

INTRODUCTION: THE PACE OF CHANGE AND THE CHALLENGE TO KEEP UP

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The social and political landscape for sexual minority (SM) and transgender and gender nonconforming (TGNC) people has improved in the United States during the past several years. The Supreme Court's ruling that made same-sex marriage legal in all 50 states was a visible, dramatic, and (for some) surprising change that affected the quality of life for many SM individuals. Shifts in attitudes and policies on other key issues (e.g., domestic partnership benefits, adoption, parenting) affecting both SM and TGNC communities have gained positive ground (American Civil Liberties Union, 2015) since the last publication of this handbook. However, in comparison with people in the general population, SM and TGNC people still face high rates of discrimination, interpersonal harassment and violence (Federal Bureau of Investigation, 2014), and mental health challenges (e.g., Burgess, Lee, Tran, & van Ryn, 2008; Mustanski, Garofalo, & Emerson, 2010). In this latest edition of the handbook, we examine the ongoing challenges faced by

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Handbook of Sexual Orientation and Gender Diversity in Counseling and Psychotherapy, K. A. DeBord, A. R. Fischer, K. J. Bieschke, and R. M. Perez (Editors)

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SM and TGNC people and offer a contemporary guide to affirmative therapy for this population. This, too, was the primary goal we had for our last two handbooks (Perez, DeBord, & Bieschke, 2000; Bieschke, Perez, & DeBord, 2007), but we came to realize that an update was needed: Sociocultural factors change over time, and so too does the shape of affirmative therapy. Affirmative therapy still incorporates therapeutic ways of being, questioning, and exploring, but the focus and sophistication of these processes continue to evolve. This handbook attempts to define, characterize, and guide the current state of affirmative therapy, while situating it within the social values and forces that have molded it. In this Introduction, we identify a number of the factors that motivated our decision to pursue this goal at this time. We start by addressing some of the sociocultural changes that have occurred in the United States and some of the changes that have occurred in the mental health profession. Next, we describe themes identified by our authors and themes we asked our authors to address. We then consider the critical significance of language use. We conclude by providing brief descriptions of the chapters that follow.

CULTURAL SHIFTS

“Why would you even need a book on that?” was a question recently posed to one of the editors of this handbook. The discussion that followed made clear the questioner’s opinion that by now, the social climate for SM and TGNC people had improved so dramatically that there was no need to articulate a distinct therapeutic approach. Furthermore, he seemed to assume that most mental health care providers would already be affirming of SM and TGNC people, making a book on affirmative therapy redundant. Those sentiments represent some of the challenges to capturing and refining the description of affirmative therapy with SM and TGNC clients. Unfortunately, those sentiments are not uncommon, yet they ignore the experiences of trauma, hardship, and stress so frequently endured by SM and TGNC people that are well documented in this handbook (see, e.g., Chapters 7 and 13). It is true that social changes have led to improvements in the lives of SM and TGNC individuals at a pace that has been unparalleled. A few years ago a pollster commented about same-sex marriage: “Attitudes on this issue are changing faster than on any other issue in the history of public-opinion polling” (quoted in Clift, 2012; see also Chapter 3 this handbook). The attitude changes have been accompanied by swift changes in the law. During the development of this handbook, we asked some authors to repeatedly revise their commentary on the number of states with legalized same-sex marriage because the numbers were changing so fast. We had no idea that by the completion of this text, same-sex marriage would be the law of the land in the United States.

However, it is important to keep in mind that many progressive political and social changes are often met with backlash in the interpersonal experiences of SM and TGNC people. The National Coalition of Anti-Violence Programs announced that the network's calls in 2013 from lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals or HIV-positive survivors requesting support after physical hate crimes increased by 21% in comparison with the previous year. A substantial majority (59%) of these survivors were people of color, and about one third (32%) had disabilities. Transgender women in the sample suffered physical violence in interactions with police at a rate about six times higher than other survivors. Because of such realities, this handbook is necessary.

