LGBTQ+ AFFIRMATIVE INTERSECTIONAL COUNSELING: DEVELOPMENT AND EVALUATION OF A TRAINING WORKSHOP FOR COUNSELING STUDENTS

By

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Despite the documented mental health disparities that impact LGBTQ+ people due to the impacts of societal stigma, (Institute of Medicine, 2010), counselor training related to LGBTQ+ competencies is inconsistent and research on this topic is sparse. Furthermore, counselor training related to intersectionality and the experiences of clients who hold multiple marginalized identities is also unstandardized as multicultural courses often utilize a single-axis approach to examining identity categories.

The purpose of this qualitative study was to learn from counselors and counseling students about their experiences in a two-day training workshop about LGBTQ+ affirmative counseling. A feminist focus group methodology (Munday, 2014) was used for data collection, and the data was analyzed using qualitative thematic analysis (Braun & Clarke, 2006; 2012). The themes that emerged were: (1) Role of Intersectionality as a Critical Framework/Paradigm Shift in Counseling, (2) LGBTQ+ Affirmative Intersectional Counseling and Social Justice, and (3) Social/Political Issues and Privilege, (4) Feeling Uninformed/Intimidated, (5) Impacts of the Workshop, (6) Challenges of Ambiguity/Wanting Guidelines, and (7) Wanting to Have Intersectionality Integrated Throughout Counselor Training.
CHAPTER 1
INTRODUCTION

Overview and Scope of the Problem

Research has shown that lesbian, gay, bisexual, and transgender (LGBTQ+) people (a) are at higher risk for multiple negative mental health outcomes and (b) seek counseling services at higher rates than their heterosexual and cisgender peers (Budge, 2013; Ginicola, Filmore, Smith, & Abdullah, 2017; Institute of Medicine [IOM], 2011; Lynch, Bruhn, & Henricksen, 2013; National Alliance on Mental Illness [NAMI], n.d.; Rutter, Leech, Anderson, & Saunders, 2010). And yet, there is a lack of training and evaluation for mental health professionals to ensure that sexual minority and gender minority clients receive competent care (Bidell, 2014a; Graham & Carney, 20120; Rock, Carlson, & McGeorge, 2010). The full extent of this issue is not well understood because the research literature related to counselor training and LGBTQ+ counseling competencies is sparse.

The aforementioned issues of mental health disparities and lack of counselor training become even more alarming when placed in historical context. The oppression, marginalization, and stigma faced by LGBTQ+ people in the United States has been perpetuated by and within the psychological fields, leaving a legacy of pathologization. One major example of this legacy has been the use of “conversion” methods (counseling intended to change one’s affectional orientation), which are still legal in most states despite research showing that such methods cause psychological harm to clients (American Psychological Association [APA], 2009; IOM, 2011; Southern Poverty Law Center, [SPLC], 2016; Whitman, Glosoff, Kocet, & Tarvydas, 2013). For some people in the LGBTQ+ community, this legacy of pathologization has led to a sense of reluctance or fear that could prevent them from seeking services.
When LGBTQ+ people do seek counseling services, counselors may perpetuate social stigma within the counseling relationship, even if unintentionally, because of the lack of LGBTQ+ affirmative training in counseling programs. As Rock, Carlson, and McGeorge found in a 2010 study, more than 60% of counseling students reported that they received no LGB affirmative training within their counseling programs. While some students may receive limited training within a general multicultural course, Bidell (2014a) found that such courses were not associated with increased scores on the Sexual Orientation Counselor Competency Scale. Because the Trans* Counselor Competency Scale is newly developed, even less is known about the transgender and gender non-conforming competencies of counseling students. In a field with a long history of marginalizing LGBTQ+ people, which will be discussed in depth in Chapter 2, such a lack of training can lead to both (a) a dearth of competent counselors available to LGBTQ+ clients and (b) the continuation and perpetuation by counseling students and professionals, whether intentionally or not, of oppressive practices and beliefs that have been ingrained into the fabric of the field.

**Theoretical Frameworks and Rationale for Study**

Because of the historical context in the psychological professions, which will be discussed in depth in Chapter 2, it has been necessary for an overtly affirmative approach to LGBTQ+ counseling to emerge. Bidell and Whitman (2013) define affirmative counseling as follows:

LGB affirmative counseling rejects biased heteronormative and heterosexist notions that LGB sexual orientations are representative of mental disorders, inferior status, immorality, or social deviancy. Instead, it affirms LGB people have a sexual orientation that is normal, healthy, and legitimate. As such, the disproportionate levels of mental health problems found among LGB people are not resultant of having a minority sexual orientation but linked to the stressful and detrimental effects of LGB prejudice, discrimination, and stigmatization. With this foundational understanding, competent LGB affirmative counselors examine and
advance their attitudinal awareness, develop a comprehensive knowledge of LGB issues, and utilize ethical, professionally based, and nondiscriminatory counseling skills (p. 113).

Furthermore, Singh and dickey (2017) defined affirmative counseling with transgender and gender nonconforming (TGNC) people as “counseling that is culturally relevant and responsive to TGNC clients and their multiple social identities, addresses the influence of social inequities on the lives of TGNC clients, enhances TGNC client resilience and coping, advocates to reduce systemic barriers to TGNC mental and physical health, and leverages TGNC client strengths” (p. 4). To address TGNC affirmative counseling with people of color, Singh, Hwahng, Chang, and White (2017) use an intersectional approach.

In addition to affirmative counseling as a framework, I will also use the theory of intersectionality throughout this research. Intersectional analyses and intersectional pedagogy can be used to incorporate LGBTQ+ affirmative counseling competencies into counselor training, and it can be an analytical tool for conceptualizing and working with LGBTQ+ clients in a mental health setting. This theory, which originated from black feminist thought, was developed to conceptualize how existing in multiple marginalized identity categories and the corresponding social positions can create an experience of interlocking, or intersecting, oppressions (Bowleg, 2012; Crenshaw, 1989; Crenshaw, 1991). Intersectionality focuses on social justice and social change, and therefore, emphasis is placed on examining the impact of having multiple marginalized identities (Bowleg, 2012; Collins & Bilge, 2016 Grzanka, 2014). Because of the focus on social change, intersectionality incorporates not only the individual perspective of how one is impacted by holding multiple marginalized identities (for example, the experiences of being black, a woman, and a lesbian), it also incorporates the political perspective by examining interlocking societal systems of oppression (racism, sexism, and heterosexism) (Collins & Bilge, 2016; Grzanka, 2014). This emphasis on (a) working at the individual level
with a client who has experienced oppression and (b) at the political level through education, activism, and advocacy is in line with the concept of LGBTQ+ affirmative counseling.

In this study, I took an intersectional approach to (a) the understanding of LGBTQ+ mental health disparities, (b) the lack of counselor training to work with LGBTQ+ clients, (c) case conceptualization and interventions in clinical practice, (d) research design, (e) research questions, and (f) the development and implementation of the training workshop. In Chapter 2, I will further discuss the theory and history of intersectionality as an analytical tool, as well as the synthesis of intersectionality with LGBTQ+ affirmative counseling.

Furthermore, Minority Stress Theory (Meyer, 1995; Meyer, 2003) and Fundamental Cause Theory (Link & Phelan, 1995; Hatzenbuehler, Phelan, & Link, 2013) are frameworks that can help counselors understand how social stigma and oppression are linked to increased psychological distress and mental health disparities. Given that LGBTQ+ people are at higher risk for many negative mental health outcomes (Budge, 2013; Ginicola, Filmore, Smith, & Abdullah, 2017; Institute of Medicine [IOM], 2011; Lynch, Bruhn, & Henricksen, 2013; National Alliance on Mental Illness [NAMI], n.d.; Rutter, Leech, Anderson, & Saunders, 2010), affirmative and intersectional approaches compel us to move beyond an intrapsychic approach to also examine the larger social and relational causes of these disparities.

**Need for the Study**

There is an urgent need for this study given that there is a lack of LGBTQ+ affirmative counselor training even though LGBTQ+ people seek counseling at higher rates and face mental health disparities as a result of social stigma. This lack of training perpetuates the problem, as LGBTQ+ clients may feel covertly or overtly stigmatized when seeking services (IOM, 2011). The counseling field as a whole has an ethical responsibility to address the mental health
disparities, the lack of consistency in care, and the history of marginalization of LGBTQ+ clients. One way that these issues can begin to be addressed is through training entry-level counseling students to develop LGBTQ+ affirmative counseling competencies while they are still in their clinical training programs.

**Purpose of the Study**

The purpose of this research was to examine the experiences of counselors and counseling students who attended a two-day training workshop about LGBTQ+ affirmative counseling and intersectionality theory. The training workshop was developed using the foundational elements of affirmative counseling and the theory of intersectionality as a guiding framework. A qualitative study was conducted using semi-structured focus group interviews after the completion of the workshop. This approach allowed me to gain a rich understanding of the students’ experiences in the training workshop and their reflections on the process. Moreover, the qualitative data allowed me to gain information about the students’ understanding of intersectionality as a framework that can be used for clinical conceptualization and social justice advocacy.

**Research Questions**

This study addressed research questions related to the participants experiences of the training workshop, as well as their descriptions of the topics covered. Interview questions were developed to elicit responses related to both the process and the content of the training experience. As stated by Sprague (2005) in regards to feminist qualitative research, “the [participant is not just a source of information, but rather a person who is constructing meaning for the researcher…the agenda is no longer set by the interviewer but by the interviewee” (p. 141). Additionally, in feminist focus group research, participants co-construct meaning regarding both content and process as they interact with the researcher and with each other (Munday,
This study was guided by broad research questions that allowed for the participants’ thoughts, feelings, and experiences to emerge. These questions were:

1. How do the participants conceptualize intersectionality after the training?
2. How do participants conceptualize affirmative counseling after the training?
3. How do participants link intersectionality, affirmative counseling, and social justice after the training?
4. How did participants experience the training?

**Definition of Terms**

LGBTQ+ (lesbian, gay, bisexual, transgender, queer) is an acronym often used as an umbrella term to refer to people in the community of sexual and gender minorities (HRC, n.d.). The “+” is utilized to be inclusive of new and evolving language that people may use to identify themselves. This term (LGBTQ+) will be used throughout when referring to the overall community. Sexual orientation is a term that has often been used to describe “an inherent or immutable enduring emotional, romantic or sexual attraction to other people” (HRC, n.d.). The term affectional orientation is preferred by many because it is more inclusive of love, commitment, and romance rather than focusing solely on sexual acts (Ginicola, 2017). Furthermore, this term is inclusive of asexual individuals who may have romantic feelings and relationships (Ginicola, 2017). Because much of the literature cited still utilizes the term sexual orientation, I will use the term sexual/affectional orientation throughout this paper to be conscious of this transition in scholarship to more inclusive language.

The term gender identity is used to indicate one’s personal identification of their own gender (HRC, n.d.). Transgender and gender nonconforming (TGNC) is an umbrella term often used to include people who identify as a gender other than what was assigned to them at birth, which can include identities such as transgender, gender nonbinary, and genderqueer, while
those who do not identify as TGNC are referred to as cisgender (HRC, n.d.; Singh & dickey, 2017). The terms sexual minorities and gender minorities are used in some of the existing literature to describe people in the LGBTQ+ community, particularly in discussions regarding systemic oppression based on these identities (Hendricks & Testa, 2012; Meyer, 1995; Meyer, 2003). I will utilize all of these definitions throughout these texts. When referencing literature that relates only to sexual/affectional orientation, I will use the terms LGB or sexual minority(ies). When discussing literature or research related to gender identity, I will use the terms TGNC or gender minority(ies).

**Organization of the Study**

In Chapter 1, I have provided (a) an overview of the problem to be addressed, (b) a brief description of the theoretical frameworks, (c) the rationale for the current study, and (d) a brief discussion of the study design. Chapter 2 contains a more extensive literature review related to the historical and current context of the problem. Furthermore, I have discussed the theoretical frameworks in depth in Chapter 2, as well as a review of the literature regarding LGBTQ+ affirmative counselor training. Chapter 3 contains the design and methodology of this study. This section will also include discussion of data analyses and an overview of the training workshop I have designed. Chapter 4 includes the results of the data analysis, and Chapter 5 includes a discussion, implications, and recommendations for future research and training.
CHAPTER 2  
LITERATURE REVIEW

Intersectionality

The term “intersectionality” has become more common in counseling literature in the last decade. However, the growing popularity of the term has led to misunderstandings and misuse through extraction of the language without the foundational and historical grounding. Collins and Bilge (2016) noted that there are multiple different ways people may define and explain intersectionality, which can at times lead to contradictions. The practice of intersectionality can look very different depending on the issues to be addressed and the profession and background of those practicing it. There is no one correct definition of intersectionality, nor is there a clear-cut explanation of how to utilize it. Still, several scholars have provided working definitions that can help practitioners, researchers, and educators to develop intersectional projects. Collins and Bilge (2016) provided the following description:

Intersectionality is a way of understanding and analyzing the complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people’s lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and themselves. (p. 2)

Collins and Bilge (2016) conceptualize intersectionality as an analytical tool to be used for “critical inquiry” and “critical praxis” (p. 31). They describe it as having the following six “guideposts”: Inequality; Relationality; Power; Social Context; Complexity; and Social Justice (p. 25). Furthermore, Bowleg (2008) stated that “intersectionality examines how distinctive social power relations mutually construct each other, not just that social hierarchies exist” (p.
intersectionality is not primarily a theory of identity. Grzanka stated:

Intersectionality is a structural analysis and critique insomuch as it is primarily concerned with how social inequalities are formed and maintained; accordingly, identities and the politics thereof are the products of historically entrenched, institutional systems of domination and violence. While intersectionality helps us to explore social and personal identities in complex and nuanced ways (Sengupta, 2006, Unit III, reading 12), intersectional analyses direct their critical attention to categories, structures, and systems that produce and support multiple dimensions of difference (Dill, Nettles, and Weber, 2001). In intersectionality, “dimensions of difference” is the term used to denote systems of inequality, such as heterosexism and ageism, that are organized around and coproduce social identity categories, such as sexual/affectional orientation and age [...] Intersectionality is foremost about studying multiple dimensions of inequality and developing ways to resist and challenge these various forms of oppression. (p. XV)

The six guideposts, along with the critical, political, and activist aspects of intersectionality, are what may be lost as the term intersectionality becomes mainstreamed. Misrepresentations of intersectionality occur by those who use the term without considering these fundamental aspects (for example, using the term simply to indicate that study participants have multiple identities) and by those who criticize intersectionality (for example, deriding it as “identity politics” or “elitist”) (Collins & Bilge, 2016). Whether intentional or not, these misrepresentations dismiss and erase the decades of intellectual and activist work by women of color in developing intersectional theory as a form of resistance against oppression, which occurred even before the term was introduced by legal scholar Kimberlé Crenshaw in 1989.

History

Some scholars would identify Sojourner Truth as one of the founders of intersectionality, which is also commonly referred to as intersectional feminism, due to the impact of her 1851 speech “Ain’t I a Woman?” (Crenshaw, 1989; Collins & Bilge, 2016; Grzanka, 2014; Truth, 1851). This speech was cited by Crenshaw (1989) in her article “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine,
Feminist Theory, and Antiracist Politics.” It was from this paper that the term intersectionality was coined. The speech by Truth challenged sexism and the “ideological myths of womanhood”, while also challenging the racism of white first-wave feminism (Crenshaw, 1989, p. 153; Truth, 1851). Intersectionality, though not yet named, continued to develop in multiple locations and contexts in response to and outside of white second-wave feminism. Collins and Bilge (2016) described how women engaged in analyses of oppression from a multiples-axes perspective in the 1960s and 1970s. It vital to note that “the intellectual production and activism of black women, Chicanas, Asian-American women and Native American women were not derivative of the so-called second-wave white feminism but were original in their own right” (Collins & Bilge, 2016, p. 65).

A major foundational text of intersectionality that included analysis and discussion of heterosexism and sexual/affectional orientation was “A Black Feminist Statement” by the Combahee River Collective (1977). This statement became a seminal text of black feminist thought and activism. Collins and Bilge (2016) described the impact and uniqueness of this statement because “not only were [the Combahee River Collective] a collective, a community of black feminists, they [also] developed their intersectional analysis in the context of social movements for decolonization, desegregation, and feminism” (p. 68). Additionally, the Combahee River Collective had formed because the members experienced homophobia with the National Black Feminist Organization, which makes this a pivotal moment in regards to LGBTQ+ people and intersectionality (Collins & Bilge, 2016).

By the 1980s and into the 1990s, through the activism of the previous decades, “political activists moved inside those same institutions” from which they were previously excluded (Collins & Bilge, 2016, p. 77). This led to a need for different types of activism within these
hegemonic systems. It was during this time that Kimberlé Crenshaw’s (1989; 1991) work related to black women and discrimination led to the widespread use of the term “intersectionality.” The development of academic programs in gender studies, sexuality studies, and race and ethnicity studies allowed space for intersectionality to enter institutions of higher education, which had both positive and negative effects for the development of intersectional theory (Collins & Bilge, 2016; Grzanka, 2014).

Throughout the last few decades, many scholars in various fields have incorporated intersectionality. Several scholars have discussed how the dispersion of intersectionality through and across multiple fields in academia has led to what Dill and Kohlman (2011) describe as “weak” and “strong” intersectionality (Carbado, 2013; Collins & Bilge, 2016; Grzanka, 2014). Grzanka (2014) analyzed these concepts by comparing them to critiques of incorporating multiculturalism and diversity into pre-existing systems, such as academia and higher education. He discussed how multiculturalism has been used to add “difference into systems that are opposed to difference” and stated that this is “the hallmark of contemporary multiculturalisms that pursue superficial diversity to escape critiques of their actual agendas, which are generally much more regressive” (p. XIX). Furthermore, Grzanka (2014) stated that “as intersectionality continues to grow in popularity and become institutionalized, different research may take on the label of intersectionality without doing anything that involves systemic critique” (p. XIX). These types of intersectionality that work within oppressive systems without challenging them are what Dill and Kohlman (2011) described as weak intersectionality, while strong intersectionality challenges the systems themselves (Carbado, 2013; Collins & Bilge, 2016; Grzanka, 2014).

It is important for white scholars to examine their own positionality and privilege when engaging in intersectional projects. Intersectionality was born out of resistance to oppression
with an emphasis on demarginalization. When white scholars (a) use the term intersectionality without practicing intersectionality, (b) attempt to depoliticize intersectionality, (c) fail to give credit to the women of color who created intersectionality, and/or (d) center themselves or other white people in their intersectional work, they/we are only perpetuating oppression, marginalization, and appropriation.

**Concept of Identity in Intersectionality**

A major area of discussion, and perhaps confusion, is the role of identity in intersectional work. As discussed by Grzanka (2014), intersectionality is not a theory of identity, but rather explores identities as they relate to oppression and dimensions of difference. Intersectionality is a tool for analyzing and resisting oppressive systems, such as racism, heterosexism, sexism, cissexism, and ableism. Both critics of intersectionality and those who unintentionally misuse it have placed emphasis on a “checklist” intersectionality that forgoes the fundamental concerns and tenets of intersectionality and instead focuses on including as many individual identities and identity combinations as possible, a task which is clearly prohibitive and unpragmatic (Carbado, 2013; Collins & Bilge, 2016; Dill & Kohlman, 2011; Grzanka, 2014). Thus, critics can dismiss intersectionality as impossible, while others can claim projects as intersectional without taking a political or anti-oppressive stance. However, simply having a diverse sample of research participants or working with people who hold multiple minority identities, for example, does not in and of itself make a project intersectional.

Another important element of identity as it relates to intersectionality is the concept of “double-jeopardy”, or an additive approach to conceptualizing the experiences of people with multiple minority identities (Bauer, 2014; Bowleg, 2008; Carbado, 2013; Parent, DeBlaere, & Moradi, 2013). These approaches treat individual identities (such as race, gender, and affectional orientation) as separate constructs that can be added together to “double” (or triple, and so forth)
one’s experiences of oppression. From an intersectional standpoint, the impacts of different identities cannot be added because they cannot be separated (Parent, DeBlaere, & Moradi, 2013.) Furthermore, oppressive systems cannot be separated and addressed as distinct in how they privilege some and marginalize others because they are interlocking.

Crenshaw (1991) addressed the impact of oppressive systems on individuals by describing three different categories of intersectionality. Structural intersectionality refers to the experiences of people who are located “at the intersections” (p. 1245). For example, she discussed how the impact of gender-based violence for black women at the intersection of gender and race would be different from the experiences of white women. Political intersectionality is the analysis of how different political movements, such as civil rights movements, gay rights movements, and feminist movements, may have different or even contradictory agendas, leaving out and erasing people at the intersections. Representational intersectionality is about how cultures shape and control the representations of people at the intersections, which can include negative stereotypes and erasure.

The use of strong intersectionality as an analytical tool and theoretical framework in counseling, counselor education, and counseling research can lead to deeper and more nuanced understandings of the history and systems that impact clients’ experiences and clinical concerns. Minority Stress Theory (Meyer, 1995; 2003) and Fundamental Cause Theory (Link & Phelan, 1995) can be synthesized within an intersectional framework to inform counselors of the relationships among stigma, oppression, discrimination, and health disparities. The following section will address how these theories can be used specifically to conceptualize the documented mental health disparities in LGBTQ+ populations.
Theoretical Frameworks for Understanding LGBTQ+ Mental Health Disparities

Multiple research studies have shown that LGBTQ+ people are at higher risk for depression, anxiety, substance use disorders, suicidality, and other psychological and social challenges (Budge, 2013; Ginicola, Filmore, Smith, & Abdulllah, 2017; Institute of Medicine [IOM], 2011; Lynch, Bruhn, & Henricksen, 2013; National Alliance on Mental Illness [NAMI], n.d.; Rutter, Leech, Anderson, & Saunders, 2010). It is vital that counselors understand these disparities within a social rather than solely intrapsychic perspective. Minority Stress Theory and Fundamental Cause Theory are helpful lenses that can be synthesized with intersectionality to examine the historical and current contexts that affect LGBTQ+ people (Hatzenbuehler, Phelan, & Link, 2013; Hendricks & Testa, 2012; Meyer, 1995; Meyer, 2003).

Minority Stress Theory

Meyer’s (1995; 2003) Minority Stress Model can help clinicians better understand the documented mental health disparities for sexual minority people. This model provides a conceptual framework for understanding how stressors related to minority status, such as stigmatization, discrimination, and prejudice in society, are related to the increased risk for negative mental health outcomes experienced by sexual minority clients. Meyer described distal stress processes as those which are objective events, such as experiences of discrimination, and proximal stress processes, which are the individual’s subjective perception of the events and the related outcomes. Meyer reported four stress processes that are specific to LGB individuals: (1) chronic and acute external stressful events (distal), (2) expectations of external stressful events (proximal), (3) internalization of social prejudice and negative societal views (proximal), and (4) the concealment or hiding of one’s sexual/affectional orientation (proximal).

Hatzenbuehler (2009) proposed a psychological mediation framework that incorporated some aspects of Meyer’s Minority Stress Model to further explore the increased risk for negative
mental health outcomes in sexual minority populations. This model also included empirically supported risk factors for psychological distress that are not specifically related to LGB or minority identities. The latter factors are categorized by Hatzenbuehler as general psychological processes that can affect all people, and the stigma-related distal and proximal stressors that specifically impact LGB people are categorized as group-specific processes. Within this framework, Hatzenbuehler proposed that the distal process (an event related to stigma and discrimination) will lead to both the proximal and general psychological processes, which then lead to psychological distress/psychopathology. Liao, Kashubeck-West, Weng, and Deitz (2015) expanded on Hatzenbuehler’s mediation model and tested a framework using structural equation modeling that included three potential mediator variables: (1) expectations of rejection, (2) anger rumination, and (3) self-compassion. The results supported their hypotheses that these variables would mediate the relationship between experiences of discrimination and psychological distress (Liao, Kashubeck-West, Weng, and Deitz, 2015).

Gender Minority Stress Theory

Hendricks and Testa (2012) expanded upon Meyer’s (1995; 2003) Minority Stress Theory, which was developed for use with sexual minority populations, to adapt the model for use with the TGNC population. Like Meyer’s (1995;2003) model, this model categorizes stress processes that are specific to minority populations as either distal or proximal. Distal stressors are those that are objective events, such as experiences of discrimination, while proximal stressors are subjective experiences that include expectations of rejection, hypervigilance, concealment of identity, and internalized stigma (Hendricks & Testa, 2012). They proposed that these minority-specific stressors account for the higher rates of mental health concerns when compared to the general population and non-minority counterparts. From an intersectionality perspective, we can conceptualize how a client with multiple minority identities, such as a TGNC person of color,
could be impacted by multiple systems of oppression and stressors based on multiple identities, such as experiences of both racism and transphobia.

