

Working therapeutically with LGBTI clients: a practice wisdom resource



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Practice Wisdom Guide Coordinator and Editor:

Dr Marcus O'Donnell, University of Wollongong

Mindout! Senior Project Officer:

Barry Taylor, National LGBTI Health Alliance

Practice Wisdom Resource Practitioners Panel:

Ben Bradstreet, Western Australian AIDS Council

Suzanne Calver, FPWA Sexual Health Services

Rodney Kent, psychotherapist in private practice, Queensland

Tim Klein, psychologist in private practice, Queensland

Mani B Mitchell, Counsellor, E.D. ITANZ, New Zealand

Dr Daniel Parker, North Metropolitan Older Adult Mental Health Service,
Western Australia

Mary Rawson, Bisexual Alliance Victoria

Dr Liz Short, Victoria University, and community and clinical psychologist
in independent practice

Vikki Sinnott, psychologist in private practice, Victoria

Angela Trevaskis, ACON

Vanessa Watson, psychologist at YouthLink, Western Australia

National LGBTI Health Alliance

PO Box 51 Newtown NSW 2042

Inquiries: info@lgbtihealth.org.au

Phone: 02 8568 1123

www.lgbtihealth.org.au

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Introduction

The following manual draws from the consulting room experience of a number of psychologists, psychotherapists and counsellors who have worked with a broad range of sex, sexuality and gender diverse clients.

The National LGBTI Health Alliance uses “LGBTI” as a recognisable acronym to collectively refer to a group of identities that includes lesbian, gay, bisexual, trans/transgender and intersex people and other sexuality and gender diverse people, regardless of their term of self-identification because they all share experiences around sexual and/or gender identity and sexual and/or gender expression that are outside the dominant paradigms of Australian society. Each of these groups also has a unique set of experiences that will colour the therapeutic encounter.

You will recognise here principles of good therapy that you will know from your experience with other clients, because working with LGBTI clients has much in common with the encounter any therapist has with any client. But the special context and specific lived experience of LGBTI people will often bring a particular focus or emphasis to the way we use these familiar techniques.

Allies of all genders and sexualities are important in building a society that is affirming and safe for LGBTI clients. Affirmation by therapists from outside their own communities can be a very important experience of acceptance for LGBTI clients, just as awkward or non-affirming experiences can add to a sense of isolation. That is why building the capacity of all helping professional to deal effectively with LGBTI clients is so important.

Some of the practitioners consulted during the development of this resource have been contacted by colleagues who had questions about how to work well with LGBTI clients. Some expressed concern that they didn't have the expertise, or experience, to deal with LGBTI clients. The response of these practitioners and the message of this resource, is that if you are willing to listen to your client and do some research about the needs of LGBTI people there is no reason to think you may not have the skills or expertise to deal with issues of sex, sexuality and gender. In some cases you may need to seek advice from colleagues more experienced than yourself, just as you would in other situations. You may also find issues brought up by LGBTI clients challenge your own values, beliefs or experiences – just as any other client might do – and you need to seek appropriate professional support in supervision. Yes, there are important areas of context you should be aware of; yes, it is important to be familiar

with the language and terms used in these communities; but the basic rules of listening to your client and creating a safe affirmative space for them, are the same as those you would use with any other client.

What is this document and how was it produced

This document is not a formal set of clinical guidelines; there are already a range of these produced by national psychological associations and LGBTI organisations – a number of which are listed in the resources section of this guide. This is a collection of practice wisdom from the consulting room. Although at times we will refer to certain theories and to research done about the needs of LGBTI clients, this is primarily a resource that compiles the professional experiences of those working with LGBTI people.

It was written through a unique consultative process that involved workshops and interviews with some of Australia and New Zealand's most experienced counsellors, psychologists and therapists working with LGBTI clients.

It is designed to assist a broad group of helping professionals who may want to work with LGBTI clients. It may be useful to psychologists, counsellors, psychotherapists, social workers, community workers or youth workers.

Throughout the text we use the terms “therapy” or “counselling” in flexible and various ways to refer to mental health interactions between clients and professionals.

