Harper et al., 2012). Several key aspects can inform the learning process for family members and strengthen their relationships with LGB children and adolescents. An explicit example involves counselors teaching family members foundational language about LGBTGEQIAP+ communities, particularly surrounding sexual and affectional diversity (Goodrich et al., 2017). It would be helpful for a counselor to provide family members language to maintain curiosity and ask questions about sexuality and diversity in a supportive manner. For instance, a family member can explicitly state, "In our house and our society, people can choose to love anyone of any gender. If you feel comfortable sharing with us, how would you describe who you love and how you might identify your affectional or sexual identity? We want to make sure we use the language that supports you". Another example might involve explicitly discussing forms of oppression, where a parent might share, "It is possible that you have been hurt or might get hurt because people have failed to understand how you feel attracted to or love someone else. It does not mean there is an issue with you. It is more of an issue with that person or with society". In this instance, family members and parents/caregivers can characterize a supportive response and environment while socializing their LGB children and adolescents for the potential harm they might face in society. Teaching parents/caregivers and family members about these examples can also illustrate a method to socialize LGB children and adolescents for the grief process when society fails to affirm them (Luke et al., 2017).

## Empowerment and Encouragement

Counseling with LGB children and their family members entails an explicit approach on language, knowledge of key issues, and recognition of cultural and environmental contexts. Several of these areas revolve around the tools of affirmation, but can be broadened even further through empowerment and encouragement. A prominent tool of social justice for LGB children stems from the skill of empowerment in interpersonal relationships – concepts upon which this book is based. From this experience, LGB children can apply such empowerment to their own personal lives and feel validated in a multitude of their experiences. Additionally, counselors can collaborate with LGB children to build upon experiences of empowerment to ultimately culminate in systemic interventions, programming at school or the community, and advocacy-based initiatives.

For LGB children, cultivating a safer space for students to name their experiences and their social identities with sexuality and affection can be widely impactful. Throughout time and history, children navigating their sexual and affectional identities have often been positioned within the boundaries of several identity categories, primarily gay and lesbian. However, the history and context surrounding affectional/sexual minority categories create barriers for children to understand and feel more congruent in their affectional and sexual identities. This issue can instill an experience of exclusion for children who identify outside of affectional/sexual binaries, such as pansexual, demisexual, omnisexual, bisexual, and queer (Cor & Chan, 2017; Moe, Bower, & Clark, 2017). Even for children identifying as gay and lesbian, barriers surrounding sexuality and affection can deter them from naming and disclosing their sexual and affectional identities in order to fit assumptions within the identity categories. Operating from this perspective, counselors can encourage LGB children to recognize an anti-essentialist viewpoint, which means that their affectional or sexual identity may not appear the same as everyone else (Lugg, 2003; Lugg & Murphy, 2014). Additionally, anti-essentialism includes a viewpoint that illustrates sexuality and affection as unique experiences, despite sharing identities (Misgav, 2016). For instance, two

children may identify as gay, but carry a variety of differing experiences and socializations. They do not automatically face or hold the same experiences simply as a result of their identity, which realizes the uniqueness of each individual (Chan, 2018; Chan, Erby, Farmer, & Friday, 2017a; Cor & Chan, 2017; Goodrich et al., 2017).

To continue empowering LGB children, counselors can also highlight negative cultural messages (Singh, 2019), notably to locate external forces affecting their well-being. Specifically with the advances in microaggression literature, LGB children internalize experiences associated with discrimination on interpersonal and systemic levels (see Gartner & Sterzing, 2018; Harkness & Israel, 2018; Nadal, Whitman, Davis, Erazo, & Davidoff, 2016). Counselors can increase critical consciousness around the effects of microaggressions and how they communicate problematic messages for LGB children and adolescents (Singh, 2013). In doing so, they are raising awareness for children and adolescents as clients and students to recognize they are not the root of their problems (Ratts & Greenleaf, 2018). Oppressive experiences can result in a multitude of mental health disparities, health disparities, and lowered outcomes of wellness (Harper et al., 2012; Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014). In fact, Boyas, Villarreal-Otálora, Alvarez-Hernandez, and Fatehi (2019) identified an increasing prevalence among Latinx LGB youth regarding suicidal ideation, planning, and lethal attempts. Within the Boyas et al. (2019) study, factors contributing to suicidal ideation illustrated a connection with substance use and experiences of oppression and bullying. More critical to the Boyas et al. (2019) study, practitioners and communities could more adequately address this issue by eliciting interventions at multiple systemic levels (e.g., micro, meso, macro, chrono) while targeting harmful messages diminishing a climate of safety.

Similarly, counselors can use a myriad of strategies to highlight the practice of resilience among LGB children (Singh, 2013, 2019). One way to assist LGB children in discovering their own practices of resilience emanates from the emphasis on curating materials on LGB heroes into their personal libraries, curricula, and collections of resources (Simons, Beck, Asplund, Chan, & Byrd, 2018; Simons, Chan, Beck, & Asplund, 2019), which would allow children to see a positive representation of their own identities. Another characteristic aspect to resilience is drawing from intersectional resilience (Chan, 2018; Singh, 2013) by (a) using experiences from another marginalized identity to detail how they might have bounced back or (b) understanding the uniqueness of their intersecting identities. Similarly, recognizing the intersections among multiple marginalized identities and the ability to navigate these identities can elicit moments of resilience for LGB children since they were able to build on their tools, resources, and coping (Singh, 2013). To further increase encouragement about sexual and affectional identity, counselors can ask children and adolescents to (a) discuss their identities when they feel safe and (b) use stories to elaborate on the meaning of their sexual and affectional identity (Chan et al., 2017a; Simons et al., 2019).

## Intersecting Identities for Consideration

LGB children and adolescents consist not only of one singular identity. Rather, they function in a multitude of systems and social contexts that shed light on numerous social identities (e.g., race, ethnicity, sexual identity, gender identity, gender expression, social class), their linkages, and their overlapping forms of oppression (see Bowleg, 2012, 2013; Chan, 2018; Singh, 2013; Singh & McKleroy, 2011). Of visible importance, researchers have postulated the importance of examining LGB communities and the intersection of race and ethnicity to identify complex connections between racism and heterosexism (e.g., Bowleg, 2013; Chan et al., 2017a; Chan, Erby, & Ford, 2017b; Mosley, Gonzalez, Abreu, &

Kaivan, 2019; Singh, 2013). This prominent aspect is especially important to consider, given that LGBTGEQIAP+ communities are subject to oppression internally within communities. LGBTGEQIAP+ communities can maintain oppressive dynamics, such as racism, ableism, and genderism, within communities (Chan et al., 2017a, 2017b; Farmer & Byrd, 2015). It is also important for counselors to broach these linkages while foreseeing potential intersections that might influence another identity (Chan, 2017, 2018). Additionally, counselors must take social context (e.g., school, church, policies) into account (Collins & Bilge, 2016), which might exacerbate the prevalence and manifestation of certain forms of oppression. For example, LGB children and adolescents of color may face more racism in certain environments while experiencing more heterosexism in other environments. Supportive adults, specifically parents and family members, can reduce the likelihood of suicidal ideation and the effects of heterosexism (Abreu, Black, Mosley, & Fedewa, 2016; Boyas et al., 2019; Chan, 2018; Levy, Russon, & Diamond, 2016).

### *Advocacy*

Important to the discussion on extending affirmative practices, resilience, and empowerment for LGB children and adolescents, counselors can benefit primarily from the Multicultural and Social Justice Counseling Competencies (MSJCC) endorsed by the ACA (Ratts et al., 2015; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Ratts and colleagues (2016) constructed the MSJCC on the basis of meeting the current state of multicultural research and reinforcing the urgency to move toward a fifth force of social justice. With the inclusion of social justice in the most recent document, counselors were encouraged to realize their responsibilities in advocating for historically marginalized communities (Ratts, 2017; Ratts & Greenleaf, 2017). As a result, counselors are required to reconceptualize their professional development of multiculturalism and social justice as integral factors within their practice while meeting ethical standards to view these aspirational goals as a lifelong developmental process (Ratts et al., 2016). Crucial to the development of the MSJCC, counselors attend to knowledge, attitudes, beliefs, and skills both for clients/students and themselves, but more importantly, they must attend to action and advocacy (Ratts & Greenleaf, 2017).

Applied to LGB adolescents, the MSJCC position on advocacy intertwines with the previous development of the ALGBTIC guiding documents over the past decade (e.g., ALGBTIC, 2009; Goodrich et al., 2017; Griffith et al., 2017; Harper et al., 2012). It is crucial for counselors to constantly enhance their knowledge, address their biases, and conduct further research to integrate more cultural empathy for LGB children and adolescents (Singh, 2019). In certain circumstances, counselors potentially rely on the strategy of asking LGB children and adolescents to teach them knowledge about sexual and affectional diversity, which creates an antithetical approach to the MSJCC (Guth et al., 2019). Additionally, this strategy positions clients and students uncomfortably in the role of teaching the counselor and reinforces the power and privilege of the counselor (Ratts, 2017; Ratts & Greenleaf, 2018).

Counselors also primarily need to dismantle internalized binaries about sexuality by expanding sexual and affectional identity categories (Lugg & Murphy, 2014). Additionally, counselors can enhance their knowledge on affirmative and updated language to recognize the identities and lived experiences of LGB children and adolescents (ALGBTIC, 2009; Harper et al., 2012). It is vital for counselors to increase their knowledge and attitudes and beliefs specifically about their own biases (Abreu et al., 2016; Simons et al., 2018, 2019). Increasing knowledge about LGB-affirmative practices can also provide opportunities to sustain efforts surrounding LGBTGEQIAP+ advocacy, resources, supports, and community partners (Beck, Maier, Means, & Isaacson, 2018a). Education about personal biases can

assist counselors with effectively planning interventions and reducing the likelihood of discriminatory behaviors in counseling (Day-Vines et al., 2018). Examples of advocacy can involve interpersonal forms of advocacy, such as educating other paraprofessionals, teachers, family members, and counselors about different forms of language (Abreu et al., 2016; Beck et al., 2018a; Beck, Rausch, Wikoff, & Gallo, 2018b). Other examples of advocacy can result in more systemic changes, such as examining community agency and school efforts and policies to support the climate of safety for LGBTGEQIAP+ students (Astramovich, Chan, & Marasco, 2017; Chan, 2018).

## Summary

The importance of language usage was reiterated for the LGBTGEQIAP+ community and in this chapter specifically, our LGB children and adolescents. We outlined many troubling statistics for LGB children and adolescents, including information on suicide statistics, dating violence, harassment, experiences at home and school, drug use, and homelessness. Legal and ethical considerations were addressed, while emphasizing that counselors must understand that advocating for LGB children and adolescents is both an ethical and a legal obligation. Counselors were provided with information for working with family members of LGB children and adolescents. Many recommendations were made for creating and supporting safe spaces in multiple settings while seeking to also support intersecting identities. Strategies and techniques for empowering and encouraging our LGB children and adolescents were also emphasized.

## Clinician's Corner

Years ago, when working in an inpatient psychiatric setting, many patients stood out to me and still come to mind today. One in particular was a young woman who ended up in the unit multiple times for suicide attempts and ideation. Approximately two years later, at around the age of 16 with a diagnosis of borderline personality disorder, she was once again on my caseload at an outpatient day crisis treatment facility. She noticed me and remembered me and said she felt more comfortable with a familiar face. Still struggling with suicidal ideation, it was a few months before she came out – in a session with me and her mother. Mom was supportive but noted family and school were not, and that these were exceptionally hard times. We continued to work together and I watched the young woman grow in self-acceptance, confidence, and self-compassion. She had a wonderful team of professionals advocating for her in the community, in-home, and school settings. School ended up being supportive and she was out and proud and helped to advocate for others. Many youth have very different outcomes once coming out to family, friends, and classmates – to whom this likely sounds like a fairy tale. I couldn't help but wonder how many of our LGB children and youth frequent both inpatient and outpatient centers with suicidal ideation (among other presenting issues) and are diagnosed with axis II disorders who are really struggling with society's acceptance of them. How many counselors question (often) rapidly made diagnoses? How many clients question these diagnoses, as well? This is one of many stories, and we know from our suicide statistics that many aren't as fortunate. How will you stand up and advocate for LGB children and adolescents?

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# 8

# ISSUES OF GAY MEN AND BOYS

In 2004, 19-year-old Garrard Conley, raised in Arkansas in a highly religious conservative Southern Baptist family, was 'outed' to his family by a man who had raped him at college. Conley's father's response was: 'You'll never set foot in this house again if you act on your feelings. You'll never finish your education.' Conley agreed to be admitted to a program called 'Love in Action,' a conversion therapy treatment facility designed to 'cure' gay and lesbian young people of their 'sickness.' In this program, run by an 'ex-gay' man (a gay man who claimed to have been cured by God), Conley was told he was a sexual deviant and enjoined to follow the rules in a 274-page handbook that outlined 12 'steps' to recovery loosely modeled on AA. Conley soon fled the program and later wrote about it in a memoir that was made into the 2018 film *Boy Erased* (Conley, 2019).

According to studies by the UCLA Williams Institute, more than 700,000 LGBTQ people have been subjected to conversion therapy, half of them teenagers, and an estimated 80,000 LGBTQ youth will experience programs like LIA in coming years, often at the insistence of well-intentioned but misinformed parents or caretakers.

Conley's experience is an example of the one of worst experiences possible for a young gay man: not only to have one's gayness made visible against one's will, but then to suffer negative consequences from this 'outing.' Fortunately, these kinds of situations are becoming less common. While there are certainly still families who reject their gay children, that number is decreasing. The Pew Research Center found that from 1985 to 2015, the percentage of people who said they would be upset if a child told them they were gay fell from 89% to 39%, and the percentage who said they would not be upset rose from 9% to 57% (Gao, 2015). That is important because

numerous studies have shown that 'Family acceptance predicts greater self-esteem, social support, and general health status; it also protects against depression, substance abuse, and suicidal ideation and behaviors' (Ryan et al., 2010). To an extent, having a supportive family even compensates for harassment and bullying from peers.

Unfortunately, peer harassment of LGBT youth is still common. A 2017 nationwide survey showed that 33% of LGB youth reported being bullied on school property in the prior year, 27.1% were cyberbullied, and 10% reported not going to school because of safety concerns; these numbers were twice that of their non-LGB peers (Kahn et al., 2018).

Of those LGB students who are bullied, the most persecuted are gay boys and teens who do not conform to masculine stereotypes. While not all gay men are 'girly' as children, multiple studies have shown a strong correlation between childhood gender nonconformity and adult male homosexuality. This puts gay boys at high risk for peer harassment. Harold Daniel, a young gay man who shared his story with GLAAD ('Gay & Lesbian Alliance Against Defamation,' a non-governmental media monitoring organization), wrote: 'I feared going to school throughout my elementary and middle school years. Being mocked for my feminine mannerisms affected my mental health. I was called names, names that I didn't know the meaning of at the time.' Tae Johnson said:

> I first experienced bullying when I was in elementary school, but the most extreme point was when I reached middle school. I used to get verbally and physically harassed every day to the point I hated waking up in the morning & I seriously battled with finding the strength to continue living.