**Fundamental Cause Theory**

Fundamental Cause Theory can also be integrated with intersectionality and Minority Stress Theory to help scholars and clinicians understand the experiences of LGBTQ+ clients (Hatzenbuehler, Phelan, & Link, 2013). Link and Phelan (1995) developed this framework for understanding health disparities from a structural and social perspective, as opposed to epidemiological perspectives that focused on individual behaviors in regard to disease risk and prevention. They described a “causal chain” in which proximate causes/proximal risk factors are those that occur “closer” to the disease and could potentially be controlled by individuals, while distal causes/distal risk factors are farther from the outcome on this causal chain and therefore receive less attention in health disparities research and interventions (Link & Phelan, 1995, p. 80). Link and Phelan (1995) stated:

This focus on proximate risk factors, potentially controllable at the individual level, resonates with the value and belief systems of Western culture that emphasize both the ability of the individual to control his or her personal fate and the importance of doing so. (p. 80)

They argued (a) that risk factors should be examined through a social context to understand what puts some people “at risk of risk”, and (b) that social conditions are the fundamental causes of health disparities, enacted through various and changing mechanisms (Link & Phelan, 1995, p. 85).

Link and Phelan (1995) posited that, because humans have a dynamic relationship with diseases (i.e., treatments change, diseases are cured, new diseases emerge, and so forth), the impact of diseases will be disproportionate due to power and privilege. Those in privileged positions will be less affected by preventable and/or treatable diseases because they have access
to what Branstom, Hatzenbuehler, Pachankis, and Link (2016) describe as “health protective resources,” which includes “knowledge, prestige, power, and supportive social connections” (p. 1113). Furthermore, Link and Phelan (1995) stated that people of lower status in society will be at a greater risk for many diseases, and therefore research and interventions that address a disparity related to only one disease, or that address only individual level behaviors, will be insufficient in addressing the fundamental causes of disparities (Link & Phelan, 1995).

Hatzenbuehler and colleagues (2013) posited that stigma is a fundamental cause of health disparities with multiple mechanisms, outcomes, and mediators. They defined stigma as “the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised” (Hatzenbuehler, et al., 2013, p. 813). Stigma encompasses, but is broader than, individual and structural discrimination, and it can affect people based on multiple social positions and identities, such as race, sexual/affectional orientation, gender identity, ability, mental health status, and more (Hatzenbuehler, et al., 2013). In this conceptualization of stigma, it is inherently related to power. As stated by Hatzenbuehler and colleagues, those with power use stigma for “keeping people down (exploitation), keeping people in (enforcement), and keeping people away (disease avoidance)” (p. 816). They stated that potential outcomes of stigma are: (1) exclusion, (2) discrimination, (3) segregation, (4) stress, and (5) diminished SES (Hatzenbuehler, et al., 2013.) Furthermore, they stated that the mediating factors between stigma and health outcomes are (1) resources, (2) social isolation, (3) psychological and behavioral responses, and (4) stress (Hatzenbuehler, et al., 2013).

The mechanisms of a fundamental cause are contextual, and new mechanisms will develop if the fundamental cause is not addressed (Hatzenbuehler, et al., 2013; Link & Phelan, 1995). For example, Hatzenbuehler and colleagues (2013) discussed the history of racism against
black Americans to illustrate this concept. As they described, it was of benefit to white Americans to stigmatize black Americans, starting with slavery. When the mechanism of slavery was abolished, or “blocked”, new mechanisms emerged, such as Jim Crow laws. As these overt forms of racism were also blocked in society, new mechanisms formed that were more covert and that continue to this day (Hatzenbuehler, et al., 2013).

Because Fundamental Cause Theory focuses on structural analysis, social conditions, historical and political contexts, and the interrelation of systems of power that marginalize “others”, it can be synthesized with intersectionality to help clinicians better understand the mental health disparities of LGBTQ+ people. According to this theory, eliminating health and mental health disparities requires interventions at the systemic level to address stigma rather than only addressing each mechanism as a separate issue. This framework has similarities to intersectionality given that multiple forms of stigma (such as racial stigma, gender stigma, and sexual/affectional orientation stigma) can interact to create multiple marginalized statuses in which people are placed.

Furthermore, Fundamental Cause Theory shares similarities with Minority Stress Theory. As discussed by Hatzenbuehler and colleagues (2013), social isolation is a mediator between stigma and health. They stated that individuals may choose to conceal their identities if possible for fear of negative consequences; moreover, self-esteem and mood may increase when they are with others who share the stigmatized identity. They stated that people with concealable stigmatized identities (such as sexual minority status) are less likely than those with visible stigmatized identities (such as those related to race and ethnicity) to experience being around others who share their identity (Hatzenbuehler, et al., 2013). Furthermore, Hatzenbuehler and colleagues (2013) link stigma to health disparities through the psychological and behavioral
responses of internalization and maladaptive coping. They also discussed the increase in stress for people with stigmatized identities, which has been linked to negative health outcomes (Hatzenbuehler, et al., 2013).

As discussed earlier, Meyer’s (1995; 2003) Minority Stress Theory proposed that the following stress processes are specific to LGB individuals and can lead to psychological distress: (1) chronic and acute external stressful events, (2) expectations of external stressful events, (3) internalization of social prejudice and negative societal views, and (4) the concealment or hiding of one’s sexual/affectional orientation. The similarities and overlaps in these theories allow us to conceptualize how stigma acts as a fundamental cause of LGBTQ+ mental health disparities. Fundamental Cause Theory and intersectionality can provide a historical and current context that provides a basis for understanding how power and social conditions contribute to the individual processes of Minority Stress Theory that lead to psychological distress.

Moreover, Hatzenbuehler and colleagues (2013) stated that:

Studies have tended to examine single outcomes (e.g., associations between stigma and self-esteem) and at 1 (sic) level of analysis (typically at the individual level, without attention to structural conditions […] the field of population health would benefit greatly […] from the development of a theoretical framework that provides insights into the processes that generate health inequalities among members of stigmatized groups. (p. 813)

Intersectionality can provide this theoretical framework. Scholars in public health (Bowleg, 2012; Hankivsky, 2010), nursing (Kelly, 2009; Rogers & Kelly, 2011), and medicine (Bauer, 2014) have called for the incorporation of intersectional approaches to research and interventions for addressing health disparities. Such an approach (a) would include current and historical analyses of power structures that affect health outcomes (including fundamental causes and related mechanisms), and (b) could lead to structural, political, and policy changes within
hegemonic systems that are currently maintaining the status quo through lack of social analysis and continued emphasis on individual level behavioral interventions.

**LGBTQ+ Counseling History and Clinical Concerns**

To begin an intersectional analysis of the mental health disparities that affect LGBTQ+ people, the clinical concerns and presenting issues that may arise in counseling should be examined within the context of history and the current political climate. The Institute of Medicine (2011) and the American Psychological Association (2009) have described how LGBTQ+ oppression in the United States is related to psychological distress in this population. For the purposes of this paper, I will focus specifically on the history and current context of how LGBTQ+ people have been treated in counseling and related fields. It will become apparent that new mechanisms have emerged over time related to the stigma of LGBTQ+ people as old mechanisms were blocked or dissolved, and that individual level interventions related to specific clinical issues have failed to address the fundamental cause of disparities. This context will illustrate (a) the necessity for counseling approaches that are actively affirming (i.e., not just “tolerant”) and that incorporate structural analysis and advocacy, (b) the urgent need to address the lack of training in counseling programs related to LGBTQ+ competencies, and (c) the importance of an intersectional approach to teaching and practicing LGBTQ+ affirmative counseling. The following section will address: (a) historical context, (b) current context, (c) clinical concerns, and (d) wellbeing and resilience, the latter of which is essential to an affirmative approach. Because sexual/affectional orientation and gender identity are different constructs with differing (but overlapping) histories, assessment instruments, and counseling competencies, these constructs will be addressed separately.
Affectional Orientation

For many decades, pathologization of non-heterosexual orientations was institutionalized in medical and mental health fields, in part through the Diagnostic and Statistical Manual of Mental Disorders (DSM, APA). In the original DSM, homosexuality was listed in the category of “sociopathic personality disturbances” (APA, 1952). In 1973, the term homosexuality was replaced with “sexual orientation disturbance” in the DSM-II. According to Rudolph (1989), 37% of the APA membership were opposed to removing homosexuality as a mental illness. The DSM-III in 1980 again changed the previous terminology to “ego-dystonic sexual orientation”, which was intended to capture the personal conflict of having one sexual/affectional orientation but desiring another, rather than labeling the orientation as a diagnosis itself. This diagnosis was removed from the DSM-III-R in 1987, but there was still a long road ahead for activists and advocates of affirmative counseling.

The conceptualization of homosexuality as a mental disorder led to attempts by mental health professionals to alter clients’ orientations through methods often referred to as conversion or reparative therapy. A task force of the American Psychological Association (2009) systematically reviewed existing research literature on this topic and resolved that such methods are both (a) unsuccessful in their aim to change sexual/affectional orientation and (b) harmful to those who receive such therapies, increasing the risk of depression, anxiety, suicidal thoughts or actions, and other psychological distress. Official statements opposing the treatment of homosexuality as a mental disorder and the use of conversion methods were issued by the American Psychological Association, the American Psychiatric Association, and the American Counseling Association in 1975, 1988, and 1998/1999 respectively (Southern Poverty Law Center, [SPLC], 2016). However, these statements do not legally prevent clinicians from
practicing conversion, and they are not enough on their own to undo the damage that had been caused to LGBTQ+ people and communities.

**History and current events**

The study of sexual/affectional orientation in psychology and psychiatry dates to as early as the mid- to late-1800s. Much of the early work in this area focused on the experiences of gay men (Lev, 2004). The pervasive ideas during these early studies focused on the idea of “homosexuality” as either (a) deviant and criminal or (b) pathological (Broido, 2000). Krafft-Ebing (1894) described homosexuality as a mental illness and stated that it was caused by an “emotional shallowness” that created an inability to form relationships with members of the opposite sex. Furthermore, Freud (1905) believed that homosexuality was only a natural phase in the development of a heterosexual identity; thus, to be homosexual was to be immature or incomplete in development. Rado (1940) described homosexual behavior as aberrant and psychopathological, and he attributed it to fear of the opposite sex resulting from adverse childhood experiences. Bieber (1962) furthered this notion by stating that a distant father and overbearing mother were the cause of male homosexuality.

In 1971, just two years after the Stone Wall riots that were a critical moment in the gay rights movement, Raymond R. Killinger published “The Counselor and Gay Liberation” in the Personnel and Guidance Journal (which is now the Journal of Counseling & Development). He addressed the history of gay oppression in psychiatric and psychological fields, stating:

The sad history of our cultural-medical-religious attitude toward homosexuality can be summarized by saying that we disowned demons as the cause when we discovered genes. We survived the Kraft Ebbing Psychopathic Sexualis era and switched to “Mother” when Freud came along. This skipping about in an attempt to find a cause is reflected in the American Psychiatric Association’s diagnostic handbook. Each new edition bounces this hot potato into another category of illnesses – from constitutional psychopath to character disorder and now maybe to neurotic. What’s next? (p. 715)
Furthermore, Killinger (1971) described a new stance emerging with the gay liberation movement:

A new social force in American life is coming into evidence in the form of homosexuals who categorically reject assuming guilt and who are banding together to push for acceptance by the community at large […] To the liberated gay, the old straight-gay dichotomy is becoming archaic. They have lost, or are trying to lose, the need to suppress and deny the homosexual portion of their psyche. They reject the Puritan ethic as sick, seeing it not just as anti-sexual but as anti-life, anti-freedom, and anti-love (p. 715)

Killinger (1971) called on counselors to decide where they stood on the issue of gay liberation, and called on those who would accept homosexual identities and relationships as natural and normal to “rid themselves of their own narrow or destructive attitudes to homosexuals” (p. 718). He also emphasized that counselors have a responsibility to advocate against discrimination in their own work places (Killinger, 1971).

During this same time period, in 1970 and 1971, gay liberation advocates, sometimes known as “zappers”, organized to “zap”, or disrupt, conference sessions related to homosexuality at American Psychiatric Association conventions (Faderman, 2015; Killinger, 1971). Advocates disrupted a talk by Bieber that promoted shock therapy for conversion from homosexuality to heterosexuality through showing gay men erotic images of both men and women and shocking them when they viewed the former (Faderman, 2015). The commotion caused by this disruption in 1970 led to the American Psychiatric Association allowing a gay and lesbian panel at the convention the following year (Faderman, 2015). At this convention in 1971, activists from the Gay Liberation Front (GLF) and the Gay Activists Alliance (GAA) infiltrated a convocation while chanting “psychiatry is the enemy”, and were physically and verbally attacked by some of the psychiatrists inside, who yelled slurs and attempted to eject the protesters (Faderman, 2015). According to Faderman (2015), one of the zappers was able to reach the stage and take the microphone:
“We are here to denounce your authority to call us sick or mentally disordered,” Kameny shouted amidst psychiatric boos and jeers. Someone pulled the microphone’s plug, but Kameny only shouted louder. “For us, as homosexuals, your profession is the enemy incarnate. We demand that psychiatrists treat us as human beings, not as patients to be cured! You may take this as a declaration of war against you!” Pandemonium reigned. The convocation was over. (p. 282)

Faderman (2015) and Killinger (1971) asserted that these tactics of resistance and the challenging of oppressive systems led to conversations in the psychiatric field, and the term “homosexuality” was removed from the DSM in 1973. At the 1975 conference of the American Personnel and Guidance Association (now the American Counseling Association [ACA]) the Caucus of Gay and Lesbian Counselors was formed. This group would become what is now the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC), though it was not recognized as an official division of ACA until 1997 (Rhode, 2010).

Throughout the 1970s and early 1980s, mainstream counseling scholarship found in the Journal of Counseling and Development explored the issue of homosexuality as either pathological or natural (Ivey, 1972; Kremer, Zimpfer, & Wiggers, 1975; Sophie, 1982). The work of Kinsey (1947), a biologist and sexologist, was cited as evidence that sexuality exists on a continuum and is normal and healthy whether one identifies as heterosexual, bisexual, or homosexual. Conversations about whether homosexuality and bisexuality were an adolescent phase continued, as did new discussions regarding gay and lesbian identity development and the impact of social stigma on mental health and counseling issues (Groves & Ventura, 1983; Ivey, 1972; Kremer, Zimpfer, & Wiggers, 1975; Sophie, 1982; Winkelpleck & Westfeld, 1982). Also during this time, identity development models were created by scholars in related fields (Cass, 1979; Goodrich & Ginicola, 2017; Troiden, 1979).

While progress was made regarding the treatment of sexual minority people in mental health fields throughout the 1970s and early 1980s, the mid-1980s to mid-1990s showed the
emergence of a “new homophobia” resulting from the HIV/AIDS epidemic (Carney, Werth, & Emanuelson, 1994; Croteau & Morgan, 1989). The disproportionate impact of this epidemic on the gay male population was seen by some in society as a reinforcement of existing homophobia and heterosexist beliefs, which were emboldened to resurface due to beliefs that HIV/AIDS was a “gay disease” (Croteau & Morgan, 1989). The literature related to gay, lesbian, and bisexual issues in counseling increased in the Journal of Counseling and Development during this time, and include topics such as the following: discrimination, stigma, and internalized homophobia; counselors’ responsibilities as advocates; counselors’ attitudes, beliefs, and competencies; coping with the impacts of HIV/AIDS on individuals and communities; identity development; lifespan development and issues; career counseling; and family and couples’ issues (Barret, 1989; Bridges & Croteau, 1994; Carballo-Dieguez, 1989; Carney, Werth, & Emanuelson, 1994; Chojnacki & Gelberg, 1995; Coleman and Remafedi, 1989; Cramer, 1986; Croteau & Morgan, 1989; Gumaer, 1987; Hetherington & Orzech, 1989; Hetherington, Hillerbrand, & Etringer, 1989; Holahan & Gibson, 1994; Johnston & Bell, 1995; Martin, 1989; McDermott, Tyndall, & Lichtenberg, 1989; Miranda & Storms, 1989; Morrow & Hawxhurst, 1989; Murphy, 1989; Price, Omizo, & Hammett, 1986; Rudolph, 1989). Additional topics that began to emerge were: inclusion of sexual minority status under the umbrella of multiculturalism and multicultural competencies for counselors; experiences of people who are sexual minorities and racial minorities and the impacts of living with both racism and heterosexism; definition and importance of affirmative counseling; and rationale and recommendations for counseling research and training related to sexual minority clients (Buhrke, 1989; Carballo-Dieguez, 1989; Chan, 1989; Chojnacki & Gelberg, 1995; Croteau & Morgan, 1989; Dworkin, 1989; Iasenza, 1989; Loiacano, 1989; Pope, 1995; Rudolph, 1989; Sang, 1989; Schneider & Tremble, 1986).
More progress occurred in the counseling field throughout the late 1990s. The American Counseling Association Governing Council Resolution issued in 1998 stated that the ACA “opposes portrayals of lesbian, gay, and bisexual individuals as mentally ill due to their sexual orientation” (Whitman, Glosoff, Kocet, & Tarvydas, 2013). Furthermore, the governing council stated in 1999 that they are opposed to the use of conversion therapies, due to the following: (a) homosexuality is not a mental illness and therefore does not need treatment, (b) literature on conversion therapy shows that it is not effective, and (c) research on conversion shows that it can be harmful to clients (Whitman, et al., 2013). In 1997, ALGBTIC (at the time known as AGLBIC) became an official division of ACA (Rhode, 2010). Yet, there was a decrease in articles published regarding sexual minority identities in the Journal of Counseling and Development from 1996 to 2005.

In 2006, AGLBIC (now ALGBTIC) published its first issue of the Journal of LGBT Issues in Counseling. Ned Farley, the first editor of this journal, stated in the first issue: “We are hoping that our journal will uniquely address the role of the field of counseling in furthering the healthy growth and development of lesbian, gay, bisexual, and transgendered (sic) peoples, as well as their families and communities” (2006, p. 1). The Journal of LGBT Issues in Counseling provided a space for strength-based and affirmative approaches to research, practice, and counselor training to flourish and develop. Furthermore, ALGBTIC developed Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally (LGBQIQA) Individuals in 2013.

In the last decade, there has been an increase in visibility and acceptance for sexual minority people, both within counseling and in U.S. society as a whole. A recent Pew Research Center study showed that 63% of Americans believe “homosexuality” should be accepted in
society, as compared to 51% who believed the same in 2006 (Brown, 2017). Additionally, 92% of LGBT adults believe that society has become more accepting of them according to a 2013 survey (Brown, 2017). Affirmative approaches have been endorsed by the American Psychological Association and the American Counseling Association (ALGBTIC, 2013; APA, 2009). Still, challenges exist related to value-based conflicts, as well as political and legislative backlash.

Value-based conflicts is a term that emerged in recent years to describe conflicts between personal values and professional values and ethics (Francis & Dugger, 2014). Conversations about value-based conflicts came to the forefront of the counseling profession in recent years due to several high-profile court cases in which counseling students were dismissed from their training programs for refusing to counsel gay and lesbian clients due to personal religious beliefs and then proceeded to sue the universities that dismissed them (Dugger & Francis, 2014; Francis & Dugger, 2014; Herlihy, Hermann, & Greden, 2014; Kaplan, 2014). The cases of Ward v. Wilbanks (2010) and Keeton v. Anderson-Wiley (2010) are two examples that have been discussed extensively in counseling literature. Similarly, practitioners who have been fired by their employers for refusing services to gay and lesbian clients have sued their past employers, claiming religious discrimination (Herlihy, et al., 2014). These cases have brought attention to conflicts between the religious freedom of students and counselors and the ACA ethical codes that prohibit discrimination against clients (ACA, 2014).

Although the results of these court cases are complicated due to multiple appeals and out-of-court settlements, courts ruled in favor of the employers and the universities (Herlihy, et al., 2014). A major factor in these decisions was the ACA Code of Ethics (ACA, 2005; 2014). Counselors and counseling students have a responsibility, upon entering the profession, to abide
by the Code of Ethics despite their personal beliefs. The counselors and students involved in these cases were offered remediation opportunities to help them align their practice with the Code of Ethics, but their refusal to follow these remediation plans justified their dismissal (Herlihy, et al., 2014). In 2014, in part due to these legal concerns, the ACA revised their Code of Ethics to be more specific in their language regarding non-discrimination and acceptable practices for the use of referrals (ACA, 2014).

The dialogue in the counseling field regarding value-based conflicts is ongoing, and is complicated by political and legislative actions. For example, a law was passed in Tennessee in 2016 that allows counselors specifically to refuse clients based on “sincerely held principles” (Sisk, 2016). Additionally, because such practices violate the ACA Code of Ethics that is currently used by the Tennessee licensure board, another bill has recently been introduced that would allow licensed counselors in Tennessee to abide by a new, and not yet created, code of ethics in lieu of the ACA Code of Ethics.

Furthermore, despite statements of opposition from professional organizations such as the American Counseling Association, the American Psychological Association, the American School Counseling Association, the American Association for Marriage and Family Therapy, the American Medical Association, the World Health Organization, and other professional organizations, counseling methods intended to alter one’s sexual/affectional orientation with the goal of conversion to heterosexuality are still legal in most of the United States. As of 2017, only California, Connecticut, the District of Columbia, Illinois, Nevada, New Jersey, New Mexico, Oregon, and Vermont have statewide legislative bans on conversion therapy (Movement Advancement Project, 2017). The state legislation that does exist only prohibits the use of conversion therapy with clients under the age of 18, and typically only prevents the use of
conversion by licensed professionals, thereby allowing non-licensed mental health professionals to continue with these harmful practices.

It is important to understand this historical and political context to gain more insight into where we currently are as a field in regards to competent services for sexual and affectional minority people. Stories of oppression and activism such as those presented here show us that progress in the treatment of LGBTQ+ people in counseling was hard-fought and did not occur passively due to the passage of time. These stories are vital not only for honoring those who were harmed by mental health professions and the activists who put themselves at risk, but also for understanding the continued importance and need for active and progressive advocacy in the counseling field regarding LGBTQ+ people.

**Specific clinical concerns**

In addition to general counseling concerns that are not related to sexual or affectional orientation, LGBQ+ people are at a higher risk for multiple clinical issues that can be understood through Minority Stress Theory and Fundamental Cause Theory. Increased risk for depression, anxiety, suicidality, and substance abuse can be due to the effects of stigma and the related distal and proximal stressors (Ginicola, Filmore, Smith, & Abdullah, 2017; IOM, 2011; Meyer, 1995; 2003). These concerns can be further exacerbated through barriers to care and past experiences with clinicians who did not have the necessary affirmative competencies, whether due to heterosexist and homophobic beliefs or due to a lack of appropriate training (Ginicola, et al., 2017; IOM, 2011).

Additionally, LGB people may present with distress due to past experiences of conversion therapy (APA, 2009; Horner, 2010). Although it has been found to be a harmful and unethical practice by counseling, psychological, psychiatric, and medical associations, there are individuals who have experienced conversion therapy and may seek additional counseling due to
the negative effects (APA, 2009; Horner, 2010). Horner stated that individuals presenting to therapy post-conversion therapy may present with sexual and spiritual identity crises, depressive and anxiety-related symptoms, sexual dysfunction, and posttraumatic stress related symptoms (2010). The APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) recommended the use of an affirmative approach when working with clients who are seeking or who have already experienced some type of sexual orientation change effort (SOCE).

**Wellbeing and resilience**

Remley and Herlihy (2010) have emphasized that counselors practice by “a wellness model of mental health”, as opposed to a medical model (p. 26). Thereby, there is a focus placed on wellness, resilience, and empowerment rather than on illness and cure (Remley & Herlihy, 2010). This approach is particularly important when working with LGBQ+ people who have been historically pathologized and harmed by attempts to “cure” who they are. Ginicola and colleagues (2017) emphasized the importance of internal protective factors, such as self-acceptance and high self-esteem, and external protective factors, such as community involvement, supportive relationships, and role models, as potential sources of resilience. LGBQ+ people have developed resilience in the face of stigma and oppression and have taken great risks to advocate for themselves and their communities. However, resilience is a complex issue because while it may be a protective factor for people facing oppression, too much emphasis on resilience can lead to (a) addressing how to cope with oppression instead of addressing the oppression itself, and (b) feelings of inadequacy in those who do not identify themselves as resilient. It is important for counselors to be careful not to let the narrative of resilience lead them to put the responsibility on people for their own oppression.
Gender Identity

In the past decade or so, several scholars have noted that literature regarding TGNC populations is limited and that research with TGNC people can be challenging to conduct (Institute of Medicine [IOM], 2011; Moradi et al., 2016; Tebbe & Budge, 2016). Sampling concerns exist because most national surveys have not included gender identity as a demographic variable (IOM, 2011). Additionally, TGNC individuals might make up a relatively small percentage of the U.S. population (approximately 0.6% per a 2016 study published by The Williams Institute), which can lead to challenges in recruiting TGNC people for studies if sampling procedures are aimed toward the general population (Flores, Brown, & Herman, 2016).