The need for such a resource was identified as part of the MindOUT! LGBTI Mental Health and Suicide Prevention Project. This project of the National LGBTI Health Alliance was funded by the Commonwealth Department of Health to improve the mental health and suicide prevention outcomes for LGBTI people. As part of the project's work to assist mainstream mental health and suicide prevention organisation to increase to response to the particular social and therapeutic needs of LGBTI people, a series of resources were produced. This practice wisdom resource should be used with reference to the other resources in the series:

- The cultural competency framework – which looks at how organisations as a whole can increase their capacity to take on LGBTIQ issues, and
- Going upstream: a framework for promoting the mental health of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people – a framework for undertaking mental health promotion and suicide prevention with LGBTI people.

Why is an LGBTI counselling guide needed?

Two key things you need to know

Working with LGBTI people is similar to working with clients from any cultural group. Like other cultural minorities LGBTI people have a series of particular experiences and particular stresses in their lives that can impact on their mental health. Gaining an understanding of their social situation, and potential needs, is the first step in conducting effective psychological work with LGBTI clients. That is why resources like this one are needed.

Most LGBTI people live fulfilling lives with the same range of psychological issues and problems that confront their heterosexual and cisgender colleagues and friends. Legal reforms and social changes have meant that discrimination against LGBTI people in Australia has decreased and many LGBTI people now live open and successful lives in all sectors and regions of the country.

However, in spite of the many advances in achieving equality and cultural acceptance, LGBTI people still regularly experience discrimination, marginalisation, bullying, and rejection. The cumulative as well as the acute effects of these experiences lead to higher levels of mental health issues in LGBTI populations. The mental and physical damage caused by these social pressures are often an important part of presenting and/or underlying therapeutic issues.

LGBTI people are resilient in the face of such challenges and will have individually crafted sets of resilient strategies to allow them to navigate a world that marks them as different. This narrative of resilience is an equally important part of the therapeutic work with LGBTI people. While acknowledging the social and cultural stresses that cause psychological distress is important, developing a focus on resilience supports strength-based, affirmative psychological work.

Discrimination and minority stress

All LGBTI people, even those who have grown up with supportive family and friends, will most likely have experienced some degree of discrimination or prejudice.

This is a complex experience because discrimination manifests in a range of ways, some of which is very explicit and some of which is very subtle and even possibly unintentional. It includes such things as name-calling, bullying, and exclusion by peers or family, through to job loss or denial of services. At its most extreme, prejudice and discrimination leads to violence, or the threat of violence, and can be life threatening for LGBTI people.

Although laws have been improved, discrimination is still institutionalised in some areas and discrimination and prejudice is still widespread. One recent survey (Robinson 2013) of Australian LGBTI youth revealed that 64% of the participants, aged 16-25, had been verbally abused, 18% physically abused, and 32% experienced other types of homophobia and transphobia.

Prejudice and discrimination tells LGBTI people that they are less important than their peers and can lead to experiences of shame, isolation, lack of confidence or trauma.

This does not mean that all LGBTI clients will present in therapy with under-developed confidence or shame about their sex, sexuality or gender. But many will present with some residual expressions of trauma simply because they have lived with a sense of chronic stress due to their position in society as a member of a minority group.

This experience of stress and the potential threat of discrimination, rejection and/or violence endured by members of various cultural minorities has been theorised by psychologists as “Minority Stress”. Ilan Meyer (1995, 2003, 2008) has shown how this is experienced in LGBTI people. Meyer, and other psychologists who have worked with his theories, conceptualise that LGBTI people experience a variety of stresses in their lives. These include:

1. External stressful events

These could include a range of discrimination and prejudice from ongoing alienation by family to physical violence

2. Expectations of such events

This not only produces anxiety but also calls for hyper-vigilance which produces its own stresses

3. The possible internalisation of negative societal attitudes

Potential shame, guilt and negative attitudes about sexuality, sex and gender difference

4. Concealment

Even for those who are in some ways “out” they may still engage in some level of concealment as part of their vigilance strategies

Researchers have concluded that this experience of acute and chronic, low-level stress – from external and internalised events and process – contributes to the notably high levels of stress related physical illness, anxiety, depression and even suicidality reported in LGBTI clients.