Daniel Segobiono wrote:

> I'm a femme, gay man … I was bullied for being 'too femme' and to avoid being teased I'd deepen my voice around others. In P.E. I'd always be told that I 'played like a girl' or that I was not good enough to play with the other boys because I was 'too gay.'
>
> (Kenny, 2018)

All of these young men were traumatized by peer violence, and sometimes by violence that came from within their families (Friedman et al., 2011), as it has been shown that LGB youth are subject to more parental abuse than non-LGB childen. The links between trauma, stress, and mental illness have been well established. Given these childhood experiences, it is not surprising that many adult gay men suffer from psychological problems and mental disorders. According to the American Psychiatric Association (2018), gay

men are two to three times more likely than heterosexual men to suffer from mood disorders, including depression and anxiety. They are more likely to report suicidal ideation, plans, and attempts than heterosexual men: one in six gay men have made one or more suicide attempt in their lifetime. They display higher rates of alcohol and drug use and dependence.

## Mental Health Issues of Gay Men

The elevated rates of psychological problems in gay men means that therapists working with gay male clients must be prepared to deal with a wide range of mood and behavioral disorders. Three in particular are worth commenting upon: substance abuse, eating disorders, and intimate partner violence. Early theories of why drug and alcohol problems are more common among gay men and lesbians centered on bars: before the Internet, bars were the social venues of choice for gay people, and the constant proximity to alcohol seemed to encourage use and abuse. Since online venues have in part replaced the 'bar scene,' this is less true. However, the Internet did not replace the events called 'circuit parties.' Circuit parties are large, professionally produced events that include a dance event that lasts all night into the next day as well as other parties and events planned around the main party. They are highly publicized, often occur in the same place every year – for example, the White Party in Palm Springs, the Black Party in New York – and attract thousands of men often from around the world. Besides dancing, circuit parties are known for sex and drugs, and have given rise to the phenomenon called 'Party and Play,' or PNP, also called 'chemsex,' the tendency to combine certain drugs like ecstasy and crystal meth with sexual activity. It is likely that PNP contributes to higher rates of substance abuse, as well as to unsafe sexual practices and new incidences of HIV infection. Chemsex/PNP remains a problem in many gay male urban communities.

Gay men are seven times more likely to report binge eating and 12 times more likely to report purging behaviors than heterosexual males, and they represent over 40% of males with eating disorders (Feldman and Meyer, 2007). This may have its roots in particular aspects of gay male culture. Heterosexual men, compared to heterosexual women, are often very focused on the physical beauty of their partners. Gay men are just as likely to value attractiveness as heterosexual men, perhaps because men in general have sexual arousal patterns more dependent upon visual stimulation. Moreover, because so many have suffered from being perceived to be 'effeminate,' gay men often place a high value on hyper-masculine beauty. So personal ads written by gay men often include phrases like 'straight acting, straight appearing' or 'no femmes or fatties wanted.' It is believed that eating disorders in women are rooted in social pressure to be attractive; gay men suffer from a comparable social pressure to be attractive.

Gay men in relationships experience domestic violence at the same rate as heterosexual women in relationships. About one-third of gay male couples experience such violence. One 2018 study showed 46% of gay men in couples had experienced intimate partner violence in the last year (Suarez et al., 2018). However, the same machismo-based stigma that prevents heterosexual men from disclosing if they are victims of intimate partner violence contributes to silence in the gay community. In fact, gay men are more likely to disclose being a perpetrator than a victim, probably because of the shame in admitting victimhood. Therapists working with gay men should be aware that clients may not be forthcoming about violence in their relationships.

Perhaps as a reaction against the accusation of 'effeminacy,' hypermasculinity has been a norm in gay male culture from at least the 1970s. It is not an accident that the Village People, the rock band formed in 1977 specifically to appeal to gay disco-goers, contained members dressed as a policeman, an American Indian chief, a soldier, construction worker, and a guy dressed entirely in black leather. It is tempting to speculate that the fetishization of hypermasculinity, as epitomized in the very popular drawings of Tom of Finland, represent a subtle form of internalized homophobia. Just as women have been damaged by unrealistic norms of feminine beauty, many gay men have been damaged by the inculcation of macho norms that are difficult, if not impossible, to attain.

## The Role of Sex in Gay Male Culture

Gay male culture, since the 1970s or earlier, has not only incorporated hypermasculine norms, it has often revolved around sexuality, perhaps because the uber-masculine is connected to the uber-sexual. Researcher James Martin has written:

> Across the sweep of modern history, men such as these have risked their careers and reputations in order to have erotic contact with other men. Is it surprising, then, that the erotic is so central to gay men's identities and culture?
>
> (p. 214)

Martin grounds this centrality of the erotic in the centuries of stigma that have surrounded homosexuality. But the centering of sex in the gay male ethos may also have a simpler explanation: at least as indicated by behavior, sex is more important to all men, regardless of sexual orientation, than it is to women. For example, research has shown that all sex acts, from masturbation through all forms of partner sex, are more common among males than females. Men become sexual at an earlier age than women and continue this throughout the life span (Peplau, 2003). In fact, it could be hypothesized that

heterosexual men would be far more sexual if their sexual desires were not to an extent constrained by the lower sex drive of heterosexual women. As my deceased friend and colleague, the social worker, writer, and activist Michael Shernoff, used to say: 'Gay men have the sex lives that straight men can only dream of.' Gay men don't have to wine and dine their prospective partners before sex; indeed, often they don't even have to say their name. The gay male culture that emerged in urban 'gay ghettos' in the 1970s glorified and celebrated male-male sexuality, not only with its norms and ethos but with physical spaces. Bars, back rooms, bath houses, 'cruising' areas in parks and other public spaces all became venues for sex that was casual, commitment-free, and often anonymous. Studies of male homosexuality done in the 1970s (Bell and Weinberg, 1978) revealed that many men numbered their sex partners in the hundreds or even thousands. Gay male couples incorporated this into the norms for relationships: Mattison and McWhirter's groundbreaking book, *The Male Couple*, published right before the AIDS epidemic hit, reported that of their international sample of long-term male couples, 100% were nonmonogamous (Mattison and McWhirter, 1984).

## HIV and Gay Male Sexuality

HIV changed this. At the beginning of the AIDS blight, gay men protested the suggestion that HIV was sexually transmitted. I can remember being at a meeting of the National Association of Gay and Lesbian Health Care Professionals in 1981 when the gay men in attendance shouted down US Center for Disease Control representatives who were trying to explain their theory of HIV transmission. The gay male professionals believed that the idea of sexual transmission was a myth promulgated by the government specifically to destroy gay male communities. This paranoia contributed to the resistance to closing bath houses and back rooms, as documented in Randy Shilts' book *And the Band Played On* (2011). And when gay men finally accepted that AIDS was transmitted through sex, it had a devastating impact on mental health. Many men retreated into complete celibacy, the practice of nonmonogamy decreased in gay male couples, and most men struggled with feelings that they (or their semen) were toxic, contaminated, and poisonous.

Community organizations like GMHC (Gay Men's Health Crisis) in New York City focused on prevention efforts, not on promoting monogamy or celibacy, but rather on educating men about 'safer sex.' They focused on the fact that it was not the number of partners that mattered in transmission, but the nature of the sex acts: condomless sex, especially for the receptive anal sex partner, was the culprit. And so besides emphasizing condom use, gay men's health organizations promoted sex acts, like mutual masturbation, that did not carry a transmission risk. To an extent, back rooms and bath

houses were replaced by 'J.O. Parties' (jerk off). Condoms were available in places that were venues for gay male sex. During the 1980s and 1990s, I frequently vacationed in the Fire Island, New York communities known to be gay-dominated. During one of those summers, our son, about eight or nine years old at the time, came back to our bungalow with a huge box containing hundreds of condoms that he had found on the 'Meat Rack,' a part of the sand dunes known to be a gay cruising area. He had no idea what they were, and his discovery provided a teaching moment for sex education!

As a result of prevention and education efforts and behavioral changes, the number of new HIV infections in the United States declined dramatically from a high of approximately 130,000 in 1985 to an estimated 50,000 in 2010. However, from 2010 to the present, the rate of new infections has stabilized at about 39,00 per year, and gay men account for two-thirds of new infections, with the rates for African American and Latino gay/bi men higher than those for whites (Centers for Disease Control and Prevention (CDC), 2020). There are many reasons for this: new infections are concentrated in the South, where HIV resources are scarce; an estimated 14% of HIV positive people are unaware of their status; the stigma associated with HIV prevents many people from getting tested or seeking help.

Indeed, even though many gay men in the 1980s developed the feeling that their semen was 'toxic,' that feeling seems to have shifted or disappeared. Certainly, the advent of antiretroviral treatments in 1996 helped transform HIV from a death sentence for all to a lifelong chronic disease for many, at least those who could afford these medications. And as the generation most affected by HIV has aged, younger gay men often have never known anyone to die from the disease. This has contributed to a lessening of fear. But beginning in the late 1990s there has been a resurgence of what is called 'barebacking,' or condomless anal sex (Shernoff, 2013). In 2013, the CDC reported that the number of gay men who had unprotected anal sex at least once in the past year had jumped from 47% in 2005 to 58% in 2011 (Paz-Bailey et al., 2013). Part of this resurgence is undoubtedly a reaction to the 'semen-shaming' of earlier days of the AIDS epidemic. Gay men often report, not simply that condomless sex provides more stimulation, but also that it leads to a sense of greater intimacy. Chemsex is also associated with barebacking, so the prevalence of the 'Party and Play' ethos contributes to unsafe sex. But a great deal of the resurgence of barebacking can be attributed to two things that are now common knowledge among many gay men. First, HIV positive men on antiretroviral drugs have undetectable amounts of HIV in their semen, meaning they cannot transmit the virus to another. Second, since around 2012, a drug regimen called PrEP – Pre Exposure Prophylaxis – has been increasingly available in the United States. PrEP is a combination of two medicines that are commonly used to treat HIV, and when taken daily, this regimen reduces the chances of HIV by over 90%. When initially

introduced, PrEP (often known by the trade name of Truvada) was controversial. Some feared that it would increase the incidence of unprotected anal sex among gay men so much that the protective effects would be overridden; 10% risk is not negligible. In fact, those fears have not been borne out. New infections among gay men, while they have leveled off and not decreased in recent years, are not the result of PrEP failure. They are related to factors such as inconsistent use of PrEP or ignorance about one's HIV status or the status of one's partner.

Gay male sexuality, despite HIV, is robust, enthusiastic, and varied. It includes acts which are alien to many heterosexuals or lesbians, such as fisting, or the insertion of the entire hand into the rectum. BDSM practices, called 'leathersex,' are so common as to be unremarkable. Gay men are usually very forthright about declaring their sexual preferences. For example, 'top,' 'bottom,' or 'versatile,' referring to one's preferred position for anal sex, are standard terms on gay dating apps. Although there are fewer gay bars, bathhouses, and backrooms than there were 30 or 40 years ago, they have been replaced by apps like Grindr and Scruff, which allow gay men to find nearby partners for casual sex at any time and any place.

## Clinical Work with Gay Men

What does all this mean for therapists working with gay men? First, as I mentioned in the prior chapter, it means you should be prepared to do trauma work with clients who were victimized in childhood by family or peers. I have found PTSD to be so common among adult gay clients that it influenced me to learn Eye Movement Desensitization and Reprocessing (EMDR). I suggest that all therapists working with this population be well versed in some methods for handling PTSD. Second, be aware that family relations may be fraught. In particular, gay men who were effeminate as children may not only have suffered bullying from peers, but from family members, especially fathers. If your client has not 'come out' to their family, they may have good reasons for staying in the closet, reasons you need to appreciate and respect. Low self-esteem is common among gay men, and it may frequently be focused upon perceptions of attractiveness and body image. Your gay male client is more likely to suffer from depression, anxiety, or an alcohol or substance abuse issue than a heterosexual male, and much more likely to have an eating disorder, while less likely to disclose this to you. He is just as likely to be involved in intimate partner violence as his heterosexual counterpart.

The gay male client may have effectively conquered his internalized homophobia. What is less likely is that he has evaluated his internalization of heterosexual male norms and that he acknowledges the destructive role they play in his psyche. In other words, he is not necessarily questioning the

wisdom or appropriateness of the 'macho' norms that impact him, and that often make him feel like a failure. To the extent that your client is involved in an urban gay community, it may be difficult for him to recognize the macho norms of this community and the impact of these norms upon his self-image. Many gay men can benefit from some basic lessons of feminist theory. As his therapist, you may be able to help him understand how 'the patriarchy' has negatively affected him by imposing unrealistic and unattainable standards for his behavior. If he stops internalizing those standards, he may be able to stop feeling like he is deficient.

Your gay male client is as likely as a heterosexual man to value sex highly, and more likely to have an extensive sexual history with many partners. He is likely to have, or desire, nonmonogamy in his relationships. In fact, if he wants to be monogamous he may experience negative judgments from his peers and/or partner. He may be HIV positive and feel some shame about that. If he is HIV negative, he may use PrEP, or he may not use it for fear of the stigma attached to this. A 2018 study of men using PrEP found that 20% had experienced 'slut shaming' from other gay men for their use of this protocol (Whitfield et al., 2018). If your client engages in barebacking, he may be reluctant to tell you, fearing judgment. As a therapist working with gay men, it is important that you examine your own values and beliefs. It is not enough to be gay positive. You also need to be sex positive, and non-judgmental about sex acts that you have possibly never heard of before!

