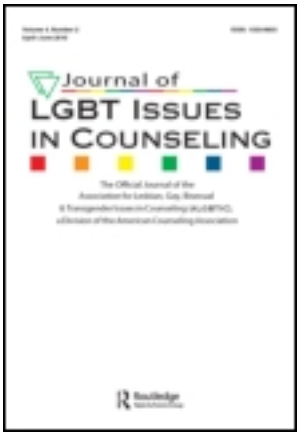

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Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals

ALGBTIC LGBQQIA Competencies Taskforce , Amney Harper , Pete Finnerty , Margarita Martinez , Amanda Brace , Hugh C. Crethar , Bob Loos , Brandon Harper , Stephanie Graham , Anneliese Singh , Michael Kocet , Linda Travis , Serena Lambert , Theodore Burnes , Lore M. Dickey & Tonya R. Hammer

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Approved by the ALGBTIC Board on June 22, 2012

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I. INTRODUCTION

Theoretical Framework and Background

This document is intended to provide counseling and related professionals with competencies for working with lesbian, gay, bisexual, queer, intersex, questioning and ally (LGBQIQA) individuals, groups, and communities. Those who train, supervise, and/or educate counselors may also use these competencies as a framework for training, practice, research, and advocacy within the counseling profession to facilitate trainee growth toward LGBQIQA competence. Transgender people are not addressed in this document as the document *American Counseling Association's (ACA) Competencies for Counseling with Transgender Clients* (2010) specifically addresses counseling with these individuals.

The aim of these competencies is to provide a framework for creating safe, supportive, and caring relationships with LGBQIQA individuals, groups, and communities that foster self-acceptance and personal, social, emotional, and relational development. The current competencies are geared toward working with adult individuals, groups, and communities, and though much

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that is written is applicable to children and adolescents, counseling professionals and related professionals should certainly take into consideration the specific developmental needs in their work with individuals across the life span. Furthermore, as each counseling professional enters their work with LGBQIQA individuals, groups, and communities at a different level of competence, the body of this document and the resources at the end are intended to provide direction for growth in knowledge, skills, and awareness for counselors. However, counselors should always seek appropriate consultation and supervision with an individual who has knowledge, awareness, and skills working with LGBQQ individuals for continued self-reflection and personal growth to ensure that their own biases, skill, or knowledge deficits about LGBQQ persons do not negatively affect the helping relationships.

The authors also felt it was important to be transparent about our personal biases and perspectives as we wrote the current competencies, to provide those who would use this document with an understanding about its creation. The authors of the competencies represent a wide range of professionals: recent graduates, counselors, counseling psychologists, and counselor educators. Additionally, the authors have a wide variety of personal backgrounds, lived experiences, gender identities, affectional orientations, and other identities (e.g., race/ethnicity, ability, class, religious/spiritual affiliation). This range of identities and experiences certainly affected our perspective as we developed the current competencies, as well as lent depth to our work developing them. Early on, knowing we had such a variety of backgrounds, we sought to come to an agreement about the theoretical perspectives that would guide our work. What we agreed upon is that it was important to us to provide a strength-based, feminist, multicultural, social justice perspective. These theoretical perspectives also ground the *ACA Competencies for Counseling with Transgender Clients* (ACA, 2010), and this document was an important resource in developing the current LGBQIQA competencies.

Collectively we believe in the resiliency and strength of the LGBTQIQA community. We also believe that the role that counseling and related professionals assume in working with individuals, groups, and communities is a very important one and that the relationships we build have the potential to serve to affirm and honor the lived experiences of LGBQIQA individuals. To do so, it is important that counseling and related professionals have a strong base of knowledge, skills, and awareness in working with LGBQIQA individuals, groups, and communities. To do so, it is especially important that counseling and related professionals have an understanding of the social justice issues that affect these groups.

The central role of social justice in the lives of LGBTQIQA individuals, groups, and communities can be explained well by understanding the minority stress model (Meyer, 2003), which greatly influenced the work in these competencies. The minority stress model describes that individuals who hold

minority status (LGBTQIQA identities) experience daily stressors above and beyond the day-to-day stressors that everyone experiences (alarm doesn't go off, flat tire, annoying coworker). These stressors result from the pervasive nature of oppression within our societies, and they result in an increase in overall stress for individuals with minority status. The intensity of such stressors can range from microaggressions up to and including the threat or actuality of physical violence, even death. *Microaggressions* are defined within the context of racism as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (Sue et al., 2007, p. 271). The authors believe the spirit and letter of this definition apply equally to LGBTQIQA individuals, groups, and communities.

Historically, the mental health community has pathologized LGBTQIQA individuals, groups, and communities. However, the authors believe that struggles arise not as a result of individual dysfunction, but as a result of a natural response to increased stress of living in an environment that is hostile to those who hold a particular identity. It is for this reason, the authors believe that it is important to extend the role of counseling and related professionals beyond the confines of their individual practices or settings to address the systemic issues that are responsible for these added stressors. In accordance with the *ACA Advocacy Competencies* (Lewis, Arnold, House, & Toporek, 2002; Toporek, Lewis, & Crethar, 2009), the authors of this document believe that it is important to advocate with and for LGBQIQA individuals, groups, and communities to continue to promote their empowerment and a more socially just society. Thus the following competencies incorporate these perspectives into each area as a focal point for work with LGBQIQA individuals, groups, and communities.

LGBQIQA Language and Definitions

The language used throughout these competencies is an attempt to recognize and utilize the most common, current, and inclusive language that is in use as well as is consistent with the language found commonly in scholarly literature. There are limitations with how inclusive and empowering certain terms are due to their historical use. For example, the terms *lesbian*, gay, and *bisexual* are commonly understood in terms of the gender binary. However, there are individuals who utilize these terms but have a more broad and inclusive understanding for themselves (e.g., Bisexuals who are affectionally oriented to a wider range of gender identities and expressions beyond just "woman" and "man"). Additionally, language is constantly evolving, and therefore the language used in this document will become outdated over the course of time. The terminology included in the appendix does not fully address the wide diversity of language in use across North America, much less the remainder of the world. There are many terms that are in less

frequent use and are not present here due to the limitations of the scope of this document, such as *omnisexual, two-spirit, woman loving woman, men who have sex with men, genderqueer*, and so on. The authors acknowledge the use of these terms and any others that are not present in our work and encourage the use of language by LGBTQIQA individuals, groups, and communities that are empowering or that challenge the current limitations of language.

Additionally, throughout the document we have used the terms *internalized homophobia*, *biphobia*, and *transphobia* instead of using newer terms like *internalized heterosexism*. The authors agree with the spirit of the term *internalized heterosexism*, as it focuses on how institutionalized and systemic heterosexist messages from society are internalized rather than individual attitudes about oneself. However, though it is a good substitution for *internalized homophobia*, it does not address the nuances of different identities that are found in the three terms we chose to use. Additionally, the terms we chose are in more common use currently in the general population, and in this instance we chose what is more common over what is more current for the reasons discussed here. We encourage readers, however, to be critical of how they understand internalized oppression to connect it to larger, systemic issues and to be careful not to attribute it to individual fears or hatreds.

The authors also acknowledge that gender and sex exist along a continuum and are not exclusive to the gender binary system, which dominates most of discourse in counseling. The authors urge counselors to acknowledge the client's selected identity(s) and language as an effort to foster self-determinism and empowerment, and also to reflect on their own general use of language to utilize words and/or labels that are inclusive, preferred, and empowering. The authors also recognize that the language we use may hold various meanings for different individuals; therefore, for the sake of clarity, we have provided our understanding and use of the language utilized in these competencies in the appendix. In addition to defining terms that are used in this document, we have also included some words that the authors feel important for the readers to understand why we did not choose to use those terms.