In addition to the logistical challenges, the historical treatment of TGNC people by mental health systems has led many TGNC people, and other historically marginalized populations, to be distrustful of researchers (Tebbe & Budge, 2016). The pathologizing of TGNC identities in past versions of the DSM, and the corresponding non-affirmative treatment, have created tension between TGNC communities and mental health practitioners and researchers (Tebbe & Budge, 2016). The lack of clinical training related to TGNC client competence is alarming given that TGNC people utilize counseling and therapy at a rate of 25 times that of the general population according to Budge (2013).

Although the amount of literature regarding counseling with TGNC people is limited, there has been an increase in recent years. In their content analysis of TGNC related literature from 2002 and 2012, Moradi and colleagues (2016) found that more than half of the articles had been published within the latter four years of the decade examined. In 2015, the APA published “Guidelines for Psychological Practice with Transgender and Gender Nonconforming People,” which calls for TGNC-affirmative practice. In 2017, the APA published the text book “Affirmative Counseling and Psychological Practice with Transgender and Gender
Nonconforming Clients,” which was written from an affirmative and intersectional perspective (Singh & Dickey, 2017). Within counseling in particular, the Journal of LGBT Issues in Counseling has provided a space within the professional discourse for issues related to TGNC people and affirmative counseling since the journal was founded in 2006.

**History and current events**

In regards to TGNC and other gender variant identities, much of the literature from psychological and social science fields has been pathologizing until very recently. Gender identity and sexual/affectional orientation were often conflated, with many believing that gay men had a psychological condition known as “inversion”, essentially indicating that they wanted to be women (Lev, 2004). As with much of the older literature related to sexual/affectional orientation, much of the historical literature regarding gender identity was focused on people who were identified as male at birth. In the 1960s, Harry Benjamin, an endocrinologist, was one of the first professional advocates against the psychological pathologization of TGNC people (Lev, 2004). He was opposed to psychological interventions intended to cure TGNC identities, and advocated instead for compassion and medical transitions (Lev, 2004).

In the DSM, TGNC identities were pathologized up until the most recent version (DSM-5, APA, 2013). Both the DSM-I and the DSM-II included the diagnosis “transvestism” (APA, 1952; 1973). The DSM-III included “gender identity disorder” as a diagnosis for children, and “transsexualism” as a diagnosis for adults (APA, 1980). The DSM-IV removed these and added “gender identity disorder” (APA, 1994). In the DSM-5, “gender identity disorder” was removed, and “gender dysphoria” was added to refer to the dysphoric feelings that might be associated with feeling that one’s body does not match their gender identity (APA, 2013). Important distinctions to make are that (a) gender dysphoria is not an experience that every TGNC person will have, and (b) having a TGNC identity is not a mental disorder. The APA (n.d.) stated:
A psychological state is considered a mental disorder only if it causes significant distress or disability. Many transgender people do not experience their gender as distressing or disabling, which implies that identifying as transgender does not constitute a mental disorder. For these individuals, the significant problem is finding affordable resources, such as counseling, hormone therapy, medical procedures and the social support necessary to freely express their gender identity and minimize discrimination. Many other obstacles may lead to distress, including a lack of acceptance within society, direct or indirect experiences with discrimination, or assault. These experiences may lead many transgender people to suffer with anxiety, depression or related disorders at higher rates than nontransgender persons. (p. 3)

There still exists a gap in the literature regarding the history of how TGNC people have been treated within mental health fields and how that impacts the current context. According to Singh and dickey (2017), the ACA Counseling Competencies for Counseling with Transgender Clients, developed by an ALGBTIC taskforce, was “the first of its kind from [a mental health providers’] professional association” when they were published in 2010 (p. 8). However, the Standards of Care by the World Professional Association for Transgender Health were first published in 1979 (Singh & dickey, 2017). Moradi and colleagues (2016) conducted a content analysis of literature about TGNC people across several disciplines, including psychology, sociology, public health, political science, medicine, and more, from 2002 to 2012. Additionally, content analyses of literature regarding TGNC people is one of the recommendations made by Tebbe, Moradi, and Budge (2016) for enhancing TGNC scholarship.

Specific clinical concerns

Using an integration of the frameworks previously discussed, we can examine the negative mental health outcomes that may impact TGNC people who seek counseling services. Hendricks and Testa (2012) distinguished two major categories of issues that may arise for TGNC people seeking counseling. They distinguished between (a) transition-related services, which can include a diagnosis of gender dysphoria and recommendation letters to medical professionals for transition-related services, and (b) all other emotional, social, and mental health concerns that
one might present with in counseling. One reason why they separated clinical concerns into these categories was to highlight that clients who are seeking letters of recommendation for transition-related services may be hesitant to share any issues that could be associated with a mental health diagnosis (other than gender dysphoria) for fear that this could be used as evidence that they are not prepared to transition or are not making the decision of sound mind (Hendricks & Testa, 2012). Therefore, counseling sessions related to transition-services may look very different from those that focus on other concerns.

Several scholars have noted the disproportionate rates of mental health concerns such as substance use disorders, anxiety, mood disorders such as depression, self-injurious behaviors, hypervigilance, reduced coping abilities, and suicidality within the TGNC population (Budge, Adelson, & Howard, 2013; Hendricks & Testa, 2012; White Hughto, Reisner, & Pachankis, 2015). Experiences of stigma and stressors related to minority status may account for the increased levels of psychological and social distress (Hendricks & Testa, 2012). White Hughto and colleagues (2015) utilized Fundamental Cause Theory to discuss how structural-, interpersonal-, and individual-level stigma can contribute to negative health and mental health outcomes for transgender people. They referred to structural stigma as “symbolic violence” (White Hughto, et al., 2015, p. 224). Examples include policies that harm and further stigmatize TGNC people, a lack of affirmative and competent care in healthcare and mental health care, and the medicalization and pathologizing of TGNC identities, currently and historically. Examples of interpersonal stigma include specific events of discrimination, hate crimes, rejection by family and friends, and physical and sexual assault (White Hughto, et al., 2015). Examples of stigma at the individual level can include internalization of transphobia and the hiding of one’s identity to avoid negative experiences (White Hughto, et al., 2015).
We can conceptualize these examples of stigma within Gender Minority Stress Theory, as some would be categorized as distal stressors (overt events) and others as proximal (subjective experiencing) (Hendricks & Testa, 2012). From an intersectional perspective, we can conceptualize how experiencing stigma due to multiple minority statuses at all three of these levels could have interactive effects on the wellbeing of individuals and communities (Bowleg, 2012). Budge, Thai, Tebbe, and Howard (2016) conducted an intersectional study using structural equation modeling to examine the mental health outcomes of people who identify as TGNC, highlighting the fact that being TGNC is not a single, universal experience. Their results showed that participants with multiple minority identity statuses reported higher levels of anxiety, providing support for the idea that stigma and stressors related to multiple marginalized identities may intersect (Budge, et al., 2016).

The negative impact of stigma on the wellbeing of TGNC clients cannot be overlooked by counselors and other mental health professionals. Yet, a lack of training in TGNC competent care is itself one of the mechanisms of stigma that needs to be addressed (Hendricks & Testa, 2012; White Hughto, et al., 2015). A lack of competent care for TGNC clients could also deter TGNC people from seeking services when needed.

Witten (2016) addressed specific challenges of aging transgender and gender nonconforming people that could present as clinical concerns. Witten (2016) discussed how the identifiers and terminology that now exist were not available for older generations of TGNC people and how these differences could impact how people have identified themselves across the lifespan. Furthermore, Witten (2016) stated that many TGNC people may have gone their entire lives without coming out because it was not safe to do so. Currently, older TGNC people may still face discrimination and incompetent care in nursing homes, assisted living facilities, and
medical and mental health contexts due to stigma and a lack of training for these service
providers (Witten, 2016). Clinicians need to gain competencies to work with older TGNC people
on TGNC related issues, such as experiences of violence and internalized transphobia, and non
TGNC related issues, such as end-of-life planning, dementia, and existential and relational
concerns (Witten, 2016).

**Wellbeing and resilience**

Although there are many negative mental health outcomes that affect TGNC people due
to societal stigma, it is important to also acknowledge the strengths and resiliencies of
individuals, families, and communities. Clinicians can also help clients develop wellness and
identify protective factors and coping skills.

Witten (2014) discussed resilience in regards to the aging process for older transgender
adults. While many challenges that this population faces were examined and discussed, the focus
on “robustness, resilience, and successful aging” was a major theme and contribution of this
article (Witten, 2014, p. 27). Witten (2014) distinguished between robustness and resilience.
While resilience as a construct is related to how one returns to a previous state after a
“perturbation” to the system, robustness refers to the system’s ability “to resist a perturbation” (p.
29). Witten (2014) stated, “robustness is, in one sense, the opposite of resilience” (p. 29). Witten
(2014) noted that most of the literature related to resilience and robustness in LGBT people
focused primarily on LGB individuals rather than TGNC individuals.

Budge, Chin, and Minero (2017) also pointed out that the bulk of existing literature on
the mental health and counseling of TGNC people is related to negative mental health outcomes.
They conducted a grounded theory study with 15 TGNC identified participants to examine
“facilitative coping” (Budge, et al., 2017, p. 12). They defined this as active coping skills that
can include seeking services, learning skills, and positively changing behaviors (Budge, et al.,
2017). They stated that, at the time of their article, “no research has framed trans coping through
the lens of internal and external processes of coping” (Budge, et al., 2017, p. 13). They
identified nine themes related to the facilitative coping of their participants. From these themes,
they developed a theoretical model that includes aspects of identity development as well as both
internal and external coping processes. They stated that external coping processes were most
likely to be used after a participant had developed and disclosed their TGNC identity, and they
examined how themes corresponded to lifespan development and identity development (Budge,
et al, 2017). Such information can be incredibly useful to clinicians who may work with TGNC
clients of diverse ages and in diverse levels of identity development. Furthermore, from an
intersectional standpoint, clinicians may want to consider how the development of other
identities, such as racial identity or sexual/affectional orientation identity, may interact with
TGNC identity development and whether there are coping skills that apply to minority stress
experienced due to multiple minority identities.

In regards to external coping and protective factors, Barr, Budge, and Adelson (2016)
examined the construct of “transgender community belongingness” and its role as a mediator for
well-being and the strength of one’s transgender identity. They emphasized that members of
minority groups may feel a sense of not belonging in the larger society and thus may only feel a
sense of belonging within their own cultural groups. This sense of community and of belonging
are interrelated and have an impact on mental health and wellness (Barr, et al., 2016). They
found that the participants with the strongest transgender identification levels also had a stronger
sense of belonging in their communities, which contributed to increased well-being (Barr, et al.,
2016). Clinicians can incorporate this information into their work with clients through helping
clients develop their levels of identification as TGNC people and through assisting TGNC clients in finding and joining local TGNC communities.

Additionally, Mizock and Mueser (2014) conducted a study that incorporated both quantitative and qualitative methodologies to examine experiences of TGNC stigma and related coping strategies. They stated that, due to the increased risk of mental health issues in the TGNC population, TGNC people face the “double stigma” of transphobia and mental health stigma (p. 146). They found that lower levels of internalized stigma and transphobia were associated with higher levels of coping. In the grounded-theory qualitative component, they explored coping strategies at the individual, interpersonal, and systemic levels. Several coping strategies were found related to each of these levels. These coping strategies can be incorporated into counseling and therapy interventions. At the interpersonal level, the counseling processes itself can be considered a coping strategy because it corresponds to the category “social-relational coping”, which was defined as “accessing relational supports and engaging interpersonally with others to cope with transphobia” (Mizock & Mueser, 2014, p. 153). Furthermore, counselors can help TGNC clients explore and develop individual level coping strategies and can help them to identify other social and relational supports. Systemic level coping can be developed through advocacy efforts with clients. Still, as discussed before, it is important for counselors when discussing and conceptualizing resilience to not focus solely on individual and community coping skills but also on resistance to oppressive systems. An intersectional approach to counseling incorporates this systemic and social-justice oriented perspective.

**LGBTQ+ Affirmative Counseling**

Due to the historical context previously discussed, it has been necessary for the mental health field to distinguish, label, and define an approach to counseling that rejects heterosexism and addresses the societal stigma and stressors that can increase the risks of negative mental
health outcomes for LGBTQ+ people. An affirmative approach is strengths-based and affirmative of LGBTQ+ identities, behaviors, and relationships as healthy, natural, and as equally valid as heterosexual identities, behaviors, and relationships (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2013; Bidell & Whitman, 2013). Like intersectionality, LGBTQ+ affirmative counseling focuses on social justice and therefore includes examinations and discussions of stigma, oppression, and marginalization (Bidell & Whitman, 2013). The term “affirmative” implies an active approach that is distinguished from being tolerant or even merely accepting of sexual minority identities. It is similar to the concept of allyship in that it is viewed as a verb and includes an emphasis on social justice advocacy at institutional and political levels (Finnerty, Kocet, Lutes, & Yates, 2017).

Thus, LGBTQ+ affirmative counseling can be practiced and understood through awareness of the historical context and a synthesis of Minority Stress Theory, Fundamental Cause Theory, and intersectionality.

As discussed by Goodrich and Ginicola (2017), there is a lack of literature that identifies what specific interventions may be considered affirmative. Moreover, several researchers found that counseling students had higher levels of affirmative competencies in the domains of awareness and knowledge, and lower levels in the domain of skills (Farmer, Welfare, & Burge, 2013; Graham, Carney, & Kluck, 2012; Grove, 2009; LaMantia, Wagner, & Bohecker, 2015; Rock, Carlson, & McGeorge, 2010). Similar to intersectionality, affirmative counseling cannot be achieved with a checklist approach. Furthermore, from an intersectional perspective we can understand that the LGBTQ+ community is diverse and not monolithic, and therefore different skills and interventions will be helpful to different clients based on numerous factors. This can contribute to the challenge of completing research that shows the effectiveness of affirmative
approaches, as Goodrich and Ginocola (2017) described. However, as several scholars noted (Farmer, Welfare, & Burge, 2013; Graham, Carney, & Kluck, 2012; Rock, Carlson, & McGeorge, 2010), many students and counselors report believing that they have not been adequately trained in LGBTQ+ affirmative counseling skills. While it is important to acknowledge the methodological challenges in researching the effectiveness of LGBTQ+ affirmative counseling, the lack of training remains glaring due to the historical context and the urgent need to address the mental health disparities that affect LGBTQ+ people.

**Counseling Competencies**

Several scholars have created affirmative counseling competencies for counseling with sexual and gender minority people. These competencies can guide practicing counselors and students in developing their awareness, knowledge, and skills. Furthermore, these competencies can be used by counselor educators who have a responsibility to train new counselors as LGBTQ+ affirmative practitioners.

**Affectional Orientation**

The Association for Lesbian, Gay, Bisexual & Transgender Issues in Counseling address intersectional perspectives and affirmative counseling in their Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals (LGBQQIA, 2013). These competencies can be very useful to counselors and counseling students because they have been organized to correspond to the areas of practice required for accreditation by the Council for Accreditation of Counseling & Related Educational Programs (CACREP, 2009; 2016). By organizing the competencies according to the eight required domains of the CACREP standards, these competencies can be incorporated throughout counselor education programs to set a standard for affirmative counseling. The authors of these competencies stated, “it was important to […] provide a strength-based, feminist, multicultural,
social justice perspective” with these competencies (ALGBTIC, 2013, p. 3). These authors additionally discussed the importance of a historical understanding of LGBQQIA oppression within mental health fields, and they incorporated Meyer’s (1995; 2003) Minority Stress Theory as a framework for understanding the impact of oppression and stigma on the mental health of LGBQQIA people. Additionally, they call on counselors to recognize and understand the intersections of identities and of oppressive systems and to be aware of current professional and legislative issues (ALGBTIC, 2013). Although no specific intersectional counseling competencies were found, the LGBQQIA Competencies are a helpful framework for synthesizing intersectionality with affirmative counseling (ALGBTIC, 2013). Counselor educators can use these competencies to infuse an intersectional and affirmative counseling approach into counselor training courses.

**Gender Identity**

The Association for LGBT Issues in Counseling (2010) created Competencies for Counseling with Transgender Clients as a separate document from ALGBTIC’s LGBQIQA competencies. The authors determined that the historical context and experiences of TGNC people and sexual minority people were distinct and needed specific attention. The authors adopted a strengths-based approach that is affirmative and focuses on wellness and resilience. They combined theoretical frameworks related to multicultural counseling, social justice in counseling, and feminist theories. Although they did not provide a detailed description of intersectionality, they did specifically mention the intersection of identities and the intersection of oppressive systems (transphobia, racism, sexism, etc.) several times throughout the competencies. As described before in regards to sexual/affectional orientation competencies, the ALGBTIC transgender competencies follow the domains of CACREP (2009; 2016) standards.
and can be a useful tool for training counselors to practice affirmative intersectional counseling (Dispenza, Viehl, Sewell, Burke, & Gaudet., 2016).

The American Psychological Association (2009) published a report on the experiences of TGNC and gender variant people and implications for the profession. They provided recommendations related to clinical practice, research, education/training, and advocacy. Both the ALGBTIC competencies and the APA taskforce report highlight the importance of terminology and the need for mental health professionals to use the names, pronouns, and other terminology preferred by the client. The APA (2009) highlighted the importance of an affirmative stance in practice and research, and emphasized that representation within psychological fields is a necessary component of progress, stating that:

It was not until gay men and lesbians became actively involved in research about themselves and there was a critical mass of gay and lesbian psychologists and scholars in other disciplines that mainstream research on sexual/affectional orientation could be described as positive and affirming. (p. 26)

**Conceptualizing and Operationalizing Intersectional LGBTQ+ Affirmative Counseling**

The complexity of intersectionality as an analytical tool creates challenges in describing how it might look in counseling practice. Rather than a set or list of behaviors and interventions, intersectionality can be used as a framework for critical thinking in regards to assessment, diagnosis, treatment planning, interventions, and advocacy. Intersectionality can be used as a framework for conceptualizing clients’ presenting issues, such as the impact that oppression can have on well-being and psychological distress (Moradi, 2017; Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009).

Several scholars in counseling, psychology, social work, and other related fields have promoted the use of an intersectional approach to counseling, therapy, and advocacy (Dispenza,
et al., 2016; Moradi, 2017; Murphy, et al., 2009). Moradi (2017) discussed the importance of “refocusing” intersectionality from what Dill and Kohlman (2011) referred to as weak intersectionality and back to a strong intersectionality that is rooted in challenging oppressive systems. Moradi (2017) emphasized how long-standing biases in psychological practices continue to center those with the most privileged positions as reference groups. For example, Moradi (2017) stated that “when we consider sexual minority issues, the experiences of white gay men serve as the implicit reference point; and when we consider gender and sexism, the experiences of white heterosexual women serve as the implicit reference point” (p. 109).

Through allowing the most privileged members of marginalized groups (for example, white women and white gay men) to gain some power and visibility in existing hierarchical and oppressive systems, there can be a sense that social justice has been achieved while the oppressive systems continue as usual and others (such as LGBTQ+ people of color) continue to be marginalized. Therefore, a counselor who practices from an intersectional approach would need an awareness of how oppressive systems impact people in different ways based on their social locations, and should also have awareness of their own biases and any proclivities they may have to relying upon implicit reference points in their clinical work. Moradi (2017) provided examples of specific questions that clinicians may ask themselves to gain better awareness of such biases and behaviors. For example: “When I think about sexual minority, trans, and gender nonconforming people, what prototype comes to mind automatically for me?”; “With which clients am I likely to attend to (or to overlook) issues of sexual orientation and gender identity and expression?”; and “How can I promote consideration of intersectionality across dimensions, including dimensions that are not intersectionality prototypes (e.g., ability status)” (Moradi, 2017, pp. 111-112).
Murphy and colleagues (2009) also emphasized the importance of continuous self-awareness and awareness of oppressive systems when incorporating intersectionality into social work practice. They discussed how there is a discrepancy in social work practice between acknowledging one’s privilege as a clinician and actually using that knowledge to correct for power differentials when working with clients (Murphy, et al., 2009). Similar to elements of feminist and multicultural counseling practice, intersectional practice in counseling would be relational and interactionist rather than intrapsychic (Day, 2004). For example, rather than working with clients to develop individual coping skills for dealing with oppression, counselors can work to create an egalitarian relationship with clients in which they can: (a) analyze systems of power, (b) have open discussions about power differentials in relationships (including the counseling relationship), (c) talk honestly about the role that mental health professions have in the promotion and maintenance of oppressive social systems, (d) discuss the impact of stigma and marginalization on mental and relational health, (e) engage in social justice advocacy at local and policy levels, and more.

Dispenza and colleagues (2016) used a grounded theory method to develop a model based on “the effective practices that rehabilitation counselors reported exhibiting when working with sexual minority persons living with” a chronic illness or disability ([CID], p. 3). The central category that emerged from their interviews was affirmative intersectionality. They described the concept of affirmative intersectionality as follows:

As a core construct, [affirmative intersectionality] considers the various forms of oppression that are associated with possessing both a sexual minority identity and CID, while supporting and encouraging a sense of pride for possessing both identities simultaneously. Furthermore, affirmative intersectionality was the mechanism fueling our participants’ overt and covert cognitive, affective, and behavioral processes when delivering professional services to sexual minorities living with CID. It was viewed as the facilitating agent exercised by our participants to promote action and change with their clients, whether the counseling
goals of the client were vocational, psychological, or health related. As such, affirmative intersectionality was viewed as an approach that takes into account (a) aspects directly related to the counselor and the rehabilitation counseling process; (b) expectations of achieving outcomes that enhance the vocational, health, and psychosocial lives of sexual minority persons living with CID; and (c) diverse sexual minority persons across different developmental ages within different systemic contexts. (p. 148)

LaMantia and colleagues (2015) discussed the importance of intersectionality to the development of LGBTQ+-ally identities of counseling students. They emphasized the need for understanding not only the experiences of individuals with multiple identities, but also the social systems that affect people based on these socially constructed identities and positions. Smith and Shin (2015) highlighted the importance of understanding and analyzing dominant discourses as an intersectional practice. They stated that:

Dominant discourses often reinforce systems of power and privilege by providing the justifications for institutionalized forms of discrimination such as white privilege, classism, sexism, heteronormativity, and ableism. With regard to the discourse of heteronormativity, those who adhere to the dominant social identities of heterosexual and cisgender are positioned with privilege, whereas those who transgress these identities are devalued, marginalized, and oppressed.” (Smith & Shin, 2015, p. 1460)

By examining the historical context of how LGBTQ+ people have been oppressed within mental health fields, we can illuminate the dominant discourses that have perpetuated this marginalization in the counseling profession itself. Thus, a major component of intersectional affirmative counseling is acknowledging and working to dismantle oppressive systems within the counseling field.

**Counselor Training**

Currently, the Council for Accreditation of Counseling & Related Educational Programs (CACREP), which accredits master’s-level counseling programs, only addresses LGBTQ+ identities as one of multiple categories to be covered in the required multicultural counseling course (CACREP, 2016). No specific recommendations regarding the amount of time that must
be spent on this topic, specific theories to be incorporated, or an emphasis on specific LGBTQ+ counseling competencies or an affirmative approach are provided. This lack of specific training for LGBTQ+ competencies is concerning given that Bidell (2014a) found that general multicultural counseling courses did not increase levels of LGB counseling competencies. Furthermore, given the historical context previously discussed and the recency of LGBTQ+ affirmative counseling approaches, counselor educators might not have the knowledge and competencies necessary to teach this perspective unless they have chosen to seek continuing education in this area.

In a 2010 study, Rock, Carlson, and McGeorge found that more than 60% of counseling students reported that they received no LGB affirmative training in their clinical programs. Using the Affirmative Training Scale (ATS), a measurement tool developed by the authors for examining the affirmative nature of couple and family therapy programs, and the Sexual Orientation Counselor Competency Scale, they found that: (a) the scores of the ATS were a significant predictor of scores on the SOCCS, and (b) the students’ self-reported competencies were predicted by the number of weeks of LGB-affirmative course content received (Bidell, 2005; Rock, Carlson, & McGeorge, 2010).

Bidell (2013) used a comparison group design to evaluate the impact of a graduate-level LGBT counseling course on SOCCS and Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI) scores (Bidell, 2005; LGB-CSI, Dillon, et al., 2003). This course focused on the development of awareness, knowledge, and skills, as measured by these instruments. Course content included traditional lecture, guest lectures, panels comprised of LGBT community members, process discussions, film groups, reading assignments, journals, and other experiential activities. Those who took the course showed significant improvement on
both the SOCCS and the LGB-CSI, and they showed significant increases in scores compared to the students who did not take the course.

Bidell (2014b) also used the SOCCS to examine the relationship between religious conservatism and LGB affirmative competencies, which is currently a relevant issue due to the professional discussions regarding value-based conflicts. Bidell (2014b) found that counselors with higher scores for religious conservatism had significantly lower scores for LGB counseling competencies, particularly in the skills domain, and that this held true when controlling for the other variables. Furthermore, Bidell (2014b) again found that whether a student had taken a general multicultural course did not predict a difference in SOCCS scores. Additionally, results showed that LGB-specific training (such as attending a workshop) and interpersonal contact with LGB people were related to significant increases in SOCCS scores. (Bidell, 2014b).