In the report cited above, of Australian queer youth, 41% of participants had thought about self-harm and/or suicide, while 33% had harmed themselves, and 16% had attempted suicide (Robinson 2013).

In working with LGBTI clients it is important to acknowledge the key role that minority stress, arising from negative social attitudes and discriminatory practices, can play in the psychological wellness of LGBTI people. The higher incidence of reported mental health issues in LGBTI populations stems from these circumstances and is not a product of sexual orientation, intersex status, gender expression or identity. Clarifying this point with clients can be particularly powerful: to help individuals understand that their anxiety and distress may, at least in part, be due to chronic stress and social stigma, rather than some 'fault' or 'badness' of their own making, is often very liberating.

This experience of stress can lead to major presenting symptoms like depression and anxiety but it will also often lead to internalised self-doubt and self-pathologising stories and beliefs which disrupt LGBTI people's lives in subtle and not so subtle ways. Part of good therapy or counselling will involve listening for beliefs and stories of self that contain social negativity about being LGBTI and the beliefs and stories that resist these cultural stereotypes.

For many LGBTI clients the therapeutic journey is part of a journey out of trauma, and it often begins by openly recounting the narrative of distress or possible trauma, and resilience in their lives.

Survival and resilience

Because LGBTI people often do experience a lack of acceptance and varying degrees of discrimination, prejudice and trauma, they are often unusually resilient – they will have developed a set of unique personal strategies to deal with societal prejudice and to survive in a stressful environment.

Although much of the psychological research on LGBTI issues is still "deficit-based" – what are the problems LGBTI people experience? – psychologists have now begun to investigate LGBTI resilience.

Mark Smith and Susan Gray (2009) noted in their study:

Those who regularly encounter individuals who may be lesbian, gay, bisexual, or transgender know from first-hand experience that the many stereotypes found in popular media that have become so deeply etched in public perception have little correspondence with actual experience. In fact, practitioners familiar with LGBT individuals find that their clients are usually quite tough, that they respond to hardships and personal tragedies with notable resiliency, are remarkably creative

in devising ways of transforming hardships into opportunities, and continue to make significant contributions to society despite being denied access to environmental supports available to most other groups.

Seeking out supportive communities – individual and group support – is one of the key ways that minority group members develop a resilient response to discriminatory experience. However in their efforts to remain self-contained and "hardy," reaching out or help seeking skills, may remain underdeveloped. Finding a balance between an internally generated sense of strength and having this validated through supportive others is sometimes difficult for LGBTI people. An exploration of these different internal and external strategies of resilience in client's lives is an important part of developing an affirmative strengths-based assessment.

LGBTI people's lives are also resilient in the face of challenges and each LGBTI person will have an individually crafted set of resilient strategies to allow them to navigate a world that marks them as different.

Individual coping styles will vary enormously.

Smith and Gray, in their study focus on what they call "The courage to challenge" as one marker of LGBTI self-efficacy. Part of developing a resilient approach can be developing a sense of personal efficacy through the readiness to publically challenge negative views about LGBTI people and issues encountered in their day-to-day life.

However other LGBTI people, or even some of those who exhibit an ability to challenge on some occasions, may strategically choose to avoid unnecessarily hurtful events. Some LGBTI clients will attend family events and debate with non-supportive family members while others will adopt a protective strategy of staying away. Neither is a right or a wrong strategy and individuals may adopt a different strategy at different points in their life, or in different situations.

Therapy with LGBTI clients involves identifying and validating existing strategies for resilience and where possible assisting clients to develop additional ones.

I'm told I just need to allow my mind to allow the war zone between my legs to be at peace. So then what? What happens when I tell my body that this time it better enjoy sex or else – and my body still doesn't? Then will people believe me that it's not just in my head? ... my scar tissue is not in my head. My skin, my muscles and my bones have memorised it. I feel it every time they draw my blood and I have a panic attack. I feel it every time I go on a date with someone, or go to bed with someone, and I know that the playing field is uneven. It's not that I can't love. I can. I just hate what they did to me. And so, I try to ignore it. But pretending I don't know what I know isn't working anymore.