Acronyms Used in This Document

In addition to understanding the terminology in the document, we also felt it important for the reader to understand the acronyms used in this document. In the first eight Council for Accreditation of Counseling and Related Educational Programs (CACREP) areas, for example, we use *LGBQQ* (Lesbian, Gay, Bisexual, Queer, and Questioning) to refer to those identities that are focused on in these areas (CACREP, 2009). We use *LGBTQIQ* (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Questioning) when we are seeking to discuss the shared aspects of oppression of these groups. We use *LGBTQIQA* (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Questioning, and

Ally) to refer to communities. Please note that we have capitalized these terms to highlight the identities of focus in this document as well to affirm these identities in an empowering way that speaks to pride, the use of voice, and the importance of having a positive self-identification.

In addition, we have chosen to use the term *communities* throughout the document instead of the singular version *community* to acknowledge the diversity among LGBTQIQA communities. Although certainly there is a sense of "community" among all LGBTQIQA groups, regional and local differences, as well as the diversity of the make-up of group membership (geographic, intersecting identities, philosophical identities/ideas) from one group to the next are important to consider when working with any particular community. As is the case in working with individuals, understanding these differences is paramount to honoring, respecting, and understanding the particular community with which one works.

Current Issues and Stances on LGBQIQA Counseling

Throughout this document, counseling professionals are encouraged to educate themselves regarding the many current issues in the field that affect the lived experiences of LGBQIQA individuals. The authors feel it important to be clear about our perspectives regarding the issues of reparative therapy, physiological changes forced on Intersex individuals and the relative dearth of empirical and qualitative data regarding effectively serving this population. Reparative therapy (also known as conversion therapy, reorientation therapy, sexual orientation change efforts) is the practice of attempting to change or alter the affectional orientation of an individual from Lesbian, Gay, Bisexual, Queer, or Questioning to that of heterosexual. Consistent with the stance taken by the ACA and the American Psychological Association (APA), the authors hold that attempts to alter ones' affectional orientation (reparative therapy) "are unlikely to be successful and involve some risk of harm" (APA, 2010, p. v). Additionally, the authors believe reparative therapy poses serious ethical concerns because of the risks to clients.

Understand that attempts to "alter," "repair," "convert," or "change" the affectional orientations or gender identities/expressions of LGBQQ individuals are detrimental or may even be life threatening, are repudiated by empirical and qualitative findings, and must not be undertaken. When individuals inquire about previously noted techniques, counselors should advise them of the potential harm related to these interventions and focus on helping individuals to achieve a healthy, congruent affectional orientation or gender identity/expression. Counseling approaches that are affirmative of these identities and realities are supported by empirical findings, best practices, and professional organizations such as ACA and APA.

A second issue within the counseling field that is discussed in these competencies relates to the practice of any forced changes for Intersex

individuals. Consistent with a resolution passed by the Governing Council of ACA and the position of the Intersex Society of North America (ISNA), the authors are opposed to any practices that promote forced changes of Intersex individuals. In addition to stating opposition, the authors encourage counseling professionals to advocate for Intersex individuals' right to self-determinism and full disclosure regarding their bodies and health.

The authors also acknowledge the limits of research with LGBQIQA populations due to bias as well as lack of studies normed on the LGBQIQA population, specifically related to intersecting identities (e.g., race and affectional orientation). Additionally, the authors affirm the use of qualitative methodology in research with LGBTQIQA individuals. A strength of this type of research is that it can provide a means to address some of the heteronormative bias that can be present in some quantitative measures and allow for the rich narratives of LGBQIQA individuals themselves to direct subsequent research about their lives, identities, and experiences.

Overall Organizational Structure

The competencies are organized into six main sections (detailed below):

I. Introduction
II. Competencies for working with Lesbian, Gay, Bisexual, Queer, and Questioning Individuals
III. Competencies for Working with Allies
IV. Competencies for Working with Intersex Individuals
V. References and Additional Resources
VI. Appendix

In the first section, Competencies for Working with Lesbian, Gay, Bisexual, Queer and Questioning Individuals, the authors organized the sections according to the 2009 CACREP Standards Sections in accordance with the previous ALGBTIC LGBT (2003) competencies' structure, as follows:

A. Human Growth and Development
B. Social and Cultural Foundations
C. Helping Relationships
D. Group Work
E. Professional Orientation and Ethical Practice
F. Career and Lifestyle Development
G. Assessment
H. Research and Program Evaluation

The Ally section is separated into two parts. The first part provides a framework for counselors themselves who identify as Allies. The second section presents competencies for counseling individuals who identify as Allies.

The Intersex section is organized by first providing some basic information about people who are Intersex, as counselors may not be as familiar with this population as they are with other LGBTQIQA populations. Counseling competencies for working with Intersex individuals are then presented.

The Reference and Additional Resource section lists resources used to develop these competencies as well as some resources the authors felt might be beneficial to readers who are seeking more information to increase their competence. All of the resources are APA formatted and thus are listed alphabetically.

The appendix contains a list of definitions and important concepts used in this document. The definitions are listed alphabetically.

Intersex and Allies Sections

In this revision of the ALGBTIC competencies for working with LGBT individuals, the authors sought to be more inclusive through additionally addressing competencies for working with Queer, Questioning, Intersex, and Ally individuals. The authors note that not all identities are addressed here (e.g., we did not address working with Asexual individuals), and there are many labels that people use that are individual to them or are used by specific cultural groups (e.g., Two-Spirit) that we do not address fully here. As the understanding of counselors and related professionals continues to evolve and LGBTQIQA communities themselves change over time, it is the hope of the authors that these competencies will be revised as needed to reflect these changes, and that research and work will continue to promote further inclusivity.

In this work, there were clear commonalities among some of the concerns and issues that would need to be addressed among LGBQQ individuals. However, the authors felt that individuals who are Intersex or Allies have unique concerns that could not necessarily be subsumed into the main body of the document (following the eight CACREP areas). Instead, these sections are addressed separately to allow the appropriate focus on the unique differences of these two groups. Although the authors believe that this document will add an important piece to understanding what it means to work with these two groups, we also acknowledge that each of these groups deserves the full attention that the Transgender Competencies document provided for Transgender individuals. Although it was outside of the scope of the work of this taskforce, the authors strongly encourage expansion of the Allies and Intersex sections in the future.

II. COMPETENCIES FOR COUNSELING LESBIAN, GAY, BISEXUAL, QUEER, AND QUESTIONING INDIVIDUALS

A. Human Growth and Development

COMPETENT COUNSELORS WILL:

A. 1. Understand that biological, familial, cultural, socioeconomic, and psychosocial factors influence the course of development of affectional orientations and gender identity/expressions.
A. 2. Affirm that LGBQQ persons have the potential to integrate their affectional orientations and gender identity into fully functioning and emotionally healthy lives and relationships.
A. 3. Identify the heterosexism, biphobia, transphobia, homophobia, and homoprejudice inherent in current life-span development theories and account for this bias in assessment procedures and counseling practices.
A. 4. Be aware of the effects internalized homophobia/biphobia/transphobia may have on individuals and their mental health.
A. 5. Notice that developmental periods throughout the life span (e.g., youth, adolescence, young adults, middle adults, older adults) may affect the concerns that LGBQQ clients present in counseling.
A. 6. Recognize how stigma, prejudice, discrimination, and pressures to be heterosexual may affect developmental decisions and milestones in the lives of individuals regardless of the resiliency of the LGBQQ individual.
A. 7. Know that the normative developmental tasks of LGBQQ youth, adolescence, young adults, middle adults, and older adults may be complicated, delayed, or compromised by identity confusion, anxiety and depression, suicidal ideation and behavior, academic failure, substance abuse, physical, sexual, and verbal abuse, homelessness, prostitution, and STD/HIV infection.
A. 8. Understand that the typical developmental tasks of LGBQQ older adults often are complicated or compromised by social isolation and invisibility.
A. 9. Understand that affectional orientation is not necessarily solid, it is or "can be" fluid, and may change over the course of an individual's life span.
A. 10. Recognize the influence of other contextual factors and social determinants of health (e.g., race, education, ethnicity, religion and spirituality, socioeconomic status, role in the family, peer group, geographical region, age, size, gender identity/expression) on the course of development of LGBQQ identities.
A. 11. Understand that LGBQQ individuals' family structures may vary (e.g., multiple coupled parenting families, polyamorous families), and they may belong to more than one group they consider their family.
A. 12. Understand that an LGBQQ individual's family of origin group and/or structure may change over time, especially as it relates to the family's acceptance/rejection of the LGBQQ member, and acknowledge the impact that being rejected from one's family may have on the individual. If problems

exist in the "family of origin," the individual may create a "family of choice" among supportive friends and relatives.