### *Case Vignette: a Harm-reduction Approach with a Barebacking Man*

*The therapist in this case was my late colleague Michael Shernoff. The year was 2002, and Anthony was a 35-year-old HIV negative man who entered therapy because he was concerned that his barebacking activity was putting him at risk of infection. He was single and had mostly anonymous sex with several different men a week, men whom he met online and who also desired only casual sex. Indeeed, his activity was putting him at risk: he was engaging in condomless anal sex, as a 'bottom' or recipient, with men whose HIV status he did not know. Michael's first task was to assure Anthony that he did not judge him negatively for barebacking, that in fact he understood the allure of the practice and knew many men who engaged in condomless anal sex, and that he certainly did not judge him for his taste for casual sex and multiple partners. (Note: Michael felt a need to explicitly reassure Anthony despite being a gay man himself; if you are the therapist in a situation like this and are a woman and/or non-gay, you will need even stronger statements of acceptance.) Anthony's history included a period where he had been overweight during which he developed a great deal of insecurity about his attractiveness. Despite now being thinner, he still lacked confidence. His confidence could be temporarily restored by having sex with very*

*attractive men. Anthony believed that his willingness to be penetrated anally without a condom increased his desirability, and that without barebacking he would have far fewer sexual partners.*

*Clearly, Michael needed eventually to work with Anthony's low self-esteem and to help him find other ways of boosting his regard for himself. But in the short term, not only was controlling the barebacking Anthony's presenting problem, it was by anyone's standards very risky behavior in need of intervention. When Michael saw this patient, PrEP did not yet exist, or he would have suggested this immediately. However, even today some men reject the PrEP alternative for many reasons, including the fear that they won't follow a daily regimen, concerns about stigma, and worries about putting powerful chemicals in their body. Thus Michael's approach is still relevant.*

*Without PrEP, Michael instead needed to work on Anthony's behavior. Anthony knew he should be using condoms but didn't trust that, when he was seeking sex with a new and unknown partner, in the heat of the sexual moment he would have the impulse control to say no. Michael suggested a technique that is sometimes used by HIV negative gay men who bareback: serosorting or, in simple terms, finding out the HIV status of a partner and only barebacking with other HIV negative partners. While Anthony in principle agreed that serosorting was a great alternative, he confessed that he did not feel able to approach potential partners, whom he met online, with this question. His fear of rejection was too great.*

*To combat this, Michael suggested Anthony at first attempt to ask only men he did not find attractive. Anthony was actually able to do this, and he learned through experience that while some men were indeed offended by the question and rejected him, many others didn't and some seemed relieved that Anthony had raised the issue. Once Anthony was able to 'ask the question' of men he did not find attractive, Michael had him repeat this exercise with men he was slightly attracted to, then moderately attracted. In about three months Anthony was able to ask all the men he interacted with online about their serostatus and only bareback with those who were HIV negative.*

*This method was not foolproof, but it greatly reduced Anthony's chances of being infected. Once this problem was addressed, it was possible for Michael to help Anthony work on the underlying lack of self- esteem that led to his risky behavior. It is important to note that Anthony's therapist needed to be not only gay-affirming, but sex positive in a way that encompassed a comfort with a wide range of non-traditional sexual practices.*

### *Case Example: A Gay Man with Trauma-induced Alcohol Abuse and Self-defeating Behavior*

*David was a 27-year-old man seen at our IPG practice not long ago. Attractive and personable, he asked for help with procrastination. The therapist who*

*treated him was a psychology intern I supervised who was about the same age as David. In the first session, the intern, whom I will call Jules, told David that he himself was not gay, that he hoped that wouldn't be a problem, and that he was very gay-affirming and knowledgeable. This openness created an immediate bond between David and Jules, a bond that became more solid as therapy progressed. David reported that he had recently moved back home to Central Jersey after several years living in Manhattan where he was attempting to establish himself as a dancer. After many auditions and rejections, David gave up, moved into his mother's house, and got a job as a bartender. The procrastination he complained about was that he could not get himself to apply for other jobs. Although he was quite good at it, he hated being a bartender.*

*Over time Jules learned that David frequently drank to excess and that the bar job increased his alcohol consumption. He also found that David was prone to mood swings and that he comforted himself by buying things on the Internet; as a result, David was not even close to his goal of saving enough to move out of his mother's house. David minimized these issues and did his best to conceal his depressed moods, even from Jules. But slowly David began to talk about his painful past. As a child, he was seen by his father as 'effeminate' and this provoked contempt and anger toward David. He was not beaten, but his father took every opportunity to criticize and belittle his son. Moreover, his interests in dance, art, and fashion made him stand out as 'different' and 'girly' in the working-class traditional community in which he was raised, and he was often the target of bullies at school. High school was marginally better because his school had a Gay Straight Alliance (GSA) that provided some refuge. After high school he escaped to New York where he quickly became absorbed in a community of other gay Millennials. His move back home had been precipitated by a depressive episode during which David spent too much money and drank too much. This had forced David to go back to an environment that had been hostile growing up.*

*True to nature, when Jules pointed out the likely trauma induced by childhood events, David initially minimized the impact of them. But slowly Jules returned to these themes in sessions, speculating that the depressed moods David finally admitted to had their origin in the childhood contempt and disapproval he experienced coming both from his father and his classmates. He was even capable eventually of being in touch with the feelings triggered by memories of his childhood, and he cried in session, a big milestone.*

*Since interns only see clients for one academic year, it was inevitable that David would 'lose' Jules. Before this could happen, David decided to move to Los Angeles, where he had friends he could live with temporarily. It is unclear whether the knowledge that his sessions with Jules were ending factored into this decision. However, it did mean that David 'left' Jules before he could be abandoned. Treatment ended with David's commitment to seek therapy in Los*

*Angeles, and to look for a practitioner who could help him heal from his earlier trauma.*

This case is an example of how non-gay therapists might handle having a gay client. In retrospect, it was clear that Jules' 'coming out' as heterosexual facilitated bonding. It showed David that he was aware of their differences, unafraid to address them, and very eager to be helpful in any way he could despite them. Not all therapists might be quite so forthright in this kind of declaration. However, all therapists should be prepared to answer their clients' questions about their sexual orientation. Given the degree of homophobia that still exists in our culture, it is rational for gay clients to be wary of therapists and need to assess the therapist's knowledge, background, and attitudes toward homosexuality. Many gay men entering therapy look specifically for a gay male therapist. It makes sense for gay male clients to need to size up a non-gay therapist.

## Takeaways for the Clinician

Doing clinical work with gay male clients requires both an acceptance of same-sex orientation and some knowledge of specific issues. Your gay male clients are more likely to have suffered from bullying as children than female or heterosexual male clients, and to have self-esteem injuries related to mainstream standards of machismo, standards that may be to an extent reinforced by gay culture. Sex may play an important role in his life, and his sexual experience may challenge your knowledge, and your own standards. His support network may include his family of origin, but it may also be centered around 'chosen' family more than blood relations. You need to be equipped to do trauma-informed treatment. However, you should also be prepared to be awestruck by the resilience of clients who have triumphed over discrimination, rejection, and stigma.

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# 3

# TRANSGENDER TEENS AND GENDER-IDENTITY DISCLOSURE

Laura R. Haddock

***Suggested Uses:*** Activity, homework

### Objective

This activity is designed for use with adolescents who identify as transgender or gender nonconforming and are contemplating disclosing their gender identity to friends or family.

Disclosing as trans or genderqueer to parents, caregivers, guardians, or loved ones is an important step toward empowering youth to feel confident in their gender identity. This activity was designed to be used with individuals who have not completed a gender role transition. The exercise can be used in individual or group therapy or can be assigned as homework for clients to engage in privately. Clients will be asked to articulate and explore their feelings related to changing gender identity during a letter-writing exercise to allow them to practice finding the words they would like to use to deliver this message, as well as explore any fears or concerns that may need to be addressed in the therapeutic process before initiating the disclosure process.

### Rationale for Use

Much of the literature related to the coming-out process that aims to be inclusive of transgender experiences treats sexual orientation and gender identity disclosures as parallel (Liang, 1997; Wood, 1997). However, Zimman (2009) challenges the assumption that the coming-out processes for those who identify as trans are analogous to the coming-out process for sexual identity. For those who identify with a gender that does not match their natal sex assignment, there is frequently great societal pushback related to failure to "enact gender in socially prescribed ways" (Gagné, Tewksbury, & McGaughey, 1997, p. 479). Any variation from traditional male and female gender roles, gender identity or expression, and heterosexuality is met with condemnation, control, modification, punishment, or efforts of behavioral extinction (Chen-Hayes, 2001). It is important to note that researchers have identified critical differences between the coming-out processes for gender identity and those for sexual identity, which emphasizes the need to consider all individuals on their own terms and not make assumptions of commonalities with other queer groups (Zimman, 2009).

Beals, Peplau, and Gable (2009) found that individuals reported lower psychological well-being (self-esteem, positive affect, and satisfaction with life) on days when they concealed rather than disclosed their gender identity. Research has shown that negative reactions from close friends and family following disclosure happened less frequently than anticipated (Gagné et al., 1997), findings that offer a positive perspective on the benefits of disclosure. However, therapists cannot discount the reality that hate violence is a prevalent and deadly issue faced by transgender communities. The 2013 report on hate violence (NCAVP, 2014) highlights the incidence of hate violence against trans individuals at disturbingly high rates. In addition, trans people are frequently targets for fatal hate violence. For example, the report indicates that transgender people of color are six times more likely to experience physical violence from the police than white cisgender survivors and victims. Transgender women are 1.8 times more likely to experience sexual violence when compared with other survivors. Additionally,

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transgender women are more likely to experience police violence, discrimination, harassment, threats, and intimidation. These startling statistics demonstrate the pervasive violence and harassment that those in the trans community face from both the police and overall society. According to FBI statistics, in 2014 there were 218 reported hate crimes in the United States related to gender identity and gender nonconformity (U.S. Department of Justice, 2014). Aggression such as verbal harassment can be pretty terrifying under certain conditions. Thus, incorporating a therapeutic exercise designed to facilitate thorough exploration of the coming-out process allows clients to express themselves without interruption, choose and revise their words until they feel comfortable with them, and explore potential reactions within the safety of the therapeutic environment before initiating a formal disclosure.

According to Erikson (1963), identity formation is the most significant developmental task during adolescence. For gender-nonconforming adolescents, an additional task is developing a positive gender identity (Dispenza & O'Hara, 2016). Gender identity formation is complicated for many adolescents who feel pressures to conform to an assigned gender identity and societal gender norms. This pressure to conform often conflicts with an internal need to express authentic feelings of self (Gagné et al., 1997). When youth disclose their nonconforming identity to parents, they know they must deal with their parents' immediate and long-term reactions (D'Amico, Julien, Tremblay, & Chartrand, 2015). Managing the transition into a minority identity status can be stressful, especially if adolescents fear potential change in significant family relationships or relationships with friends and other caring adults (Russell, 2003). Because trans adolescents often lack access to identity-affirming resources (dickey, Singh, Chang, & Rehrig, 2017), many of them feel alienated. Klein, Holtby, Cook, and Travers (2015) have captured themes common in counseling literature for adolescents struggling with identity development. These themes include feeling different from peers and experiencing a need to disclose these differences. Additionally, the process of gender-identity development typically includes a rejection of societal norms, which may include shocking acting-out behavior before becoming comfortable in their own identity (Maguen, Shipherd, Harris, & Welch, 2007).

The professional counselor's role includes advocating for social justice and challenging oppression and violence (Chen-Hayes, 2001). Affirmative practice includes advocating against oppression and violence that targets gender-nonconforming and transgender youth. Clinicians are ethically bound to promote environments that affirm all gender identities. Although the American Counseling Association's (ACA, 2014) *Code of Ethics* (C.5) states that counselors must provide nondiscriminatory services that are based on variables inclusive of gender identity, the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) (2009) competencies for counseling transgender clients offer a comprehensive guide for use in counseling transgender clients.

Coming out or disclosing a nonconforming gender identity is one indicator that identity development is crystalizing (Bussey, 2011). In accordance with the ALGBTIC (2009) competency A.1, counselors should affirm that all persons "have the potential to live full functioning and emotionally healthy lives throughout their lifespan while embracing the full spectrum of gender identity expression, gender presentation, and gender diversity beyond the male-female binary" (p. 4). While disclosing nonconforming gender identity to parents is considered a difficult process, there can be many psychological benefits (dickey et al., 2017). However, it is critical for clinicians to recognize and understand the importance of using appropriate language (e.g., correct name and pronouns) with transgender clients; be aware that language in the transgender community is constantly evolving and varies from person to person; seek to be aware of new terms and definitions within the transgender community; honor clients' definitions of their own gender; seek to use language that is the least restrictive in terms of gender (e.g., using clients' names as opposed to assuming which pronouns the clients assert are gender affirming); recognize that language has historically been used to oppress and discriminate against transgender

people; understand that the counselor is in a position of power and should model respect for the client's declared vocabulary (ALGBITIC, 2009, B.1, p. 15).

Unfortunately, unlike gender-nonconforming people, whose developmental experience emerges from an intrinsic need for identity authenticity, family members are often unwilling participants on this journey (Gagné, Tewksbury, & McGaughey, 1997).

Supporting adolescents who choose to disclose gender nonconformity to their caregivers promotes the emotional well-being of these youth. Identity disclosure allows adolescents to acknowledge a nonconforming identity to others. According to the American Psychological Association (APA, 2011), though development, expression, and disclosure often occur sequentially, others may display nonconforming identity behavior but not identify themselves as transgender or genderqueer. APA (2011) further suggests that others may define and disclose their gender identity but choose not to express it. Adolescents often choose not to reveal a gender-nonconforming identity, opting instead to withdraw from friends and family and withhold sharing their true identity. This withdrawal is often grounded in fear of parental rejection and abuse and a desire to avoid hurting or disappointing parents (D'Amico et al., 2015). Disclosing one's gender identity to those closely connected (or not so closely) is rarely a onetime event. It is a process that clients often find continues throughout their life, as they disclose to many people over time. Coming out refers to the lifelong process of the development of a positive transgender identity or gender-nonconforming identity. Unfortunately, some young people perceive this as an isolated event that is characterized by simply saying the words out loud and setting the record straight (Morrow, 2006). For some, it is a very long and difficult struggle because they often have to confront many transphobic attitudes and discriminatory practices along the way.

Before initiating the process of informing others, clients need to explore any of their own existing negative stereotypes and feelings of transphobia that they learned growing up. To learn to feel good about who they are, individuals ideally need to feel movement away from repulsion and pity, and tolerance toward feelings of appreciation and admiration (Corrigan & Matthews, 2003). However, therapists must remember that because the adolescent is identified as the client, they should carefully adhere to ACA (2014) ethics code B.5.b. and remain sensitive to the "cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians regarding the welfare of their children/charges according to law" (p. 7). Counselors will ideally work to establish, as appropriate, "collaborative relationships with parents/guardians to best serve clients" (p. 7).

There are multiple issues counselors should be aware of that have the potential to create barriers to disclosure to parents or to complicate the emotional well-being of trans or genderqueer clients. For example, friends or family could demonstrate transphobia such as emotional disgust, fear, anger, or discomfort felt or expressed toward people who do not conform to society's gender expectations (Fisher et al., 2016). Negative reactions can include a variety of behaviors that range from disapproval to criticism for not coming out sooner. If, after disclosing gender identity, an individual is accused of not coming out sooner as a result of a perceived gain acquired by continuing to hide the nonconforming identity, the result is a lose-lose situation for the client (Corrigan & Matthews, 2003). Under this logic, courageously opening up about personal identity constitutes evidence of dishonesty. "People come out when they are ready to do so, and shaming them for not doing so sooner constitutes a rejection of their own experience with their identity" (Ford, 2014, p. 1). If deemed appropriate, the following activity is designed to promote an exploration of thoughts, feelings, and potential fears related to coming out as gender nonconforming, the initial act of disclosure, and life following initial disclosure.