— Intersex Activist Pidgeon Pagonis



I keep thinking about power. The intuitive flash of power that ‘coming out’ can give: I have an indestructible memory of walking along a particular block in new York City, the hour after I acknowledged to myself that I loved a woman, feeling invincible. For the first time in my life I experienced sexuality as clarifying my mind instead of hazing it over; that passion, once named, flung a long, imperative beam of light into my future. I knew my life was decisively and forever different; and that change felt to me like power.

— Poet Adrienne Rich



Some other things to remember when working with LGBTI people

LGBTI people have rich multi-component identities

Sexuality and gender identity are often an important part of all clients', including those who are LGBTI. Even if a LGBTI client's presenting issues are not explicitly about sexuality, sex or gender issues their experience as an LGBTI person will more than likely provide important background.

However LGBTI people are not defined by their LGBTI experience; they also have a range of other identities and associations. Race, ethnicity, religion, gender, age, class and professional identities are valuable other lenses that will be equally important in understanding and assessing clients' experiences and needs. It is essential to look at the intersections of all these various identities rather than looking at sexuality, intersex status or gender identity in isolation.

In many beliefs, concerns, and life choices individual LGBTI clients are just as different from each other as they are from non-LGBTI people.

The typical LGBTI client does not exist

Although this resource is written in the belief that there are some things that can be usefully said about working with LGBTI people, it must also be acknowledged that LGBTI clients come in all shapes, sizes, personalities and states of wellness. Although they share the common experience of coming to terms with being LGBTI in a culture that is ambivalent at best about differences in sexuality, sex and gender, they are individuals whose personal experiences need to be understood. In many beliefs, concerns, and life choices individual LGBTI clients are just as different from each other as they are from non-LGBTI people.

LGBTI communities can bring support and conflict

Part of the journey for LGBTI people as they discover more about themselves is usually meeting and interacting with other LGBTI people. Developing a sense of connection with other LGBTI people or community helps to overcome feelings of isolation and aloneness. Often, if therapists are working with clients at an early stage of awareness in relation to being lesbian, gay, bisexual, transgender or

intersex, facilitating connections with LGBTI community organisations or events can be a helpful step. However, just like any community, the LGBTI communities are diverse and have a range of problems, restrictions and codes of behavior that can be less welcoming to new LGBTI people. Some LGBTI people of diverse cultures experience racism, for example, and commercial venues are often focused around stereotypical measures of age and beauty. So while connections with community may well be an important aid for LGBTI people, any therapist must realise that it can also be a source of challenges.