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

A. 14. Recognize that the coming "out" process may impact an individual's return to earlier stages of development that may or may not be congruent with her/hir/his chronological age.

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

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

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

A. 18. Understand that coming out is an ongoing and multilayered process for LGBQQ individuals and that coming out may not be the goal for all individuals. Although coming out may have positive results for persons' ability to integrate their identity into their lives, thus relieving the stress of hiding, for many individuals coming out can have high personal and emotional costs (e.g., being rejected from one's family of origin, losing a job/career, losing one's support system).

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

B. Social and Cultural Diversity

Competent Counselors Will:

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

B. 2. Be aware that language is ever evolving and varies from person to person, honor labels and terms preferred by the client, recognize that language has historically been used and continues to be used to oppress and discriminate against LGBQQ individuals, understand that the counselor is in

a position of power and should model respect for the individual's declared vocabulary.

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

B. 4. Be aware of the social and cultural underpinnings to mental health issues (e.g., high suicide rate of LGBQQ children and adolescents, particularly in response to anti-LGBTQIQA bullying. Also be aware of how anti-Gay bullying affects children and adolescents from all communities, not just LGBTQIQA communities).

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

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

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

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

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

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

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

B. 12. Recognize that spiritual development and religious practices may be important for LGBQQ individuals, yet they may also present a particular

challenge given the limited LGBQQ positive religious institutions that may be present in a given community, and that many LGBQQ individuals may face personal struggles related to their faith and their identity.

C. Helping Relationships

Competent Counselors Will:

C. 1. Acknowledge that affectional orientations are unique to individuals and they can vary greatly among and across different populations of LGBQQ people. Further, acknowledge an LGBQQ individuals' affectional orientation may evolve across their life span.
C. 2. Acknowledge and affirm identities as determined by the individual, including preferred labels, reference terms for partners, and level of "outness."
C. 3. Be aware of misconceptions and/or myths regarding affectional orientations and/or gender identity/expression (e.g., that bisexuality is a "phase" or "stage," that the majority of pedophiles are Gay men, Lesbians were molested or have had bad experiences with men).
C. 4. Acknowledge the societal prejudice and discrimination experienced by LGBQQ persons (e.g., homophobia, biphobia, sexism) and collaborate with individuals in overcoming internalized negative attitudes toward their affectional orientations and/or gender identities/expressions.
C. 5. Acknowledge the physical (e.g., access to health care, HIV, and other health issues), social (e.g., family/partner relationships), emotional (e.g., anxiety, depression, substance abuse), cultural (e.g., lack of support from others in their racial/ethnic group), spiritual (e.g., possible conflict between their spiritual values and those of their family's), and/or other stressors (e.g., financial problems as a result of employment discrimination) that may interfere with LGBQQ individuals' ability to achieve their goals.
C. 6. Recognize that the counselor's own affectional orientation and gender identity/expression are relevant to the helping relationship and influence the counseling process. Use self-disclosure about the counselor's own affectional orientation and gender identity/expression judiciously and only when it is for the LGBQQ individual's benefit.
C. 7. Seek consultation and supervision from an individual who has knowledge, awareness, and skills working with LGBQQ individuals for continued self-reflection and personal growth to ensure that their own biases, skill, or knowledge deficits about LGBQQ persons do not negatively affect the helping relationships.
C. 8. If affectional orientation and/or gender identity/expression concerns are the reason for seeking treatment, counselors acknowledge experience, training, and expertise in working with individuals with affectional orientation and/or gender identity/expression concerns at the initial visit while discussing informed consent and seek supervision and/or consultation as necessary.

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

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

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

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

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

C. 14. Conduct routine process monitoring and evaluation of the counselor's service delivery (treatment progress, conceptualization, therapeutic relationship) and, if necessary, reevaluate their theoretical approach for working with LGBQQ individuals given the paucity of research on efficacious theoretical approaches for working with LGBQQ individuals.

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

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

C. 17. Demonstrate the skills to create LGBQQ affirmative therapeutic environments where disclosure of affectional orientation is invited and supported, yet there are not expectations that individuals must disclose their affectional orientation.
C. 18. Continue to seek awareness, knowledge, and skills with attending to LGBQQ issues in counseling. Continued education in this area is a necessity for competent counseling due to the rapid development of research and growing knowledge base related to LGBQQ experience, community, and life within our diverse, heterocentric, and ever-changing society.

D. Group Work

Competent Counselors Will:

D. 1. Understand LGBQQ group members have the resiliency to live fully functioning, healthy lives despite experiences with prejudice, discrimination, and oppression.
D. 2. Recognize the power the group process has for LGBQQ members in affirming identity, community development, and connection during all group modalities (e.g., psychoeducation, group tasks, counseling, psychotherapy).
D. 3. Recognize that within-group power differentials and oppression among LGBQIQA members may occur, and counselors should be able to use their knowledge of group process and social justice to address such oppression.
D. 4. Demonstrate an awareness of their own affectional orientation, the fluidity of sexuality, and how stereotypes, prejudice, and societal discrimination may have influenced group counselor attitudes toward LGBQQ members.
D. 5. Integrate current research and best practices into group work with LGBQQ individuals, recognizing the paucity of research on group work with LGBQQ individuals, and utilizing supervision and consultation as needed.
D. 6. Acknowledge the challenges and opportunities related to voluntary disclosure of affectional orientation by group members and group leaders.
D. 7. Demonstrate the skills to create group environments where disclosure of affectional orientation is invited and supported, yet there are not expectations that group members must disclose their affectional orientation.
D. 8. Recognize the emotional, psychological, and sometimes physical harm that can come from engaging clients in approaches which attempt to alter, "repair," or "convert" individuals' affectional orientation/gender identity/expression. These approaches, known as reparative or conversion therapy, lack acceptable support from research or evidence and are not supported by the ACA or the APA. When individuals inquire about these above noted techniques, counselors should advise individuals of the potential harm related to these interventions and focus on helping clients achieve a healthy, congruent affectional orientation/gender identity/expression.
D. 9. Acknowledge that group work has been used in the past by mental health professionals to attempt to change a member's affectional orientation/

gender identity/expression and that group members may have valid reasons for mistrust in group settings.

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

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

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

D. 13. Understand the potential benefits of flexibility and collaboration with group members in establishing group rules. For example, a group rule that members do not socialize outside of group may be limiting or impossible for LGBQQ individuals given the close-knit nature of LGBTQIQA communities.

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

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

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

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

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

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

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

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

E. Professional Orientation and Ethical Practice

COMPETENT COUNSELORS WILL:

E. 1. Utilize an ethical decision-making model that takes into consideration the needs and concerns of the LGBQQ individual when facing an ethical dilemma.
E. 2. Utilize a collaborative approach with LGBQQ individuals to work through ethical dilemmas that affect the professional relationship when appropriate.
E. 3. Consult with supervisors/colleagues when their personal values conflict with counselors' professional obligations related to LGBQQ individuals about creating a course of action that promotes the dignity and welfare of LGBQQ individuals.
E. 4. Seek consultation and supervision from an individual who has knowledge, awareness, and skills working with LGBQQ individuals for continued self-reflection and personal growth to ensure that their own biases, skill, or knowledge deficits about LGBQQ persons do not negatively affect the helping relationships.
E. 5. Use language, techniques, and interventions that affirm, accept, and support the autonomy of intersecting identities and communities for LGBQQ individuals.
E. 6. Recognize the emotional, psychological, and sometimes physical harm that can come from engaging clients in approaches which attempt to alter, "repair," or "convert" individuals' affectional orientation/gender identity/expression. These approaches, known as reparative or conversion therapy lack acceptable support from research or evidence and are not supported by the ACA or the APA. When individuals inquire about these above noted techniques, counselors should advise individuals of the potential harm related to these interventions and focus on helping clients achieve a healthy, congruent affectional orientation/gender identity/expression.