### Instructions

This exercise can be used in individual or group therapy or can be assigned as homework for clients to engage in privately. The two main purposes of the exercise are to empower clients to articulate their identity in their own words and to illuminate any unresolved fears related to the coming-out process. The exercise of writing the letter is broken into three primary topics: self-awareness, self-affirmation, and action steps. Suggestion 1 facilitates exploration of the client's self-

awareness and offers an opportunity to reflect on childhood memories that are meaningful in relation to gender-identity development. Suggestion 2 provides an opportunity for clients to build confidence related to their gender identity and offer reassurance to others, if appropriate, that a shift in gender identity does not mean an end to the person they have known. Suggestion 3 invites clients to determine which actions they would like to see occur following the disclosure, including name and pronoun changes. Finally, Suggestion 4 gives clients the opportunity to set boundaries with regard to those with whom they are comfortable having the information shared.

If the exercise is used in session, the client may be given the questions one at a time or all at once. Ideally, allow the client to read all the questions in the session before completing the exercise so they can give thoughtful consideration to the topics before formally answering the questions. When executing the exercise, the client should be provided with the exercise in printed form and allowed some quiet time to complete the answers. Because most sessions are limited to roughly an hour, that is probably not enough time to fully answer and explore all four parts of the draft of the letter. Thus, one session may be devoted to having the client draft the letter and another to exploring the content. Alternatively, administer the questions and explore the answers one at a time over the course of several sessions. If the exercise is assigned as homework, give consideration to the same conditions for administration, determining whether to offer all questions at once or to administer them independently in a series of assignments.

### Brief Vignette

Jessica is a sixteen-year-old white adolescent who was assigned female at birth. She currently resides with her paternal grandmother, who became Jessica's primary caregiver after the death of Jessica's mother and the incarceration of her father. Jessica and her grandmother reside in a rural area and are part of the white racial majority that appears to have little tolerance for racial diversity. Jessica reports she holds conservative Christian views, and she is currently living in depressed socioeconomic conditions: the primary income is provided by government assistance. Jessica is an only child, and Jessica's parents married when they were teenagers after her mother became pregnant. Neither parent completed high school. Jessica is very assertive about her Christian beliefs; her grandmother has not expressed any indication of assigning the same meaning to her own spiritual beliefs, which she defines only as "believing in God." Jessica reports that her mother also identified as Christian when she was alive, though she displays distress when reporting that her father claims he has converted to Islam while in prison. Jessica was referred to outpatient individual counseling as aftercare following a brief inpatient hospitalization for depression and suicidal ideation. Jessica has a history of cutting herself on multiple occasions and withdrawing from friends and family, and she has a deteriorating relationship with her grandmother.

Through the course of therapy, Jessica shares the information that for several months she has struggled with feeling that she does not fit in at school and that her family does not understand her. It proves to be fairly easy to establish a therapeutic rapport with Jessica, as she seems to desire genuine connection and acceptance. During the therapeutic process, she is increasingly open about her interests and identity. She reports that she is interested in trying out for the power-lifting team, which has been met with confusion by her school because she is the only girl who has expressed a desire to participate. Her grandmother, who has allowed her to pursue the sport, expresses confusion over why she wants to participate in a "sport for boys." Jessica also mentions being sexually attracted to a girl whom she identifies as her best friend. Ultimately, as Jessica begins to explore her sexual identity, she reports that she does not identify as gay. This report is somewhat incongruent with her sexual interest in her female friend. At this point, Jessica reveals that she identifies as male. She goes on to explain that her pronouns are male and asks to be called Jesse.

During exploration of his gender-identity development, Jesse reveals that his depression and isolation are primarily a result of the assumed rejection and reprimand he has felt from his grandmother related to his interests and identity, which do not align with traditional female gender norms. He reports making an effort to introduce his grandmother to the concept of transgenderism by making vague references and

comments. He reports that his grandmother's response was passive, and he perceived her attitude to be one of disdain and disapproval, although her attitude was not entirely clear because she refused to be open to any discussion. She assertively responded that being transgender was a "sin" and that Jesse is simply "confused." She now insists that Jesse wear makeup and nail polish, "like girls are supposed to," which offends Jesse's sense of self. Jesse verbalizes a desire to communicate with his grandmother about his gender identity. Jesse and his therapist determine that writing a letter will be the first step toward articulating his thoughts about his identity and the steps he would like to take moving forward. He has specifically expressed a desire to secure a binder and investigate the option of hormone blockers. The therapist asks Jesse to write the letter as a homework assignment after establishing that he has a secure and confidential way to do so and does not feel that his private writing is at risk of being discovered. Jesse reports that he has a password-protected tablet and that he is comfortable completing the exercise at home. He is motivated to complete the exercise, as he is determined to "accept myself and move forward."

Jesse returns to his next therapy appointment in two weeks and has completed all four components of the letter. He describes those two weeks as "two of the most agonizing weeks of my life." He describes the activity as simultaneously painful and liberating. He admits that he did not expect giving words to thoughts that had lived only in his head would be so challenging. He reports having difficulty even reading his own words without crying. The focus of therapy for several weeks following the exercise is exploring Jesse's thoughts and feelings as articulated in the letter and subsequently addressing his grief and fear about what will happen after disclosing his identity to his grandmother and other family members. He worries what his aunts and cousins might say; however, he is convinced that his school peer group will be accepting, which leaves him feeling more confident that he will have a solid support system. Ultimately, he expresses a desire and willingness to give the letter to his grandmother and formally come out to her as transgender.

### Suggestions for Follow-up

The exercise of writing the letter may unleash a flood of emotion for the client. Following the creation of the client's disclosure script, you may want to follow up with an exploration of the client's thoughts and feelings, discussing the client's authentic self as an affirmative practice that facilitates client empowerment. The process of writing the letter may be quite painful, and you should follow up and allow the client to spend time processing their thoughts and feelings before determining readiness to deliver the letter to the intended recipients.

After crafting the disclosure letter and evaluating the timing for coming out, an additional follow-up could include facilitating an opportunity to prepare for various types of responses to the disclosure. It is impossible to predict how others will respond to it. Thus, consideration for the reactions anyone could have, as well as how the client might plan to deal with them, are a good follow-up to the activity. Cultural norms inform belief systems, frames, perceptions, understandings, and behaviors, which can result in a complex challenge for even the most culturally sensitive counselor. Explore the client's feelings and potential responses if someone reacts with hate, unconditional love, or apathy.

### Contraindications for Use

Because of the sensitive and confidential nature of the exercise, it is important to carefully weigh the risk of discovery with the benefit of the exercise. Carefully exploring the client's vulnerability to discovery is critical before assigning this exercise as homework. In addition, this exercise can be deeply emotional; thus, it is important to weigh the potential for activating a powerful emotional response that would be better managed in the presence of the therapist before assigning this exercise as homework. Every therapist should thoroughly consider whether there is a risk for the parent or caregiver to discontinue treatment or respond violently if the letter is discovered. If therapists are concerned that the client's emotional or physical safety would be at risk in any way, this exercise may not be appropriate for use as homework.

## Professional Readings and Resources


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## GUIDELINES FOR THE LETTER

Making the decision to come out as trans or genderqueer to your friends and family is an important first step toward embracing your authentic self.

**Here are some suggestions to get you started:**

**1**. Describe how long you've known you were different and how you came to realize that trans/gender-queer/etc. is the term that best communicates your identity. This can help others understand this is not a stage, an impulsive decision, or an act of teenage rebellion.

**2.** Reassure family and friends that you are and will always be the same person inside. Tell them that you will be okay and know you can still have a happy life that includes your future goals, such as going to college, having a career and a family, travel. Anything you want for your future is still possible!

**3.** End your letter with "action steps."

- What do you want or need from your family?
- You may also want them to start using a different name or pronouns for yourself. Let them know what they are and why these things are important to you.

**4.** Be specific about whom you do or do not want them sharing this information with.

**Here are some helpful hints to remember as you are writing:**

**a**. Your goal is to share this aspect of your identity with your loved ones, not ask for their permission to be who you are.

**b**. Keep a respectful tone. You are looking for respect and support, so show the same toward those you are writing to.

**c.** This information or even the concept might be new to them, and they may have a lot to learn about gender identity before they fully understand. Be simple. Transgender identities can seem completely foreign to many people. Stick to the basics as you begin.

**d**. Your family loves you and, consequently, they worry about you. Negative reactions often come from their being worried about you, your future, and your safety.

**e**. Be yourself. The most important thing is to relax and just tell your story! Keep it personal and about you.

**f.** Your loved ones will also need emotional support, so it's unfair to ask them not ever to tell anyone at all. It is appropriate to ask that they let you have your own conversation with a sibling, other parent, or family member first. Try not to wait too long, though, because withholding information about something important and emotional can be quite stressful.

**g.** Finally, remember that this will not be a "one and done" conversation. Think of this as your "opening monologue."

# 2

# ETHICAL CURIOSITY

*Lucie Fielding*

"Fascinating!" he said, leaning forward in his seat, opposite mine. His eyes scanned me, taking in my form, scrutinizing every inch of me. I could have sworn that he licked his lips and rubbed his hands together, but I cannot say for certain. What I am sure of is that I felt in that moment as if he had. He was my first clinical supervisor. I had just come out to him as trans, and, sitting in that chair, facing his queries, his penetrating gaze, every molecule in my body wished that I hadn't.

His questions had been innocent enough, at first. (They seem to always begin that way!) But before I knew it I was being asked whether I would have "the surgery" (meaning, for him, a vaginoplasty), whether my wife and I would be staying together, how she identified sexually, and what sex was like with us. It went on like that for half an hour: a barrage of questions, each followed by a "fascinating!" And when I finally stumbled out of my supervisor's office, I felt like there was not a hot shower long enough to cleanse me. I felt exposed, nauseated, dirty; and I felt a sharp pang of shame. It was the type of shame that would, two and a half years later, greet me following two sexual assaults. It's taken me a long time to learn that my failure to fight back or to flee the space was not something I should be ashamed of in the least. And so, as tears welled in my eyes and I slumped in the chair of my shoebox of an office, exhausted, I instead lambasted myself that I hadn't cut off my supervisor's interrogation the moment he had slipped into sexualizing territory, that I hadn't firmly told him that his questions were not ok.

The thing is, this was neither the first nor the last time something like this would happen to me. And the general contours of this story—with its insistent questions and its fetishizing, objectifying gaze—are not uncommon

to many trans and non-binary folx. As Perry Zurn states, trans and non-binary folx "consistently experience themselves as the object of" cis folx's curiosity, whether that takes the form of "long looks, stares, or outright gawking by people on the street […], the well-meaning, but often invasive questions of friends and family […], the battery of questionnaires and exams conducted by medical professionals […], or the spectacularizing attention afforded trans icons across various social media."[1]

And so much of the curiosity that trans and non-binary folx experience from cis people is related to *if* we, *how* we, *with whom* we, and *with what* we fuck; or the shape, character, and function of our genitals. "Have you had 'the surgery'?" "What have you got going on 'down there'?" "How do you go to the bathroom?" "Do you still have a penis?" "Do you still get your period?" As a result of this invasive, objectifying cis gaze, Zurn notes, many trans and non-binary folx "live defensively, constantly parrying unwanted attention, often in a vain attempt to guard not only their privacy but their legitimacy."[2]

Each of the chapters of this book places a heavy emphasis on cultivating curiosity, wonder, and exploration; or evoking a client's capacities for engaging their erotic imaginations. In Chapter 1, for example, I briefly discussed Zurn's concept of "trans curiosity." And in the next two chapters (Chapters 3 and 4) I will introduce two conceptual stances—coming into passionate relationship, and coming into compassionate relationship, with the embodied sexual self—that depend on nurturing curiosity and wonder about one's embodied sexualities. And as providers we are often taught that curiosity is a value worth cultivating in ourselves. Indeed, how often do we, as providers, begin an intervention with something along the lines of, "I'm curious…"? Curiosity in and of itself is not bad and there are many instances when it can be empowering and open us up to possibility. The problem is that it can also be dehumanizing and disempowering and can shut us down. In these instances, curiosity can actually be unethical.

In this chapter, the first of four that explore conceptual frameworks for work with trans sexualities and erotic embodiments, I introduce a clinical stance I call *ethical curiosity*, one that is constituted by three fundamental principles: dismantling entitlement, seeking permission, and treating the client in the room. This stance emerges out of the observation that curiosity is not an ethically neutral value.[3] A curiosity grounded in ethics also recognizes that members of marginalized groups and vulnerable or underserved populations often have to perform a great deal of emotional labor for their care providers (in the form of educating) and that this labor is not only depleting but also a source of rupture in the provider–client relationship. If the clinical gaze can often be perceived as invasive, othering, and de-humanizing, ethical curiosity proposes another model of relating, one that respects and empowers the client.

## Mangogul's Ring

In our contemporary understanding of it, curiosity has a positive value, a capacity that speaks to a deep desire to explore and to know. Research psychologist Todd Kashdan defines curiosity as "the recognition, pursuit, and desire to explore novel, uncertain, complex, and ambiguous events" as well as a "feeling of interest in a situation where a potential exists for learning."[4] For Kashdan and others, curiosity is a "fundamental human motive" and a prosocial behavior that ultimately allows one to "expand knowledge, build competencies, strengthen social relationships, and increase intellectual and creative capacities."[5] This book and this author generally promote the view that curiosity is a virtue worth nurturing and developing both interpersonally and intrapersonally. But curiosity is not *intrinsically* good or a virtue, and the desire to know and explore, particularly within the person of the provider, needs some examination, unpacking, and troubling. For, largely missing from the ways that curiosity is explored in the psychological literature are the ways that curiosity can be experienced interactionally and how it can replicate oppressive dynamics that exist within society at large. To put it another way, we often talk about the positive benefits of being a curious person, but we rarely consider the impact of curiosity on the folx who are its objects, on whom curiosity's appetitive gaze is turned. In an interpersonal setting, what the curious person may experience as an opportunity for growth and learning might be experienced by the object of that curiosity as objectifying, tokenizing, or fetishizing. And engaging in curiosity without regard for how the person experiences that curiosity is not only unethical but shuts down possibilities for reciprocity and joining-with.

Curiosity's shadow, particularly with respect to how certain (sexual) bodies can become a focus of a probing, invasive, and essentializing gaze, is nicely emblematized by *Les Bijoux indiscrets,* an erotic novel by the Enlightenment philosopher Denis Diderot.[6] First published in 1748, *Les Bijoux indiscrets,* or, in English, *The Indiscreet Jewels*, focuses on the misadventures of a vaguely non-European potentate, Mangogul, and his efforts to overcome ennui through a penetrating investigation into (cis) female sexuality. The basic plot is that a genie presents the bored prince with a magical ring. The ring, when rubbed and pointed at the women at court, forces their genitalia—their *bijoux*, or jewels—to recount their owner's sexual adventures. What follows is a series of vignettes narrated by these indiscreet and loquacious jewels that reveal and lay bare secret and suppressed sexual stories. Once unmuffled by the ring's power, the genitals, per Diderot's reckoning, were compelled to speak sexual truths that their bearers' mouths would—or could—not speak. (These forced sexual confessions, as one might imagine, were deeply disconcerting for women upon whom the ring was turned.)