Graham and Carney (2012) also examined the relationship between LGB-specific counselor training and SOCCS scores. Students who reported attendance at an optional workshop or other training, not including brief sessions at conferences, did score higher in all three domains of the SOCCS (Graham & Carney, 2012). These results regarding additional training are promising given that many counselors who did not receive LGBTQ+ affirmative training are already practicing, and many students may be enrolled in programs that do not have specific LGBTQ+ affirmative counseling training components. Training workshops can provide an alternative for developing LGBTQ+ affirmative counseling competencies.

Furthermore, LaMantia, Wagner, and Bohecker (2015) published a conceptual model for developing allyship in counseling students using intersectionality and feminist pedagogy as a framework. Developments such as these show promise that the field may be moving toward an affirmative and intersectional approach to working with LGBTQ+ clients. The authors believe
that the incorporation of intersectionality and feminist pedagogy will help counseling students to gain a better understanding of systems of oppression and how those systems impact their clients. They further believe it will help their students to develop critical thinking skills that allow them to conceptualize clients who hold multiple identities and are impacted by multiple systems. They also emphasize that the term “ally” refers to an active engagement similar to social justice advocacy work and feminist activism.

Intersectionality as a pedagogical tool shares common history, goals, and philosophical foundations with critical education (Collins & Bilge, 2016). An important concept in critical education is the idea of praxis, defined by Freire (1970) as a cycle of “reflection and action directed at the structures to be transformed” (p. 126). According to Collins and Bilge (2016), critical inquiry and critical praxis are fundamental to the use of intersectionality. Critical inquiry and praxis are the tools that people use to understand and transform systems.

Moreover, intersectionality and critical education share a goal of social justice and the acknowledgement that educational systems can either reinforce the existing inequalities or provide students with critical thinking and transformative skills (Collins & Bilge, 2016; Naples, 2009). This latter approach to education helps students to develop critical consciousness, or conscientização (Freire, 1970). Furthermore, the use of experiential activities and dialogue are central to the strategies of intersectional and critical pedagogies (Case, 2017; Collins & Bilge, 2016). This use of dialogue moves away from the traditional forms of classroom learning, that Freire (1970) referred to as “banking,” in which students are taught a purportedly objective truth from an authority; i.e., the truth of the world is “deposited” into students without critical analysis. It is within dialogue that students can share different perspectives and beliefs about
what truth is, and voices that would be marginalized in the banking system can move to the center.

Case (2017) discussed the use of intersectional theory in classroom practice using the following four interventions: “(1) centering the experiences of people of color; (2) complicating identity; (3) unveiling power in interconnected structures of inequality; and (4) promoting social justice and social change” (p. 154). Counselor educators can use these four intervention categories to guide structure, content, and experiential activities for teaching an intersectional approach to LGBTQ+ affirmative counseling from an intersectional pedagogical framework.

Conclusion

The lack of training in LGBTQ+ affirmative competencies for master’s-level counselors is an urgent and pressing issue given both (a) the higher rates at which LGBTQ+ people seek services and (b) the historical context that shows the oppression that LGBTQ+ people have faced within mental health fields (ALGBTIC, 2009; ALGBTIC 2013; Budge, 2013; Ginicola, Filmore, Smith, & Abdullah, 2017; Institute of Medicine [IOM], 2011; Lynch, Bruhn, & Henricksen, 2013; National Alliance on Mental Illness [NAMI], n.d.; Rutter, Leech, Anderson, & Saunders, 2010). While organizations such as the Institute of Medicine (2010) and the Office of Disease Prevention and Health Promotion (ODPHP, 2017) have acknowledged the severity of LGBTQ+ mental health disparities, the role of stigma and oppression on LGBTQ+ mental health, and the need for an intersectional approach, there is still a well-documented gap in counselor training (Bidell, 2013; Bidell, 2014a; Bidell, 2014b; Graham & Carney, 2012; Rock, Carlson, &McGeorge, 2010).

Intersectionality, minority stress theory, and fundamental cause theory can help counselors to understand the impact that multiple systems of oppression can have on LGBTQ+ clients, and the impacts of the cycle of (a) increased risk for many psychological concerns,
paired with (b) discrimination in mental health settings and other LGBTQ+ specific barriers to care (Hatzenbuehler, Phelan, & Link, 2013; Hendricks & Testa, 2012; IOM, 2011; Meyer, 1995; Meyer, 2003; ODPHP, 2017). It is through an intentional focus on progress and social justice that the mental health professions can move from the harmful and pathologizing approaches of the past to affirmative and intersectional approaches that can help alleviate the negative mental health outcomes and related risks that disproportionately impact LGBTQ+ people.
CHAPTER 3
METHODOLOGY

Theoretical Grounding

This research study was designed from an intersectional feminist standpoint. As stated by Brooks and Hesse-Biber (2007), “feminist research goals foster empowerment and emancipation for women and other marginalized groups, and feminist researchers often apply their findings in the service of promoting social change and social justice” (p. 4). Additionally, Brooks and Hesse-Biber (2007) discussed feminist critiques of positivistic approaches to research, which challenge the assumption that there is a true objective reality that can be discovered or measured. When conducting research related to populations that have been historically marginalized, such positivistic approaches have often contributed to further oppression because the reality that is assumed to be objective tends to be the perspective of those who are privileged in dominant culture. As Brooks and Hesse-Biber explained:

Feminists posed a serious challenge to the so-called value neutrality of positivistic social science. Feminist scholars and researchers’ illumination of women’s experiences disrupted the positivistic claim to universal knowledge, and the so-called objective methodologies that accompanied and justified that claim. Indeed, feminists exposed the dominance of the positivistic paradigm as stemming not from its objectivity or its universality, but from its privileged location within a historical, material, and social set of patriarchal value relations. In short, despite all claims to the contrary, knowledge building was never value-free, social reality was not static, and positivism or social scientific inquiry did not exist outside of the social world. (p. 7)

Considering the history of oppression that LGBTQ+ people have faced in mental health research and practice, a feminist perspective that challenges objectivity as a privilege of those with the most power can be helpful in improving scholarship related to LGBTQ+ populations. Although this research project did not require that participants identify as LGBTQ+ or as women, the feminist approach can still help to illuminate the
issues of power, privilege, and marginalization that emerge from participants experiences in the training workshop. Additionally, the purpose of this research is to gain information that can help counselors develop affirmative and intersectional skills, which could potentially improve services for LGBTQ+ clients; thus, social change and social justice are central goals of this study.

According to Munday (2014), focus group interviews can be well-aligned with the goals and methods of feminist research. Because of the social nature of focus groups, knowledge can be co-constructed and essentialism can be avoided (Munday, 2014). Munday (2014) further stated that the focus group design can help to alleviate power differentials between the researcher and participants, and data can be gathered about both the content and the process of the interview. Given that the proposed training takes place in an intensive group context, a focus group interview may function well to capture not only content data but also process-based contextual information. As Munday (2014) stated, “the collective and interactive nature of focus groups is particularly appealing to feminist researchers because it links to ideas of empowerment and feminist praxis” (p. 242). Furthermore, there can be a mutual benefit to the focus group interview process, as participants may continue developing their awareness, knowledge, and skills through their conversations with each other, while the researcher gains valuable information and insights.

**Researcher Positionality**

I am a white, cisgender woman who is comfortable with the labels of either bisexual or pansexual in regards to my affectional orientation. I am privileged in society due to my race and my gender identity, and I have experienced oppression related to my affectional orientation and my gender. My interests in increasing social justice for
LGBTQ+ people is both professional and personal. I believe strongly that intersectionality is necessary for social justice and that single axis approaches to social justice projects are (intentionally or unintentionally) exclusionary and incomplete. I believe that (a) counselors and counselor educators have an urgent ethical imperative to address the lack of training related to LGBTQ+ competencies, and (b) that training should incorporate intersectionality as a framework in order to provide students with the critical thinking skills necessary for working with clients who may have multiple marginalized identities without resorting to stereotypes, prototypes, or a checklist mentality. To the best of my ability, I designed the training workshop with these elements in mind. I was intentional about developing a workshop that could potentially provide new knowledge, awareness, and skills to participants of diverse identities rather than using an ally development model catered specifically for counselors with privileged statuses.

**Design**

Qualitative data was collected through six semi-structured focus groups interviews. The interview questions were created primarily to examine the students’ thoughts about intersectionality, an intersectional approach to affirmative counseling, the role of intersectionality in counseling as a tool for social justice, and their specific and general thoughts about the training workshop. To analyze the data, I used the six steps of qualitative thematic analysis as described by Braun and Clarke (2006; 2012): (1) transcribing and becoming familiar with the data, (2) initial coding, (3) examining codes for themes, (4) reviewing and mapping themes, (5) labeling and defining themes, and (6) reporting the data.
Participants

There is ongoing debate in social sciences research regarding the determination of sample sizes for qualitative research; some scholars may choose a predetermined sample size as recommended in past literature, while others may continue gathering and analyzing data until they have reached thematic saturation (Fugard & Potts, 2015). Because I collected qualitative data through focus group interviews at predetermined times, the latter approach would not necessarily be feasible. I instead aimed to be within the range of Creswell’s (2007) recommendation for phenomenological research, which calls for five to 20 participants. 14 participants engaged in the focus group interviews.

Participants (N=14) in the focus group interviews included 11 counseling students and three practicing counselors. The demographics form (Appendix A) allowed participants to write in their answers to several demographics questions. Of the 14 participants, 12 identified as white, one identified as Hispanic, and one identified as African-American. 10 participants identified their affectional orientation as straight, while one identified as “predominantly gay bisexual”, one identified as gay, one identified as a lesbian, and one identified as pansexual. 11 participants identified as female or woman, with four specifying that they were cisgender women. Two identified as cisgender men, and one identified their gender as fluid. The participants ages ranged from 21 to 57.

Data Collection

Semi-structured focus group interviews took place on the second day of each training workshop following the training activities of that day. These interviews were conducted by a second researcher who had experience in both qualitative interviews and focus group facilitation. The nine interview questions were related to the larger research questions,
and can be found in Appendix B. Some examples of these questions are “How would you describe intersectionality?”, “What is the role of intersectionality in counseling?”, “How would you describe LGBTQ+ affirmative counseling?”, and “How are intersectionality and affirmative counseling related or integrated?” The focus group facilitator may have asked follow up questions or clarifying questions throughout the interviews. The focus group interviews were audio recorded and then transcribed by the primary researcher for thematic analysis (Braun & Clarke, 2006; 2012).

**Procedures**

Five workshops were held at a large university in the southeastern United States, and one workshop was held at a second university also located in the southeastern United States. Recruitment materials, which included a flyer and an email message (Appendix C), were shared with several counseling programs and with the state counseling association. The recruitment information was shared with faculty in counseling programs (mental health counseling, marriage and family therapy, and/or school counseling) located within three hours of the training site.

After IRB approval, the recruitment materials were shared with faculty in several counseling programs mentioned and with the state counseling association branch. The recruitment materials included information for the training registration through Eventbrite. There were 6 training workshops held in January, February, March, and April of 2018. The workshops lasted from approximately 9am to 2pm each day. Once participants signed up through Eventbrite, they were assigned random identification number and their information was entered into Qualtrics. Participants completed their demographics survey through Qualtrics and received emails related to the training through this platform. When the data is downloaded from Qualtrics, survey responses
were automatically labeled with the participants’ email addresses and their ID number. I immediately deleted their email addresses, and any other identifiable information that was collected by Qualtrics, from these files so that only their ID number was associated with their data.

The informed consent documents (Appendix D) were also provided to participants via Qualtrics. They were asked to agree to the informed consent, as well as several inclusion/exclusion questions (Are you at least 18 years old? Are you currently a student in an entry-level counseling program?), before completing the demographic survey. A hard copy of the informed consent was also provided to each participant at the start of the training workshop, and the informed consent was reviewed and discussed at this time. At this time, participants were also reminded that they could choose to participate in a qualitative focus group interview immediately following the second day of the training workshop. Additionally, participants were invited via Qualtrics email to participate in member checking following the analysis of the data.

Training Workshop

The schedule for the training workshop is included as Appendix E. The training workshop was designed to align with the domains of the Sexual Orientation Counselor Competency Scale (Bidell, 2005), which are Knowledge, Awareness, and Skills. Content related to intersectionality and LGBTQ+ affirmative counseling competencies were be included and integrated into all three domains. As previously mentioned, this training workshop was not designed as an ally training but was designed to provide beneficial information regarding intersectionality and affirmative counseling to participants with diverse identities and social locations. All activities are included in Appendix F.
Day 1: Knowledge domain

On the first day of the training workshop, I covered information related to the knowledge domain. After discussing informed consent and confidentiality, we engaged in introductions and an icebreaker activity. Next, I provided a lecture related to the rationale for the study and the definition and need for affirmative counseling. I then provided a lecture on intersectionality as a theory, which included history of the development of intersectionality. We then discussed the historical and current context of LGBTQ+ issues in counseling. We next discussed a feminist perspective on the social construction of gender before engaging in an activity titled “Vocabulary Extravaganza 3.0” to help students learn and understand important vocabulary and terminology. This activity is uncopyrighted and provided for free use by Safe Zone Project (n.d.).

I then provided a lecture I about the impact of stigma on mental health disparities. We discussed the mental health disparities that impact LGBTQ+ people as reported by the Institute of Medicine (2011) and other literature. We discussed both Minority Stress Theory and Fundamental Cause Theory. We then began to discuss how the theory of intersectionality could be incorporated into counseling practice and advocacy. Lastly, we discussed the concept of affirmative intersectional counseling. I provided a brief lecture on this concept, with examples from literature and my own thoughts on the integration of intersectionality and affirmative counseling. Participants were given the following articles to read that evening in preparation for the following day: (Re)Focusing Intersectionality: From Social Identities Back to Systems of Oppression and Privilege, by Bonnie Moradi (2017), Standards of Care in Assessment of Lesbian, Gay, Bisexual, Transgender, Gender Expansive, and Queer/Questioning (LGBTGEQ+) Persons, by Kristopher Goodrich and colleagues (2017), and A Model of Affirmative Intersectional
Rehabilitation Counseling With Sexual Minorities: A Grounded Theory Study, by Franco Dispenza and colleagues (2016). I chose these articles they all incorporate foundational elements of both theory and practice related to intersectionality and/or affirmative counseling. This emphasis on both theory and theory-informed practice/action is in line with the concept of praxis, which is fundamental to intersectional pedagogy.

Day 2: Awareness and skills domains

The content on the second day of training was designed to address both awareness and skills. The awareness domain included content related to the participants’ attitudes, values, and beliefs. The curriculum for this domain started at the beginning of the second day with a discussion of the articles that were assigned. Students were asked to discuss their personal reactions to the assigned readings. They were also asked how the concepts discussed relate to their identities and work as counselors. Next, participants engaged in an experiential activity titled “Identity Signs,” which is another activity developed for free use by the Safe Zone Project (n.d.) This activity is designed to help participants understand how their different identity locations impact them based on context. Signs were placed around the room with different identity categories, such as “sexual orientation,” “race,” “gender identity,” “class,” and more. Students were asked to walk to the sign that best answers for them questions such as “The part of my identity that I am most aware of on a daily basis is ______.” After the activity, we processed this activity and discussed how it relates to intersectionality. I asked students to discuss what it was like to be asked to pick one identity for each category and whether they believed that is representative of their lived experiences.

To further address the Awareness domain, another Safe Zone Project activity was used. This activity, titled “First Impressions of LGBTQ People 2.0,” was designed to
uncover biases and the socialization that created said biases. Participants had about 15 minutes to complete the worksheet that asked questions such as “Where did most of the influence of your initial impressions/understanding of trans* people come from? (e.g., family, friends, television, books, news, church).” Participants could choose whether they wanted to share their specific answers, and were asked to discuss what the process was like and what they learned that may influence their work as counselors.

The rest of the training focused on the skills domain. This component began with a discussion of the ALGBTIC competencies and affirmative counseling skills. I then presented a lecture about intersectionality in counseling and intersectional affirmative counseling skills using a presentation I created. Next, there was a skills activity. Participants viewed a portion of the “Thanksgiving” episode of a television show called Master of None. The clip I was a scene where Denise, an African-American lesbian woman, comes out to her mother. I created a set of questions related to LGBTQ+ affirmative intersectional counseling for participants to consider while they watch the clip (Appendix F). The participants were asked to discuss their answers to these questions first in small groups and then in large groups. These questions were related to clinical knowledge, systemic issues that may be impacting the client, and potential interventions or responses that they might have for the characters of they were clients. Next, the participants formed small groups and were given a case study example (see Appendix F). The participants will be asked to conceptualize the client(s) using affirmative intersectional counseling skills. Some participants also chose to role play based on their conceptualization. After this last activity, students were reminded about the process and purpose of the focus group interview. The primary researcher left the room and
participants chose whether to stay to be a part of the focus group interview with the second researcher. The interviews took approximately 25 to 75 minutes.

**Data Analysis**

The first step of the data analysis was transcribing and becoming familiar with the data. Memos were taken at this time to record initial reactions. During the second step, I read through all of the transcripts and created initial codes. When examining the initial codes for themes, I took into account how many participants discussed the codes and whether it would be appropriate as a major theme. Most of the themes were brought up by at least half of the participants, though the subthemes may not have been mentioned by as many. The themes were then reviewed and mapped to determine which were themes and which were subthemes, as well as which were Content/Theory and which were Process/Reflection. The themes were then given final names and definitions for reporting.

**Trustworthiness**

While a feminist focus group methodology is not within a positivistic frame and does not presuppose an objective and neutral reality, trustworthiness can be established through the use of multiple strategies (Lietz, Langer, & Furman, 2006). I utilized several of the strategies discussed by Lietz and colleagues (2006), including reflexivity, peer debriefing, triangulation, and member-checking. Reflexivity was described by Leitz and colleagues (2006) as follows:

Reflexivity involves deconstructing who we are and the ways in which our beliefs, experiences and identity intersect with that of the participant (MacBeth, 2001). This reflection occurs both in individual thought and through dialog with others that acknowledges the researcher’s own experience and perspectives (Johnson and Waterfield, 2004). Instead of trying to hide behind the false sense of objectivity, the researcher makes his or her own sociocultural position explicit. Finally, reflexivity is not a point in time event as the term ‘strategy’ might suggest. Rather, reflexivity is a
I engaged in the process of reflexivity throughout all stages of the research project, including the initial planning stages. I engaged in this work through relevant coursework in Women’s Studies, independent study, writing initial reactions and memos throughout the data analysis process, and consistent consultation and discussions with colleagues and other researchers. I gained deeper awareness of my own identities, both privileged and marginalized, and considered the impact they would have on the training, my expectations, and interpretations of the results.

To account for my own subjectivity and potential biases, peer debriefing and triangulation were also employed. Focus group interviews were conducted by a second researcher to account for any influence that the primary investigator and training workshop facilitator might have on participants’ responses. There was only one exception to this, when the primary investigator conducted a training workshop in a different city and conducted the focus group interview herself. The two researchers debriefed following each of the five interviews conducted by the second researcher. Additionally, I engaged in peer debriefing with the second researcher several times throughout the process of transcription and following the analysis of the data. Additionally, the raw data (transcripts) and the primary researcher’s codes and themes were shared with the second researcher, and the themes and codes were shared with a third researcher, for purposes of triangulation. Lastly, the researcher reached out to participants to share the analyzed data for the purposes of member-checking, or participant validation. One participant contacted the researcher and engaged in the process of member-checking.
CHAPTER 4
RESULTS

Qualitative Themes

The qualitative themes that emerged from the data were in the categories of Content/Theory and Process/Reflection. Themes in the Content/Theory category were those related to the participants' understandings of the content that was discussed in the training. There were several themes related to this category: (1) Role of Intersectionality as a Critical Framework/Paradigm Shift in Counseling, (2) LGBTQ+ Affirmative Intersectional Counseling and Social Justice, and (3) Social/Political Issues and Privilege.

The Process/Reflection category included themes that were related to the participants' experiences of and feelings about the workshop, their training programs, or their work in clinical settings. The themes related to process were: (1) Feeling Uninformed/Intimidated, (2) Impacts of the Workshop, (3) Challenges of Ambiguity/Wanting Guidelines, and (4) Wanting to Have Intersectionality Integrated Throughout Counselor Training (See Table 1 for categories, themes, and subthemes.)

Content/Theory 1: Role of Intersectionality as a Critical Framework/Paradigm Shift in Counseling

Participants described intersectionality as a critical and holistic framework or lens that could be utilized within a counseling context, both in counseling sessions and in advocacy work. As a theory, they described intersectionality as a way of viewing the interconnected and interlocking nature of multiple identity categories that are mutually constructed and cannot be separated or viewed individually. As one participant stated, a client’s identities are “woven together.” Another participant elaborated on the concept of identities being inextricably woven together in a way that cannot be separated:

If you see in a lens of intersectionality, then you’ll be able to consider…the multiple layers of a person, rather than…dividing it and only seeing it as,
“well, we’re going to add this many points for her being black, and this many points for her being a woman, and this many points for her being gay”…because the experiences of having all those three together is…very different from them separate.

Further, participants described intersectionality as being concerned with the interlocking nature of systems, such that multiple systems might have an oppressive impact on clients who have multiple marginalized identities. Another participant described intersectionality as “an analysis of systems and patterns of oppression against multiple identities and how that integration of power and privilege and oppression all tie together.”

In regards to the role of intersectionality in counseling, participants discussed how they would utilize the theory directly with clients and in their work as social justice advocates. One participant stated, “for me, it’s a way of remembering to address an individual client or a group of clients as individuals in the context of multiple planes where they may be interacting with social, or political, or relational oppression.” One participant stated how an intersectional perspective differs from other theories they had learned:

I think the difference comes in, like with other counseling theories versus intersectionality, comes with the idea that we’re not going to look at one thing and then the next thing and then the thing after that. It’s like race and how that affects you and then gender and how that affects you. It’s like, it’s all fluid…and how can you address [clinical concerns] knowing about the oppression you are facing based on your title in society.

Another participant discussed how an intersectional approach would be a paradigmatic shift in clinical work through allowing counselors to view issues or intersections that were previously marginalized:

I think the role of intersectionality is just giving a voice to a group of people that…fall in that intersection that may have been silenced or not given a voice. So, I think the role of it in counseling is just to provide another paradigm. It will go to a new paradigm in a sense of issues and concepts
and different things that need to be addressed in the world of counseling that are not being addressed. So, if anything, I think it’s like a shift in paradigms… It helps individuals that are impacted most by being marginalized within certain groups. It gives them more of a voice. It puts more of a spotlight on those issues that have kind of fallen through the cracks for a lot of people.

Participants also noted that an intersectional perspective would place emphasis on systemic issues that could have a negative impact on clients mental health and wellness, in advocacy and counseling contexts:

I would say that it kind of goes back to like the advocacy piece because advocacy is a big part of counseling, whether it be advocating for the profession, advocating for clients, or advocating against systemic issues as a whole. But really just making sure that we're holistically looking at a client, understanding the integration of their multiple identities and the influence of the different systems that are affecting them. And then as far as how it looks against different counseling approaches, I would just say that it takes more of a feminist stance in really looking at like the multicultural issues, looking at the systems. So it does integrate lot of different approaches of counseling together. But really looking at not just the individual and their whole self but also the systems outside of the client.

Participants explained that an intersectional approach to counseling would place emphasis on the role that oppression and privilege have in affecting mental and relational health and wellness. They noted that an intersectional approach would require a counselor to view client issues in context, rather than as primarily intrapsychic. One participant expressed this idea by stating:

A lot of times in counseling theories they say that your issue is just this internal thing, that you’re not thinking about something correctly or you’re missing something. But within intersectionality, you realize that someone is in a social context that is impacting them and has an impact…on their mental health.

Another further emphasized the particular focus on external factors that they viewed as being related to an intersectional perspective:

I think it’s, for counseling, it just encourages the counselor to see the client in a more holistic view. And while other theories do that, this one puts a
strong emphasis on the external factors that affect a person and the oppression that goes with that.

One participant discussed how they would integrate intersectionality with a person-centered counseling approach as a “second wave.” Two participants elaborated on this concept in the following interaction:

P1: So, I think that it sounds like the second wave of changing the way counselors view their clients. Person-centered theory became person-centered approach. Like, everybody’s supposed to come to a client with a person-centered perspective. I think [intersectionality] would be an appropriate second wave. Like, everybody should be viewing their clients intersectionally in context. So, I think it layers nicely with, like, the Bronfenbrenner and social learning theories and other things.

[...]

P2: Yeah, it’s person-centered but more contextualized. You’re seeing this person and you’re also stepping back and seeing them within a social context, so in a way it is still person-centered because intersectionality acknowledges that each person’s experience is unique, and they are also part of systems that impact them and there are trends, there are power structures.