Reparative therapy has been formally repudiated as ineffective and even harmful through policies adopted by numerous organizations and associations including the following:

- American Association of School Administrators
- American Academy of Pediatrics
- American Counseling Association
- American Federation of Teachers
- American Medical Association

- American Psychiatric Association
- American Psychoanalytic Association
- American Psychological Association
- Council on Child and Adolescent Health
- The Interfaith Alliance Foundation
- National Academy of Social Workers
- National Education Association
- World Health Organization

E. 7. Continue gaining specialized training/education through professional workshops, reading relevant research, and staying up to date on current events for LGBQQ individuals and the LGBTQIQA community.
E. 8. Recognize and acknowledge that, historically, counseling and other helping professions have compounded the discrimination of LGBQQ individuals by being insensitive, inattentive, uninformed, and inadequately trained and supervised to provide culturally proficient services to LGBQQ individuals and their loved ones. This may contribute to a mistrust of the counseling profession.
E. 9. Recognize the resiliency of LGBQQ individuals and their unique ability to overcome obstacles.
E. 10. Advocate with/for LGBQQ individuals to provide affirming, accepting and supportive counseling services when divergent viewpoints exist between supervisors and supervisees.
E. 11. Advocate with and for LGBQQ individuals on various ecological levels of community systems (e.g., micro, meso, and macro; Toporek et al., 2009) to provide affirming, accepting, and supportive counseling services (e.g., educating the community and promoting changes in institutional policies and/or laws as the mental health of LGBQQ individuals is often affected by stigma and oppression).
E. 12. Be aware of and share relevant LGBTQIQA affirmative community resources with LGBQQ individuals when appropriate.
E. 13. Understand that due to the close-knit nature of LGBTQIQA communities, multiple relationships with LGBQQ individuals are not always avoidable or unethical and may affect the helping relationship. Counselors should seek appropriate supervision and/or consultation to foster ethical practices.

F. Career and Lifestyle Development

Competent Counselors Will:

F. 1. Assist LGBQQ individuals in making career choices that facilitate identity acceptance and job satisfaction.
F. 2. Understand how current career theories may not take into account the unique barriers and challenges that LGBQQ individuals face in their career

paths and integrate the use of career theories in ways that are affirming of the needs of LGBQQ individuals. Understand that the use of particular career theories may not have been normed for LGBQQ individuals, and that interventions based on such theories will need to be assessed for their efficacy.

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

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

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

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

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

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

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

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

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

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

G. Assessment

Competent Counselors Will:

G. 1. Become informed (via empirical and theoretical literature and supervision/consultation with LGBTQIQA communities and resources) of the spectrum of healthy functioning within LGBTQIQA communities. Appreciate that differences should not be interpreted as psychopathology, yet they often have been interpreted in harmful ways to LGBTQIQA individuals/couples/families (e.g., the history of support and use of reparative/conversion therapy within the mental health field).
G. 2. Acknowledge that affectional identity, gender identity, and other intersecting identities (race, ethnicity, class, ability, age) may or may not be the presenting concern for LGBQQ individuals, but that experiences of oppression may impact presenting issue(s).
G. 3. Understand that at times individuals may present more positively to counseling than their actual experiences if they have not identified the oppressions or identity stresses they may have experienced or if they have high levels of internalized oppression. Internalized oppression presents in a variety of ways and can sometimes be difficult to identify. Some examples are an individual who uses heterosexist language while not understanding how this correlates to low self-esteem, low desire for partners, and/or low tolerance for people of the same community; individuals who believe that the stereotypes they hear about their identity are indeed true of all people of that identity; individuals who feel incapable of success because they have heard so many negative things about people whose identity they share.
G. 4. Be aware of how their own biases and/or privileges may influence their assessment with each LGBQQ individual, for example, promoting a particular course of treatment and/or overlooking an individual's challenges.
G. 5. Utilize supervision and consultation (from an individual who has knowledge, awareness, and skills in working with LGBQQ individuals) as a tool to help counselors recognize and minimize biases and avoid misuse/abuse of privilege and power.
G. 6. Understand and be aware of the historical and social/cultural context regarding the practice of assessment, particularly in relation to underserved populations, such as LGBQQ individuals/couples/families.
G. 7. Recognize that assessment procedures can be potentially helpful as well as potentially harmful to individuals/families and be cognizant of the legal and ethical guidelines regarding best-practice standards for assessment with LGBQQ individuals/couples/families, (e.g., ACA Code of Ethics and Standards for Multicultural Assessment). Also be aware that legal codes and

ethical guidelines may conflict, especially where LGBQQ individuals do not have equal rights and protections.

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

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

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

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

G. 12. Become aware of professional education and resources of assessment tools adapted and/or created for LGBQQ individuals/couples/families and how those may be used in conjunction with multicultural and advocacy models to address the whole person and all of their intersecting identities.

G. 13. Review intake paperwork, intake forms, interview methods, initial interventions, screening in the assessment measures to ensure use of inclusive language, which would allow for the fluidity of affectional orientation and gender identities and how those labels (or lack thereof) vary by individual. (For example, allowing space to self-identify gender and affectional orientation and to include intersecting identities such as class, race, ethnicity, ability.)

G. 14. Develop awareness of how technology has affected the counseling profession in regards to appropriate assessment and treatment planning for LGBQIQ individuals (e.g., increased accessibility of LGBQQ communities to information, confidentiality and anonymity of online counseling, and the dangers of dual relationships with the advent of the use of social networking services).

G. 15. Understand how assessment measurements, the *Diagnostic and Statistical Manual of Mental Disorders*, and other diagnostic tools may perpetuate heterosexist, genderist, and sexist norms that negatively affect LGBQQ individuals.

G. 16. Understand any type of labeling that results from assessments may negatively affect LGBQQ individuals, especially labeling of symptomology due to oppression and/or minority stress.

H. Research and Program Evaluation

Competent Counselors Will:

H. 1. Be aware that the counseling field has a history of pathologizing LGBQQ individuals and communities (e.g., studies of homosexuality as a "disorder" and research agendas that seek to "prove" that affectional orientation and/or gender identity/expression can be "changed"). Understand that these approaches to research and program evaluation have been deemed harmful and unethical in their research goals by professional organizations in the field (see Introduction).
H. 2. Be aware of existing LGBQQ research and literature regarding social and emotional well-being and challenges to identity formation, resilience and coping with oppression, as well as ethical and empirically supported treatment options.
H. 3. Have knowledge of the gaps in scholarship and program evaluations regarding understanding the experiences of LGBQQ individuals, families, and communities (e.g., research on couples may not include the experiences of LGBQQ partners or relationship configurations). Understand how this gap widens when other marginalized identities are considered (e.g., LGBQQ people of color, LGBQQ people who are differently abled).
H. 4. Understand how to critically consume research and program evaluations with LGBQQ individuals and communities so that future research endeavors may assist with understanding needs, improving quality of life, empowering LGBQQ individuals, and enhancing counseling effectiveness for LGBQQ individuals.
H. 5. Be current and well informed on the most recent scholarship (e.g., research studies, conceptual work, program evaluation) with LGBQQ individuals and communities.
H. 6. Understand limitations of existing literature and research methods regarding LGBQQ individuals with regard to sampling (e.g., racial/religious diversity), confidentiality issues (e.g., LGBQQ youth who are not "out" to their parents and cannot seek parental consent for participating in studies), data collection (e.g., accessing samples who are not "out"), and generalizability across the distinct identities within LGBQQ identities and experiences (e.g., research on Gay men may not be generalizable across Lesbians or Bisexual men).
H. 7. Seek to be intentional when sampling LGBQQ individuals and communities so that participant samples represent a wide range of diversity (e.g., race/ethnicity, gender, ability status, social class, geographic region, national

origin) and note in limitations when it is not possible to generalize to particular populations.