The pace of social change on SM and TGNC issues has been complemented by responses from researchers and policymakers in the arena of mental health that have informed and nurtured the growth of affirmative therapy in recent years (see Chapter 13, this volume). Statements about therapeutic guidelines, best practices, and standards of care for SM and TGNC clients have been recently developed and revised by several organizations (e.g., American Psychological Association, 2012, 2015; Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009; World Professional Association on Transgender Health, 2012). Being cognizant of this progress, we asked our authors to incorporate into their chapters the most recent and relevant empirical work on SM and TGNC mental health. They responded by creating a text that can serve not only as a guide for providing affirmative therapy but also as a launch pad for those interested in expanding the research base in this area. Furthermore, some authors (see Chapters 5 and 15) used the guidelines and recommendations of the professional bodies in this field to stimulate consideration of how complex SM and TGNC affirmative therapy can be. This handbook is intended to summarize and synthesize the factors that have shaped the face of affirmative therapy to this point in time.

THEMES IN THE HANDBOOK

A number of topics are addressed consistently by the authors in this handbook. The authors' unique and creative approaches to these topics provide refreshing and enhanced appreciation for their complexity, addressing as they do such themes as minority stress, stigma management, resilience, and intersectionality.

We invited authors to entertain and explore the sometimes conflicting schools of thought that collectively inform the state of affirmative therapy today—and we were not disappointed. Complexity may be the defining feature of how SM and TGNC lives are currently depicted in the scholarly

literature. This complexity presents both challenges and promises to those who seek to offer affirmative therapy to their clients. One example of how this kind of complexity can present challenges is illustrated by Fassinger (Chapter 1), who probes the complexity and depth of the academic work in this field by reviewing perspectives that question the very validity of the identities that the SM and TGNC abbreviations stand for. Also addressing the complexity of therapy, Russell and Hawkey (Chapter 3) address the multiple, shifting contexts of clients' lives, in which external stigma experiences (e.g., prejudice, discrimination) may come to be internalized. By adopting a cognitive perspective that encourages clients to see how specific events in time are related to broad, long-term social and political movements, these authors identify ways to help clients connect their suffering to societal forces without succumbing to the helplessness that sometimes comes from awareness of oppressive systems. As a third example of complexity, Dickey and Singh (Chapter 16) discuss the basic contradiction of mental health providers being both gatekeepers and evaluators, on the one hand, and supporters or advocates, on the other hand, for gender nonconforming individuals who wish to make a medical transition. Another example of the challenges posed by the complexity of this field is the paradox identified by Phillips and Fitts (Chapter 14). They question how it is possible to endorse a form of therapy that, by its existence, reifies and strengthens the idea that normalcy is represented by heterosexual and cisgender lives.

As we encountered the questions that naturally emerged from our authors' exploration of the complexities inherent in SM and TGNC lives and in affirmative therapy, we realized that there were no clear-cut answers to them. Nevertheless, deliberation of possible responses to those questions consistently leads to rich understandings of effective therapeutic services. At times, our authors offer inspired and imaginative suggestions for how to tackle the dilemmas posed by providing affirmative therapy. We believe that readers benefit from contemplation of this complexity.

We were not overly surprised when chapter authors spontaneously converged on the themes of minority stress (Meyer, 1995, 2003), stigma management, and resilience factors in the practice of affirmative therapy today. In the first edition of the handbook (Perez et al., 2000), lesbian and gay identity development models were popular and assumed to be important to providing sound affirmative therapy. In the second edition (Bieschke et al., 2007), Fassinger and Arseneau described the identity development process as having a critical social component, with connection to a lesbian, gay, bisexual, and transgender community being a unique and important facet of the mental health outcomes of our populations of interest. Today, a sociological perspective has successfully inverted the focus of affirmative therapy from one that emphasized individual problems to one that challenges providers to adopt a

strengths-based approach for clients and to actively consider the pathologizing influences of a culture plagued with prejudice. This approach opens the potential of affirmative therapy to actively nurture the multiple pathways of individual expression encompassed by the endless intersectional identities of SM and TGNC people. As editors of a handbook that endeavors to depict the current nature of affirmative therapy, we support and appreciate the marked shift that this signifies.