Nearly 230 years after the publication of *Les Bijoux indiscrets*, French theorist Michel Foucault used the novel as an allegory for how power operates through discourses of/on sexualities, declaring in the first volume of his *Histoire de la sexualité* that his chief aim was to "transcribe into history the fable of *Les Bijoux indiscrets*."[7] According to Foucault, "we have all been living in the realm of Prince Mangogul: under the spell of an immense curiosity about sex, bent on questioning it, with an insatiable desire to hear it speak and be spoken about."[8] One of Foucault's central assertions is that over the course of the eighteenth and nineteenth centuries a medico-moral discursive apparatus developed to interrogate the contours of pleasure as well as to medicalize cultural anxieties surrounding emergent constructs of sex, gender, and sexuality. This apparatus, which, among other things, culminated in *catalogues raisonnées* of disorders of sexualities such as Krafft-Ebing's *Psychopathia Sexualis* and the creation of Freudian psychoanalysis (the so-called "talking cure"), Foucault argues, emerged from older confessional modes.[9] This new mode re-deployed and secularized the Catholic sacrament of confession with its dogged pursuit of sexual thoughts, urges, and behaviors down to their "slenderest ramifications," but within the exacting language of social science, psychiatry, medicine, and the law—a "regulated and polymorphous incitement to" sexual speech.[10] And, like sacramental confession, the types of confession that would proliferate beginning, roughly, in the eighteenth century would "[unfold] within a power relationship, for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile."[11]

Thus, we might consider the so-called fundamental rule of classical psychoanalysis, an instruction Freud gave to all analysands at the beginning of treatment to speak of "whatever comes into their heads, even if they think it unimportant or irrelevant or nonsensical…or embarrassing or distressing."[12] As for the analyst, their corresponding imperative was to receive these images, phantasies, and utterances with "evenly suspended attention" and intervene only sparingly and with well-formulated interpretations of analysand material.[13] Thus, the analyst is given license to ask the analysand to delve into the most intimate details of their lives, while concomitantly maintaining a sense of privacy and propriety over their own, all so that the analyst might serve as a blank screen upon which the analysand might project their unconscious phantasies. The analyst becomes "a receptive organ toward the transmitting unconscious of the patient."[14]

Crucially, Foucault's allegorical deployment of Diderot's *Les Bijoux indiscrets* does much to raise suspicion about the supposedly morally neutral stance of the therapist-confessor, revealing how power operates and

replicates itself through the production of speech about sex, but also how the act of taking confession—the act of sitting with—can itself be titillating.

> *Pleasure in the truth of pleasure, the pleasure of knowing that truth, of discovering and exposing it, the fascination of seeing it and telling it, of captivating and capturing others by it, of confiding it in secret, of luring it out in the open – the specific pleasure of the truth discourse on pleasure.*[15]

I think, here, of a clip from the 1962 remake of Robert Weine's German Expressionist psychological thriller, *The Cabinet of Doctor Caligari* (1920). Beginning with the age at which she first allowed a man to "make love" to her, Dr. Caligari (a psychoanalyst) insistently and mercilessly bombards his hapless analysand with a series of increasingly revealing questions designed to incite sexual speech; here, the detailed narrative of the analysand's sexual debut:

> *What did you feel, what did you think? Were you pleased, frightened, ecstatic, disgusted? What did he say? What words did you speak? That's what I want to know. Now, tell me, now, now, all of it, now, tell me, yes!*[16]

The film's director, Robert Kay, presents psychoanalysis as a nightmarish vision of prurient excess, a psychic sexual assault. Caligari probes relentlessly, insistently, veritably assaulting his young, female analysand with questions while never allowing her to respond. His demand: "tell me now, now, all of it now." Each "now" builds toward crescendo, confirming Caligari's sexual tension, while his exclamatory "yes!" is delivered almost as if it were an orgasmic ejaculation.

Although contemporary psychoanalysis and psychotherapy are, in so many ways, a far cry from how they are represented by both Robert Kay's Caligari and Foucault's ring-bearing analyst-confessors, I maintain that Foucault's critiques remain trenchant and useful. At the very least, they illuminate the shadow side of therapeutic action, and how we, as providers, can all too easily find ourselves operating as unwitting tools of social control or working from a place that serves our desires rather than those of our clients and patients.

"Every time we speak," suggest narrative therapists Jill Freedman and Gene Combs, "we bring forth a reality. Each time we share words we give legitimacy to the distinctions that those words bring forth."[17] This does not constitute an injunction against offering reflections or interpretations or posing questions, but rather a warning that we need to do so with care and

as informed, ethical users. For, as the genie warned in depositing the magic ring in Mangogul's hands, "remember that curiosity can be misdirected."[18]

## Curiosity and Entitlement

For many trans and non-binary folx, Diderot's phantasy of genitals forced to speak their truths and relate their stories for others' entertainment feels all too real. Trans folx attract a particular form of invasive curiosity about their sexual lives and sexual bodies, what J.R. Latham calls "genital-curiosity."[19] Genital curiosity shows up in so many domains of trans folx's lives, from media and popular culture to interactions with cis friends and family members.

Part of this is the superordinate value placed on "the surgery" as well as a fascination with how trans and non-binary folx date and have sex. As the actress and activist Laverne Cox states in *Disclosure*, a documentary she co-produced, "This focus on surgery became the ways in which trans people have really been talked about for 60 years."[20] One of the more discomfiting things *Disclosure* does is highlight the media's decades-long, obsessive genital-curiosity. The film shows clips of talkshow hosts, from Tom Snyder interviewing Christine Jorgensen in 1982 about the significance of gender-affirmative surgeries, to Katie Couric interrogating the model Carmen Carerra in 2014 about her "private parts"— asking they're "different now, aren't they?"[21]

This curiosity arises out of a deep sense of entitlement. It is an entitlement to hear about medical history and to probe trans sexualities (as well as the trans subject's feelings about said medical history and sexuality). Interviewers often claim to speak for a faceless general public who "want to be educated," as Couric declares in her interview with Carerra.[22] But is this education really necessary? Interviewers rarely ask about the genitals of their cis subjects; doing so would be impolite, after all. In media appearances, trans and non-binary people are offered no such consideration of their right to privacy. Reflecting on the experience of being interviewed by cis folx, activist and writer Janet Mock explains that she feels as if she is tasked with carrying "the burden of people that, they're expecting me to communicate all these things, but also to give all this private information about my body and my journey and my life."[23] This is done, she suggests, because her interviewers occupy "a space of entitlement" but cloak that entitlement in the position that, "Well, our viewers really want to know. This is something people really wanna know."[24]

The same objectifying, de-humanizing curiosity and entitlement to know also show up in interactions with friends, family, and colleagues. Zurn notes that the "relative position of intimacy with a trans person" can give groups and individuals the impression that they have their own sense of entitlement,

a "right to full disclosure, warranting any demand for information they can muster, whether regarding names or pronouns, hormones or surgery, sexual practices or dysphoria."[25] Again, the disposition of cis folx's genitalia are regarded as a private matter that is not particularly important to anyone other than their partners. And yet somehow it is viewed as acceptable to ask trans and non-binary folks these questions and acquiring such private information is often seen as somehow relevant to understanding how trans a person truly is, or where they are in the course of their transition.

For my part, when I began my transition, many friends and family members were particularly interested in knowing about the status of my relationship with my wife, asking whether we were "ok" and whether we would choose to separate or remain together. Some of this was genuine concern for how my wife was dealing with my transition, but some of it was an unstated set of misgivings about whether these friends and relatives could see themselves as remaining in a relationship with a trans person. Friends and family members also inquired about whether I would ultimately pursue a vaginoplasty, assuming that this would be my end goal for gender affirmation. This came along with a scrutiny of images of me, seeking hints of physical traits or mannerisms that would betray gender presentations and expressions culturally consonant with the gender I was assigned at birth. Finally, I found that my transition, my gender identity, quickly became public property, in a sense. When introducing me to new people, family members would sometimes divulge my history, including what my deadname is, the gender I was assigned at birth, and when I opted to pursue elements of social and medical transition. Did a colleague of a family member really need to know that I am trans, or did that family member simply decide that their friend and colleague was *entitled* to that information at the outset?

To be sure, as Sam Orchard rightly points out in an article and accompanying set of comics he composed for *Dude* magazine, "[depending] on the context and scenario, certain questions might be totally okay to ask."[26] It is entirely appropriate to ask about how a sexual partner wants to be touched, what they want certain body parts to be called, and how they like to fuck.

But for the most part, the scrutiny trans and non-binary bodies seem to attract is unnecessary and invasive. And, indeed, beside the point! The preoccupation cis folx have with "the surgery" and how we use our genitals objectifies and fetishizes trans people, such that we don't get to talk about our real, lived experiences.[27] As Julia Serano puts it in *Whipping Girl*, by focusing on genitalia, this invasive, prurient curiosity reduces "us to the status of objects of inquiry" and cis folx can "free themselves of the inconvenience of having to consider us living, breathing beings."[28] As such, the specific needs and concerns of certain populations of trans and non-binary people can be rendered "invisible, including the needs of trans refugees, migrants,

sex workers, drug users, poor trans people, and homeless trans people."[29] Also left out?—the complexities and heterogeneity of trans desire, eroticism, pleasure, and relationships. Genital curiosity, as Amy Marvin notes, pulls us in to "wonder" about trans worlds and experiencing, "but not in order to actually see ourselves from the vantage points of [those worlds], or really understand it in careful, particular, and historical complexity."[30] In short, a direct line might be drawn between the kinds of imaginative failures I explored in the last chapter and genital curiosity.

Because genital curiosity is a phenomenon with which most trans and nonbinary folx are all too familiar, they often go into social interactions or spaces of public accommodation girding their loins for inappropriate questions, denuding stares, and ill-informed statements. In public, I perceive a host of non-verbal cues that translate to a person attempting to assign a gender to me, a process some of my trans clients refer to as "clocking." I know these cues because I know I give them off too sometimes, in spite of my continued efforts to unlearn them. Many of us do, cis or trans, but it rarely feels good for the person whose body is being psychically processed so that it can be fit into a ternary of gender boxes: male, female, or, unassignable. The gawking, the stares, the non-verbal assignments of gender are uncomfortable in and of themselves to perceive, but they also can lead to physical violence and verbal assault. To this day, each and every time I enter a restaurant or store or bathroom I make a mental map of my surroundings, hypervigilant to potential areas of threat and identifying escape routes to safety.

Therapeutic interactions can also be fraught for many trans and nonbinary clients. Under the historically prevailing diagnostic model of care, a primary role of the provider, and particularly the qualified mental health practitioner, is to assess whether their client meets the diagnostic criteria for Gender Dysphoria in the DSM-5, criteria which includes evidence of "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[31] This enshrines a power dynamic that puts the provider in the position of inciting speech via a probing, assessing curiosity, and entitles them to expect specific performances of presentation and expression from their clients. That is, in order to access particular forms of desired medical care (e.g., particularly gender-affirming surgical interventions, but, in some cases, even hormone therapies), clients have had to learn the particular stories "they must tell to achieve their goals."[32] This is a very real example of how an entitlement to curiosity is written into the standards of care for trans folks. There is no instance I can think of where cis individuals have to prove something about themselves to a mental health provider to access desired or needed medical interventions.

As providers, we have to anticipate and work to create spaces to address the stress occasioned by our curiosity, a work that starts from the first moment an individual or relational unit inquires about working with us.

It begins with intake paperwork and extends to how we hold space in the room itself from the first session onwards. The first principle grounding that holding of space is actively working to dismantle our burning desire to know about particular aspects of a client's story and personal history, a principle that I begin to unpack in the next section.

## Dismantling Entitlement

At the heart of a process of dismantling our entitlement to know is a guiding question, "Who is this for?" This question can be broken down further as we enquire why we feel we need to know certain information, what assumptions or dominant narratives we might be bringing to our work with trans and non-binary clients, and when we should ask them for information vs. when we should do our own research.

It is important to recognize that dismantling entitlement is not so much a set of hard and fast rules as a process and a way of thinking about what we do and do not ask of our clients. These are never easy questions to answer; I struggle with these issues in working with clients, despite the fact that my trans identity may make me in many ways intimately familiar with what some of my trans clients are facing. For instance, in one-off sessions in support of a client's desire for top or bottom surgeries, I sometimes find it difficult to know when and how far to probe with respect to the client's motivations for surgery. This is all to say that dismantling the power and privilege that has been invested in us while continuing to serve clients is a practice and a process, an art rather than a science. Dismantling entitlement—and each of the principles discussed in this chapter for that matter!—constitutes a framework, a guide to promote a curiosity that can open up avenues of discussion rather than unwittingly shut them down.

**Why am I asking this?** Other ways of phrasing this question might be: is there a clinical value to this particular query? Does this serve the client's needs, or my own? What purpose does this question have? If I bring my awareness to my body and check in with it, do I find myself experiencing a thrill? Or perhaps titillation? A kind of excited thirst for "understanding"?

One way we can get at our motives for a particular line of inquiry is by bringing awareness to our bodies in the present moment and noting sensations, images, feelings, or thoughts that might be surfacing. When a client says something that piques your curiosity, or tickles at the edges of intuition, you might examine, for example, how you're holding yourself, or moving. Are you leaning forward in your chair, for example, a physical stance that can communicate interest and curiosity? Depending on the client or the content being brought into the room, this leaning in might be viewed as an act that communicates an intent to engage, to join with; or it might be viewed as an invasive stance, a crossing of physical boundaries that

might evoke a startle response in the client. What about your heart rate? Is your heart beating faster, suggesting hyperarousal, as if you are on pins and needles awaiting the client's or patient's answer to a query with anticipatory relish, perhaps even titillation? Sometimes, our bodies' interoceptive signals are experienced as images that bubble up to the surface, images that elude language or are pre-verbal. I refer to this phenomenon in Chapter 4 as the *somatic-imaginal*.