H. 8. Have knowledge of qualitative, quantitative, and mixed-methods research processes, the application of these methods in potential future research areas such as individual experiences of LGBQQ people, counselor awareness and training on LGBQQ concerns, reduction of discrimination toward LGBQQ individuals, advocacy opportunities for positive social change in the lives of LGBQQ individuals, and strengths of LGBQQ families and parenting.

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

III. ALLIES

Note: In this section, you will notice that *T* is often included in the acronym LGBTQIQA. This is intentional as Allies can be Allies to all members of the LGBTQIQA community.

Section I – Counselors Who Are Allies

In addition to being competent working with LGBTQIQ individuals, counselors who are Allies will demonstrate behaviors and attitudes that may be outside their role as counselors. Counselors who are Allies of the LGBTQIQ community will observe the following guidelines (adapted from Minnesota State University at Mankato, LGBT Center Resource Library, n.d.):

Awareness

Competent Allies Will:

I. 1. Become aware of who they are and how they are different from and similar to LGBTQIQ people. Such awareness can be gained through conversations with LGBTQIQ individuals and communities; reading about LGBTQIQ people, their lives, and their histories; attending workshops, seminars, conferences, and meetings; and self-reflection.

Knowledge:

Competent Allies Will:

I. 2. Educate themselves on current issues affecting LGBTQIQ individuals and communities, through conversations with LGBTQIQ individuals and communities; reading about LGBTQIQ people, their lives, and their histories; and attending workshops, seminars, conferences, and meetings.

I. 3. Know and understand how sociocultural, political, and economic climates and the resulting institutional practices, laws, and policies affect the LGBTQIQ community.
I. 4. Know and understand how LGBTQIQ individuals experience their intersecting identities within their own development and their communities.

Supporting Individuals' Decisions About Coming Out

Competent Allies Will:

I. 5. Acknowledge that the process and extent of coming "out" should be the decision of the individual.
I. 6. Validate the potential struggle of LGBTQIQ persons as they navigate their coming-out process through such techniques as empathic listening and reflective feedback.
I. 7. Allow LGBTQIQ persons to define and place in perspective their own developmental process.
I. 8. Take proactive measures in seeking out a competent and experienced supervisor/consultant with expertise working with LGBTQIQ individuals, use remediation efforts to develop expertise and competence, and make adjustments in providing services as needed.

Facilitate Supportive Environments:

Competent Allies Will:

I. 9. Encourage and promote an atmosphere of respect through such actions as displaying LGBTQIQ-supportive periodicals, books, or posters in the office, or providing take-home LGBTQIQ-oriented literature.
I. 10. Acknowledge, appreciate, and celebrate differences among individuals and within groups (e.g., acknowledging the intersecting identities of a Gay, African-American male of the Muslim faith).
I. 11. Use inclusive and respectful language (e.g., using the term *partner* rather than specific terms like *spouse, wife, husband, boyfriend*, or *girlfriend* in general situations and using specific terms to honor personal choices when directed to do so by the individual).
I. 12. Be a safe and open-minded person to talk with by facilitating open and honest discussions about LGBTQIQ issues.
I. 13. Object to and eliminate jokes and humor that put down or portray LGBTQIQ people in stereotypical ways.
I. 14. Counter statements regarding affectional orientation or gender identities that are not relevant to decisions or evaluations concerning LGBTQIQ individuals (e.g., Responding to statements such as, "Well you know he's Bisexual, but that doesn't matter as long as he does his job" or "Well you

know they are a female couple raising a child so they may not have the resources a 'normal' couple has").
I. 15. Encourage continuing education and professional development activities regarding LGBTQIQ topics.
I. 16. Confirm with LGBTQIQ staff their willingness to consult on LGBTQIQ issues with other staff members.
I. 17. Refrain from referring all LGBTQIQ issues to LGBTQIQ staff/faculty because they may not have any expertise in LGBTQIQ issues and/or their expertise may not be limited to LGBTQIQ issues. Promote an atmosphere where all individuals are encouraged to know about LGBTQIQA identities.
I. 18. Be purposeful in recruitment and retention of staff and faculty who identify as LGBTQIQA.
I. 19. Include affectional orientation and gender identity/expression in discussions of diversity and promote an atmosphere in which LGBTQIQ identities are desired in a multicultural setting.
I. 20. Advocate with administrators to require competency in working with LGBTQIQ individuals (e.g., staff, faculty, students, or clients).
I. 21. Acknowledge that a safe and supportive environment may enable LGBTQIQ people to openly share their identity, among other benefits. However, the decision of when, how, and who to come "out" to should always be made solely by the individual.
I. 22. Recognize that polices ensuring nondiscrimination based on affectional orientation, gender identity, and gender expression are the responsibility of the agency/organization and not the LGBTQIQA individual.
I. 23. Ensure that all clinical-related paperwork and intake processes are inclusive and affirmative of LGBTQIQ individuals (e.g., including "partnered" in relationship status question, allowing individual to write in gender as opposed to checking male or female).

SECTION II – COMPETENCIES FOR COUNSELING ALLIES

This section is specific to a counselor working with individuals who identify as Allies. Allies include friends, family, significant others, colleagues/associates, mentors, those who seek counseling before they identify as Allies and may be heterosexual, cisgender, and/or members of the LGBTQIQ Communities (e.g., a Cisgender, Bisexual Woman who is a Transgender Ally), particularly when the individual holds an identity that has traditionally been marginalized in the LGBTQIQ community. As such, this document refers to the identity labels that are self-assumed, rather than externally applied. Additionally, Ally development varies from individual to individual and should be considered when counselors conceptualize working with an individual on issues related to what being an Ally means (considering the counselor's and individual's own development). Due to the fact that there are more available resources for heterosexual Allies, more information

is available about their development (see resource list in this article for heterosexual ally development model; Poynter, 2007). For example, according to this model, the first status of Ally development includes that the individual does not hold an identity of Ally and/or negative beliefs/attitudes towards LGBTQIQ individuals. This document addresses issues that relate to the various statuses of Ally development and covers a wide range of situations that counselors might encounter in working with individuals related to their role as an Ally. Additionally, due to the lack of research on Allies in general, this document seeks to begin a dialogue and encourage future research in this area.

Competent Counselors Will:

I. 23. Recognize the important contributions of Allies to their respective LGBTQIQA communities and the importance of the support they provide to LGBTQIQA individuals.

I. 24. Help Allies become aware of their own affectional orientation and gender identity and the privilege and/or oppression they face as a result of those identities. Recognize and work with Allies on their cycle of positive acceptance of their privilege and help them realize how they can use their privilege to work with supporting the LGBTQIQA community.

I. 25. Recognize that Allies also have a coming "out" process and that this process has implications for them and their identity. For example, many heterosexual cisgender Allies may ask themselves for the first time about whether to disclose their identity, what the potential risks for doing so in each setting they enter are, and potentially lose privilege as a result of coming out as an Ally.

I. 26. Recognize the potential costs in the workplace for Allies who have advocated for and with LGBTQIQ individuals (e.g., tension, harassment, discrimination, loss of advantages such as possible promotions, loss of employment altogether).