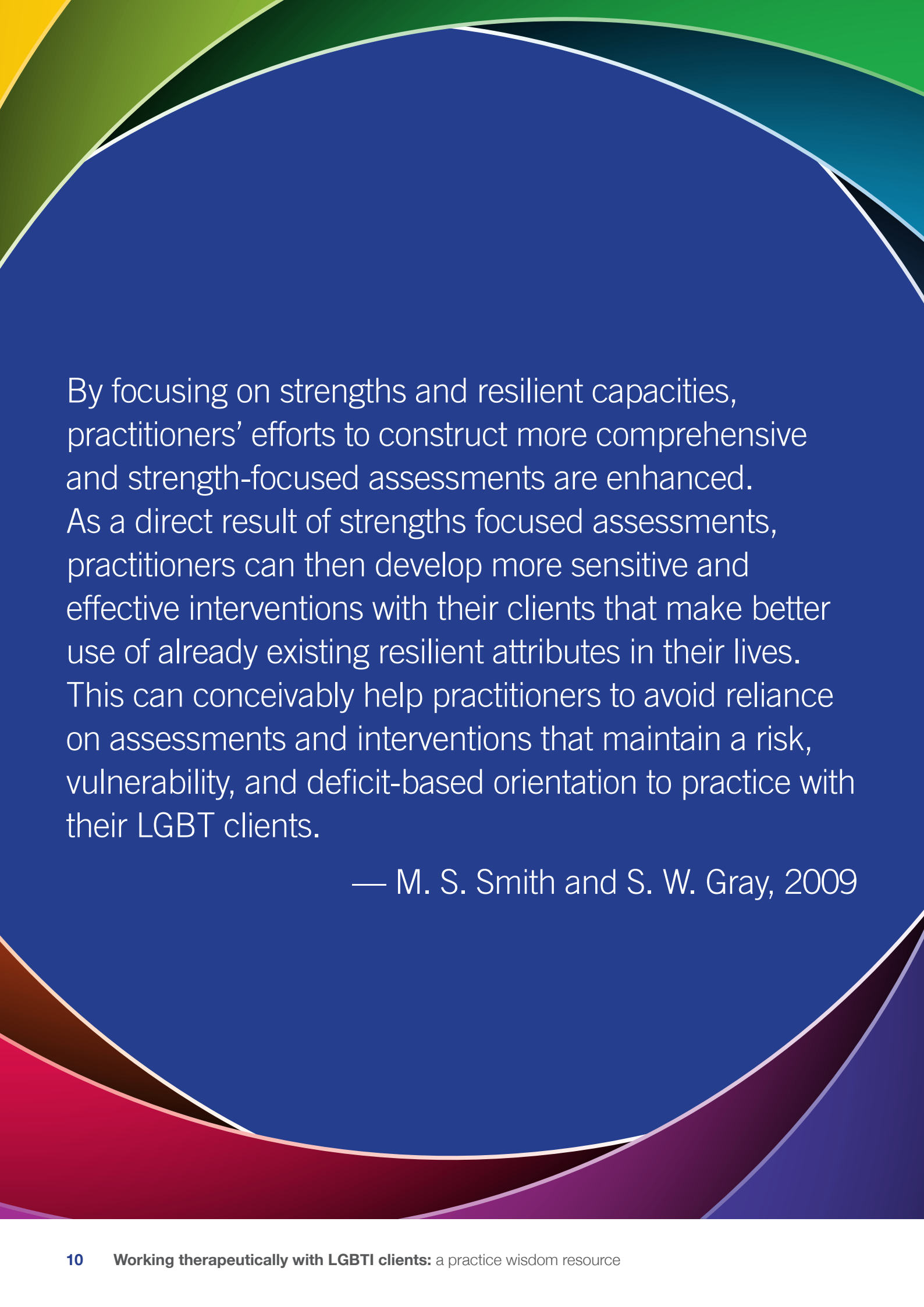
Many LGBTI people feel an important sense of affirmation through participation in these communities and their social and political events and organisations. But for some LGBTI people, sub-cultural expectations are experienced as a new set of stereotypes or constraints.

Any client may be an LGBTI client

Many LGBTI clients are not going to present with an LGBTI identified issue. Some may not bring up issues of intersex related experiences, sexual or gender identity and/or expression unless explicitly asked or unless they feel comfortable with you. In talking with your clients or taking a history it is important that your questions don't betray assumptions about their lives. For example don't assume a heterosexuality, exclusively heterosexual desires or behaviour or that the client is comfortable with their assigned gender. In asking about relationships don't ask in a way which makes assumptions about the gender of their partner.

Behaviours, identities and experiences

In starting to think about sexuality, sex and gender it is important to keep in mind the differences between behaviours, identities and experiences. Although these categories can overlap they are not identical. People may, for example, have had sexual experiences with both men and women but not identify as gay, lesbian or bisexual. People may have had no physical sexual encounters but still identify strongly as gay because of their experience of sexual, affectional or romantic attraction. Some people may have always lived as their assigned gender but will still claim a different gender identity. Intersex people have a vast range of experiences and how this impacts their identity and relationships with others and their body. It is important to listen to your client's experience carefully and discern what it is they are talking about and how they are framing their own experiences.



By focusing on strengths and resilient capacities, practitioners' efforts to construct more comprehensive and strength-focused assessments are enhanced. As a direct result of strengths focused assessments, practitioners can then develop more sensitive and effective interventions with their clients that make better use of already existing resilient attributes in their lives. This can conceivably help practitioners to avoid reliance on assessments and interventions that maintain a risk, vulnerability, and deficit-based orientation to practice with their LGBT clients.

— M. S. Smith and S. W. Gray, 2009

Some things you will need to explore before working with LGBTI clients

This booklet is written in the belief that any mental health professional can work well with LGBTI clients if they want to. Working with LGBTI clients involves using a range of common psychological interventions. However mental health professionals who wish to work well with LGBTI clients need to do so reflectively and supported by appropriate professional resources.