Furthermore, participants emphasized that intersectionality can be used as a critical lens or framework, rather than a checklist of techniques or a prescriptive approach to working with clients. One participant stated, “it’s not so cut and dry…there’s not a way to make it cookie cutter.” Participants discussed that intersectionality in practice cannot be explained as a set of specific actions because it takes into account the uniqueness of each client. One stated, “I know this is so cliché, but it really depends on your client.” However, as will be discussed later, participants still stated a desire to know specific skills or techniques that could be used in counseling sessions.

**Content/Theory 2: LGBTQ+ Affirmative Intersectional Counseling and Social Justice**

Participants described the connections between intersectionality, LGBTQ+ affirmative counseling, and social justice, both in general and in regards to their work as
counselors. Participants mentioned that both social justice and affirmative counseling would be lacking without the intersectional perspective. One participant said of intersectionality and social justice, “You can’t really separate them. They are linked.” Another participant expressed the relationship between intersectionality and social justice as follows:

I think that the goal of social justice is to change systems that don't work. And I think intersectionality explains how those systems truly work holistically. And so, I think like we were talking about, a lot of models of social justice are very individualized. And so, they're very, you know, social justice with race, social justice with immigration, social justice with LGBTQ issues. And so, it's difficult for, I think, a lot of models of social justice to have lasting impact unless they take intersectionality into account because, you know, the nature of reality is integrated. And so, I think social justice then needs to also be integrated, and that integration, the nature of that integration I think is with intersectionality is at its core.

Participants connected intersectionality and LGBTQ+ affirmative counseling through the importance of social justice and advocacy in affirmative counseling and the need to understand and affirm all of a client’s identities. Further, participants stated their views on an affirmative intersectional approach to counseling:

I think when we recognize intersectionality, it’s almost impossible to not be affirmative. If we’re looking at social justice and groups of us that have been oppressed for whatever reasons… I think it would be difficult to not be affirming at the same time. I think after we have the awareness, I think it will be difficult to go backwards and not be affirming.

Another participant discussed how they could utilize an affirmative intersectional approach to counseling:

For me, in my critical thinking lens with this, I’d say [intersectionality and affirmative counseling] are integrated. If I’m going to be working with a client, I need to be affirming of each and any identity or life experience they are bringing, and so I now have another theoretical tool to bring in the analysis of what is before me.

Participants also noted the potential for intersectionality to improve the effectiveness of LGBTQ+ affirmative counseling. One participant stated, “I think
intersectionality makes affirmative counseling, and just counseling in general, more effective.” Another elaborated on this point, stating:

They really need to go together…This is a thought I had. It isn’t necessarily intersectional because if you’re just focusing on the LGBTQ+ aspect of this person, then you might not be affirming their other identities. So, I think to be really effective as a counselor, you really need to combine them both to hold space for the LGBT aspect of the person if that’s there and also holding space for their other identities and how those interact and impact a person’s experience.

Participants further described LGBTQ+ affirmative intersectional counseling as strength-based, empowering, and normalizing. They also noted that an affirmative approach to counseling moves beyond acceptance of LGBTQ+ identities. One participant stated of affirmative counseling:

I think it’s creating a space where you are enabling LGBTQ clients to not just accept and be who they are but to then move forward. And, you know, we talked about it’s not just accepting, like “yeah, this is great,” but stepping into, you know, advocacy and doing something about addressing discrimination and the systems in place that are still trying to prevent them from being who they are. And in a completely healthy environment and healthy way. And so, I think it’s taking both the personal acceptance and the systemic advocacy of changing, you know, still existing problematic structures that are preventing that from happening and doing something about it.

Content/Theory 3: Social/Political Issues and Privilege

Some participants discussed the impact of social and political events on their training and understanding of their roles as counselors. When asked an open-ended question about any final thoughts on the training workshop, one participant stated how the current political climate has an impact on their counselor training and development:

It's hard to bring into a conversation without getting too polarizing. But definitely the current political and social context that we're living in. There's a lot happening, going on outside of our little program here and we feel its effects within our program. And so really being able to address those pieces of what's currently going on and how we can incorporate those pieces under the current context of what's happening.
Additionally, other participants discussed the potential challenges of being an openly affirmative counselor and the potential impact on clients who do not share such views.

I think another issue that I'm thinking of now too as a counselor, the struggle is because we have to serve the other side of this, like the people that are against LGBT or have racist beliefs or sexist beliefs, and are heterosexuals...I almost feel, like, contained by being a counselor, like I can't be as out there or that politically active because then that would make certain clients maybe feel some type of way about "Oh, well she's that, well then she couldn't be my counselor." I've had people talk about okay do you put up a rainbow sticker or not? Because it helps some people feel safe, and other people feel unsafe. And yes, you want to probably put more work into helping people who have a minority status feel more safe, but that may be a lost opportunity for me to give someone else, someone that is in a privileged position to maybe work through to maybe get to the other side...That's a whole other conversation. Do you say, "Hey, what you just said is racist? Because you make fun of, you know, how Asian people talk." How do you navigate that? So that's another part of the conversation. I've had just as much if not more issues dealing with clients- It's how do I approach a client that's telling me racist things or sexist things?

Participants also discussed how an intersectional perspective could be beneficial to clients who have privileged identities.

Even if clients don't have that many marginalized identities, it's still good for them to understand, like, their identities do play a role in the greater world. Because it all seems to be related so you can't really exist without playing into the system. I've heard that like if you're not stopping the change just like kind of a bystander like you're contributing to the oppression. If it's doable like they are ready for it, trying to help them to help others.

**Process/Reflection 1: Feeling Uninformed/Intimidated**

Feeling uninformed or intimidated is the first theme is the Process/Reflection category. Some participants expressed that their feelings related to this category were lessened after attending the workshop, which will be addressed more in the following theme, Impacts of the Workshop. Several participants expressed feelings of being uniformed and/or intimidated related to their knowledge, awareness, or skills vis-à-vis specific identities. Others expressed a more general sense of feeling uniformed or intimidated about counseling in general due to their status as students. One participant
said, “I actually mentioned that I didn’t feel comfortable in a role play… I wouldn’t want to do that. I know enough to know I don’t know what to say yet.” Another participant said, “I am struggling with the basic skills of counseling, and so there is just so much work I need to do.”

Several participants expressed that their comfort in the training workshop was increased due to the homogeneity of the group members, or rather, that they expected their discomfort would have been increased by the presence of participants different from themselves. One example of this is evidenced in the interaction below:

P: I think we were lucky to be a small group to be honest I think. I think we all identify as white people. So, I think that eliminated certain, like- If we said something that was- we weren't as worried about saying something racist we could just say what we felt were classist or ableist because this is a small enough group and I think that really helps me share more and not hold myself back. And then you know have a conversation about it.

R: So, the smaller group made it feel safer that if you didn't know something or if you did use an incorrect terminology or something that it would be a safe place to be able to talk about that?

P: I would feel like I'm not hurting as many people and I think as white people that's a big fear that white people have when they're with a bigger group of different races and different abilities and different classes.

R: Maybe saying something from an implicit bias without realizing?

P: Yeah, and then feeling like, "Ooo, what if I get called on it?" or embarrassed or whatever. And I've been in those situations, it's fine. They're all learning experiences, but I appreciated this.

Participants in another focus group shared a similar sentiment, this time related to LGBTQ+ identities:

P: I think I feel that [intimidation] more whenever there are people that have expressed that they are part of the LGBTQ+ community because I'm like, alright watch out for your words because you don't want to hurt anyone's feelings or be politically incorrect… But normally with people in the group that are part of the community makes it a little- I feel more anxious about it. I don't want to hurt anybody or make them think that I think a certain thing about them.
The following interaction further reflected participants’ feelings of intimidation:

P1: I feel like, especially with that language and terminology packet, I wouldn't have asked half those questions had there been someone a part of that community sitting right there.

P2: It's intimidating.

P1: It's very intimidating. Like, "you don't know what this word means?" That's what I would think in my head.

R: So where is the intimidation factor now? Like you mentioned maybe you are more comfortable because now you feel you know certain things.

P2: Oh. Well now I feel like- I feel more comfortable because I know certain words and what they mean. And also, how they've been used in the past.

Some participants stated that their feelings of intimidation were lessened since participating in the workshop, and some participants noted that the content of the workshop and certain characteristics about the workshop facilitator helped them to feel more comfortable. The former will be addressed further in the following theme, Impacts of the Workshop. Characteristics of the facilitator that were mentioned as helpful to the process were: normalizing questions and misconceptions, allowing time for dialogue, the facilitator’s knowledge and passion, and the facilitator’s own identity.

P1: I think it's very important to have someone like the person that we had. We felt- Like we discussed it earlier, so that's why I'm saying we. But at least I felt very comfortable asking her questions. And not feeling like ignorant about it or silly. And maybe that has to do with the fact that it's just us three and in a bigger group I would have felt that more. But it's kind of like, a stupid question is the one that you don't ask…and I felt very comfortable to ask her and not judged at all for not knowing it… Like, even if we say something and it's like "actually that's incorrect" it could be like "okay, I can understand why you would think that because of these factors and" you know, it's kind of like normalizing. And like, "yeah, that's a very common misconception. But this is actually what the research shows" and I think she did that for us. We're like, "oh we thought it was this" and she'd say "yeah, that's very common." But is more like these things.

P2: And going off that, she also took a lot of time to pause and ask if we had questions, and not just being like "do you have any questions?" and pausing for a second, but she actually took a good chunk of time to have us
digest everything to ask those questions. Which I think was really beneficial for all of us.

Participants also said that the preparation and passion of the facilitator was beneficial to the process:

P1: I liked all the materials she used. She's very well-informed…I thought that was really important that it's based on her hard work and her research that she's done… I could tell that she prepared really well. Like it was very obvious that she knew what she was talking about.

P2: She definitely seems committed and passionate about it.

Another participant said later, “a lot of us started in a very ignorant and stereotypical place and, like I said, [the facilitator’s behaviors] normalizes that it's okay to be where you are in your knowledge, but we're moving forward now.”

Another participant noted that they felt more comfortable in the training because the facilitator identified within the LGBTQ+ community.

I appreciate that [the facilitator was] open about like you know “I am a member of the community and this is how I identify” because in my experience too I've had a lot of people talk about the LGBTQ community but not be part of it. And there's just, I mean, I take it for what it's worth. But you know, it's different being a part of it than not being part of it. And there's just a difference of experience that I think adds, to me, it adds a component of- not quite authenticity, but I mean there's just there's an element of personal experience that I think helps with the material because you already are familiar with what you're talking about...It immediately made me comfortable. Like, okay, like she's you know- because I enjoy when people are speaking from their experience because you know that tells me like you're not just doing this academically you're doing this both from academic experience and personal experience. And you're marrying the two together. I think that is helpful because I mean that's what we're doing in counseling. You know, after all. So, I appreciate that too.

Process/Reflection 2: Impacts of the Workshop

Participants were able to express the impacts of attending the workshop on their growth in knowledge, awareness, and skills. Participants expressed, as previously mentioned in the last theme, that their new knowledge and awareness reduced their fears
of being uniformed or intimidated. While participants noted that an affirmative intersectional approach is not prescriptive, several participants expressed the desire to learn more specific skills or techniques that they could use in counseling.

Knowledge

In regards to knowledge, participants discussed specific components of the training workshop that advanced their knowledge, such as the theoretical content, historical background, current context, discussions about the social construction of gender, and language and terminology. One participant stated, “I would say a door has been opened” through learning the theory of intersectionality. Related to learning the historical context of the need for LGBTQ+ affirmative counseling, one participant shared:

I think the history component is really important too, because for me it helped to show how important the work is in doing it this way and knowing what people are going through based on what they have gone through. I think that showed to me that like it's really important that as counselors we know how to use these things because there is a need out there for it and there's been a need for decades.

Another elaborated on this point, saying:

Yeah, for me too. It's very similar. The terminology was really important to me, and then learning about the history as well. And I think that helped me because I was worried about having clients that were like this and me not being good enough or capable of handling it, not because I didn't want to but just because I didn't know enough. And I feel a lot better about that now.

Another participant stated the following, which related to knowledge, awareness, and skills:

I think in terms of what I learned, I learned like so, so much. I feel like I came in not knowing anything and I'm really happy that I did it. And I have a much better understanding, and not just like in terms of like memorizing it, but like actually understanding and looking at clients differently. In terms of skills, I don't think my skills really changed all that much because we didn't really focus on a whole lot of that, like actually putting it into
practice. At least not- Like we did a roleplay which was fantastic, but I think that's going to come with time and practice.

Awareness

Participants discussed experiencing an increase in their awareness related to their experiences, biases, assumptions, and beliefs. Several participants discussed a prior assumption that LGBTQ+ clients would primarily work with LGBTQ+ counselors:

P1: For some reason, before this workshop I always thought that, this is generalizing but most of the time, that the LGBTQ+ community would try to find counselors that were LGBTQ+ themselves, and so I guess I kind of didn't really feel like it was something that I would ever have to worry about, which is really stupid. But now I just feel like there's so much to advocate for, especially after learning the history and everything, and being reminded of the history as well. And knowing that I definitely will have clients that I will feel the need to advocate for and have that social justice aspect of the process.

P2: I too was with [other participant] in the sense of, like, I genuinely didn't think that I would have any LGBTQ+ community people come to see me for counseling, and so I really always disregarded any talk about it. But it's always been something that I wanted to know more about, and so coming to this has really opened my eyes to so many different parts of it.

Several participants expressed their concerns related to the potential for contributing to or colluding with oppression as counselors. A participant stated, “I also feel responsibility to not add to [clients’] oppression. I think that’s one of the biggest things I’ve gathered from this.” Another participant stated:

I think that some people, just because a person is transgender they will automatically be given gender dysphoria [as a diagnosis]. And this material is saying, well, that doesn’t really fit unless they have an issue with their gender, unless they feel upset or depressed about- I didn’t know that and it bothers me that I didn’t know that because I am, like, how have I colluded in that? I think that’s oppressive.

Another participant expressed a new awareness from learning about an LGBTQ+ affirmative intersectional approach related to how some client concerns may be erased or marginalized:
I think I’ve had a tendency to erase things myself in they fell into that intersection, which I look at now as the wayside. I’ve had a lot of things fall into the wayside. But, and looking back I don’t- they wouldn’t have fallen into the wayside. They would have had more of a platform to stand on that would have allowed them to avoid that wayside. And even looking at some of the LGBTQ clients that I’ve worked with and am working with, there are a lot of thing that I would do differently.

**Skills**

In regards to skills, participants expressed that their skills would develop over time through counseling practice, but they also discussed wanting to know more about specific techniques and guidelines that could be used in counseling sessions that would be LGBTQ+ affirmative and intersectional. The topic of wanting more specific guidelines will be further discussed in the second major theme of the Process/Reflection category.

One participant said:

In terms of skills, I don't think my skills really changed all that much because we didn't really focus on a whole lot of that, like actually putting it into practice. At least not- Like we did a roleplay which was fantastic, but I think that’s going to come with time and practice.

One participant shared that the knowledge they gained regarding the diagnosis of gender dysphoria would have an impact on their diagnostic skills in practice, as would information from a conversation regarding whether it is appropriate to include affectional orientation and gender identity on clinical intake forms. Several participants also discussed how the increased awareness of systemic issues and the knowledge gained about language and terminology would affect their future work with clients. This is represented here:

I can make my intentions more clear. I can feel more comfortable saying, like she said, her introduction alone: she said my name is this, she said her status, like she's a PhD candidate, and then she said she uses she and her pronouns. And just something like that, I never would have thought of that. Like, I'm already learning. First sentence. So now I feel more comfortable with that and that is a way of expressing your intention and your openness [with clients].
Participants noted that an affirmative intersectional approach would not necessarily involve a specific set of skills, but is rather a conceptual and critical framework as previously discussed. For example:

It’s not necessarily a specific technique, like you do XYZ. It’s more like…a critical framework to think about and conceptualize your clients. And with that being said, you might be more likely to ask certain questions or think about certain questions or be mindful of certain language.

This participant later added:

It's really the framework. I don't think it's a specific, like we're going to do this technique in this number of sessions or whatever. It's like how you conceptualize you clients. It's like you said, questions that you ask yourself when you're thinking about that client, do you have any biases? The ways that you're interacting with the client, because you may be falling into some biases or reinforcing power structures in the way you're interacting. She also talked about potentially doing some psychoeducation with the clients, and like, "you know, it's normal that you would feel this way in a situation" or "this may be impacting how you're feeling" or "this is a lot of people's experience, is that true for you?" Like, giving people space to talk about these things. I think that's part of intersectionality.

Process/Reflection 3: Challenges of Ambiguity/Wanting Guidelines

Although participants were able to describe intersectionality as a framework for conceptualizing clients with multiple identities and unique experiences, discomfort with the ambiguity and a desire to have specific guidelines for specific clients still emerged. One participant stated, “I wish there was a better template to know this is what it looks like. Not necessarily a manual but just kind of a template.” Another participant mentioned that they would like to see or experience an intersectional and affirmative approach to counseling in specific scenarios: “If I had the opportunity to role play someone going through the process of trying to come out to their parent or telling their parent they want to change genders or something like that I think that would be really helpful because I think internally I am going to be freaking out when that happens because I’ve never had to deal with it.”
Additionally, a participant mentioned wanting to know generalizations about how different cultures may intersect with LGBTQ+ identities.

I don’t want to say that like there are stereotypes, but there are still general feelings of, like, Western culture versus other cultures and how other cultures view the LGBTQ community that would be really important in my work with clients. Like the Latino community, and the black community, not stereotyping that, but just kind of talking about how the LGBTQ is impacted by the black community, the Christian community, and more about how those intersectionalities have happened in history I think would be helpful for me in my scope of practice.

Another participant wanted to learn specifically how to apply affirmative counseling with clients who have different identities under the LGBTQ+ umbrella:

P: I would say the thing that's important to look at that, granted if this was a much longer training there would be space to do that, is looking at affirmative counseling in the lens of each of the different identities under the LGBT umbrella. Because it looks different based on the identities that they are showing. So intersectionality addresses that really well. Saying that we’re addressing these multiple areas but like how are we affirming people that identify as lesbian, how are we affirming people that identify as transgender, and looking at the breakdown of like those different identities.

R: So more of like being- identifying as bisexual and identifying as transgender, those are two different experiences in the LGBTQ community, so you know how do we apply intersectionality on those more individual or like subgroup basis?

P: Mmhmm. And even across the affectional spectrum and across the gender spectrum as well. So affirmative counseling for transgender clients, and then affirmative counseling for gender nonconforming clients, with those pieces.

Another participant discussed wanting to know more about whether they were coming up with the “correct” responses to the case study activities. The participant said:

So what I think kind of make that better is if, like, when we did our case study and- and again this is helpful because we were a small group I’m not sure how it would work if we were a bigger group- but, like, at least…go through [a case study exercise] with us and be like "ok so like this is what I think is important what do you guys think is important?" And kind of having one to do all together first and then kind of conceptualize one on my own, just because I think it was a little difficult for me. Like, it was like "Am I doing this right? Am I getting the right answers? Like, what do
counselors do?” Like now I counsel and I don't know how to do that yet, you know, so I think that would have helped kind of moderate some of the feeling of like I don't really know how to counsel people yet but I'm going to try with this case study.

**Process/Reflection 4: Wanting to Have Intersectionality Integrated Throughout Counselor Training**

Several participants stated that they would appreciate having an intersectional approach integrated throughout counselor training programs, to address both LGBTQ+ competencies and multicultural competencies. In regards to LGBTQ+ competencies, one participant stated:

> What I can think of as I'm sitting here, it's like I'm poignantly aware of the dearth of knowledge and understanding that a lot of our profession has in this topic especially- even in academia. And I think my question is, like maybe, like what are some of the best ways I can, like, transfer this knowledge and, you know, equip my colleagues and my peers, even like my professors and other people, to get that 60 percent that had no training. Like, you know, what are some ways that we can get that number down? Just because at least- maybe again this is just because it's maybe personal in my life- but you know when I hear that number I think of just all the clients that we are unwittingly hurting by that lack of training that we could very easily offer these kind of things, you know, in programs. I mean it's not difficult and would just be so beneficial.

Another participant stated the following in regards to multicultural competencies in training programs:

> I just feel like it shouldn't be one class though, you know. Like, I almost feel like things like this feel so integrative to anything we do… I think we think of multiculturalism as this separate thing, right. As like we talk about these and we talk about this and now we're going to talk about multiculturalism when it's like this should be in every class take…: I just don't think it's integrated as strongly as it could… I wish all counselors like us came to these trainings and really learned how much all of these things impact everything we do all the time.

Similarly, another participant stated:

> I wonder how multicultural- what if this was the frame you took to multicultural class? This is what we’re going to be teaching is intersectionality rather than, like, “African-Americans are like this. Hispanic/Latino people are like this.” Or, "These are women's issues." If
instead you spent all that time doing critical conceptualization, critical thinking of cases based on intersectionality. How different that would be.

**Summary**

There were several major themes that emerged from the qualitative thematic analysis (Braun & Clarke, 2006; 2012) of the focus group interviews within two larger categories. The first category, Content/Theory, included themes that were related to what participants learned about LGBTQ+ affirmative intersectional counseling and intersectionality. Participants described what they learned in their own words, and linked the theory and concepts to their work as counselors. The major themes related to this category were (1) Role of Intersectionality as a Critical Framework/Paradigm Shift in Counseling, (2) LGBTQ+ Affirmative Intersectional Counseling and Social Justice, and (3) Social/Political Issues and Privilege.

In the first theme, participants described the theory of intersectionality as they understood it. They also conceptualized how intersectionality could make a difference as a new critical lens in the counseling profession. They discussed the impact intersectionality could have on counseling and advocacy, and they noted that intersectionality is not only about looking at the multiple identities of clients, but is also about acknowledging overlap in systems of power that can lead to marginalization. They also discussed the impact that oppression and marginalization can have on clients’ mental health and wellness, and thus noted the importance of acknowledging and discussing systemic issues.

In the second theme, participants conceptualized LGBTQ+ affirmative counseling and emphasized the social justice components. Participants discussed their beliefs that both LGBTQ+ affirmative counseling and social justice in counseling and advocacy would fall short if not approached from an intersectional framework. They noted the
importance of affirming all identities and the unique experiences of clients that may not fit within expectations based on stereotypes or prototypes. They also explained that an intersectional approach could increase the effectiveness of LGBTQ+ affirmative counseling, and they explained an affirmative intersectional approach as normalizing of identities, empowering, and strengths-based. Participants linked an affirmative intersectional approach to social justice and systemic advocacy, and acknowledged that it has to go beyond mere acceptance of LGBTQ+ identities and should incorporate actions to change systemic barriers that can have a negative impact.

The third theme in the category of Content/Theory was related to the impact of social issues, political issues, and privilege in counseling and counselor training. Some participants noted that their training programs do not exist in a vacuum and are impacted by the current political climate, and that conversations about this impact can be difficult or polarizing. Participants also discussed how taking a clear stance as LGBTQ+ affirmative, intersectional, or feminist could impact their relationships with or ability to work with clients who hold privilege identities and/or oppressive beliefs. One participant expressed fear that the use of a rainbow sticker could help LGBTQ+ clients to feel safe, but might cause those opposed to LGBTQ+ identities to feel “unsafe.” Other participants noted that intersectionality could be of benefit to clients who hold more privileged positions in society by helping them to see their role in systems and ways that they can help to end oppression of others.

The second major category of themes, Process/Reflection, included themes that were related to the participants experiences and feelings either within the workshop or related to the topic of the workshop. The major themes in this category were (1) Feeling Uninformed/Intimidated, (2) Impacts of the Workshop, (3) Challenges of
Ambiguity/Wanting Guidelines, and (4) Wanting to Have Intersectionality Integrated
Throughout Counselor Training. The first theme had two subthemes, (a) homogeneity of
the group and (b) characteristics of the facilitator. Both of these subthemes were related
to the participants’ comfort during the workshop. The second theme, Impacts of the
Workshop, had three subthemes that corresponded with the organization of the workshop
material. These subthemes were (a) knowledge, (b) awareness, and (c) skills.

Most of the participants expressed that they had little knowledge related to
intersectionality or LGBTQ+ affirmative counseling prior to attending the workshop.
Several expressed that they felt a sense of ignorance or of being uninformed before
completing the workshop. In addition to feeling uniformed about the specific workshop
topics, some participants who identified themselves as students expressed that they felt
uncomfortable or not ready to engage in counseling skills in general.

Out of the six focus groups, there was one group that appeared to the participants
to be homogenous related to race and one that appeared to participants, based on what
they shared with each other, to be homogenous in regards to gender identity and
affectional orientation. This homogeneity corresponded to privilege related to race
(whiteness) for the former group and straight and cisgender identities for the latter. Some
participants in both of these groups expressed that it would have contributed to their
discomfort to have participants different from themselves in the workshop. In the other
groups that had more heterogeneity, this topic did not come up. Interestingly, participants
who identified with more marginalized identities did not express discomfort regarding the
more privileged members of the groups.