I. 27. Help Allies recognize and process microaggressions, bias incidents, harassment, discrimination, heterosexism, and transphobia that they may have witnessed or experienced. Help empower Allies to minimize the internalization of those messages and to use their voice in speaking out against such acts as determined appropriate by the individuals involved. Recognize that cisgender Heterosexual individuals may also be targets of anti-LGBTQIQ incidents by their association with LGBTQIQ persons.

I. 28. Help cisgender Heterosexual Allies explore oppression they may face in LGBTQIQA Communities, such as use of derogatory terminology like "fag hag" or "fruit fly," or in experiences of others disregarding their identity through statements like "You know you will come out eventually" or negative statements about heterosexuals, such as referring to them as "breeders" or referencing them as the enemy, or myths and stereotypes of cisgender

heterosexual Allies (e.g., every straight woman wants a Gay best friend to shop with).

I. 29. Be aware of their biases regarding Ally privilege(s) and how those biases may influence their assessment of each individual (e.g., promoting a particular course of treatment, overlooking individual's challenges, and/or heterosexism and sexism).

I. 30. Help Allies to be aware of national, state, and local community resources for LGBTQIQA communities (e.g., local Parents and Friends of Lesbians and Gays (PFLAG) Chapter, community LGBTQIQA resource center, LGBTQIQA events in the area, Gay, Lesbian, Straight Education Network [GLSEN]).

I. 31. Where appropriate, help Allies connect with other Allies as mentors and/or role models to develop their own identity as an Ally and help them to develop as role models and mentors.

I. 32. Help heterosexual, cisgender Allies to address issues related to questioning their own identity in relation and response to another's identification as LGBTQIQ. This person may be a sibling, parent, child, family member, spouse, or significant other.

I. 33. Help Allies to understand and incorporate what it means for them to have a significant other, friend, family member, or partner in their life who identifies as LGBTQIQ. Help Allies to explore how and when they can best support their significant other, friend, family member, or partner. In particular, Allies may struggle with core beliefs from spiritual or religious upbringing that may not support LGBTQIQ identities.

I. 34. Recognize the emotional, psychological, and sometimes physical harm that can come from engaging clients in approaches which attempt to alter, "repair," or "convert" individuals' affectional orientation/gender identity/expression (e.g., Allies may ask about these interventions on behalf of their child, friend, family member, spouse). These approaches, known as reparative or conversion therapy, lack acceptable support from research or evidence and are not supported by the ACA or the APA. When individuals inquire about these above noted techniques, counselors should advise individuals of the potential harm related to these interventions and focus on helping them encourage LGBTQIQ individuals to achieve a healthy, congruent affectional orientation/gender identity/expression.

I. 35. Acknowledge that the use of inclusive language by Allies may or may not indicate that they have an LGBTQIQ identity or relate to their presenting concerns (e.g., neutral gender and affectional orientation identities).

I. 36. Help Allies, who are members of the LGBTQIQ communities themselves, to find a healthy balance between advocacy for others and advocacy for themselves. Also acknowledge that advocacy activities may take place on the micro-, meso-, and/or macrolevels (Toporek et al., 2009).

I. 37. Acknowledge that there is a general paucity of research regarding Allies and stay abreast of current research as it becomes available.

I. 38. Be aware that for members of the LGBTQIQ community who also identify as Allies to other identities within the community, sometimes the label of "Ally" is externally applied in an effort to discredit that person's membership in the LGBTQIQ community (e.g., a Bisexual activist is represented in the media as a supporter or Ally of the LGBTQIQA community instead of a member).

IV. INTERSEX

J. Competencies for Counseling People Who Are Intersex

The Competencies for Working with People who are Intersex is divided into two sections, a basic background overview regarding people who are Intersex and then the competencies. Some basic information is provided upfront due to the reality that people who are Intersex have been historically marginalized by the LGBTQIQA community.

Brief Informational Overview on Intersex

What is intersex?

- Although this term is most commonly used to refer to developmental anomalies that result in ambiguous differentiation in of external genitalia (e.g., micropenis, clitormegaly), it may be used to describe the lack of concordance in the chromosomal, gonadal, hormonal, or genital characteristics of an individual.
- Thus a person who is Intersex is born with sex chromosomes, external genitalia, or an internal reproductive system that are not considered "standard" for either "males" or "females" (also known as disorders of sex development).
- Often there is confusion about how individuals who identify as Intersex differ from individuals who identify as Transgender. Although the authors note that Intersex persons may identify and be a part of the Transgender community, we wish to acknowledge that many do not. Therefore we sought to provide a more inclusive, representative section in this document to cover Intersex concerns separately. As noted above there are particular physical developmental considerations that Intersex individuals encounter that differ from individuals who identify as Transgender in general. As noted in the appendix of terminology, persons who are Transgender "challenge social norms" regarding "gender" whereas those persons who are Intersex represent the developmental anomalies noted above regarding differentiation in genitalia, chromosomes, hormones, and so on in regards to biological sex. Although there may be some overlap when Intersex individuals hold a primary identity of Transgender (which can

make it confusing for individuals who have not had extensive connection to these two groups), the important thing to remember with all identities is that counselors should always follow the client's lead in terms of the appropriate terminology, labels, and issues of importance to them individually. This section will hopefully provide a guide to helping individuals whose primary identity is Intersex.

Conditions that can produce intersex.

- Chromosomal abnormalities including: Klinefelter's syndrome (XXY), Turner's syndrome, XXX syndrome (also called "triple X" or "superfemale")
- Congenital adrenal hyperplasia (CAH) (genetic female appears male)
- Fetal exposure to progestins (progestins - oral) or androgens
- Testicular feminization syndrome (TFS)
- Androgen insensitivity syndrome (AIS)
- XY gonadal dysgenesis
- XY gonadal agenesis
- Cryptophthalmos
- Smith-Lemli-Opitz
- 4p syndrome
- 13q syndrome
- Mayer Rokitansky Kuster Hauser syndrome (MRKH)
- Mixed adrenal dysgenesis
- Maternal ingestion of certain medications (particularly androgenic steroids)
- Lack of production of specific hormones, causing the embryo to develop with a female body type regardless of genetic sex
- Lack of testosterone cellular receptors

How common is intersex? The instance of Intersex anomalies has been estimated to be between 1 in every 100 to 1 in every 4,500 (1 in 2,000 is cited most often). This means that it is likely that more babies are born Intersex than those born with cystic fibrosis, the incidence of which is one in 2,500.

What happens when a child is born intersex? Physicians and parents faced with the birth of an Intersex child may choose a treatment strategy that promises the "best outcome" given the current understanding of the complex genetic, hormonal, psychological, and social factors that form an individual's sense of gender identity (Reiner, 1996). Many Intersex conditions do not require immediate medical intervention, especially those that are not apparent at birth.

Concealment versus client-centered models. The concealment-centered model comes from a stance that Intersex is an abnormality that needs to be concealed and/or augmented, whereas the client-centered model regards Intersex as an anatomical variation from the "standard" male and female

	Concealment-Centered Model	Client-Centered Model
What is intersex?	Intersex is an anatomical abnormality that is highly likely to lead to great distress in the family and great distress for the person who is Intersex. Intersex is pathological and requires medical attention.	Intersex is an anatomical variation from the "standard" male and female types; just as skin and hair color vary along a broad spectrum, so does sexual anatomy.
Are Intersex genitals a medical problem?	Yes. Untreated intersex is highly likely to result in depression, suicide, and possibly homosexual orientation. Intersex genitalia must be "normalized" if these problems are to be avoided. (Note: There is no solid evidence for this position, and there is evidence to the contrary.)	No. Intersex genitals are not a medical problem. They may signal an underlying metabolic concern, but they themselves are not diseased; they just look different.
What should be the response to the discovery that a child has been born Intersex?	The correct treatment for Intersex is to "normalize" the abnormal genitals using cosmetic surgical and hormone technologies, and so on. Doing so will eliminate the potential for psychological distress.	The whole family should receive psychological support, including referrals to qualified counselors and peer support groups, as well as complete information regarding their child and options available. Actual medical problems (such as urinary infections) should be treated medically, but all cosmetic treatments should be postponed until the patient can himself/herself consent to them.

sexes, much like the variation in regards to one's hair, skin pigment, or eye color.