As editors, we were excited to see the themes that spontaneously emerged from the minds of our authors, but we also invited them to consistently concentrate on some topics. Intersectionality was one of them. Moradi (Chapter 4) calls on readers to resist dismissing this crucial topic as “buzzworthy” and faddish; she illustrates that a thoughtful consideration of intersectionality compels one to analyze how social and political power are wielded by certain groups in a society. She asks us all to examine how some SM and TGNC experiences become prototypes while others become invisible. With this idea in mind, we asked all of our authors in the second section of this handbook to develop a case study for each of their chapters that featured the application of affirmative therapy to a client whose identity represented the intersection of multiple, often stigmatized, backgrounds. In doing so, we sought to use our positions as editors to inspire readers to always think about the unique challenges and resilience factors that SM and TGNC people bring to the consulting room. Also, we hoped engaging in such reflection would bring to the forefront the issues of power and privilege and how they play out in clients’ lives and counselors’ lives and in the interaction between the two. We also invited authors to describe the impact of their own social positions and biases on their topics; our purpose was to encourage contributor transparency. (We note that not all contributors decided to reveal this information about themselves.) This type of analysis and reflection calls into question the language and words we use in discussing and doing affirmative therapy, a topic we turn to next.

USE OF TERMS IN THE HANDBOOK

The titles of our three handbooks—*Handbook of Counseling and Psychotherapy With Lesbian, Gay, and Bisexual Clients* (first edition; Perez et al., 2000); *Handbook of Counseling and Psychotherapy With Lesbian, Gay, Bisexual, and Transgender Clients* (second edition; Bieschke et al., 2007); and the present *Handbook of Sexual Orientation and Gender Diversity in Counseling and Psychotherapy* (third edition)—reflect shifts in social power about who was included in the discussion of SM and TGNC lives in the scholarship and research literature relevant to affirmative therapy. The first handbook did not

include discussion of TGNC people. The second handbook did, but the discussion was limited to two chapters. In this handbook, we asked all but three sets of authors to include consideration of empirical or theoretical work on TGNC people and to offer suggestions about the implications of their chapter for TGNC people. (The chapters on affirmative therapy and physical health for SM and TGNC clients are separate. In addition, the chapter on sexual orientation change interventions focused only on SM people.) This inclusivity demanded careful deliberation about what terms to use to refer to people not only in the TGNC community but in all of our populations of interest.

The use of appropriate terms in lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and ally (LGBTQQIAA) communities is a complex issue loaded with political implications and emotional valence. Many people in these communities shun the use of labels, sometimes arguing that labels cannot, and should not, try to reflect lived experience. Some people feel that many of the commonly used terms do not adequately represent the diverse backgrounds and subcultures that exist within the community (see Scholz, 2013). No term is perfect; many are cumbersome. Not one is all-inclusive. The dynamic nature of language itself translates into an ever-evolving use of terms that will be different tomorrow than it is today.

As editors of this handbook, we had to decide which terms to consistently use throughout the text in referring to the client populations of interest. We concluded that the best way to proceed was to consult the literature, the popular websites for political activism in these communities (e.g., GLAAD, Williams Institute, the National Center for Transgender Equality), authors with a history of professional writing in the area, leaders in Division 44 (Society for the Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues) of the American Psychological Association, and members of the communities we knew personally. We were confronted with more complexity and controversy than we had bargained for. Repeatedly we were told that no matter what terms we decided upon, we could expect to anger and alienate some while satisfying others.

After careful consultations and consideration of the implications, we selected the terms *sexual minority* and *transgender and gender nonconforming* because of their perceived inclusiveness and simplicity. We recognize that there will likely not be consensus on which terms are best for anybody given the varieties of backgrounds, situations, and temporal fluidity that can affect self-selected identities. In fact, Scholz (2013) challenged researchers to avoid invoking categories of identity unless we explicitly acknowledge their conditionality as “local, situational, and temporary” (p. 271). We also acknowledge that some people consciously choose not to self-identify at all, refusing to participate in a system of naming that may limit, silence, or render unacceptable experiences that do not easily fit within identity boundaries. One

set of boundaries of particular relevance is the *gender binary*, an overarching cultural construction that shapes what we see and experience in terms of sex and gender. The gender binary in the United States, for example, structures institutions and individual experience to “allow” for two and only two sexes and genders (male and female, masculine and feminine).