Some of the participants expressed that their comfort was increased and their
feelings of being uniformed or intimidated were lessened due to characteristics or
behaviors of the facilitator. Participants discussed how the facilitator normalized their feelings of being uniformed and provided them with information that countered common misconceptions. They expressed that the facilitator seemed informed, prepared, and passionate. Additionally, some expressed that the facilitator was flexible with the timing of the workshop and would spend as much time as needed to answer questions and engage in conversations with participants. One participant who identified as a part of the LGBTQ+ community stated that knowing the facilitator also identified within the LGBTQ+ community was related to an increase in comfort.

The second theme in the Process/Reflection category is related to the impacts of the workshop on participants. This theme overlaps with the previous theme, Feeling Uninformed/Intimidated, and the following theme, Challenges of Ambiguity/Wanting Guidelines. The participants discussed what they learned from the workshop in the areas of knowledge, awareness, and skills. The workshop was organized around knowledge, awareness, and skills to correspond with LGBTQ+ counseling competencies (ALGBTIC, 2009; ALGBTIC 2013.)

Within the knowledge subtheme, participants discussed specific components of the workshop that were helpful, such as the language and terminology activity and the discussion of historical and current context. Within the awareness subtheme, they discussed how they had gained awareness through the workshop. Some participants discussed an awareness of how they may have contributed to or colluded with oppression when working from a perspective that is not affirmative and intersectional. Participants discussed how their specific counseling skills would continue to develop over time through their work with clients, and they noted that an affirmative intersectional framework is a critical lens for conceptualization rather than a specific set of techniques.
Yet, as discussed in the following theme, participants did want more specific guidelines for using LGBTQ+ affirmative intersectional skills with clients.

The third theme in the Process/Reflection category is related to the challenges of ambiguity and the participants’ desires to have more specific guidelines or sets of skills that could be used in counseling. Some participants wanted to see more examples of affirmative intersectional counseling, and some also expressed a desire to learn more about what affirmative intersectional counseling would look like with specific client identities or in specific clinical situations. Although it was previously discussed that affirmative intersectional counseling is not prescriptive or a checklist, some participants expressed wanting to know how to work with clients who have different identities under the LGBTQ+ umbrella.

The final theme, Wanting to Have Intersectionality Integrated Throughout Counselor Training, emerged from several of the focus group interviews. Participants expressed the desire to learn LGBTQ+ competencies and multicultural competencies throughout their coursework through integrated and intersectional approaches. They expressed that it would be helpful to counselor development for identities to not be taught as single-axis categories, and for multicultural and LGBTQ+ competencies to be taught consistently throughout every course in their training program. Participants expressed concern over a lack of training for LGBTQ+ competencies and a stereotypical or prototypical approach to learning multicultural competencies.

In the following chapter, I will discuss related literature to place these themes in professional context. I will discuss how these themes relate to counselor development and counselor training, and I will provide implications for teaching and research.
Additionally, I will discuss recommendations for future research, as well as the limitations of this study.

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CHAPTER 5
DISCUSSION

While there is an urgent need to train counselors in LGBTQ+ affirmative counseling, many counselors enter into the field without this training. This is evidenced by past literature that shows more than 60% of counseling students reported they did not receive any LGB affirmative training in their counseling programs (Rock, et al., 2010). Moreover, there is very little research related to counselor training and development of LGBTQ+ counseling competencies, especially in regards to TGNC competencies. Further, there is a dearth of scholarship related to taking an intersectional approach to LGBTQ+ affirmative counseling and counselor education.

The purpose of this study was to hear from counselors and counseling students about their experiences in a two-day workshop about affirmative intersectional approaches to counseling. A qualitative feminist focus group was designed to learn from students about their experiences of the content and the process of the training. Qualitative thematic analysis (Braun & Clarke, 2006; 2012) was used to analyze the interview data. The participants’ rich descriptions of what they learned, and what they found or would find helpful in their training, can contribute to further development of similar workshops and/or graduate level courses about LGBTQ+ affirmative intersectional counseling. Additionally, the interview data provides support for incorporating intersectionality and intersectional pedagogy throughout counselor education coursework as a new paradigm for counseling and for counselor training related to LGBTQ+ competencies (ALGBTIC, 2009; 2013) and the Multicultural and Social Justice Counseling Competencies (Ratts, et al., 2016).

I sought to learn from the participants about their answers to four broad questions: (1) How do the participants conceptualize intersectionality after the training?, (2) How do...
participants conceptualize affirmative counseling after the training? (3) How do
participants link intersectionality, affirmative counseling, and social justice after the
training? (4) How did participants experience the training? In order to address these
questions, students and counselors voluntarily participated in a two-day training
workshop about LGBTQ+ affirmative counseling and intersectionality theory. Attendees
were invited to participate in focus group interviews following the workshops. Six
workshops and focus groups were held, and a total of 14 people participated in the focus
groups. The focus group design allowed participants to engage with each other in the co-
construction of knowledge, which is integral to feminist research theory.

Qualitative thematic analysis (Braun & Clarke, 2006; 2012) was conducted using
the focus group interview transcripts to examine for common themes. As described by
Braun and Clarke (2012), thematic analysis “is a way of identifying what is common to
the way a topic is talked or written about and of making sense of those commonalities”
(p. 57). The data were systematically analyzed through the six-step process of (1)
becoming familiar with the data, (2) initial coding, (3) seeking themes in the codes, (4)
reviewing the developing themes, (5) naming and defining the themes, and (6) reporting
the themes (Braun & Clarke, 2006; 2012).

From the thematic analysis, seven themes were identified in two broad categories:
Content/Theory and Process/Reflection. The themes in the first category are (1) Role of
Intersectionality as a Critical Framework/Paradigm Shift in Counseling, (2) LGBTQ+
Affirmative Intersectional Counseling and Social Justice, and (3) Social/Political Issues
and Privilege. In the second category, the themes that emerged are (1) Feeling
Uninformed/Intimidated, (2) Impacts of the Workshop, (3) Challenges of
Ambiguity/Wanting Guidelines, and (4) Wanting to Have Intersectionality Integrated Throughout Counselor Training.

Discussion of Results

The results of this study have implications for counselor training and counselor development. The broad categories of Content/Theory and Process/Reflection align with two of the three steps of critical praxis (theory, action, reflection), which is fundamental to feminist critical education and critical consciousness (Freire, 1970; hooks, 1984). Furthermore, participants noted the importance of advocacy and action within several of the themes. Participants were able to share what they learned in regards to intersectionality theory and its use in counseling, as well as their understandings of what it means to engage in LGBTQ+ affirmative intersectional counseling. Additionally, in the second category, participants shared their reactions and reflections on the content and the training process. The results of this can guide approaches to counselor training and can provide a rationale for future research.

Implications for Training

The results of this study have several implications for counselor training and development. The 2016 CACREP Standards (Council for Accreditation of Counseling and Related Educational Programs, 2015) address several required areas of counselor education that are related to the results of this study. Within Section 2 of the CACREP Standards, Professional Counseling Identity, in Counseling Curriculum subsection 1, Professional Counseling Orientation and Ethical Practice, the standards state that counseling students will learn “advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients” (p. 8). Furthermore, in subsection 2, Social and Cultural Diversity, it is stated that curriculum will include
“theories and models of multicultural counseling, cultural identity development, and social justice and advocacy;” “the impact of heritage, attitudes, beliefs, understandings, and acculturative experiences on an individual’s view of others;” “the effects of power and privilege for counselors and clients;” and “strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination” (p. 9).

Training for LGBTQ+ counseling competencies are not specifically mentioned in the CACREP standards, which could contribute to inconsistencies in training or a lack of training. The aforementioned CACREP standards are often addressed in a single multicultural course design (Malott, 2010; Seward, 2014). However, Bidell (2014a) found that general multicultural courses were not associated with increased LGB competencies for counseling students. Additionally, Seward (2014) found in a qualitative study that counseling students of color felt unsatisfied by general multicultural counseling courses, noting that they tend to center white students and were limited in depth and breadth. Therefore, intersectional pedagogy integrated throughout counselor education may provide an innovative method of addressing the CACREP standards and the ALGBTIC competencies in a way that is more in-depth and that does not center the most privileged students in the learning environment. In the remainder of this discussion section, I will discuss the results of the current study in context of existing literature related to LGBTQ+ affirmative intersectional counseling, counselor development, and challenges to counselor training. I will also discuss the potential of intersectionality as a framework for counseling and counselor training, with a particular emphasis on teaching LGBTQ+ competencies.
LGBTQ+ Affirmative Intersectional Counseling

The concept of LGBTQ+ affirmative intersectional counseling is relatively new, particularly in regards to strong intersectionality that is rooted in the politics of women of color feminism. Thus, I sought in this study to examine the experiences of counselors and counseling students who learned about this approach in the workshop. The majority of participants stated that they had no prior knowledge of affirmative counseling or intersectionality. One participant expressed having a familiarity with intersectionality prior to the workshop, but no prior learning experiences related to LGBTQ+ affirmative counseling. Approximately 20% of participants noted on their demographics survey that they had received prior affirmative training, and about 16% stated that they did not know if their prior LGBTQ+ training had been affirmative. The remaining participants reported that they had received no affirmative training. This 64% aligns closely with the 60% who reported no affirmative training in the study by Rock and colleagues (2010).

Some scholars have previously discussed the concept of LGBTQ+ affirmative intersectional counseling. Dispenza and colleagues (2016), in a grounded theory study, developed a model of affirmative intersectionality that consisted of four major categories: (1) Professional Attributes, (2) Alliance, (3) Intersectional Sensitivity, and (4) Intersectional Interventions. Additonally, in a phenomenological study on the experiences of TGNC clients in counseling, McCullough, Dispenza, Parker, Viehl, Chang, and Murphy (2017) identified Intersectional Insensitivity as a subtheme related to a transnegative counseling approach. In this study, a lack of intersectional sensitivity was seen as an impediment to counseling.

Furthermore, Moradi (2017) discussed the potential for strong intersectionality to improve counseling and psychology services for LGBTQ+ clients who do not fit
common prototypes, which are often based on those within the community who hold the
most privilege (i.e., white, cisgender gay men). Moradi (2017) noted that non-
intersectional perspectives tend to center a normative experience against which all
experiences that do not match are deemed other. Moradi (2017) described how non-
intersectional approaches to multiculturalism and diversity can be lacking when they
focus on groups differences rather than focusing on systems and how people are impacted
by both oppression and privilege, stating “the focus on group differences can promote a
pattern of scrutinizing minority identities and cultures but not applying a parallel critical
lens to dominant identities and cultures” (p. 119).

In discussing intersectionality, participants in the current study described it as a
critical framework and a paradigm shift. They emphasized that intersectionality is about
examining interlocking systems of power that create privileged and marginalized
statuses, rather than focusing on group characteristics and prototypes. This is a
fundamental tenet of intersectional feminism, which focuses on systems of power.
Specifically related to counseling, participants explained that intersectionality would help
them to acknowledge how social and political structures impact the mental health of their
clients, and that it would also allow them to see clients holistically. Participants stated
that this new intersectional lens would help them to see parts of clients that they may
have unintentionally marginalized before learning intersectionality. Participants also
noted that intersectionality would be necessary in order to engage in affirmative
counseling and social justice advocacy. They discussed how identities and systems are
“woven together” and inextricably linked, thus requiring an intersectional approach to
affirmative counseling.
Participants highlighted the importance of validating and “normalizing” LGBTQ+ identities, as well as other intersecting identities. As one participant stated, “I need to be affirming of each and any identity or life experience they are bringing.” This aligns with the description of affirmative intersectionality provided by Dispenza and colleagues (2016) in regards to working with clients who have a sexual minority identity and a chronic illness or disability (CID). They stated:

As a core construct, [affirmative intersectionality] considers the various forms of oppression that are associated with possessing both a sexual minority identity and CID, while supporting and encouraging a sense of pride for possessing both identities simultaneously. (p. 6)

Participants in the current study described an LGBTQ+ affirmative intersectional approach to counseling as systems focused, and also strengths-based, normalizing, and empowering for clients.

Additionally, participants further stated that there is a critical action and advocacy element to affirmative intersectional counseling. This focus on action is also a fundamental tenet of intersectional feminism. They noted that it goes beyond an acceptance of LGBTQ+ identities and is concerned with changing systemic structures that marginalize or oppress LGBTQ+ people, which contributes to clinical concerns. They also discussed how social and political issues impact counselors and clients and position them in the counseling relationship based on their own social locations, which is consistent with the model of the MSJCC (Ratts, et al., 2016). Several participants brought up the importance of examining privilege, both in themselves and with privileged clients. This is consistent with Moradi’s (2017) stance that privileged identities also need to be examined and that intersectionality can be used with all clients, not just clients who hold minority identities.
Counselor Development

Marbley, Steele, and McAuliffe (2011) discussed the importance of teaching counselors to incorporate “social justice-oriented objectives” in counseling practice and advocacy. One of their two meta-objectives discussed is the development of a “critical, political consciousness” (p. 171). This idea is linked to the concept of critical consciousness as discussed by Freire (1970). They stated that:

Social justice advocacy may occur at the individual level; however, interventions aimed at creating change within social and political arenas are also important. Such interventions may include prevention, outreach, empowerment, and direct political intervention. (p. 172)

In the first theme that emerged from this study, the role of intersectionality as a critical framework or paradigm shift in counseling, participants noted the importance of the action and advocacy components of counseling that are emphasized by an intersectional perspective. Additionally, in the social/political issues and privilege theme, participants discussed sociopolitical elements that impact clients experiences and that may directly affect their presenting concerns. Additionally, Crethar, Torres-Rivera, and Nash (2008) discussed how multicultural, feminist, and social justice approaches to counseling emphasize empowerment and advocacy as vital components of the counseling process. The participants in this study identified empowerment, advocacy, and action as critical components of intersectional and affirmative counseling. Crethar and colleagues (2008) defined advocacy as “proactive efforts carried out by counseling professionals in response to institutional, systemic, and cultural impediments to their clients’ well-being” (p. 274).

Furthermore, Crethar and colleagues (2008) discussed the concept of unintentional injustices, stating that:
Unintentional injustices commonly occur when individuals are complicit in silently allowing oppressive cultural, organizational, and social policies and practices to continue to operate unabated in different environmental contexts. (p. 270)

Several participants expressed their concerns about unintentionally contributing to or “colluding” with oppression and oppressive systems in their work with clients. They expressed that the information presented to them in the training workshop helped them to gain a better awareness of situations in which this may occur so that they can practice more intentionally from an affirmative intersectional approach. Through an intersectional feminist lens, they could view and articulate how they are affected by interlocking systems of power.

**Challenges to Counselor Training**

Some of the themes and subthemes that emerged from this study were related to concepts of counselor development, whether in general or specifically related to the training materials. The participants were able to describe intersectionality and/or LGBTQ+ affirmative counseling using terms such as “framework”, “lens”, and “paradigm shift.” Additionally, participants said that the application of intersectionality and LGBTQ+ affirmative counseling is “not cookie cutter” and that the exact use would depend on each unique client and their presenting issues. And yet, participants also expressed their desire to “see what it looks like” with clients of specific identities. Although we discussed in the training workshop the problems with using a checklist approach, several participants did express wanting to have guidelines, a template, or examples of how to work with clients who have different identities.

In regards to teaching multicultural counseling competencies, Parker and Fukuyama (2007) stated that:
Beginners in any new venture want to be shown how. This desire for guidance is commonly found in any new activity, such as learning to play a musical instrument, studying a second language, or traveling in a new country, but as one learns the basics, it becomes clear that proficiency no longer depends upon directives but is developed through personal practice and integration of knowledge through experiential learning. Similarly, becoming a skilled counselor or psychotherapist requires a combination of book learning, supervised practice, and continuing educational and professional development…Our hope is to provide guidance that allows for incorporating [multicultural counseling competencies] into one’s whole person and professional practice, not a cookbook that is prescriptive. (pp. 4-5).

In this context, the participants’ desire to see how affirmative intersectional counseling would be applied with clients who hold specific identities, or specific combinations of identities, could be related to counselor development in general and the comfort that may be found in having a list of specific techniques, a manualized treatment model, or even specific recommendations for practice based on single-axis identity categories. However, prescriptive approaches that might seem easier to grasp earlier in the developmental process may in fact be a hindrance to deeper theoretical knowledge. Additionally, such approaches to development of cultural competencies are often tailored toward the most privileged counseling students, leaving others unsatisfied with the educational experience and the knowledge gained (Seward, 2014).

**Cultural Encapsulation and Safety**

Several participants stated that they felt more comfortable in the training because they were in homogeneous groups (e.g., all straight, all white). This raises concerns about the connection between cultural encapsulation and feelings of safety among counselors and counselors in training. Kagan discussed counselor encapsulation in 1964, and yet elements of this concept are still relevant today in terms of stereotypes, prototypes, and expectations. Kagan (1964) stated that “counselors are prepared to ‘discover’ certain values, attitudes, and behaviors among their impoverished or minority group clients, and
seem always a bit surprised when they don’t” (p. 361). Similarly, some participants expressed their expectations of behavior from peers who identify differently from themselves. Namely, the participants expressed an intimidation that they anticipated had LGBTQ+ participants or people of color participants been present, respectively. At the core of this intimidation was a sense of not being safe, despite holding the privileged identities in these contexts. There was an expectation and a fear of being “called out” by a minority group member. This seems to rely on stereotypes of people in minority groups as being overly sensitive or overly angry about offensive statements. One participant stated that being “called out” previously had led to learning experiences, and yet this participant was still grateful about the perception that they would not be called out in the homogenous group.

Ludlow (2004) addressed the challenges of creating safety in a learning environment, stating that safety is “inequitably available to people according to the identity groups with which they are associated, and [it] is ‘inflected with power” (p. 40). Ludlow (2004) recommended moving away from the intention of creating a “safe” space in classrooms to rather creating a “contested space” in which “knowledges are always marked by power and privilege” (p. 47). Ludlow challenged the idea of a safe space, noting that safety can further benefit those who are already privileged, thus stating:

The problem with “safety” in the feminist classroom is that it is often proclaimed from a position of innocence regarding the ways cultural spaces are inflected by power and privilege. Adrienne Rich has theorized that “[t]he word safe has two distinct connotations”: one is of “a place in which we can draw breath, rest from persecution or harassment”; the other is “the safety of the ‘armored and concluded mind,’ the safety of the barricated door which will not open for the beleaguered Stranger” (2006). The difference between these two connotations is privilege. Those for whom safety means “rest from persecution or harassment” are, by definition, persecuted or harassed, lacking privilege. Those for whom safety means “armored and concluded,” however, are likely privileged, are likely those
for whom the “Stranger” is the Other. These two connotations of safety reflect two different relationships to privilege and cultural power. (p. 44)

From the standpoint of a contested space rather than a safe space, the cultural encapsulation provided by a homogenous training group could limit the participants growth by protecting them from being “called out” for beliefs that may be offensive to people who they see as Other.

**Intersectional Approaches to Counselor Training**

The results of this study have implications for the training of counselors in regards to LGBTQ+ counseling competencies and intersectionality as a theoretical framework for counseling and counselor education. Several participants expressed their desire to have the content of the training workshop incorporated throughout their training programs. In particular, participants contrasted the potential of intersectionality as a lens for thinking critically about multicultural competencies against approaches that treat multiculturalism as either (a) additive rather than integrative in regards to the inclusion of multicultural implications or (b) as single-axis and distinct categories. Seward (2014) conducted a grounded theory study to examine the experiences of students of color in multicultural counseling courses and found that the core category was that students of color “learned from courses, but [felt] unsatisfied” (p. 68). Seward stated that “students described not only satisfaction with being exposed to cultural beliefs and practices of diverse groups, but also dissatisfaction with the depth and breadth of their course content regarding cultural issues” (p. 69). The use of an intersectional pedagogy as well as the teaching of an intersectional approach to teaching multicultural counseling competencies could address this lack of depth and breadth, as it teaches counselors a critical thinking framework rather than attempting to cover characteristics of specific groups in ways that can lead to the perpetuation of stereotypes.
As Moradi and Grzanka (2017) stated, intersectionality is not only about or applicable for people who hold minority identities or consider themselves scholars in the area of diversity. A complete analysis of systems of power and oppression includes the analysis of privilege and how multiple privileged identities are also mutually constructed and have an impact on systems and individuals. As the participants of this study mentioned, using intersectionality as a clinical tool requires analyses and conceptualizations of privilege, whether it be the counselor’s or the client’s. As previously described, the MSJCC (Ratts, et al., 2016) also direct counselors to examine the privileged and marginalized identities of both clients and counselors and how these dynamics impact (1) the counselor’s self-awareness, (2) the client’s worldview, (3) the counseling relationship, and (4) counseling and advocacy interventions. Within the theme of Social/political issues and privilege, participants discussed the importance of intersectionality when working with clients who have privileged identities, and they expressed questions related to how they might use this theoretical standpoint to respond to clients who share bigoted views.

Intersectional pedagogy has the potential to deepen the learning experiences of counselors and counseling students beyond prescriptive approaches that often end up relying on stereotypes, prototypes, or otherwise inaccurate or incomplete conceptualizations. Further, it moves beyond approaches, such as ally development, that center those with the most privilege in the learning environment. As a critical paradigm shift, intersectional pedagogy can help counselors and counseling students develop critical consciousness such that they can utilize non-prescriptive skills in clinical work and advocacy rather than relying on a checklist or manualized approach.
As previously discussed, the increased popularity of the term intersectionality has led to misuse and misunderstandings that have often stripped the term from its fundamental tenets based in women of color feminism. The researcher in this study pursued education related to intersectional theory both independently and through a graduate certificate in Women’s Studies. For counselor educators to incorporate an intersectional perspective into counselor training, it is important that they give credit to the feminist scholars who have created it. It is recommended that counselor educators gain a deep understanding of intersectionality through engagement with the core texts and feminist thought to be sure that it is incorporate correctly and with due credit given.

**Recommendations for Future Research**

The results of this study and the implications previously discussed can provide several ideas for future research. An expansion of this same study with more participants could add more richness to the themes and descriptions. Additionally, a quantitative or mixed-methods approach could be used to measure the participants LGBTQ+ counseling competencies. Additionally, because of the emphasis that participants placed on social justice and because of their discussions of potential changes to multicultural education, future quantitative research could also measure participants multicultural and social justice counseling competencies before and after the training. Because of the amount of information presented in the workshop, future research might examine the effects of a full semester course in lieu of a two-day training workshop.

**Limitations of the Study**

This study was limited in that the participants were all from similar regions within a few hours of the training site. Additionally, participants self-selected to attend the training and therefore may have had more of an interest in or commitment to this topic.
than the general population of counselors and counseling students. It could potentially pose a limitation that counselors and counseling students were in the same focus groups because they were at various levels of counselor development. However, in the feminist focus group model, this may also have been a strength as it provided differing perspectives to be a part of the co-construction. Additionally, it is a limitation that the focus group facilitator was not available for one of the focus groups due to unforeseen circumstances, and thus the workshop facilitator led one of the six focus groups.

**Conclusion**

Seven major themes emerged from a thematic analysis of the six focus group interviews: (1) Role of Intersectionality as a Critical Framework/Paradigm Shift in Counseling, (2) LGBTQ+ Affirmative Intersectional Counseling and Social Justice, and (3) Social/Political Issues and Privilege, (4) Feeling Uninformed/Intimidated, (5) Impacts of the Workshop, (6) Challenges of Ambiguity/Wanting Guidelines, and (7) Wanting to Have Intersectionality Integrated Throughout Counselor Training. These findings have implications for training counselors to utilize affirmative intersectional counseling with LGBTQ+ clients to address the mental health disparities that exist and that are impacted by the role of stigma in society and in the helping professions. An affirmative intersectional perspective can be used to teach LGBTQ+ counseling competencies to counseling students and practicing counselors through coursework and training workshops.

As participants stated, this critical framework can be integrated throughout counselor training as a model that differs from a single course model and single-axis approaches to viewing clients with minority identities. An affirmative intersectional approach can help counselors to develop the skills of critical praxis, which can be used in
lieu of a prescriptive or checklist approach to multiculturalism and diversity. This critical praxis can help counselors to develop deeper and broader awareness, and is an ongoing, career-long learning process that takes into account social and political contexts that affect mental health and wellness. This approach can start to address the mental health disparities that affect LGBTQ+ people and the lack of counselor training to work competently and affirmatively with this population. Future intersectional research is warranted to examine the quantitative effects of such training using LGBTQ+ counseling competency scales and to further examine the qualitative experiences of counselors when learning this new paradigm.
APPENDIX A
DEMOGRAPHICS QUESTIONNAIRE

Personal Characteristics
1. How would you describe your own sexual orientation?
2. How would you describe your gender identity?
3. How would you identify your race or ethnicity? (can select more than one)
4. How old are you?