**What assumptions am I bringing to this interaction?** In addition to discerning the motives behind our desire to know, we must also attend to the ways that our curiosity is shaped by—and can reinforce—repressive cultural norms. For example, as Chang and Singh assert in a paper laying out principles of affirming psychological practice with BIPoC gender expansive folx, notions of masculinity and femininity are steeped in and "based on White and/or Western dominant cultural norms."[33] And such expectations of "what femininity and masculinity look like on a client," they argue, can "consciously or unconsciously inform" a provider's approach when working with trans and non-binary folx, particularly for clients "who either do not fit these norms [and expectations] or who may be struggling to reconcile these norms" with their own identity constellation.[34] For instance, trans women are often expected to perform or embody a kind of hyper femininity. This cultural expectation negates the possibility that trans women might be butch or androgynous. A clinician working with a trans woman might thus invest a lot of their curiosity in the presence, or absence, of their clients' feminine attributes as proof of their transness and thereby impose certain cultural norms and expectations on their client. To avoid such a process, Chang and Singh suggest providers "refrain from assuming that they know what a client means when they" identify themselves using specific gender identities (e.g., "I'm non-binary" or "I'm a man") and instead ask as a follow-up to such a statement, "What kind of _____ (e.g., man, woman, [non-binary] person) are you or would you like to be?"[35]

Another way of imagining into this question is to think about how our curiosity can be a tool through which dominant discourses can act. We might ask: whose curiosity is being satisfied? Whose desire to know is operative in the present moment? For, as Michael White and David Epston suggest, as providers, we cannot allow ourselves to complacently "take a benign view of our own practices."[36] After all, most of the modalities and practices deployed in the US and Western Europe were designed by white, Western European and US cis het men operating within cisheteropatriarchy, white supremacy, and colonial logics. As such, they reflect, replicate, and reify the assumptions, biases, and normative values of those constructs. As I will argue in the next chapter, we cannot really help embodying the cultures in which we move. But we *can* be critical consumers and actors! We can do the hard deconstructive work of seeking to ensure that systems of power do not simply use

us as unwitting conduits for their replication. We can take accountability when we fuck up—and, we will all fuck up. We can re-vision how we work so as to practice radical mental health and radical sexual health. And we can thereby "come up with our own understandings for how our psyches, souls, and hearts experience the world, rather than pour them into conventional medical frameworks" that might conceive of our work with trans and non-binary clients in terms of "success," "function," "performance," "productivity," and specific treatment and transition pathways.[37] We can, in short, resist.

**Who needs to educate me about material a client is bringing into the room?** Embedded in the entitlement to know is the idea that subjects of curiosity are entitled to ask others to educate them on some of the basic elements of their experiencing. It is often the case that those who are marginalized know more about the dominant culture than vice versa. For instance, as a Jewish person, I know a lot more about Christian traditions than many Christians know about Jewish practices and history. As a result, clients from marginalized backgrounds will come into the room knowing that they may have to explain elements of their life and identities to their providers, a burden that clients from the dominant culture do not share. This can be intensely frustrating—even anxiety-provoking—for our clients and can damage the therapeutic alliance. Moreover, this means that clients are spending their valuable time in session helping providers get up to speed when a simple Google search or, at most, the pursuit of additional training, education, and experience will do. Thus, from the instant our clients enter our offices and consulting rooms, we must disabuse them of any duty to be our teachers, to be the expert on trans-ness or non-binary-ness, or queerness, disability, or Blackness.

We must educate ourselves in the heterogeneity of trans and non-binary experiencing. This book can serve as part of this education, but certainly should not be the sum total of it. It can be important to learn about the global history of gender diversity.[38] Relatedly, we might work to develop an understanding of how these histories of gender diversity—and gender-affirmative care!—intersect with histories of (settler) colonialism, Westernization, white supremacy, and the mass displacement of indigenous populations.[39] And we might endeavor to recognize and understand the health disparities, discrimination, social stigma, and minority stress to which our trans and non-binary clients might very well be subject, just as we would seek to recognize how white supremacy and institutionalized racism impact BIPoC populations. Finally, we should acquaint ourselves with the medical and gender-affirming interventions some of our trans and non-binary clients might pursue (e.g., "low-dose T," "metoidioplasty" or "zero-depth vaginoplasty," and various binding and packing options) as well as some of the terms and colloquialisms that members of trans communities are using in the present moment.

Of course, there are many elements of trans and non-binary experiencing that we can research and learn, but the client sitting in your office is not a community; they are an individual with particular needs holding a particular identity constellation. There are some things that no amount of research can tell us and that only our client can share with us. While it is not a client's job to educate us about any single facet of their identity constellation, we *can* bring our curiosity to learning their histories, the stories they have told of themselves, the stories others have told about them, the particular ways they embody their identity constellation, the facets of their identity constellation in which they instill pride and the facets that are not particularly meaningful to them. Curiosity directed in this way and for these purposes steeps the relationship in a dynamic of mutuality, active learning, shared inquiry, and discussion.[40] Both provider and client take a stake in the work. The invitation to learn from and engage in a participatory, active process might be facilitated by a framework called location of self, a framework I outline in the next section.

### BTToP: Dismantling Entitlement Vignette

As a means of illustrating the principle of dismantling entitlement I offer a vignette supplied by a colleague of mine, Allison (she/her), a licensed marriage and family therapy therapist (LMFT) based in Southern California. Allison is a white, cis, bisexual woman who is in a long-term monogamous relationship with another cis woman. A few years ago, she began to work with a client who had found her on a directory of queer therapists. The client, Elena (she/her), is a Latinx, married trans woman who had recently opened up that marriage, joined a local sex-positive group (Sex Positive Los Angeles), and was beginning to go on dates. Elena sought out Allison because she is queer and because of her experience as a gender-affirming marriage and family therapist so that Elena could process her experiences as she began to seek out community and navigate multiple relationships.

At the time, Allison, like many therapists, had limited experience working with consensually non-monogamous (CNM) clients. She knew, as soon as Elena filled out her inquiry form and identified herself as polyamorous, that she needed to broaden her scope of competence around consensual non-monogamies if she were to see Elena from an ethical perspective. As such, before she even saw Elena for an intake session, Allison sought recommendations for books and articles on polyamory and scheduled a consultation session with a colleague well-versed in working with CNM clients for just after the intake. In

addition to doing the work this way, Allison also Googled the term "Latinx," as she was unfamiliar with it and wished to ensure that Elena was not placed in the position of educating her about this aspect of her identity constellation.

At intake, as Elena began to go over her presenting concerns, a nagging set of thoughts began to bubble up into Allison's consciousness—Allison found herself wondering about Elena's wife, Meg, and how she was handling Elena's dating. She wondered to herself, "How did the conversation about opening up go down? Was it a mutual decision?" "Is Meg dating anyone?" "How's Meg dealing with Elena talking about her experiences dating?" In that moment, as she scribbled notes furiously on her notepad and worked to stay present with her client, a part of Allison was, in essence, identifying with Meg. Allison only knew of Meg's existence because she was identified as Elena's wife on the client information form. And Elena was Allison's client, not Meg, and not the relational unit. Still, in Allison's mind, Meg, the absent third, was spectrally conjured into the room as if she were a client or explicitly part of Elena's presenting concerns.

Allison did not foist her curiosity about Meg onto Elena, however, and worked diligently to direct her curiosity inward instead. "What is present for me here in this moment?" "What cultural norms are being activated in me?" "Do I really need to know the answers to any of my questions about Meg and her relationship with Elena at this time?" As she turned these questions over and brought her awareness to the sensations, images, feelings, and thoughts that were coming up for her, Allison recognized that part of her identification with Meg stemmed from messages she'd internalized about relationships. All Allison had known in her personal life were monogamous relationships and all her clients to date had, at least while they had been working with her, identified as monogamous. And nothing in Allison's training as a relationship therapist had prepared her to work with ethically and consensually non-monogamous relationships. Indeed, if anything, her training had instilled in her biases and assumptions about the value of monogamy to successful relationships.

A lot of times things come up in client sessions that intrigue us, that activate our desire to know. But our focus as providers must always remain on the client—their material, their concerns, their feelings and experiencing—rather than satisfying our burning questions. For, a lot of the time, as Allison later found out, our questions have a way of coming up in the natural flow of our work with a client or patient. Asking about Elena's relationship with Meg was not appropriate in the

moment, but a few sessions later, Elena wanted to talk about how to go about renegotiating an agreement with Meg. In this context, then, some of Allison's questions about Elena and Meg's relationship became relevant, as Elena had explicitly raised them.

## Location of Self

In any listing and bio, or whenever I introduce myself to clients during the intake session, I tend to disclose the identities I hold. Sometimes this takes the form of what we, in the queer and kink communities, refer to as *flagging*, as when I talk about offering relationship counseling/therapy on my website and refer to relationship structures and models beyond that of cis het monogamous couplings, namely, "couples, triads, D/s relationships, polycules, etc." This, I hope, signals to relationship units that are kinky and/or consensually non-monogamous that I am affirming of and knowledgeable about D/s dynamics or various forms of ethical non-monogamy, even if I don't directly say that I am myself polyamorous and kinky. Often, though, I come right out with it as I did in the introduction to this book. I will say, "I am a white, witchy, Jewish, visibly able-bodied, kinky, polyamorous, queer, non-binary femme." I do this as part of what family therapist thandiwe Dee Watts-Jones describes as *location of self*.[41]

As Watts-Jones describes it, location of self is a process in which "the [provider] initiates a conversation with a [client] about similarities and differences in their key identities, such as race, ethnicity, gender, class, sexual orientation, and religion, and how they may potentially influence the therapy process."[42] Location of self, in the first instance, involves the provider self-disclosing their social location, the various facets of their identity constellation. The provider's disclosure of their social location is designed to further the creation of the client–provider relationship, to humanize the provider, "bridge gaps in social power between therapists engaged in cross-cultural therapy," and, most of all, to open the door to dialogue.[43] The provider's socially locating self-disclosure, in sum, serves as an opening and invitation, communicating that intersections of power, privilege, and oppression are "meaningful and embedded in the work"; inviting the client to reflect upon and discuss their constellation of identities; and signaling the provider's comfort with discussing intersectionality during work together.[44]

The challenge of location of self is that it "requires a willingness to go into places that most of us," provider and client, "still feel uneasy about engaging, interpersonally and personally."[45] As sex therapists Doug Braun-Harvey and Michael Vigorito note with respect to conversations about

sexual health—another topic that can generate a great deal of discomfort in both provider and client!—provider avoidance of challenging or culturally sensitive topics may inadvertently serve to "[replicate] the client's similar avoidance of uncomfortable affect states" and create an "unnecessary burden and disincentive" for clients to initiate conversation on these topics.[46] And we want our clients to feel as if they can freely explore topics as vital to their experiencing as their identity constellation and their sexualities!

Engaging in location of self, beginning with how the provider describes themself within bios and extending into the first session with a new client/patient and beyond, can be a powerful way of fostering connection, and is part and parcel of what activist communities call "doing the work." As with other members of close-knit communities, trans and non-binary folx often "choose their therapists because they are familiar, because they respect and appreciate their background, values, and conduct."[47] My clients have often told me that they come to me precisely because I so clearly socially locate. One client, Alix (they/he/ze), a white agender individual, told me at the end of a 30-minute consult appointment that "I can actually breathe in here!" When I asked Alix if they would mind elaborating on this comment, ze told me, "It's just that, with other therapists, I always had to be on guard. But with you I know that you're not going to ask me a lot of uncomfortable questions and I'm not going to have to spend most of my session explaining myself to you. You get it."

I recognize that many of you reading this book are not trans or non-binary. The very fact that I am trans may, of course, help prospective trans, non-binary, and/or queer clients make an initial inquiry with the sense that I likely share certain aspects of experiencing with them, including both experiences of minority stress and experiences of navigating sex and relationships (platonic, sexual, romantic, professional). At the very least, they might assume that choosing a therapist from within the queer and trans community I am far less likely than a cis het therapist to be transphobic, cisnormative, "or ignorant of issues specific to [LGBTQIA2S+] people."[48]

But as Laura Kessler and Charles Waehler point out, the very fact of my membership in trans, non-binary, and queer communities may bring up multiple relationship considerations that a straight and/or cis clinician might not encounter. For one, these particular facets of my identity constellation may lead me to "underestimate the degree of power [I] hold in the therapeutic relationship and in [LGBTQIA2S+] communities."[49] For example, I sometimes feel the lure of a projective identification in which I become unconsciously cast in the role of "elder," "sibling," "parent/Mommy," and, worst of all, "authority." And this can be a challenging set of transferential projections to have hanging in the room. After all, while occupying the energy of an elder sibling, or parent, might sometimes mark me out as a kind of aspirational

ideal, it can also come with it a host of insecurities about not "measuring up" as well as some oppositional dynamics (e.g., sibling rivalry).

And even the aspirational ideal piece is hard to hold; for, as I remind my clients at every opportunity, I have no special insight into their worlds or the particular ways they embody their identity constellation. Mine is an idiosyncratic set of social locations—I have not lived their life and I have made particular choices in my life. I have no idea what it is to have a vulva, for example, or to experience menstruation. I don't know what it is to massage my chest after wearing a binder all day, or what it is to cruise in gay male spaces. My whiteness and my specific class location mean that I have no way of conceiving, really, the particular vectors of oppression or vulnerability that trans folx of color or folx who daily encounter food or housing insecurity experience. And although I may inject estradiol weekly like many of my trans feminine clients do, I do not have their physiology, and the effects of spironolactone and estradiol may manifest in different ways in my body. There is no such thing as being queer or trans enough, femmes can be thems, and there is no one, true way to be trans. As Watts-Jones notes with respect to therapists working with clients of the same race and/or ethnicity, "while I usually see my ethnicity/race as an asset in working with those of African descent, I will also say it could be a liability if I assume that I know their experience, or overlook differences."[50]

This is a roundabout way of saying that being cis and/or being straight is in no way a hindrance to joining with our trans and non-binary clients and patients. Occupying these gender and sexual identities merely means that the location of self process can potentially facilitate an even more powerful moment of joining with your trans and non-binary clients. Or, perhaps not more powerful, but perhaps powerfully different or equally powerful! After all, as the prefixes cis and trans were originally meant by activists to convey, every single one of us, cis or trans, has a relationship to gender.[51] A vital part of engaging in location of self is the way that it allows the provider to identify, name, and "give thought to […] [the] similarities or differences in the identities the client(s) and I occupy," either as they create limitations or opportunities in therapy.[52] Here, the cis provider might give their gender identity and how they came to that identity, perhaps noting places where they are non-conforming with respect to how they perform or present their gender. They might also note the training they've received in gender-affirmative care, and how they work to dismantle gatekeeping structures, deploy an informed consent model, or the ways they have actively worked as fierce advocates for their clients within their community. They might explain how they came to practice gender-affirmative care, their passion for the work. The purpose, here, isn't to "apologize" for or explain away cis-ness, but to be transparent with the client about ways in which gender impacts all of our lives.

When we engage in location of self we communicate that issues of oppression, privilege, and identity are "always relevant to some degree in therapy."[53] We also promote the imaginal reality in which our clients can cross the thresholds of our consulting rooms and find that rare place where they are held and affirmed in the fullness of their infinitely expansive embodied selves. And maybe, just maybe, like Alix, they will feel into that imaginal space and let themselves breathe with ease.

### BTToP: Intake Forms and Location of Self

Apart from engaging in self-disclosure of my identity constellation I also signal an interest in engaging in a location of self process on my client information form. Here, I request from all clients the following:

> *Please tell me about any aspects of your identity that are central to who you are (e.g., race/ethnicity, religious or spiritual identity, disability status, gender identity, sexual orientation/identity, erotic identity, relationship orientation).*

I view this prompt as an invitation, rather than a means of collecting demographic information. Although some demographic information may be crucial to collect for certain fields on electronic health record systems, my priority with this question is to empower the client to identify themselves in whatever ways they might choose. In part, this is because, as Sand Chang and Anneliese Singh point out, for some trans and non-binary folx one aspect of their identity constellation, such as their racial/ethnic background or sexual orientation/identity, or even their gender identity, "may be very salient in their day-to-day lives and identities, whereas for others," that same aspect "may not be as salient as another aspect of identity, such as religion or disability status."[54] An open-ended question like the one I use above can help the client articulate their own relationship(s) to various identity labels and community affiliations and can be used as one of many ways of guiding how you, as their provider, might relate to the identities they find the most salient.