Competencies for Working with People who are Intersex

COMPETENT COUNSELORS WILL:

J. 1. Be aware of the various ways in which people who are Intersex come to be born Intersex.
J. 2. Be aware of the commonality of people who are Intersex.
J. 3. Understand the reality that gender exists on a continuum from masculine to androgynous to feminine and that sex exists on a continuum from male to Intersex to female.

J. 4. Learn and use appropriate language to refer to people who are Intersex, with the realization that this language should honor the wishes of the individual as well as be built on an understanding of the current practices in Intersex communities (e.g., The word *Hermy* is being reclaimed by some of the Intersex community. Also, some members of the Intersex community have maintained use of the word *Hermaphrodite* instead of using the term *Intersex* while for others in the community it is considered pejorative or outdated). This language will continue to develop over time as Intersex individuals define themselves.
J. 5. Understand that one's gender is not necessarily tied to one's sex and that affectional orientation is not directly related to either.
J. 6. Understand the gender binary and its impact on people who are Intersex. For example, the gender binary refers to relationships as if only males and females exist (e.g., language such as "same" and "opposite sex"). An example of how the binary is harmful is how terminology regarding affectional orientation is not inclusive of the full spectrum of sex. Terminology that is more inclusive of people who are Intersex include terms such as "omnisexual" or "pansexual" in reference to affectional orientation. These terms are seen as more inclusive of the full spectrum of sex.
J. 7. Be aware of and invite individuals to self-select how they are referenced. For instance, individuals might prefer the use of feminine or masculine pronouns, gender-neutral pronouns such as "co," "hir," "ze," or the use of no pronouns (just proper names) when referring to them.
J. 8. Work as Allies for people who are Intersex, for example understanding the difference between and affirming the concealment model versus the client centered (see table on informational section).
J. 9. Use a systemic and systematic approach when working with people who are Intersex (i.e., collaborating with medical personnel as appropriate).
J. 10. Upon the birth of a child who is Intersex, counselors should provide counseling and support to the whole family whenever possible, offering psychological support and appropriate referrals to resources such as support groups.
J. 11. Counselors should also provide complete information regarding their child and options that are available.
J. 12. Counselors should advocate for the medical treatment of actual medical problems (such as urinary infections) but encourage families to postpone all cosmetic treatments until the child is able to consent to them. This approach is consistent with the consensus in the Intersex movement and takes into account the health and well-being of the child throughout development.
J. 13. Be aware of the Intersex movement, its interface with the legal and medical communities and its impact on people who are Intersex (e.g., the Intersex Society of North America, progressive developments in the United States and in other nations, such as the ability of people who are Intersex to be classified as Intersex instead of Female or Male in Australia).

J. 14. Be aware of the various forms of oppression, discrimination, bias incidents, microaggressions, and stressors that people who are Intersex experience on a daily basis due to societal stigma attached to the presumed dichotomy of sex as well as pressures to remain "closeted."
J. 15. Remain updated on developments in research and theory on the best approaches to working with people who are Intersex and the general paucity of Intersex-related research.
J. 16. Be aware of how the general paucity of research about counseling has been normed on people who are Intersex and thus may not generalize to this population.
J. 17. Be aware of how people who are Intersex are often marginalized in the discussion of LGBTQIQA communities but rarely experience those communities as inclusive or welcoming (e.g., although the *I* for people who are Intersex is often included, the needs and concerns of people who are Intersex are not usually included in the work of the LGBTQIQA community).
J. 18. Be aware of the official stance of the ACA in regard to people who are Intersex (Resolution to Protect Intersex Children from Unwanted Surgery, Secrecy and Shame, April 1, 2004).
J.19. Empower parents to advocate and resist oppression from medical communities and help them to talk directly to their child's doctor themselves without the counselor present.

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APPENDIX

Definitions

Ableism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted toward people who are or are perceived to be disabled, physically, mentally, and/or emotionally. Additionally, the definition of *ability* is socially constructed, and this may or may not match up with one's identity.

Adultism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted toward young people. It is a set of attitudes, ideas, beliefs, and behaviors based on the presumption that adults are superior to young people and thus not entitled to equitable rights and privileges as well as the ability to discriminate against and act upon young people without their agreement.

*Affectional orientation***:** In this document the authors use *affectional orientation* instead of *sexual orientation*. To make this easily understandable by our readership, the authors include our rationale for using this term. *Affectional orientation* refers to the direction (sex, gender identity/expression(s)) an individual is predisposed to bond with and share affection emotionally, physically, spiritually, and/or mentally. The intentional use of *affectional orientation* over the use of the term *sexual orientation* seeks to highlight the multiple layers of relationships (emotional, physical, spiritual, and mental) and deemphasize "sexual" behavior as the sole means of understanding identity. As many people's identities do not line up precisely with their sexual behavior and attraction (as is exemplified in the famous Kinsey studies, where sexual behaviors were studied and the prevalence of "homosexual" and "bisexual" behaviors are much higher than what is generally found in studies that seek to understand how people identify themselves) the use of affectional orientation more accurately reflects the multiple layers of identity.

Ageism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted toward older adults. It is a set of attitudes, ideas, beliefs, and behaviors based on the presumption that older adults are inferior to all other adults, which creates a stigma around the developmental process of aging and denies equitable rights and privileges to older adults, including the ability to discriminate against and act upon older adults without their agreement.

Ally: This term as used in this document refers to a counselor or a client who provides therapeutic or personal support respectively, to a person or persons who self-identify as LGBTQIQ. Allies include friends, family,

significant others, colleagues/associates, mentors, those who seek counseling before they identify as allies and may be heterosexual and cisgender, and/or members of the LGBTQIQ Communities (e.g., A cisgender, bisexual woman who is a transgender ally). Additionally, in this document we reference pejoratives used against allies (particularly heterosexual and cisgender allies), to demonstrate ways that allies may experience discrimination or experience difficulty finding a place within the LGBTQIQA community. These terms, used primarily by the LGBTQIQA community, include, but are not limited to, words such as *fag hag, homo honey, fag stag, fruit flies, breeders*, or references to those who are not LGBTQIQA as "the enemy." The authors felt it important to include these terms to begin a discussion that is rarely had about the experiences of Allies within LGBTQIQA communities and to urge LGBTQIQA communities to become more inclusive but also urge the reader caution in how these terms are used so that they do not further injure others.

Bias incident: A bias incident refers to any sort of act (e.g., cyberbullying, speech/expression, destruction of property, harassment, assault) that is motivated by bias targeting an individual or group based on identity (affectional orientation, race, gender identity/expression, religion, ability, nationality). A *bias incident* usually refers to an act that is intended to intimidate, harass, or harm another individual or group but does not always qualify as a hate crime (e.g., a violent crime motivated by bias is referred to as a hate crime, whereas defacing a poster on an office door does not usually qualify as a hate crime).

Biphobia**:** An aversion, fear, hatred, or intolerance of individuals who are bisexual or of things associated with their culture or way of being. *Biphobia* is found in the LGBTQ community (e.g., statements such as "I would never date a bisexual person because they would just leave me for the "opposite' sex") and the heterosexual community (e.g., "He/she will eventually settle down and get married"). Biphobia also can be internalized, which is seen when bisexual individuals believe they are indeed deserving of ill treatment because of their identity (e.g., feeling they don't belong in their LGBTQIQA community if they are dating someone of the "opposite" sex).

Bisexual**:** A man or woman who is emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with men and women.

Cisgender refers to an individual whose gender identity aligns with the sex and gender they were assigned at birth.