Training Experiences
1. Are you a master’s-level student in a counseling program?
   a. Yes
   b. No
2. Is your program CACREP accredited?
   a. Yes
   b. No
3. What type of counseling program or track are you in (school counseling, mental health counseling, marriage and family counseling, career counseling, etc)?
4. How many total semesters is your counseling program?
5. How many semesters have you completed in your counseling program?
6. Approximately how many credits have you completed, only counting credits earned in your counseling graduate program? (not counting undergraduate credits or any graduate credits earned in an unrelated field – you can count elective credits applied toward you master’s in counseling even if taken in a different program or department)
7. Are you currently enrolled in practicum?
   a. Yes
   b. No
8. Are you currently enrolled in internship?
   a. Yes
   b. No
9. Have you already completed a practicum?
   a. Yes
   b. No
10. Have you already completed internship?
    a. Yes
    b. No
11. Are you currently receiving clinical supervision?
    a. Yes
    b. No
12. Have you ever received clinical supervision as part of your counselor training?
    a. Yes
    b. No
13. Are you currently seeing clients?
    a. Yes
b. No

14. Have you ever seen clients as part of your counselor training?
   a. Yes
   b. No

15. Are you now enrolled in or have you ever taken a class that was specifically about LGBTQ+ counseling?
   a. Yes
   b. No

16. Have you received LGBTQ+ affirmative training in another course, such as a multicultural counseling course or a human sexuality course?
   a. Yes
   b. No

17. Have you ever taken a training workshop related to LGBTQ+ counseling?
   a. Yes
   b. No

18. Have you ever attended a conference session related to LGBTQ+ counseling?
   a. Yes
   b. No

19. Approximately how many hours of training do you have related to LGBTQ+ counseling?

20. If you received past trainings, were they affirmative?
   a. I have not received any past trainings related to counseling LGBTQ+ clients
   b. Training I received was affirmative
   c. Training I received was mostly affirmative
   d. Training I received was somewhat affirmative
   e. Training I received was not affirmative
   f. I do not know if my past training was affirmative

21. Have you ever learned about intersectionality theory in your counselor training?
   a. Yes
   b. I don’t know
   c. No

22. If you did learn about intersectionality in your counselor training program, where did you learn it?
   a. From a supervisor at a practicum or internship site
   b. From an individual or group supervisor in my counseling program
   c. In a counseling class
   d. In an elective course that was not in my counseling program
   e. In a workshop
   f. In a conference session
   g. On a research team
   h. Other (please specify)
APPENDIX B
FOCUS GROUP INTERVIEW QUESTIONS

1. How would you describe intersectionality?

2. What is the role of intersectionality in social justice?

3. What is the role of intersectionality in counseling?

4. How would you describe LGBTQ+ affirmative counseling?

5. How are intersectionality and affirmative counseling related or integrated?

6. How has your understanding of LGBTQ+ affirmative counseling changed? How have your knowledge awareness and skill changed?

7. What questions do you have about intersectionality or affirmative counseling after the training?

8. Is there anything you would like to be different in a future training?

9. Is there anything you would like to add that I did not ask about?
Recruitment Email

Dear Counseling Master’s Students,

You are invited to participate in a doctoral dissertation study regarding LGBTQ+ counselor training and intersectionality theory. You will receive complementary attendance at a two-day training workshop on LGBTQ+ Affirmative Intersectional Counseling held in Gainesville, Florida. There are several dates available in January and February of 2018. Exact dates will be determined based on your availability and random assignment. Each training workshop will be held on a Friday and Saturday from 9am to approximately 4pm on both days.

This is an opportunity to enhance your growth and development as a counselor while also contributing to the professional knowledge base. This intensive workshop will include information about theory, historical context, knowledge, awareness, and skills. For your convenience, lunch and snacks for both days will be provided and will include vegetarian and vegan options. For more information about the dates and times available and registration, please contact Rachel Henesy at rachelp@ufl.edu.
Recruitment Flyer

LGBTQ+ Affirmative Intersectional Counseling Training
For Master’s Level Counseling Students

With
Rachel Henesy, M.A.E., Ed.S., N.C.C.
Doctoral Candidate, Counseling & Counselor Education
University of Florida

You are invited to participate in a doctoral dissertation study regarding LGBTQ+ counselor training and intersectionality theory. You will receive complementary attendance at a two-day training workshop on LGBTQ+ Affirmative Intersectional Counseling held in Gainesville, Florida. There are several dates available in January and February of 2018.

Lunch and snacks for both days will be provided, and will include vegetarian and vegan options. For more information about the dates and times available, please contact Rachel Henesy at rachelpr@ufl.edu.
APPENDIX D
INFORMED CONSENT

Protocol Title: LGBTQ+ Affirmative Intersectional Counseling: Development and Evaluation of a Training Workshop for Counseling Students

Purpose of the research study
The purpose of this research study is to examine the impacts and effects of a two-day training workshop about LGBTQ+ affirmative counseling and intersectionality theory for master’s level counseling students. The effects of the training workshop on counseling students’ competencies to work with LGBTQ+ clients will be examined through quantitative analysis of participants’ responses to two surveys: The Sexual Orientation Counselor Competency Scale (Bidell, 2005) and the Trans Counselor Competency Scale (Cor, 2016). Participants may also choose to participate in a focus group interview to provide qualitative data about the training experience.

What you will be asked to do in this study
You will first be asked to take the two surveys and a demographic survey prior to attending the training workshop. These surveys can be taken online through a link sent to your email account after your registration for the workshop. You will then be assigned to one of the training groups. This training workshop will take two days, a Friday and Saturday. Either before or after your training, you will be asked to take the two surveys for a second time. At the end of the second day of training, you will be invited to participate in a focus group interview.

Time required
This study will take approximately 14 hours across two days.

Benefits and risks
You may experience an increase in LGBTQ+ counseling competencies that will benefit you as a practitioner. You will also learn about how to integrate intersectionality into your counseling practice. You may experience some emotional discomfort or mild physical discomfort due to the length of the training.

Compensation
There is no compensation for this study.

Confidentiality
Your identity and information will be held confidential in accordance with legal and ethical standards. Limits to confidentiality include: (a) disclosure or evidence of abuse of a minor, elderly, or disabled person, (b) statements, threats, or other evidence that you may be a danger to yourself or others, and (c) when a breach of confidentiality has been ordered in a court of law. You will have to provide your name and email address through Eventbrite to sign up for this training. The information you provide will be assigned a randomized number electronically through Qualtrics. Once the Qualtrics data reports have been downloaded, your name and email address will be removed from the report and will be stored separately in a password-protected Word document. Your participation in the training workshop cannot be held completely confidential because there will be other people at the training; however, your responses to the surveys will be held confidential as described above.
If you choose to participate in the focus group interview component of this study, your responses to interview questions will be audio recorded. These audio recordings will be transferred to a secure UF server within 12 hours of recording and will then be deleted from the original recording device. Recordings of interviews will be transcribed into a password-protected word-processing document and the audio recording will then be destroyed. Faculty members who assist with the research may access the de-identified materials (materials that do not include your name) only. To further protect your identity, faculty members who assist in analysis of interviews will have access only to de-identified transcripts and will not hear the voice recordings.

Quotations used in the qualitative report will be anonymous and not connected with your name or other identifying information. However, please keep this in mind when deciding whether to tell anyone that you are participating in this study, because people you know might be able to guess or assume which quotes belong to you if they know you participated. To protect the privacy and confidentiality of others, please do not mention the names of other people or any other identifying information about other people during the recorded interviews.

Voluntary participation
Your participation in this research study is completely voluntary and there is no penalty for not participating or for ending your participation before the completion of the study.

Right to withdraw from the study
You have the right to withdraw from the study, without consequence, at any time you choose.

Who to contact if you have questions about the study
Rachel Henesy, Doctoral Candidate, Counseling & Counselor Education program, rachelp@ufl.edu.

Ana Puig, PhD, College of Education, anapuig@coe.ufl.edu, 352-273-4121.

Who to contact about your rights as a research participant in the study
IRB02 Office
Box 112250
University of Florida
Gainesville, FL 32611-2250
352-392-0433

Agreement
I have read and understand the procedures explained above. I choose to voluntarily participate in the study and I have received a copy of the informed consent.

Participant's Signature: ___________________________ Date: __________

Principal Investigator's Signature: ___________________________ Date: __________
APPENDIX E
TRAINING WORKSHOP OUTLINE

Day 1

- Icebreaker and introductions (30 minutes)
- Knowledge Domain
  - Terminology and Language – lecture and Safe Zone Project activity (40 minutes)
  - Historical context – mostly focused on mental health (25 minutes)
  - Current context – mostly focused on counseling field (20 minutes)
  - Break (10 minutes – 10:55 – 11:05)
  - Stigma and Mental Health Disparities
    - LGBTQ+ mental health disparities (10 minutes)
    - Minority Stress Theory (10 minutes)
    - Fundamental Cause Theory (10 minutes)
    - Discussion and dialogue (25 minutes)
  - Lunch (60 minutes – 12:00-12:45)
  - Intersectionality
    - Definition, history, and foundational concepts (25 minutes)
    - Small group discussion (10 minutes)
    - Large group dialogue (15 minutes)
  - Affirmative counseling
    - Definition, need, and foundational concepts (15 minutes)
    - Discussion and dialogue (10 minutes)
  - Break (10 minutes – 2:00-2:15)
    - Safe Zone Project “Identity Signs” Activity (15 minutes)
    - Process Activity (20 minutes)
  - Affirmative Intersectional Counseling
    - Lecture (10 minutes)
    - Discussion (5 minutes)
    - Assign articles to read before next meeting (5 minutes)
Day 2

- Awareness Domain (attitudes, values, beliefs)
  - Small group discussions of assigned articles (15 minutes)
  - Large group discussion of assigned articles (15 minutes)
  - Safe Zone Project “First Impressions of LGBTQ People” Activity (30 minutes)
  - Processing activities and dialogue (15 minutes)
  - Break (10 minutes – 10:15-10:25)

- Skills Domain
  - Intersectional affirmative counseling skills
    - ALGBTIC competencies (10 minutes)
    - Intersectionality in counseling (30 minutes)
  - Lunch (50 minutes – 11:05 – 11:55)
  - Video clip from *Master of None* and discussion (40 minutes)
  - Case studies (90 minutes)
    - Case study development and conceptualization through an affirmative, intersectional perspective
    - Role plays of case studies
  - Discussion and wrap-up (20 minutes)

- Posttest (30 minutes)
- Optional: Focus group interviews (60 – 90 minutes, 3:10 to 4:40)
APPENDIX F
ACTIVITIES

Vocabulary Extravaganza

Large Group 101 Low Trust 20 mins Vocabulary

Necessary supplies

- Participant vocabulary sheet
- Writing utensil

Goals & objectives

- To provide an opportunity for participants to dig into some of the more nuanced definitions used in the LGBTQ+ community
- To emphasize how powerful language is
- Clear up any misconceptions or questions about terminology or common phrases

Step-by-step walk through

1. Start the activity by instructing the participants on what the activity will entail. Let them know they’re going to have 5 or so minutes to read through the list of terms. When they are reading through they should highlight or star any terms they don’t quite get or want to go over more after reading through that word’s definition. At the end of reading through the list they should write down any words that they don’t see on this list but that they find confusing or want to go over with the group.

2. Once everyone is done you can say that you’d like to go over the terms that they starred or added to the list of words to go over and we’ll just go down the list in alphabetical order and any time we get to a word that someone is unclear about we will go over it in detail as a group.

3. Go through the terminology that the group is unsure of. Add tid-bits of your own to highlight important learning beyond just the terms themselves, using the notes below or these: (1) none of these definitions or labels are universal (some folks who identify with these labels will describe their identity differently); it’s important to respect how others self-identify, and not use these labels to “diagnose” people; be sure to clarify parts of speech when important.

Notes

Vocabulary is essential to understanding and exploring LGBTQ issues and identities. Often times folks use specific identity labels to find community and a sense of connection with others who feel and understand identity similar to their experience of identity.
Part of speech, whether a word is a noun, verb, adjective, etc. is an essential part of vocabulary. This is because for a number of words (ex. queer, gay, and trans*(gender) they should only ever be used as adjectives and never as nouns. Adjectives modify the person whereas nouns may feel they reduce that person down to that identity. Adjectives, therefore, are always a bit safer to opt for.

This definition of terms is ever-updating and changing, as is the cultural use of these terms. Please note that we aim to make our definitions as useful as possible, and that if 51 out of every 100 people we meet who use a specific identity label agree with our definition, we consider that to be a success.

For certain terms, the way they are received is just as important as what they mean. Any word might be harmful if used in a negative or derogatory way and it is always important to consider what someone is telling you if they feel hurt or offended by a term.

**All-Star Tip**

This is a great activity to put your own spin on and one that can be modified a lot of different ways. If you’re looking for a way to make this activity interactive consider playing it like a matching game with cards cut out of definitions and words where groups have to pair the words with their definitions.
Full-list of Terms - Facilitator Edition

The bullets under the terms (with the exception of genderqueer) are tidbits, additional information you can use to flush out participants understandings of the terms.

Advocate - (noun) (1) a person who actively works to end intolerance, educate others, and support social equity for a marginalized group. (verb) (2) to actively support/plea in favor of a particular cause, the action of working to end intolerance, educate others, etc.

Ally - (noun) a (typically straight- or cis-identified) person who supports, and respects for members of the LGBTQ community. While the word doesn’t necessitate action, we consider people to be active allies who take action upon this support and respect, this also indicates to others that you are an ally.

- “Coming out” as an ally is when you reveal (or take an action that reveals) your support of the LGBTQ community. Being an active supporter can, at times, be stigmatizing, though it is not usually recognized many allies go through a “coming out process” of their own.

Androgynous - (adj; pronounced “an-jrah-jun-ee”) (1) a gender expression that has elements of both masculinity and femininity; (2) occasionally used in place of “intersex” to describe a person with both female and male anatomy

Androsexual/Androphilic - (adj) attraction to men, males, and/or masculinity

Aromantic - (adj) is a person who experiences little or no romantic attraction to others and/or a lack of interest in forming romantic relationships.

Asexual - (adj) having a lack of (or low level of) sexual attraction to others and/or a lack of interest or desire for sex or sexual partners. Asexuality exists on a spectrum from people who experience no sexual attraction or have any desire for sex to those who experience low levels and only after significant amounts of time, many of these different places on the spectrum have their own identity labels. Another term used within the asexual community is “ace,” meaning someone who is asexual.

- Asexuality is different than celibacy in that it is a sexual orientation whereas celibacy is an abstaining from a certain action.
- Not all asexual people are aromantic.

Bigender - (adj) a person who fluctuates between traditionally “woman” and “man” gender-based behavior and identities, identifying with both genders (and sometimes a third gender)

Bicurious - (adj) a curiosity about having attraction to people of the same gender/sex (similar to questioning)
Biological Sex - (noun) a medical term used to refer to the chromosomal, hormonal and anatomical characteristics that are used to classify an individual as female or male or intersex. Often referred to as simply “sex,” “physical sex,” “anatomical sex,” or specifically as “sex assigned [or designated] at birth.”

- Often seen as a binary but as there are many combinations of chromosomes, hormones, and primary/secondary sex characteristics, it’s more accurate to view this as a spectrum (which is more inclusive of intersex people as well as trans*-identified people)
- Is commonly conflated with gender

Biphobia - (noun) a range of negative attitudes (e.g., fear, anger, intolerance, resentment, erasure, or discomfort) that one may have/express towards bisexual individuals. Biphobia can come from and be seen within the queer community as well as straight society. Biphobic - (adj) a word used to describe an individual who harbors some elements of this range of negative attitudes towards bisexual people

- Really important to recognize that many of our “stereotypes” of bisexual people - they’re overly sexual, greedy, it’s just a phase - are negative and stigmatizing (and therefore biphobic) and that gay, straight, and many other queer individuals harbor these beliefs.

Bisexual - (adj) a person emotionally, physically, and/or sexually attracted to male/men and females/women. Other individuals may use this to indicate an attraction to individuals who identify outside of the gender binary as well and may use bisexual as a way to indicate an interest in more than one gender or sex (i.e. men and genderqueer people). This attraction does not have to be equally split or indicate a level of interest that is the same across the genders or sexes an individual may be attracted to.

- Can simply be shortened to bi
- Because it is the most commonly understood term outside of gay/straight many people who do not believe in the binary categories that bisexual can imply still use the term to indicate their sexual orientation because it is largely understood by others.

Butch - (noun & adj) a person who identifies themselves as masculine, whether it be physically, mentally or emotionally. ‘Butch’ is sometimes used as a derogatory term for lesbians, but is also be claimed as an affirmative identity label.

Cisgender - (adj; pronounced “siss-jendur”) a person whose gender identity and biological sex assigned at birth align (e.g., man and male-assigned). A simple way to think about it is if a person is not trans*, they are cisgender.

- “Cis” is a latin prefix that means “on the same side [as]” or “on this side [of]”

Cisnormativity - (noun) the assumption, in individuals or in institutions, that everyone is cisgender, and that cisgender identities are superior to trans* identities or people. Leads to invisibility of non-cisgender identities
**Closeted** - (adj) an individual who is not open to themselves or others about their (queer) sexuality or gender identity. This may be by choice and/or for other reasons such as fear for one’s safety, peer or family rejection or disapproval and/or loss of housing, job, etc. Also known as being “in the closet.” When someone chooses to break this silence they “come out” of the closet. (See coming out)

**Coming Out** - (1) the process by which one accepts and/or comes to identify one’s own sexuality or gender identity (to “come out” to oneself). (2) The process by which one shares one’s sexuality or gender identity with others (to “come out” to friends, etc.).
- This is a continual, life-long process. Everyday, all the time, one has to evaluate and re-evaluate who they are comfortable coming out to, if it is safe, and what the consequences might be.

**Constellation** - (noun) the arrangement or structure of a polyamorous relationship.

**Cross-dresser** - (noun) someone who wears clothes of another gender/sex.

**Demisexual** - (noun) an individual who does not experience sexual attraction unless they have formed a strong emotional connection with another individual. Often within a romantic relationship.

**Drag King** - (noun) someone who performs masculinity theatrically.

**Drag Queen** - (noun) someone who performs femininity theatrically.

**Emotional/Spiritual Attraction** - (noun) an affinity for someone that evokes the want to engage in emotional intimate behavior (e.g., sharing, confiding, trusting, interdepending), experienced in varying degrees (from little-to-non, to intense). Often conflated with romantic attraction and sexual attraction.

**Feminine Presenting; Masculine Presenting** - (adj) a way to describe someone who expresses gender in a more feminine or masculine way, for example in their hair style, demeanor, clothing choice, or style. Not to be confused with Feminine of Center and Masculine of Center, which often includes a focus on identity as well as expression.

**Feminine of Center; Masculine of Center** - (adj) a word that indicates a range of terms of gender identity and gender presentation for folks who present, understand themselves, relate to others in a more feminine/masculine way. Feminine of center individuals may also identify as femme, submissive, transfeminine, or more; masculine of center individuals may also often identity as butch, stud, aggressive, boi, transmasculine, or more.

**Femme** - (noun & adj) someone who identifies themselves as feminine, whether it be physically, mentally or emotionally. Often used to refer to a feminine-presenting queer woman.
Fluid(ity) - (adj) generally with another term attached, like gender-fluid or fluid-sexuality, fluid(ity) describes an identity that may change or shift over time between or within the mix of the options available (e.g., man and woman, bi and straight)

FtM / F2M; MtF / M2F - (adj) abbreviation for female-to-male transgender or transsexual person; abbreviation for male-to-female transgender or transsexual person.

Gay - (adj) (1) a term used to describe individuals who are primarily emotionally, physically, and/or sexually attracted to members of the same sex and/or gender. More commonly used when referring to males/men-identified ppl who are attracted to males/men-identified ppl, but can be applied to females/women-identified ppl as well. (2) An umbrella term used to refer to the queer community as a whole, or as an individual identity label for anyone who does not identify as heterosexual.

- “Gay” is a word that’s had many different meanings throughout time. In the 12th century is meant “happy,” in the 17th century it was more commonly used to mean “immoral” (describing a loose and pleasure-seeking person), and by the 19th it meant a female prostitute (and a “gay man” was a guy who had sex with female prostitutes a lot). It wasn’t until the 20th century that it started to mean what it means today. Pretty crazy.

Gender Binary - (noun) the idea that there are only two genders - male/female or man/woman and that a person must be strictly gendered as either/or.

Gender Expression - (noun) the external display of one’s gender, through a combination of dress, demeanor, social behavior, and other factors, generally measured on scales of masculinity and femininity. Also referred to as “gender presentation.”

Gender Fluid - (adj) gender fluid is a gender identity best described as a dynamic mix of boy and girl. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more man some days, and more woman other days.

Gender Identity - (noun) the internal perception of an one’s gender, and how they label themselves, based on how much they align or don’t align with what they understand their options for gender to be. Common identity labels include man, woman, genderqueer, trans, and more.

- Generally confused with biological sex, or sex assigned at birth

Gender Non-Conforming (GNC) - (adj) someone whose gender presentation, whether by nature or by choice, does not align in a predicted fashion with gender-based expectations.

Gender Normative / Gender Straight - (adj) someone whose gender presentation, whether by nature or by choice, aligns with society’s gender-based expectations.
Genderqueer - (adj) a gender identity label often used by people who do not identify with the binary of man/woman; or as an umbrella term for many gender non-conforming or non-binary identities (e.g., agender, bigender, genderfluid). Genderqueer people may think of themselves as one or more of the following, and they may define these terms differently:

- may combine aspects man and woman and other identities (bigender, pangender);
- not having a gender or identifying with a gender (genderless, agender);
- moving between genders (genderfluid);
- third gender or other-gendered; includes those who do not place a name to their gender having an overlap of, or blurred lines between, gender identity and sexual and romantic orientation.

Gender Variant - (adj) someone who either by nature or by choice does not conform to gender-based expectations of society (e.g. transgender, transsexual, intersex, gender-queer, cross-dresser, etc.).

Gynosexual/Gynephilic - (adj; pronounced “guy-nuh-seks-shu-uhl”) attracted to woman, females, and/or femininity

Heteronormativity - (noun) the assumption, in individuals or in institutions, that everyone is heterosexual, and that heterosexuality is superior to all other sexualities. Leads to invisibility and stigmatizing of other sexualities. Often included in this concept is a level of gender normativity and gender roles, the assumption that individuals should identify as men and women, and be masculine men and feminine women, and finally that men and women are a complimentary pair.

Heterosexism - (noun) behavior that grants preferential treatment to heterosexual people, reinforces the idea that heterosexuality is somehow better or more “right” than queerness, or makes other sexualities invisible

Heterosexual - (adj) a person primarily emotionally, physically, and/or sexually attracted to members of the opposite sex. Also known as straight.

Homophobia - (noun) an umbrella term for a range of negative attitudes (e.g., fear, anger, intolerance, resentment, erasure, or discomfort) that one may have towards members of LGBTQ community. The term can also connote a fear, disgust, or dislike of being perceived as LGBTQ. The term is extended to bisexual and transgender people as well; however, the terms biphobia and transphobia are used to emphasize the specific biases against individuals of bisexual and transgender communities.

- May be experienced inwardly as an individual begins to question their own sexuality

Homosexual - (adj) a [medical] term used to describe a person primarily emotionally, physically, and/or sexually attracted to members of the same sex/gender. This term is
considered stigmatizing due to its history as a category of mental illness, and is discouraged for common use (use gay or lesbian instead).

- Until 1973 “Homosexuality” was classified as a mental disorder in the DSM (Diagnostic and Statistical Manual of Mental Disorders). This is just one of the reasons that there are such heavy negative and clinical connotations with this term.

- There was a study done prior to DADT (Don’t Ask, Don’t Tell) being revoked about peoples’ feelings towards open queer service members. When asked, “How do you feel about open gay and lesbian service members,” there was about 65% support (at the time).” When the question was changed to, “How do you feel about open homosexual service members,” the same demographic of people being asked - support drops over 20%. There are different connotations to the word homosexual then there are to gay/lesbian individuals that is powerful and salient both to straight and queer people.

**Intersex** – (adj) someone whose combination of chromosomes, gonads, hormones, internal sex organs, and genitals differs from the two expected patterns of male or female. In the medical care of infants the initialism DSD (“Differing/Disorders of Sex Development”).

- Often seen as a problematic condition when babies or young children are identified as intersex, it was for a long term considered an “emergency” and something that doctors moved to “fix” right away in a newborn child. There has been increasing advocacy and awareness brought to this issue and many individuals advocate that intersex individuals should be allowed to remain intersex past infancy and to not treat the condition as an issue or medical emergency.

**Lesbian** – (noun/adj) a term used to describe females/women-identified people attracted romantically, erotically, and/or emotionally to other females/women-identified people.

- The term lesbian is derived from the name of the Greek island of Lesbos and as such is sometimes considered a Eurocentric category that does not necessarily represent the identities of black women and other non-European ethnic groups.