## Seek Permission

If we return to *Les Bijoux indiscrets* and how genitals are often asked to "speak" in contemporary society, one particularly troubling aspect of how Prince Mangogul conducts his examination of his female courtiers' sexualities is

that when he turns his magical, speech-inciting ring on women's "jewels," he often does so from a hiding place. Moreover, his incitements to sexual speech are undertaken without any regard for gathering consent; he merely turns his ring on the unwitting women to extract their sexual stories. He not only feels entitled to his courtiers' stories, but treats these women as instrumental, as objects of desire without their own agency and autonomy. Permission is not sought, negotiation is not undertaken, check-ins are never contemplated.

In the domains of sexual communication and consent education, sex educators will often discuss how gathering consent is not a one-time thing or a two-part transaction that involves a request and a verbal response of "yes" or "no." Rather, as Allison Moon describes consent gathering in *Girl Sex 101*, consent relies on consensus—namely, "All parties must agree on the activity"—and is instantly revocable—that is, each party to an activity is "allowed to change [their] mind at any point, even midway into an activity."[55] Consent is also an ongoing process. Partners will not only engage in negotiation and informed consent practices prior to engaging in sexual activity, but will often check in during and after a given activity. The second principle of ethical curiosity ports these insights from sexual communication and consent education into clinical practice.

From both a legal and an ethical perspective, clinicians are required to provide their clients and patients informed consent. As part of informed consent, the clinician is obliged to provide their client with information regarding the risks and benefits of treatment; potential side effects involved in a given treatment; possible consequences of engaging in a particular treatment pathway; the contours and limits of confidentiality; provider background and qualifications; and information about fees, payment, and billing practices. As the American Counseling Association's Code of Ethics puts it, this model enshrines the principle that clients "have the freedom to choose whether to enter into or remain in a counseling relationship."[56] Although many providers may note, verbally as well as within their intake documents, that informed consent—like transition!—is a process rather than an event, in practice informed consent is gathered primarily at the beginning of treatment. The choice whether to engage in or remain in a specific course of treatment or within a provider–client relationship draws from another ethical value, articulated explicitly within the ACA's ethics code, namely, that of the responsibility of the clinician to foster and continually evoke their client's capacities for autonomy and self-determination, i.e., "the right to control the direction of one's life."[57]

This is all to say that at the core of our ethical codes is an imperative to continuously and rigorously seek consent, all as part of an effort to promote the client's capacities to direct their own care and engage in collaborative goal-setting so as to evoke the client's "knowledge of their own beliefs, personal value systems," and their "individual conceptualization of their

own gendered experience."[58] As such, and to satisfy this ethical imperative, I suggest adopting a threefold practice of permission-seeking, checking in, and engaging in aftercare.

Permission-seeking refers to both the process of informed consent gathering, treatment planning, and collaborative goal-setting that occurs at the beginning of a unit of treatment as well as an analogous process at the beginning of sessions where you expect that sensitive or activating or culturally charged topics may arise. And a crucial piece of this permission-seeking is that consent is not blanket consent; consent is gathered and negotiation/discussion undertaken each session as well as for each activity within a given session.

One way to understand the nature of ongoing permission-seeking and informed consent gathering is in terms of Bion's dictum that the provider should go into each session without either "memory or desire," which is to say, that every session "must have no history and no future."[59] By this, Bion essentially asks the provider to treat each new session with a client as its own entity, assuming that nothing from previous sessions necessarily carries over into the present session while concomitantly resisting the urge to impose one's desire for specific outcomes on a given session. In a sense, I think Bion's dictum is a pretty tall order. After all, sometimes recalling information gathered from previous sessions helps deepen connection, as when I might recall a small detail about a client's life—a place name, a partner's name, a favorite color—or set out the coloring books and pencils that they enjoy using in session. And, let's face it, we wouldn't get too far with insurance (or our licensing boards, for that matter!) if we completely, say, neglected to reflect on treatment planning and collaborative goal-setting. But I follow the spirit of Bion's directive. I assume, for example, that in the time that has elapsed since a previous session, things have happened for and to my client and that these extra-therapeutic experiences have impacted them. I further assume that whatever I might go into a session planning to cover will likely not happen. I must hold the goals a given client and I have collaboratively set gently and provisionally. With this in mind, the beginning of each session is an opportunity to seek permission from a client, to see if they are up to delving into particular content, to ask them what they might wish to work on.

In addition to permission-seeking at the beginning of a session, I suggest checking in with clients periodically during sessions. These check-ins can take a number of shapes, shapes many of you are probably already deploying in your practice. When a client has happened upon a sensation, image, feeling, or thought that is particularly charged I will use this as an opportunity to check-in by asking, "That churning feeling in the pit of your stomach, would it be ok if we sat with this a bit longer?" or "Do you think you could close your eyes and check in with your body? What is your body trying to

communicate right now?" In IFS parts work, we might be accustomed to asking to speak to particular parts. In the Hakomi practice developed by Ron Kurtz, the practitioner might ask the client if they might engage together in "little experiments."[60] Or, similar to the pleasure/pain scale (e.g., "on a scale of 1 to 10, where is this in terms of pain?"), I often introduce to clients an arousal scale prior to engaging in trauma processing and then refer to the scale periodically during the actual processing. This scale might sound like this, "On a scale of 1 to 10, where 1 is a 'breezy walk in the park on a sunny day' and 10 is, 'if you say one more word I'm liable to either charge out of this room or try to get up from this seat and punch you,' where are you right now?" In this particular context of checking in, I don't want to even approach the higher end of the scale; even a "4" is probably a sign to me that I might want to dial the work back a bit in intensity. Here, I'm trying to keep work with a client on the upper range of their window of tolerance at a given time—just enough to perhaps work to gently expand said window, but not enough to send the client into a hyperarousal state or a hypoarousal state.[61]

The final element in the principle of seeking permission is aftercare. Aftercare is a term that originates in kink/BDSM and refers to the moments after a scene or play has ceased. The methods of working with clients I discuss in this book along with other therapeutic activities such as trauma processing can be intense for our clients (and for us, their providers). After all, so often the therapeutic situation can be a holding environment (*pace* Winnicott) wherein sensations, images, feelings, and thoughts can be brought into the room that might otherwise be too overwhelming or frightening to be experienced on one's own. For this reason, I would advocate incorporating aftercare into your sessions, provided you're not doing something similar already.

When I know I'm engaging in particularly tough/intense work with a client I will often ensure that I hold a tight container and begin at least 15 minutes before the end of session to help the client ground, bring their awareness back to the present, and regulate. Here, I might engage the client in a visualization or grounding activity, or give them a stress ball or a coloring book to play with. I might also take the client through a list of self-care strategies they might engage in once they reach the end of their days and can decompress. And sometimes I invite the client to literally shake off the session content, either by shaking the body or by engaging in a five-minute dance party (they choose the music). In many instances, I process particularly intense experiences with clients, perhaps evoking their observing egos, either immediately following the intense work or at the very beginning of the next session.

And as providers, we need to think about how we might reset, center, and engage in self-care following intense work. I will sometimes clear my office by using a singing bowl. And I'm never averse to a five-minute dance party alone in the office with the door closed. Debriefing for a provider

might involve being part of a consultation group, pursuing regular personal therapy, or seeking supervision. Lastly, don't forget to obtain sustenance—brew a cuppa, enjoy a handful of trail mix, and go to the bathroom. We often assist our clients and patients in developing self-care inventories: do you have one? If we are to engage in the work of tending to the soul or being stewards for trauma, it is vital that we remember that aftercare, like self-care in general, "is not a self-indulgence, it is self-preservation, and that is an act of political warfare."[62]

## Treat the Client In Front of You

Jack (they/them) is a masc-of-center, Asian-American non-binary person. In the fall semester of their first year at a small liberal arts college in the South with an unusually high percentage of students involved in Greek Life, they began experiencing an acute major depressive episode and a resurgence of self-harm ideation they'd first experienced in high school. At the suggestion of a faculty member, who had observed a noticeable decline in Jack's academic performance along with a withdrawal from participating in class, Jack went to the university's counseling center. Jack was assigned the center's LGBTQIA2S+-affirming counselor, an assignment that initially delighted them. At intake, however, things quickly went off the rails for them. The counselor focused the session squarely on Jack's queer and non-binary identities, attributing the dysphoric mood states they were experiencing to the fact that Jack had not come out to many folx on campus and perhaps wished to explore a gender-affirming transition. Jack continued to see this counselor for another four sessions, thinking that eventually the counselor would attend to their depression, but to no avail.

When Jack finally saw a colleague of mine, they were deeply relieved when their new therapist attended first and foremost to Jack's presenting concern rather than focusing solely on their non-binary identity. The truth, which Jack had tried to convey to the counselor at the counseling center, was that Jack had a robust social support system at the college, and while they found it challenging sometimes navigating a university with a very small population of queer and trans students and a curriculum that was fairly binary in its presentation of gender and sexuality, they felt affirmed in their identity constellation. Moreover, they did not feel as if they wished to pursue any kind of medical transition at that time.

This vignette illustrates the third principle of ethical curiosity: treat the client in the room. For some trans and non-binary clients, identity development or value clarification around transitions are why they come to see us as providers. They may wish us to provide transition support or they may wish to talk about how they are navigating social, cultural, familial, professional, or relational domains with respect to their trans and/or non-binary

identities. But, as it was for Jack, for many clients who walk through our doors, the presenting concerns may be unrelated to the client's gender or sexual identities.

I think of Katie (she/her), a friend who is a kinky, queer, white trans woman. At one point, Katie's therapist went on maternity leave for three months and she needed to work with someone new in her absence. The therapist she ultimately opted for worked in ways that excited Katie, particularly as Katie was hoping to do some intensive trauma work and the interim therapist specialized in sensorimotor psychotherapy. At intake with the interim therapist, Katie disclosed that she was kinky and a "pain slut." The therapist thanked Katie for disclosing this important aspect of her life and expressed that although Katie was the first kinky client he'd ever worked with, he was: (1) in no way troubled by kinky content; and (2) sex-positive. The therapist further expressed that he was "completely non-judgmental." A few sessions later, as they were engaging in resourcing, Katie's interim therapist proceeded to propose as a topic of study Katie's appreciation of heavy impact play and receiving marks during said play, suggesting that Katie's kinks might have their origin in her childhood trauma experiences. Here, even if the interim therapist had claimed a stance of non-judgment, he clearly evinced curiosity in the potential for a direct, causal link between Katie's presenting concern—childhood trauma processing—and her consensual kinky urges and behaviors. As with Jack, a mere element of Katie's identity constellation, disclosed at intake, had suddenly become the focus of a clinician's concern.

To be sure, sometimes a client will bring to the consulting room a detail that they minimize, despite said detail being, in reality, far more important than the client wishes to give it credit for. Every time a client utters the phrase, "I don't know if this is important but…" I get the feeling that whatever follows the "but" is probably going to be important. But when it comes to one's identity constellation, oftentimes, as the Freudian proverb goes, "a cigar is just a cigar." As a result, I tend to keep any theories I might hold about the impact of a particular identity facet on the client's presenting concerns to myself, suspended in a kind of psychic stasis. I also use said theories as an opportunity to seek supervision or consultation around any counter-transferential dynamics potentially at play. That is, I work to examine whether a specific quality of the client is activating my own material; pushing on unexamined biases, assumptions, and stereotypes; and/or provoking certain images, feelings, or sensations to surface.

To return to Jack's vignette and their first therapist in the university counseling center, in many ways their initial therapist might have been correct to suspect or surmise that Jack's depression had at least something to do with the fact that they were a queer, non-binary student in an environment in which they were likely to experience minority stress. The clinician's

imaginative failure was really in acting from a place that assumed that Jack's non-binary and queer identities should be a focus of concern, and not just as a psychosocial factor.

Relatedly, we must be able to sit with a client in the heterogeneity and specificity of their identity constellation, in the fullness of their embodied being and imaginal possibility. One thing that irks me about how many so-called multicultural counseling texts are written is that they many times provide breezy, totalizing generalities about specific cultural identities. As Paul Gorski and Rachael Goodman write in the introductory chapter to *Decolonizing "Multicultural" Counseling through Social Justice*, many multicultural counseling frameworks rely on highlighting "superficial aspects of a culture," all the while "homogeniz[ing]" these groups "in order to fit into simplistic identity development models."[63] And so, articles and books provide guidance on how to "understand" Asian-American clients, engage in counseling with LGBTQIA+ clients, or supervise transgender trainees.[64] The problem, Gorski and Goodman continue, is that:

> *There is as much diversity within Asian Americans or within the [LGBTQIA+] community than there is* between *any two groups. Also, people experience these identities within a sociopolitical context that has very real implications for their psychological well-being. Moreover, to which chapter should we turn if we want to know how to understand and counsel a lesbian Asian-American low-income Muslim client? Is the Hmong community more or less the same as the Chinese, or Pakistani, or Malaysian community as far as counseling practice goes? Is it enough, anyway, to know a little bit about this or that identity group, paying no attention whatsoever, to intersectionality, or to religious, regional, economic, or other differences ... within these enormous groups?*[65]

The point is that in sitting with a given client, our task is to sit with the whole person, and not just a sketchy facet of their identity constellation. When we fail to do so, we may fall into the trap of reducing our clients and patients to a caricature or to a single story. We may also end up replicating the kinds of totalizing narratives I explored in Chapter 1.

## Conclusion

Western history is littered with tales of genitals being compelled to tell stories. In the late 19th century, men who had sex with men were described as having pointy penises.[66] In the 18th century, women's susceptibility to mental illness was attributed to their overheated constitutions and wandering uteruses.[67] Jewish and Black men have been ascribed particularly

large penises, with size metonymously referencing a supposed societaly-destabilizing hypersexuality.[68] The indeterminate genitalia of intersex folx were, in early modern Europe, monstrous.[69] And then there is the myth of the hymen as an enduring symbol of a vulva holder's supposed sexual purity, or virginity.[70]

Genitals have something to tell us—something secret; something that cannot simply be divined; something that must be brought into the light; something that must be policed, regulated, controlled, managed, and put in its place; something we must, for the sake of society's moral upkeep, *know*. This history reveals that the curiosity about the sexual lives of some individuals cannot be separated from constructions of power and privilege. Because whose genitals have something to tell us? And whose genitals are afforded the grace of remaining silent? Those genitals and reproductive organs compelled to speak their truths most often belong to members of marginalized groups and communities. And trans and non-binary folx are merely the latest beneficiaries of our invasive genital curiosity, our deep desire to catalogue, classify, probe, and know.