We had the privilege of inviting authors to write about the factors that optimize affirmative therapy with SM and TGNC clients. In our review of chapters, it became clear that a wide variety of terms was being defined and used. For the sake of clarity and efficiency, we asked authors to consider using the terms described below and to write about how and why their use of terms might differ from ours. Although many authors agreed with our recommended terms, others preferred variations on the LGBTQ abbreviation. Russell and Hawkey (Chapter 3) used the term *sexual minority and gender expansive individuals*, for reasons they explain in their chapter. As editors, we found the definitions used by Dickey and Singh in Chapters 6 and 16 to be enlightening and helpful in distinguishing concepts that often get confused in common usage or simply are used differently by different individuals or groups. Therefore, much of what we have included below represents their good work.

Sexual orientation is used in this volume to describe one’s typical patterns of sexual and affectional attractions. If one assumes a gender binary (that people fall neatly into categories of male and female), a *gay* or *lesbian* sexual orientation refers to a person’s same-sex sexual/affectional orientation. *Bisexuality* is descriptive of those who have attractions to people of both sexes. *Men who have sex with men*, *questioning*, *queer*, *sisters*, and *same gender loving* are words and phrases often used by people to describe themselves as involved in some way in same-sex attraction or behavior. Individuals and groups often self-identify with these terms in order to distinguish themselves from gay and lesbian cultures perceived to reflect the norms, values, and standards of privileged, White, gay, or lesbian people. We use the term *sexual minority* as an umbrella term that includes all of the groups described here.

Gender identity refers to how one defines, understands, and experiences his or her gender (e.g., woman, man, transgender individual). As editors, we agreed that *gender nonconforming* was a term that provided the most inclusivity for people who were opposed to living in and seeing the world in a way that forced gender into a binary status. Consultation with our authors led us to understand the importance of including *transgender* as a unique identity because some people who identify as transgender embrace and adopt the gender binary. Thus, throughout the text we have encouraged authors to use the abbreviation TGNC to refer to transgender and gender nonconforming people.

There are many words that TGNC clients may use to describe themselves. Some clients may shorten *transgender* to *trans* or *trans** (see Chapter 13),

or they may use *trans man* or *trans woman* to designate a TGNC status and their current gender identity. Other TGNC clients may feel strongly about using words such as *woman* or *man* or *male* or *female* to describe their gender identity. *Genderqueer* is another term some people who do not associate with a gender binary may use. It is typically claimed either by someone who consciously refuses to participate in hegemonic, binary social constructions of gender or someone who identifies with components of stereotypically masculine, feminine, and/or gender-neutral expressions (or something else altogether; Lambda Legal, 2015). *Gender expression*, unlike gender identity, refers to one's outward behaviors (e.g., clothing) in experiencing and communicating gender. Words such as *masculine*, *feminine*, and *gender neutral* are common ways to describe one's gender expression.

Other terms that are often used in TGNC-affirmative counseling include *cisgender* and *cisgender privilege*. *Cisgender* refers to people whose gender identity is aligned with the sex they were assigned at birth (Lambda Legal, 2015). *Cisgender privilege* includes all of the (unearned) societal advantages that are provided to individuals whose originally assigned sex is consistent with their preferred gender expression and presentation. These privileges can range from being able to easily access safe public bathrooms and not being pushed to defend one's gender presentation to having responsive health care.

Because language is continuously evolving in TGNC communities, TGNC-affirmative therapy requires that practitioners are not only knowledgeable about the various words and expressions that TGNC clients use to describe themselves but also are prepared to use these words and understand their meanings. In cases where a TGNC client uses a term that the practitioner does not understand, asking for clarification respectfully is often the best strategy. Affirmative counseling also involves using pronouns or words that TGNC clients express as important to them. There are helpful glossaries of TGNC terms that can be found in a number of the websites listed in the Appendix (e.g., Lambda Legal's *Bending the Mold*). It is important to remember, however, that variation and fluidity in usage of terminology are constants in the continuing journey toward affirmative practice.