- Many individual women from diverse ethnic groups, including black women, embrace the term “lesbian” as an identity label.

- While many women use the term lesbian, many women also will describe themselves as gay, this is a personal choice. Many prefer the term gay because of its use in adjective form.

**LGBTQ / GSM / DSG / +** - (adj) initialisms used as shorthand or umbrella terms for all folks who have a non-normative (or queer) gender or sexuality, there are many different initialisms people prefer. **LGBTQ** is Lesbian Gay Bisexual Transgender and Queer and/or Questioning (sometimes people at a + at the end in an effort to be more inclusive); **GSM** is Gender and Sexual Minorities; **DSG** is Diverse Genders and Sexualities. Other popular options include the initialism GLBT and the acronym QUILTBAG (Queer [or Questioning] Undecided Intersex Lesbian Trans* Bisexual Asexual [or Allied] and Gay [or Genderqueer]).

- There is no “correct” initialism or acronym -- what is preferred varies by person, region, and over time
The efforts to represent more and more identities led to some folks describing the ever-lengthening initialism as “Alphabet Soup,” which was part of the impetus for GSM and DSG.

**Lipstick Lesbian** - (noun) Usually refers to a lesbian with a feminine gender expression. Can be used in a positive or a derogatory way. Is sometimes also used to refer to a lesbian who is assumed to be (or passes for) straight.

**Metrosexual** - (noun & adj) a man with a strong aesthetic sense who spends more time, energy, or money on his appearance and grooming than is considered gender normative.

**Masculine of Center** - (adj) a word that indicates a range personal understanding both in terms of gender identity and gender presentation of lesbian/queer women who present, understand themselves, relate to others in a more masculine way. These individuals may also often identity as butch, stud, aggressive, boi, trans-masculine among other identities.

**MSM / WSW** - (noun) initialisms for “men who have sex with men” and “women who have sex with women,” to distinguish sexual behaviors from sexual identities (e.g., because a man is straight, it doesn’t mean he’s not having sex with men). Often used in the field of HIV/Aids education, prevention, and treatment.

**Mx.** - (typically pronounced mix) is an title (e.g. Mr., Ms., etc.) that is gender neutral. It is often the option of choice for folks who do not identify within the cisgender binary.

**Outing** - (verb) involuntary or unwanted disclosure of another person’s sexual orientation, gender identity, or intersex status.

**Pansexual** - (adj) a person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions

- sometimes shortened to pan

**Passing** - (verb) (1) a term for trans* people being accepted as, or able to “pass for,” a member of their self-identified gender/sx identity (regardless of birth sex) without being identified as trans*. (2) An LGB/queer individual who is believed to be or perceived as straight.

- Passing is a controversial term because it often is focusing on the person who is observing or interacting with the individual who is “passing” and puts the power/authority in observer rather than giving agency to the individual
- While some people are looking to “pass” or perhaps more accurately be accepted for the identity that they feel most aligns with who they are “passing” is not always a positive experience
- Some individuals experience a sense of erasure or a feeling of being invisible to their own community when they are perceived to be part of the dominant group.
Polyamory/Polyamorous - (noun/adj) refers to the practice of, desire to, or orientation towards having ethically, honest, consensually non-monogamous relationships (i.e. relationships that may include multiple partners). This may include open relationships, polyfidelity (which involves more than two people being in romantic and/or sexual relationships which is not open to additional partners), amongst many other set ups. Some poly(amorous) people have a “primary” relationship or relationship(s) and then “secondary” relationship(s) which may indicate different allocations of resources, time, or priority.

Questioning - (verb ; adjective) - exploring one’s own sexual orientation or gender identity; or an individual who is exploring their own sexual orientation and gender identity.

Queer - (adj) used as an umbrella term to describe individuals who don’t identify as straight. Also used to describe people who have non-normative gender identity or as a political affiliation. Due to its historical use as a derogatory term, it is not embraced or used by all members of the LGBTQ community. The term queer can often be use interchangeably with LGBTQ.

- If a person tells you they are not comfortable with you referring to them as queer, don’t. Always respect individual’s preferences when it comes to identity labels, particularly contentious ones (or ones with troubled histories) like this.
- Use the word queer only if you are comfortable explaining to others what it means, because some people feel uncomfortable with the word, it is best to know/feel comfortable explaining why you choose to use it if someone inquires.

Romantic Attraction - (noun) an affinity for someone that evokes the want to engage in relational intimate behavior (e.g., flirting, dating, marriage), experienced in varying degrees (from little-to-non, to intense). Often conflated with sexual attraction or emotional/spiritual attraction.

Same Gender Loving / SGL - (adj) a term sometimes used by members of the African-American/black community to express an alternative sexual orientation without relying on terms and symbols of European descent.

Sexual Attraction - (noun) an affinity for someone that evokes the want to engage in physical intimate behavior (e.g., kissing, touching, intercourse), experienced in varying degrees (from little-to-non, to intense). Often conflated with romantic attraction or emotional/spiritual attraction.

Sexual Orientation - (noun) the type of sexual, romantic, emotional/spiritual attraction one feels for others, often labeled based on the gender relationship between the person and the people they are attracted to (often mistakenly referred to as sexual preference)

Sexual Preference - (1) the types of sexual intercourse, stimulation, and gratification one likes to receive and participate in. (2) Generally when this term is used, it is being mistakenly
interchanged with “sexual orientation,” creating an illusion that one has a choice (or “preference”) in who they are attracted to.

**Sex Reassignment Surgery / SRS** - A term used by some medical professionals to refer to a group of surgical options that alter a person’s biological sex. “Gender confirmation surgery” is considered by many to be a more affirming term. In most cases, one or multiple surgeries are required to achieve legal recognition of gender variance. Some refer to different surgical procedures as “top” surgery and “bottom” surgery to discuss what type of surgery they are having without having to be more explicit.

**Skoliosexual** - (adj) attracted to genderqueer and transsexual people and expressions (people who don’t identify as cisgender)

**Stud** - (noun) a term most commonly used to indicate a black/African-American and/or Latina masculine lesbian/queer woman. Also known as ‘butch’ or ‘aggressive’.

**Third Gender** - (noun) a term for a person who does not identify with either man or woman, but identifies with another gender. This gender category is used by societies that recognise three or more genders, both contemporary and historic, and is also a conceptual term meaning different things to different people who use it, as a way to move beyond the gender binary.

**Top Surgery** - (noun) this term refers to surgery for the construction of a male-type chest or breast augmentation for a female-type chest.

**Trans*/Transgender** - (adj) (1) An umbrella term covering a range of identities that transgress socially defined gender norms. Trans with an * is often used to indicate that you are referring to the larger group nature of the term. (2) A person who lives as a member of a gender other than that expected based on assigned sex at birth.

- Because sexuality labels (e.g., gay, straight, bi) are generally based on the relationship between the person’s gender and the genders they are attracted to, trans* sexuality can be defined in a couple of ways. Some people may choose to self-identify as straight, gay, bi, lesbian, or pansexual (or others, using their gender identity as a basis), or they might describe their sexuality using other-focused terms like gynosexual, androsexual, or skoliosexual

**Transition(ing)** - (noun & verb) this term is primarily used to refer to the process a trans* person undergoes when changing their bodily appearance either to be more congruent with the gender/sex they feel themselves to be and/or to be in harmony with their preferred gender expression.

**Transman; Transwoman** - (noun) An identity label sometimes adopted by female-to-male transgender people or transsexuals to signify that they are men while still affirming their history as assigned female sex at birth. (sometimes referred to as transguy) (2) Identity label.
sometimes adopted by male-to-female transsexuals or transgender people to signify that they are women while still affirming their history as assigned male sex at birth.

**Transphobia** - (noun) the fear of, discrimination against, or hatred of trans* people, the trans* community, or gender ambiguity. Transphobia can be seen within the queer community, as well as in general society.

**Transsexual** - (noun & adj) a person who identifies psychologically as a gender/sex other than the one to which they were assigned at birth. Transsexuals often wish to transform their bodies hormonally and surgically to match their inner sense of gender/sex.

**Two-Spirit** - (noun) is an umbrella term traditionally used by Native American people to recognize individuals who possess qualities or fulfill roles of both genders

**Ze / Hir** - alternate pronouns that are gender neutral and preferred by some trans* people. Pronounced /zee/ and /here/ they replace “he” and “she” and “his” and “hers” respectively. Alternatively, some people who are not comfortable/do not embrace he/she use the plural pronoun “they/their” as a gender neutral singular pronoun.

Identity Signs

This activity focuses on what our salient identities are in particular circumstances. How do our different identities intersect, interact, and affect our daily lives?

Necessary supplies

- Identity signs to hang up around the room

Goals & objectives

To allow a space for people in the participant group to discuss their different salient identities and to understand, on a more interpersonal level, the experiences of others

To demonstrate that even people who identify in the same way can experience different levels of (self) consciousness around a particular identity

To talk about how we experience our identities on a day to day basis

Step-by-step walk through

If possible before the workshop beings hang identity signs around the room. If not hang them before beginning the activity.

1. Explain the activity. Example: “Ok, we’re going to do an activity called "Identity Signs". As you can see there are different identity categories hung up around the room - (name each identity category). In a minute, I’m going to ask you all to stand up and I’m going to read out a question that has a blank in it. You will then move under the sign that best fills in that blank. Is anyone not clear on those directions? I’ll read out the first question and if you’re not sure what to do at that point we will discuss what to do.”

2. Get everyone standing up!

3. Read out the first question - clarify what you would like people to do.

4. Ask if anyone would like to talk about why they choose that identity or what their lived experience is like with that identity applying to that question. Allow for a few different people to share their thoughts. If everyone seems particularly eager then allow everyone to talk. Before you want to move on, let people know that someone will be the last one to talk, “Billy do you want to share before I ask another question?” This allows for a smoother transition.

5. Repeat with another question.

6. After you finish with the questions or the activity seems to be losing steam, close up with one last question and then do a wrap up of the activity.

Questions List

1. The part of my identity that I am most aware of on a daily basis is________.

2. The part of my identity that I am the least aware of on a daily basis is________.

3. The part of my identity that was most emphasized or important in my family growing up was________.
4. The part of my identity that I wish I knew more about is _________.

5. The part of my identity that garners me the most privilege is _________.

6. The part of my identity that I believe is the most misunderstood by others is _________.

7. The part of my identity that I feel is difficult to discuss with others who identify differently _________.

8. The part of my identity that makes me feel discriminated against is _________.

Guiding questions
Debrief the activity. Ask what people found surprising about the activity, or if anyone had anything more to add.

Discuss what the activity was like to do - people often name that they didn't realize how much they have in common with one another or that they were surprised about how they answered the questions

Build off of comments that may address that it was difficult, or that participants don't often think about all the parts of their identities. Draw parallels to people and talk about how one person’s frustration with people not understanding their sexuality can be a similar experience to someone else's frustration around their gender presentation. Do not use language that says one experience is harder than the other, the important element is that we can all have similar or shared experiences with our identities even when the identities are incredibly different. experiences but

Discuss how thinking about these identity categories affect us in our other identities as students self and what impact our identities has on being an educator, student, leader, team player, etc...

Make it your own
You could do this silently and reflectively - asking people to write down their thoughts/experiences/choices on a piece of paper after every question. Then you could have people reflect in a small group on the process, or switch the papers and ask people to act out and read out a different individuals sheet

Notes
It is important that this activity focuses talking on the different identity experiences and not on comparing the experiences of the different individuals. One person’s experience is not less severe or more important than another’s, and it is important to keep the questions to be about everyone’s individual truths.

Identity Categories for Signs
Sexual Orientation; Race; Class; Gender Identity; Ethnicity; Gender Presentation; Religion; Immigration Status

First Impressions of LGBTQ People

Reflective 101 Low Trust 10 mins LGBTQ

Goals & objectives

● To explore participants’ first awareness of queer and trans* identities
● Help people realize how socialization has impacted their understanding and predispositions toward gender and sexuality
● To make salient where participants are coming from and where you came from and the evolution and changes in everyone’s understanding over the years

Step-by-step walk through

1. Refer participants to the participant sheet, and let them know to ask you if they have any questions.
2. Tell them they have 5 minutes to answer, and to write as much as they can.
3. Engage in a dialogue debriefing the participants’ experiences answering the questions, thoughts on their answers, and then their answers to the final question in particular.
4. Wrap-up the activity.

Wrap-up

These are questions you may have never considered, or have answered many times throughout your life. Your answers are important to keep in mind as we continue this training, because your past experiences influence your current predispositions, and it’s important to unpack what we already know and believe before we try to learn new things or open our minds to new experiences.

Make it your own

The questions can be modified to focus more specifically on particular identities if you are doing a targeted training.

If you lead a small discussion after allowing participants to share their responses and discuss their implications - make note though this will take up more time than allotted for. Discussion questions could include: What was it like do this activity?
Were there any thoughts or realizations you had that surprised you? Is there anything that you wrote down for any of the questions that you’d like to share? Why do you think it is important to consider these types of questions?

**First Impressions of LGBTQ People - Participant Sheet**

*Answer the following questions to the best of your ability:*

1. When’s the first time you can remember learning that not all people identified as straight and that some identified as lesbian, gay, bisexual, or other queer identities?

2. Where did most of the influence of your initial impressions/understanding of lesbian, gay, bisexual, or other queer people come from? (e.g., family, friends, television, books, news, church)

3. When’s the first time you can remember learning that not all people identified as cisgender and that some people identified as trans*?

4. Where did most of the influence of your initial impressions/understanding of trans* people come from? (e.g., family, friends, television, books, news, church)

5. How have your impressions/understanding of LGBTQ people changed or evolved throughout your life?

Video Case Conceptualization

Show: Master of None
Episode: Thanksgiving
Scene: Thanksgiving, 2006 (3:09)

ACTIVITY

In small groups of two or three, discuss the following questions:

➢ If Denise and her mother were your clients, how would you conceptualize the content and process of this scene from an affirmative and intersectional perspective?

➢ What systems, spoken or unspoken, are impacting Denise and her mother?

➢ How are Denise’s personal identities impacted by these systems?

➢ As a counselor, what might you say or do next in this session?

➢ What biases or assumptions came up for you in watching or analyzing this clip?

*Activity designed by the researcher.

Case Study

Tony, a 24-year-old Mexican American cisgender man, attends counseling after being referred by his college advisor. Tony notes, “I think I need to figure some stuff out about my sexuality.” He explains, “My girlfriend dumped me because she found out I like guys and women . . . guess she couldn’t handle that.” Tony reports having had several relationships with women and men before dating this girlfriend and the desire to date either gender “if they are the right person for me . . . but to be honest, I don’t know who the right person is because I thought my friend Jose was, but he freaked out when I said I was into him.” He reports difficulty identifying as any orientation in the lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, ally, pansexual/polysexual, and two-spirited (LGBTQI+) community, noting, “Bisexual doesn’t feel right, gay isn’t right, so I don’t know.” Tony reports a traumatic history regarding his orientation, as his parents sent him to what he calls “Be straight or else camp.” During this time, Tony became depressed, even suicidal at times, but he made it through by “doing what they said, at least they thought.” After he turned 18, Tony left his parents’ home and has not “looked back since.” He worked several jobs before landing his current position, tending bar at a busy downtown restaurant where management works with his school schedule. Tony demonstrates high motivation for completing his bachelor’s degree so he can go to graduate school to become a counselor himself. Tony notes, “I want to work with other people like me. I don’t want any young person to deal with what I went through.” Tony’s motivation is high, yet he knows “I need to work stuff out. I never got help after that camp, and I want a relationship with my parents someday.”
APPENDIX G
IRB PROPOSAL

Background
Research has shown that lesbian, gay, bisexual, and transgender (LGBTQ+) people are at higher risk for multiple negative mental health outcomes and seek counseling services at higher rates than their heterosexual and cisgender peers (Budge, 2013; Ginicola, Filmore, Smith, & Abdullah, 2017; Institute of Medicine [IOM], 2011; Lynch, Bruhn, & Henricksen, 2013; National Alliance on Mental Illness [NAMI], n.d.; Rutter, Leech, Anderson, & Saunders, 2010). However, Rock, Carlson, and McGeorge (2010) found that more than 60% of counseling students reported that they received no LGB affirmative training in their clinical programs. Furthermore, Bidell (2014) found that general multicultural counseling courses often offered in master’s level counselor training programs did not increase levels of LGB counseling competencies and measured by the Sexual Orientation Counselor Competency Scale (SOCCS, Bidell, 2005). Bidell (2013) also found that attending a graduate level counseling course specifically about LGBTQ+ affirmative counseling was associated with increases in LGB competencies as measured by the SOCCS. Graham and Carney (2012) also found that attendance at a training workshop specifically about LGB competencies (not counting brief conference sessions) was also associated within higher scores on the SOCCS.

My proposed research will advance knowledge in this area in several ways. First, the recent publication of the Trans Counselor Competency Scale will allow me to examine the impact of a two-day training workshop on sexual orientation counselor competencies and transgender counseling competencies. Next, if my results show that a two-day training workshop is significantly related to increases in LGBT counselor competency, the lack of training could be addressed for those counseling students who do not have access to an LGBTQ+ specific counseling course, as well as for counselors who have already graduated and are currently practicing without ever receiving LGBTQ+ competency training. Furthermore, through the incorporation of intersectionality theory as a framework, counselors can learn about the impacts of social stigma and oppression on mental health, particularly for clients who have multiple marginalized identities, such as LGBTQ+ people of color.

Specific Aims
The purpose of this research is to address the lack of training in counseling programs related to development of LGBTQ+ counselor competencies. This is an urgent ethical need given that LGBTQ+ people seek counseling services more often than their heterosexual and cisgender counterparts and face major mental health disparities, as discussed above. The objectives of this mixed-method study are (a) to examine the impact of an intensive two-day training workshop about LGBTQ+ affirmative counseling on the Sexual Orientation Counselor Competency Scale and Trans Counselor Competency Scale scores with a group of master’s level counseling students, and (b) to examine through qualitative interviews the participants’ experiences and understanding of intersectionality theory as it relates to counseling with LGBTQ+ people. I hope to learn whether the training workshop I have developed can help counseling students increase their LGBTQ+ competencies and whether it would be beneficial to the field of counseling to disseminate this research training on a large scale to address the gap in training on a national level.

Research Plan/Study Description
I have designed a mixed-methods study that will consist of a pretest-posttest quantitative component with a treatment and control (delayed treatment) group, as well as qualitative focus
group interviews. The control group will take the pretests and posttests prior to receiving the training, and the treatment group will take the pretest prior to training and the posttest after the training. There will be four total training workshops held. The sequence will be: Treatment group training (January 26 and 27), Control group training (February 2 and 3), Treatment group training (February 9 and 10), and Control group training (February 23 and 24). Participants will be able to choose either the first or second block of trainings based on their availability, but the exact date will be decided based on random assignment to either the treatment group or the control group for each block.

Participants will be able to register for one of the two blocks on Eventbrite. The only information collected in Eventbrite will be (a) name, (b) email address, and (c) choice of first or second block. The participants’ emails will then be placed into contact lists through Qualtrics. During the random assignment process, each participant will be given an ID number. Through the Qualtrics contact list, the participants’ email addresses can be linked to their particular number. Only the researcher will have access to this number, which will be used to link pretest and posttest data together for each participant. The informed consent and all survey data will be collected through Qualtrics. Participants will have the opportunity to also participate in a focus group interview following the treatment group training workshops. These interviews will be audio recorded using a device from the College of Education that has been approved for clinical use. Only the primary researcher will hear the audio recordings to protect the identity of students. These interviews will be transcribed into password-protected Word documents, and the audio recordings will be deleted at that time.

The measurement scales that will be used, the SOCCS and the TCCS, are comprised of the following three subscales: Knowledge, Awareness, and Skills. Therefore, I have developed a training workshop that addresses all three of these domains. These workshops will last from approximately 9am to 4pm on both days (Friday and Saturday). Participants must be over 18 years old and currently enrolled in a master’s level counseling program.

For the quantitative analyses, I will conduct ANOVAs to examine the mean differences between the control and treatment groups on the SOCCS and the TCCS. A series of ANCOCAs will be conducted to examine the mean differences while controlling for potential covariates, such as number of hours of past trainings and number of credit hours already completed in their respective counseling programs. The qualitative interviews will be analyzed using the six-stage thematic analysis process: (1) transcribing and becoming familiar with the data; (2) initial coding, (3) examining codes for themes, (4) reviewing and mapping themes, (5) labeling and defining themes, and (6) reporting the data (Braun & Clarke, 2006; 2012). The hypotheses and research questions are:

1. Is there a significant difference between pretest and posttest scores on the SOCCS for the treatment group when compared to the control group? Are there significant differences for each of the three subscales?
   a. $H_0: \mu_{treatment} = \mu_{control}$
   b. $H_1: \mu_{treatment} \neq \mu_{control}$

2. Is there a significant increase between pretest and posttest scores on the TCCS for the treatment group when compared to the control group? Are there significant differences for each of the three subscales?
   a. $H_0: \mu_{treatment} = \mu_{control}$
   b. $H_1: \mu_{treatment} \neq \mu_{control}$
3. Is there a significant difference between treatment group posttest scores and control group posttest scores on the SOCCS when controlling for pretest scores? Are there significant differences for each of the three subscales?
   a. $H_0: \gamma = 0$
   b. $H_1: \gamma \neq 0$

4. Is there a significant difference between treatment group posttest scores and control group posttest scores on the TCCS when controlling for pretest scores? Are there significant differences for each of the three subscales?
   a. $H_0: \gamma = 0$
   b. $H_1: \gamma \neq 0$

5. Is there a significant difference between treatment group posttest scores and control group posttest scores on the SOCCS when controlling for hours of previous training received? Are there significant differences for each of the three subscales?
   a. $H_0: \gamma = 0$
   b. $H_1: \gamma \neq 0$

6. Is there a significant difference between treatment group posttest scores and control group posttest scores on the TCCS when controlling for hours of previous training received? Are there significant differences for each of the three subscales?
   a. $H_0: \gamma = 0$
   b. $H_1: \gamma \neq 0$

7. What impact does a two-day LGBTQ+ affirmative intersectional training workshop have on Sexual Orientation Counselor Competency Scale scores for entry-level counseling students?

8. What impact does a two-day LGBTQ+ affirmative intersectional training workshop have on Gender Identity Counselor Competency Scale scores for entry-level counseling students?

9. Does a two-day training workshop increase participants scores on the SOCCS and TCCS compared to a control group?

10. Does the training workshop have a significant effect on SOCCS and TCCS scores when controlling for pretest scores?

11. Does the training workshop have a significant effect on SOCCS and TCCS scores when controlling for hours of past training received?

12. Does the training workshop have a significant effect on the subscale scores of the SOCCS when controlling for pretest scores?

13. Does the training workshop have a significant effect on the subscale scores of the SOCCS when controlling for hours of past training received?

14. Does the training workshop have a significant effect on the subscale scores of the SOCCS?

15. How do counseling students describe and explain affirmative intersectional counseling after attending a two-day training workshop?

Possible Discomforts and Risks
The discomfort associated with this study is primarily related to the length of the training workshops. Some participants may find it physically or psychologically uncomfortable to attend two full days of training. Frequent breaks and the provision of drinks and snacks has been incorporated to help alleviate this. If participants travel to Gainesville from out of town to attend
this training, there could be financial costs for them associated with hotel and parking expenses. Because of the group nature of the training and the focus group interview, there are limits to confidentiality. There is no way to ensure for certain that participants will protect each other’s confidentiality, though the importance of doing so will be addressed at the beginning of the workshop.

**Possible Benefits**
This research study can have direct benefits to the participants’ growth and development as counselors and their competencies when working with LGBTQ+ clients. Therefore, there may also be benefits to students current or future clients due to this increase in competencies. If results show that the training workshop is associated with increased competency scores, this research could benefit the field of counseling and the larger client population through the dissemination of the results and the training workshop program.

**Conflict of Interest**
There are no conflicts of interest that I am aware of.
LIST OF REFERENCES


Grove, J. (2009). How competent are trainee and newly qualified counsellors to work with lesbian, gay, and bisexual clients and what do they perceive as their most effective learning experiences? Counselling & Psychotherapy Research, 9(2), 78–85.


BIOGRAPHICAL SKETCH

Rachel Henesy was born in St. Petersburg, Florida and is the sister to six siblings. She attended Seminole and Osceola High Schools, and earned her undergraduate degrees from Santa Fe College and Saint Leo University. In 2014, she completed her M.A.E. and Ed.S. degrees in Mental Health Counseling at the University of Florida. Following graduation, she worked as a clinician in an inpatient crisis intervention unit before returning to the University of Florida to pursue her doctorate in counselor education. She is passionate about social justice and service to the community, and has held several volunteer positions, including Graduate Student Representative for the Florida Association for LGBT Issues in Counseling, among others. She is excited to continue her work in teaching, research, and service in a university setting.