Our curiosity, as providers, can be a powerful tool in working with clients. We might find, as Harlene Anderson did, that through our "earnest efforts to learn" a client's "language" and sit with them in the richness of their internal worlds that we are able to "[participate] in therapy conversations in a different way and [develop] new kinds of relationships with our clients—listening, hearing, and responding in unique ways."[71] The next two chapters will place an emphasis on working with clients to develop capacities for curiosity and wonder as they work to come into (com)passionate relationship with their embodied sexual selves. But, as with many of the powerful tools of our trade as providers, curiosity must be wielded with care and bounded with ethics so as to avoid engaging with clients in ways that are objectifying and essentializing. Deployed without an ethical framework, our curiosity can end up harming our clients or placing to the side their autonomy and their capacities of self-determination; our curiosity can unwittingly be used to serve our own ends or function as a tool of social control.

In this chapter, I have proposed a conceptual stance which grounds the provider's curiosity within an ethical framework. Being an ethically curious provider, I suggested, relies on three principles. First, even if curiosity arises out of an intense desire to know, we must temper this desire by dismantling any sense that we are *entitled* to knowledge from our clients. Part of this, I argued, involves the provider resisting any urge to have the client educate them about any single aspect of their identity constellation while simultaneously, through the location of self process, inviting discussion of intersectionality in the work. Second, ethical curiosity requires a robust, constantly renewed process of seeking permission. And, finally, a practice of ethical curiosity asks that we treat the client in front of us, and not, as

Anderson put it, "trying to collect the client's narrative and place it in our therapists' theoretical and experience maps, to make sense of it […] from our therapists' logic and expertise," as if we know better.[72]

Like all of the conceptual frameworks discussed in this book, ethical curiosity is not a clinical stance designed solely for affirming work with trans and non-binary folx. Indeed, I would argue that bounding our curiosity within an ethical framework might very well help enhance and deepen our work with all clients, trans and cis, queer and straight, disabled and able-bodied. But, I also contend that a particular ethical praxis is demanded of us, as providers, in the context of how we deploy our curiosity with our trans and non-binary clients and patients. The present moment, in which the sexual bodies, and particularly the genitalia, of trans and non-binary folx are all too often being incited to speak, calls upon us to embody humility, consistently seek permission, see the complexity of the whole person, and dismantle any burning impulse to know. And it calls upon us to ensure that the spaces we hold are ones of care and containment rather than places where discriminatory structures replicate and reinforce themselves.

## Notes

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7 Michel Foucault, *The History of Sexuality, Vol. 1: An Introduction*, trans. Robert Hurley (New York: Vintage, 1990), 77.
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# 1 Polyamory: Bewildering and Evolving

The Polish language has a wondrous, slightly surreal expression *Jak to się je?*, which roughly translates to *How do you eat it?* Contrary to how it sounds, it is not used with reference to novelty food, but instead serves to exclaim curiosity and bewilderment when encountering something unfamiliar and confusing. When I first conceived this book, there was but one definition of polyamory. *Poly* conveys multiple, and *amory* denotes love. Polyamory implies the possibility of being involved, sexually and romantically, with more than one person. As straightforward as this definition was by yesteryear's standards, it nonetheless perplexed the lay public and the majority of clinicians. At the time of this book's publication, it is no longer necessary to spell out the term, but the bewilderment regarding this lifestyle is far from diminished. There are so many extensions of the original definition and notion of polyamory that it can be hard to know what is talked about. By some characterizations, love in polyamory could be for almost anything—partners, lovers, nonromantic involvements with dear friends, lifestyle, families of choice, communities, even the planet (Anderlini-D'Onofrio, 2009; Barker & Langdridge, 2010). How do we eat *that?*

We are dealing with an ever-expanding universe with ambiguous boundaries. From being a relatively specific phenomenon, polyamory is undergoing diffusion rather than consolidation. Polyamory is a lifestyle; it might be a sexual orientation, and it is also a social and cultural movement. In the widest understanding, almost any kind of openness and embrace of nonnormative relational expression and life strategy could be considered poly.

What is polyamory then? The prevailing understanding is that there is no one definition of polyamory. Poly structures can be complex and immensely varied. A few years ago, the dominant polyamorous constellation was hierarchical in nature. At its core there was a couple, oftentimes a married one. The spouses adopted the name of primary partners. When a primary partner got involved with somebody else, this new person became a secondary partner. If more people were involved, they were considered tertiary or, alternatively, they got assigned the designation of orbits, implying casual, consensual lovers. Since then, the discourse has shifted toward nonhierarchical polyamory, in which all partners involved are considered to be

equal in status. Hierarchical or not, polyamorous constellations fluctuate; examples of common arrangements include *triads*, *quads*, and *polyfidelious families*, to name a handful of the more familiar ones (for definitions, consult the glossary at the end of the book). For clinicians working with poly clients, keeping track of who is involved with whom can be baffling. Similar to genograms depicting family ties, poly relationships are often presented visually. The common strategy is to represent each person as a sphere and then draw the lines connecting the globes. No graphic distinction is given to males, females, or gender-nonconforming individuals. Portrayed this way, poly configurations look like chemical molecules, which earned them the name of *polycules*.

Sexual orientations, relational preferences, and lifestyle realities can be intertwined in highly intricate ways. A person identifying as poly may or may not be in a polyamorous relationship. An individual whose preference is for monogamy may be intimately involved with someone who is poly. Relational status provides a lot of information about lifestyle orientation, but they are not one and the same. Many individuals navigating this complex relationship landscape are choosing, or staying with, partners based on availability and commitment rather than personal preference, sometimes alternating between monogamy and nonmonogamy. The cases of mismatched relational preferences and actual relational status are characterized by considerable vulnerability, oftentimes sending these individuals and couples to therapy. It is not uncommon for these clients to face judgments on all sides, from their monogamous families and friends, from their poly peers, and from mental health practitioners whose help they seek.

My introduction to the complexities of polyamory from the therapy perspective was full of qualms and surprises. One spring afternoon, a man I will call Nick left me a vaguely hesitant message wondering if I would be fine working with someone who has an interest in polyamory. His voice trailed off: "Anyway, I hope to hear back from you …" I then listened to the next message. It was from Sophie. She inquired about my availability, adding that she was in a somewhat unusual relational situation. "I've read that you work with consensual nonmonogamy," she said, "and it seems like you'll be a good match." I scheduled Nick for a Wednesday the following week and Sophie for the day after.

Nick's open face and mild manner made him instantly likeable. He explained that polyamory intrigued him and he wanted to explore his feelings about this lifestyle. Nick was married and concerned about his marriage not surviving if he were to suggest opening up. He loved his wife and had no intention of ending the marriage, but he was struggling with his conflicting desires. As we were nearing the end of the session, Nick looked at me and asked, "Would you have any problems working with me if you're going to work with Sophie as well?" I was mystified. Was it the same Sophie who I was supposed to meet the next day? If so, how did he know? Seeing my bewilderment, Nick elaborated that he and Sophie knew each other, but had not known until a few hours earlier that each had scheduled a session with me.

I learned that they were postdocs in the same lab on the brink of developing a relationship. Collaborating on a project, their work relationship had morphed into friendship, and, soon enough, they discovered their mutual interest in polyamory. Both were married and, upon realizing their attraction toward each other, they decided to seek therapy "to do things right." Armed with this decision, each set off to search for a suitable therapist. Unbeknownst to each other, they happened to find my qualifications and approach appealing, leading to their respective inquiries. The revelation of this parallel experience felt like a confirmation of their spiritual connection. Hurriedly exploring their feelings about this coincidence, they concluded that, as long as I agreed, it might be helpful if they both worked with me.

If the sequence of events was less unexpected, I might have hesitated more. If it happened now, rather than several years ago, I might have suggested they inquire with other therapists before making a decision. But back then, polyamory was *terra incognita* to the absolute majority of clinicians. Nearly every client told me about their difficulty finding a therapist who knew what polyamory was, and how relieved they were to work with someone who would not be judgmental about their lifestyle. As it stood, I scheduled a follow-up session with Nick, giving both myself and him time to process this unusual situation.

In my meeting with Sophie on the following day, I received similar reassurance that she was eager to work with me. Bright and engaging, Sophie described her marriage as committed and, overall, highly satisfying. She had friends who were polyamorous, so she knew about potential pitfalls if she and her husband were to open up. She also knew that it was possible to transition to nonmonogamy without upending the marriage. Coming from a blended family, she saw the value of being intimately involved with more than one person. Just as with Nick, I scheduled a follow-up session, giving Sophie and myself more time to reflect.

Given the relatively small size of the poly community, I anticipated that, sooner or later, I might be facing the dilemma of needing to disclose a potential conflict of interest. What I could not imagine is that this conflict would present the way it did. It made me wonder—how can a therapist maintain clear boundaries and avoid breaches of confidentiality when working with polyamorous clients? How can she handle countertransference? Countertransference issues may arise even before an individual or a couple walks through the door. In traditional therapy, there is virtually no need to clarify the boundaries of coupledom; transgressions and betrayals are easy to locate within the system. Furthermore, the therapist's boundaries regarding ethics are clearly delineated; the limits of confidentiality are routinely espoused, and dual relationships are carefully avoided. As I was learning, therapy with people in polyamorous relationships was going to test this familiar known on multiple fronts.

Working with Nick and Sophie on parallel tracks helped me refine my rules. They did not seek my services as a couple, but their goals and

motivations were tightly intertwined. Because of their connection and shared focus, I found it helpful to think of their burgeoning relationship from an individual as well as a couple's therapy perspective. From the beginning, I told Nick and Sophie about my rules of privacy and confidentiality—I was not going to share any information, privileged or mundane, about the other person, unless something was common knowledge or I had explicit permission from both to talk about it. They could talk about their therapy experience as much as they wished, or not at all—that was their line to establish. If something came up in a session that I had a sense would be important for them to discuss, I would encourage them to bring it up with the other person for further exploration, but I would not mention any of it unless they did. Periodically, I checked in with each to see how they felt about working in this fashion and was reassured that the parallel format felt enriching rather than limiting.

Nick and Sophie's therapeutic journeys overlapped a lot. Both were in what might be called *mono-poly marriages*, struggling with similar issues in their respective relationships. Early on it became apparent that their spouses, without being physically present, played significant roles in the treatment process. Meghan, Nick's wife, and Damien, Sophie's husband, had no interest in polyamory but felt powerless to stop this already-moving train. Although I came to know that Meghan and Damien never talked in person and only knew about each other's preferences from what their spouses conveyed to them, they felt more confident knowing that they were not alone in their desire to prevent, or at the very least delay, the process of opening up.

With time, both Nick and Sophie agreed that it would be helpful if their individual therapy courses shifted to couple's counseling. Meghan joined Nick in his treatment, and Sophie came in together with Damien. With this shift in emphasis, each couple was able to focus more directly on what opening up would mean to them. The couples talked with greater honesty about the pain and doubts they were experiencing. It was not an easy process. There were tears, anger, guilt, shame, fear, and despair—the whole gamut of emotions one could expect in a situation like this. But there was also hope. As Meghan and Damien came to realize, their spouses meant what they said—they had no intention of ending their marriages. Nick and Sophie just hoped that their respective relationships could tolerate and eventually embrace an expansion of love.

Finding themselves on the opposite side of the spectrum—valuing monogamy more than polyamory—Meghan and Damien found their strange alliance reassuring. They had no interest in getting to know each other as it felt like too much to add to their already-conflicted emotions, but they felt comforted by what they knew was going on for the other person. There were, of course, other times, too, when one or the other felt uneasy, assuming that his or her "ally" was more on board with the process of opening up.

Transitioning to polyamory for mono-poly couples is particularly arduous, and the risks of the relationship ending are high. The way these different

relationships in my office happened to be balanced was fortuitous; it was not easy for anyone, but no one felt left out. Still, a lot was at stake. In spite of their earnest attempts at slowing down, Nick and Sophie were experiencing *new relationship energy*, or *NRE*, and, with their spouses' permission, hoped to become physically intimate. For Meghan and Damien, this movement toward increased intimacy was still advancing too fast. Much of the work at this stage of therapy involved giving voice to each person's respective insecurities and desires and managing the progression of opening up. To prevent their relationships from imploding, the married couples had to prioritize taking care of their marriages. As hard as it was for them, Nick and Sophie kept their agreement to hold back on their budding relationship.

Transitions of any sort represent opportunity and loss, and each person and couple in this poly-centered constellation was dealing with a mixture of hope and grief. After a few months of careful negotiations, Nick and Sophie were finally due to spend their first night together. We discussed in detail what they were "allowed" to do. They could kiss and cuddle but without progressing to any form of sex. To Meghan and Damien's relief, the night went as planned, but there was a lot to digest. Nick and Sophie were disappointed with the slowdown but agreed that, to avoid unrepairable ruptures, the speed of their burgeoning intimacy had to be negotiated all over again.

The process of therapy is rarely smooth, and this was definitely true in the case of these four people. There were as many discoveries of what is relationally possible as there were setbacks. Over time, Meghan and Damien officially consented to partially open their marriages. The partial opening meant that Nick and Sophie could take further steps in their relational exploration, but they were not to add any more partners. Meghan and Damien still did not find polyamory appealing, but came to appreciate that the conflict was not theirs alone. Likewise, Nick and Sophie came to learn how hard their spouses were willing to work to ensure the well-being of their marriages.

There were inevitable breaches of trust, most of them unintentional. One day Nick's car broke down and Sophie had to give him a ride. It meant that she was late coming home to dinner with Damien. It was a blow of betrayal. It took several weeks of therapy to repair this rupture but, overall, the focus on honesty, openness, and transparency—the binding agents of polyamorous relationships—was paying off. Each person and couple was learning that it was possible to reach new levels of relational integration as long as everyone's concerns were respected and heard. "Doing things right" involved a copious amount of processing, not only during our sessions but also outside of therapy.

Eventually, the weekly couples' sessions became biweekly, and the moment came when both therapy tracks came to an end. We parted ways with an understanding that we could resume therapy should the need arise. Nick and Meghan came back several months later to work through some difficulties related to his family of origin. I learned then that Nick and Sophie were still seeing each other, maintaining the kind of balance that appeared to

work for everyone involved. They were all tired of the endless processing needed to sustain this delicate balance, but affirmed their interest in making each of their relationships evolve and grow.

Working with Nick and Meghan, and Sophie and Damien, provided me with a valuable meta-perspective that I would not otherwise have. Their parallel tracks forced me to be in a constant dialog with my counter-transference, and I gained great insights from this process. This is not to say that I recommend other therapists follow suit. It is a personal judgment call how to approach situations of this level of complexity. What I have learned is that therapy boundaries do not have to be rigid to be safe, but they do need to be transparent, predictable, and negotiable. Whenever I am willing to alter the course of treatment, or be somewhat flexible about whom I accept as a new client, I emphasize that it is something we can try out as long as we are open about the process and are willing to change course if needed.

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