STRUCTURE AND ORGANIZATION OF THE HANDBOOK

The vast majority of material in this book is new and unique to the third edition. In Chapter 12, Charlotte J. Patterson offers an update to her previous version of this chapter (Patterson, 2007) about family issues in the second edition. This handbook contains three parts, each relating uniquely to affirmative therapy.

Part I: Foundational Information for Practitioners

The chapters in Part I challenge readers to consider how their therapeutic work with SM and TGNC people is supported by assumptions that have powerful implications for the nature and outcomes of their work. Fassinger (Chapter 1) tackles social constructionism, the way in which all meanings are created through social discourse; the implications for the construction and enactment of identity are provocative. Her critique of essentialist notions requires readers to contemplate how their assumptions about the essence of sexual orientation and gender identity might allow for a focus and validation of certain ways of being while negating others. She offers a model of therapy that is “transgression-affirmative,” encouraging clients to create their own stories while acknowledging the influences of broader social systems. Sánchez and Pankey (Chapter 2) elaborate upon the essentialist assumptions that underlie research on the physiological bases of sexual orientation and gender identity. They also offer an extensive review of the often conflicting findings published in the biomedical research on the influence of genes, hormones, and brain structures on SM and TGNC identities.

The politics of stigma, oppression, and privilege are explored in the remaining two chapters of Part I. Russell and Hawkey (Chapter 3) describe the impact of shifting social attitudes and policies on SM and TGNC lives. They offer an approach to therapy that focuses on responding to stigma, both internalized and external, in ways that draw on clients’ strengths and that encourage active reframing and coping with stigma-related stressors. Stigma and resilience are also themes in Moradi’s chapter on intersecting identities (Chapter 4); she critically analyzes how social power influences the questions we ask that shape our research and practice with SM and TGNC people. In addition, she offers a series of questions that all practitioners should consider while engaging in affirmative therapy (e.g., With which clients do I attend to group differences and culture as explanatory factors for presenting concerns?). Taken together, the four chapters in this section provide the groundwork for the self-reflection and self-awareness that are necessary for effective affirmative therapy with SM and TGNC clients.

Part II: Affirmative Counseling With Sexual Minority, Transgender, and Gender Nonconforming Clients

In this section, readers are invited to explore what affirmative therapy can look like with specific subpopulations of SM and TGNC people. Authors in this section identified and applied research findings to counseling and therapeutic practice and considered intersectional identities. TGNC people were

included in all but one of the six chapters in this section. The exception was made because we wanted one chapter on affirmative therapy for SM clients and a separate chapter for affirmative therapy with TGNC clients. A case study was included in each of the chapters within this section.

In Chapter 5, Paul describes the relevance of minority stress, resilience, and microaggressions and the positive aspects of being a SM to affirmative therapy while simultaneously inviting clinicians to scrutinize their potential biases that could interfere with providing care. He maps the application of several crucial guidelines and recommended competencies identified by two professional bodies, the American Psychological Association (2012) and the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC; Harper et al., 2013), to his case work. In Chapter 6, Singh and Dickey describe affirmative therapy with TGNC clients, providing excellent direction for counselors needing to learn how to work with TGNC clients who are facing social transitions as opposed to medical transition. They, too, discuss the minority stress model (Meyer, 2003) and the role of resilience factors that permit effective coping among TGNC individuals.

The next two chapters deal with SM and TGNC clients who experience trauma and conflict. In Chapter 7, Pantalone, Valentine, and Shipherd delve into the prevalence of trauma, provide guidance on how to assess it, and apply empirically based interventions to two cases using prolonged exposure therapy (Foa, Hembree, & Rothbaum, 2007) and cognitive processing therapy (Resick & Schnicke, 1992). Chapter 8 examines how stigma, rooted in a variety of religious traditions, can affect the mental health of SM and TGNC clients. Kashubeck-West, Whiteley, Vossenkemper, Robinson, and Deitz explore the statements authorities from a few religious perspectives have made publicly regarding their views on sexual orientation and gender identity. They consider approaches to resolution for those who experience conflict between their religious identities and their SM and TGNC identities.