Classism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth based on social class. Classism operates by subordinating certain class groups (typically poorer) to advantage certain class groups (typically wealthier).

Coming out is a personal (coming out to oneself) process of understanding, accepting, and valuing one's affectional orientation and gender identity,

and an interpersonal (coming out to others) process of sharing that information with others. This is a continual process that occurs multiple times for LGBTQIQA persons over the course of their lifetimes. Although many people think that one is either "out" or "in," this usually refers to a person's general openness with others about who he or she is. However, each time an individual encounters a new situation with new people, one must assess how safe and/or comfortable one is in sharing this information. Coming out involves exploring one's affectional orientation and/or gender identity and sharing this journey with others including family, friends, employees/employers/coworkers, and so on. Many times this process can be arduous and difficult because of heterosexism, sexism, genderism, homophobia, biphobia, transphobia, and so on. There are many different models which describe the process and lifelong development of LGBQTIQA persons.

Gay**:** A man who is emotionally, physically, mentally and/or spiritually oriented to bond and share affection with other men. Also used sometimes as an umbrella term, referring to individuals who identify as lesbian, gay, queer, and/or bisexual.

Gender reflects one's identity and expression (clothing, pronoun choice, how you walk, talk, carry yourself) as women, men, androgynous, transgender, genderqueer, gender nonconforming, and so on that may or may not line up as socially constructed with one's biological sex. Social constructions are made within each culture for what is deemed appropriate for one's gender identity and expression, however, sometimes a person's gender identity expression does not fit traditional socially constructed categories (e.g., one's sex and gender are congruent the way that people should behave and present themselves based on their gender).

Gender identity refers to the inner sense of being a man, a woman, both, or neither. Gender identity usually aligns with a person's birth sex but sometimes does not.

Genderism is a newer term that is perhaps more accurate than the term *sexism*, because the majority of how sexism operates relies on the performance of gender or the behaviors that are supposed to line up with one's sex.

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

He/She/Ze are pronouns that are used to refer to one's gender as either male, female, or gender neutral respectively.

Her/Hir/His are possessive forms of personal pronouns referring to gender. The term *hir* is included as the possessive form of a gender-neutral pronoun to identify a transgender, Genderqueer, transsexual, cross-dresser, or otherwise gender nonconforming person. The terms *her* and *his* are used as the possessive form for people who identify as female and male, respectively.

Heteronormative**:** The cultural bias that everyone follows or should follow traditional norms of heterosexuality (e.g., where a man and woman meet, fall in love, get married, usually have children, and stay together). Additionally, this bias also includes the idea that both individuals have cisgender identity, where males identify with and express masculinity and females identify with and express femininity.

Heterosexism**:** This refers to the assumption or idea that all people are heterosexual or should be. It represents an ideological system that denies, denigrates, ignores, marginalizes, or stigmatizes anyone who is LGBQQ by seeking to silence or make invisible their lives and experiences. It is pervasive within societal customs and institutions, and itself, like other forms of privilege, is not openly challenged in the dominant discourse, thus is passed on generation to generation through the process of socialization.

Heterosexual: This is a term that is used to describe an individual who is emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with those of the "opposite" sex. Although most people are familiar with this term, the authors felt it important to note that many people who are heterosexual prefer this term over the use of the term *straight* because the term *straight* infers "correctness."

Homophobia**:** An aversion, fear, hatred, or intolerance of individuals who are lesbian, gay, bisexual, queer, or questioning or of things associated with their culture or way of being. It often is used to target the way that gender norms are being challenged by individuals. Homophobia also can be internalized, which is seen when lesbian, gay, bisexual, queer, or questioning individuals believe they are indeed deserving of ill treatment because of their identity.

Homosexual: This is a term used historically to describe an individual who is emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with those of the "same" sex. Note that many LGBTQIQA individuals do not use this term to describe themselves given the pejorative history associated with its use (i.e., use of *homosexual* in the *DSM* and other clinical studies that classified homosexuality as a mental disorder), and therefore it is not used in this document either.

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

Isms**:** The authors refer to many different types of "isms" throughout the document, and though in many examples throughout the document only a few are listed, the authors want to stress how each of these oppressions are important, particularly when one considers how multiple and

intersecting identities may impact a person's experience as LGBTQIQA. Throughout the document, the authors tried to incorporate how multiple identities affect individuals' experiences. Additionally, it is important to note that when one holds multiple identities, often times one identity may be more salient than another due to the nature of the individual, group, or community's experiences. The authors encourage counseling and related professionals to always view the individual, group, or community holistically (with all identities accounted for), and yet to allow space in their work for the individual, group, or community to make known what concerns, identities, experiences, and so on are most salient at that time.

Lesbian**:** A woman who is emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with other women.

Lookism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted toward people's outward appearance based on commonly understood standards of beauty, which are socially constructed.

Nationalism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted toward people who are not or are perceived as not being "citizens" of a specific nation and are treated differently when they do not assimilate or conform to the culture and traditions of the nation in power. Nationalism also contains the belief that one's nation is better than all other nations, and therefore it seeks to promote the customs, traditions, and culture of one's nation as superior.

Queer generally refers to individuals who identify outside of the heteronormative imperative and/or the gender binary (e.g., those from the LGBTQIQ community, individuals who are opposed to marriage, individuals who practice polyamory). Queer may also connote a political identity as one who is committed to advocacy/activism for LGBTQIQ rights. *Queer* is also used as an umbrella term referring to the LGBTQIQA community. This term has historically been and still can be used as a pejorative by those outside of the community who hold negative attitudes/beliefs/actions toward the LGBTQIQA community. In this document, however, it is used as it has been reclaimed by members of the LGBTQIQA community.

Questioning**:** Individuals who are unsure if they are emotionally, physically, mentally, and/or spiritually attracted to women, men, or both.

Racism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted toward people because of their race or ethnicity. It also includes the belief that one race is better than others, historically seen as systemic laws and policies that prefer colonizers and conquesters over Indigenous peoples and other people of color.

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

"biological sex," it is preferable to use the words *sex* and *assignment* when discussing these constructs.

Sexism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted toward people because of their biological sex. Sexism is intrinsically linked with heterosexism because it is based on a set of behaviors that are considered appropriate for women or men, which includes expectations about engaging in heterosexual relationships.

Sizeism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted toward people of a certain size, height, or weight, based on commonly understood standards of beauty, which are socially constructed.

They/their**:** These plural pronouns that the authors have used in this document intermittently with *he/she/ze* and *her/hir/his* as gender neutral pronoun alternatives. Some individuals choose these plural pronouns as singular gender neutral pronouns over the use of *hir* or *ze* because they are already in use in language, and therefore some may find them more appealing. Unlike *hir* or *ze*, which are often found next to *her/him* or *she/he*, *they* and *their* include all three options at once and therefore one would not write *she/he/they*, but instead simply write *they*.

Transgender (or trans) is an umbrella term used to describe people who challenge social gender norms, including genderqueer people, gender-nonconforming people, people who are transsexual, crossdressers and so on. People must self-identify as transgender for the term to be appropriately used to describe them. Due to the fact that there is a separate competencies document, transgender individuals were not included here as there was no need to duplicate the work. For the purpose of this document we include the *T* in LGBTQIQA because we are referencing the entire community.

Transphobia**:** An aversion, fear, hatred, or intolerance of individuals who are transgender, genderqueer, or who blur the dominant gender norms or of things associated with their culture or way of being. Transphobia is found in the LGBTQ community (e.g., statements such as "I would never date a tranny") and the heterosexual community (e.g., "Act like a man/woman," assumptions that the person is LGBQQ, or violence). Transphobia also can be internalized, which is seen when transgender individuals believe they are indeed deserving of ill treatment because of their identity (e.g., feeling they don't belong in their LGBTQIQA community). Often, homophobia is expressed more accurately as transphobia because it targets gender norms over identifying relational aspects of being.