The final two chapters in Part II review crucial aspects of affirmative therapy with younger and older portions of the SM and TGNC populations. In Chapter 9, Starks and Millar adopt a decidedly data-based approach to considering how best to work with SM and TGNC youth. After exploring the health and mental health disparities between SM and TGNC youth and their counterparts, they apply research to developing interventions in areas key for adolescents and young adults, including substance abuse, mental health, sexual health, and relationship skills. Chapter 10 calls for providers to consider how to provide affirmative therapy for aging adults. Vacha-Haase and Donaldson examine numerous generational and cohort effects that could influence how and with what issues older clients present for therapy. Issues of health, finances, social support, sexual health, caregiving, residence, and end-of-life planning are investigated.

Part III: Essential Areas for Practice, Research, Training, and Health

As its title suggests, Part III addresses topics that readers should find useful for providing affirmative therapy, understanding the research base for practice with SM and TGNC people, developing training programs for students, and recognizing the physical health needs of SM clients and TGNC clients who are interested in physical transition. These chapters prepare readers to enhance the field of affirmative therapy by establishing the empirical groundwork in the areas of sexual orientation change interventions (SOCIs), SM and TGNC family and other relationship dynamics and influences, practice delivery, and physical health.

Chapter 11 explains the context for and nature of SOCIs. Shidlo and Gonsiorek thoroughly consider why people might seek SOCIs and what the ethical problems are with attempting to provide these interventions. The authors provide alternatives to SOCIs and potential follow-up strategies for clients who have participated in them. Patterson (Chapter 12) depicts how SM and TGNC people and their family relationships (including couples) are continuing to be affected by the evolving legal and policy landscapes across the United States that pertain to such issues as job discrimination, parental rights, adoption, and marriage. In a revision of her similar chapter (Patterson, 2007) in the second edition of this book, Patterson uses updated research findings to characterize patterns of relating and sharing power in same-sex relationships.

Chapters 13 and 14 will be especially valuable to those involved in establishing and advancing research agendas and graduate training programs that address the needs of SM and TGNC people. Worthington and Strathausen explore the relevance of intersectionality to the empirical research base and then provide a comprehensive review of research findings related to many aspects of SM and TGNC mental health and to the delivery of counseling services since the publication of the second edition of this handbook (Bieschke et al., 2007). In Chapter 14, Phillips and Fitts explore the methods and outcomes of studies that have been conducted on the effectiveness of training programs in producing practitioners competent in aspects of SM and TGNC affirmative therapy. Their identification of factors that facilitate best practices in the training of competent counselors and psychologists will be especially informative to academicians and trainees.

The final two chapters in this part address physical health issues. Haldeman and Hancock adopt a minority stress model to frame the many obstacles and risks faced by SM people in achieving optimal physical health. They shed light on health care access barriers, negative coping strategies, and specific health related problems that disproportionately affect SM lives. They respond to the health challenges faced by SM people by additionally describing SM resilience

characteristics and positive changes in health care practices, and they list recommendations for providers to help them promote the physical well-being of their SM clients. The final chapter (Chapter 16) enlightens readers about the health care issues faced by TGNC people who are considering physical transition processes. Dickey and Singh explore the controversy associated with a diagnosis of gender dysphoria as defined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), the recent standards of care produced by World Professional Association for Transgender Health (Coleman et al., 2012), the assessment of readiness for medical transition, and the specifics of hormone therapies and gender-affirmation surgeries, including their costs. The authors also advise mental health care providers on the follow-up care that is essential for TGNC clients who have participated in medical interventions. These chapters should be included on the reading lists of those interested in providing quality mental health care to SM and TGNC clients.

CONCLUSION

With topics as rich, dynamic, and politically charged as sexual orientation and gender identity, our talented authors strove to provide a comprehensive guide to the complex issues that underlie and characterize the provision of affirmative counseling and therapy. In the chapters that follow, the authors' expert reviews of previous research and their creative applications of the body of evidence will substantively enhance the quality of services provided to clients who identify as SM or TGNC. In addition, the handbook will serve as a resource for furthering dialogue and generating new ideas among researchers, practitioners, advocates, and students.

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