Firstly you will need to reflect on your own, perhaps unconscious, attitudes to sex, sexuality and gender. This is the first step to ensuring that you are prepared to work with this client group. You may also need to discuss this with your regular supervisor.

Secondly, sometimes working with LGBTI clients may bring up unfamiliar areas and you may need to seek advice or secondary supervision from colleagues who have more experience with LGBTI people. The need to seek advice, and to acknowledge and work through uncomfortable feelings that may arise, are not disqualifications for working with LGBTI people, they are grist for the mill in any creative encounter.

Finally acquaint yourself with research about LGBTI experience and best practice therapeutic interventions with LGBTI people. This is available in guides like this one, through professional training programs, through professional journals and published clinical guidelines.

Sex, gender and sexuality are important in all our lives and the emergence of vibrant gay, lesbian, trans, bi, intersex and queer cultures and identities has enriched the way we all think about ways of embodied being in the world. So thinking about and learning from LGBTIQI clients can be an enriching experience both personally and professionally.

For all of us, regardless of our sexuality, sex or gender, our experience of sexuality and gender has been socialised and we have all experienced uncertainty, fear and tentativeness around social restrictions on “appropriate” sexual behavior and gender expression. Some of us have grown up in more supportive environments than others but many of us, whether heterosexual or queer, have had to struggle with sexuality-negative and/or gender restrictive thinking in our society and our families. This restrictive thinking about sex, sexuality and gender may have also been present in the training many mental health professionals have completed.

Although some mental health professionals will have already spent many years processing their attitude to sex,

sexuality and gender it is important to honestly look at your own attitudes before working with LGBTI clients.

To be open to someone’s experience, when it is really different from your own, means that you may be challenged. Learning about their experience and seeking further information is part of answering that challenge. The other part is reflecting on your values, beliefs and attitudes: being open to how you might react positively and negatively in such an encounter.

Think about your own socialisation

Thinking about your own socialisation and your own attitudes to sex, sexuality and gender is essential.

Questions you may ask yourself include:

- What views of LGBTI people did you grow up with?
- What were some of the sources of these views?
- When and how did they change?
- How and when did you decide about your own sexuality?
- If you are heterosexual did you make a conscious choice?
- When did you ‘come out’ as a heterosexual, bisexual or homosexual?
- How do you understand the links between biology and sexual orientation and gender identity?
- What do you believe about bisexuality and why?
- What makes you think of yourself as a man or a woman?
- How do you think about the role of gender in your life?

Explore your own fears and judgments

Whether or not you are LGBTI yourself, you may have a number of friendships or associations with LGBTI people. Think critically about conversations you have had with them. Are their elements of their experiences or choices that you find puzzling? What do you most admire about them? Were there times when things they said shocked you? What have you learned from them?

Engage in an open conversation with LGBTI people you know in an effort to explore any hidden fears or judgments that you may have. Just as LGBTI people may have internalised homo/bi/trans -phobia, supportive heterosexual and cisgender allies often also have to work through a set of assumptions and internalised fears or judgments about LGBTI people.

Non-judgementalism is a therapeutic ideal, however it's impossible to be totally non-judgemental because all our lives are full of analysis and evaluations. Some unexpected judgements will shape and intrude into our thinking. Clinically it is important that we avoid inadvertently communicating our judgements to the client, and that we consider how they might shape and encroach on the therapeutic relationship.

Working with clients what is important is that we avoid inadvertently communicating our judgements to the client and look at how they might encroach on the therapeutic relationship.

Explore aspects of LGBTI cultures

Major cities will have LGBTI newspapers or magazines and both local and international publications are available online. LGBTI cultures are thriving in many cities and towns and experiencing LGBTI events and festivals can sometimes be helpful in deepening your understanding.

There are a range of LGBTI themed films and TV shows – both dramatic features and documentaries – that are widely available which can help you think about LGBTI people and their lives. Many novels with LGBTI themes regularly appear in the bestseller lists or win major literary awards.

One of the common experiences of LGBTI people is growing up feeling like you are an outsider, of being not quite right, not fitting in, asking: “How will I make my way in the world and be okay?” Many other people will also have had this experience because of their experience of race or ethnicity or some other mark of difference but many others grow up without this intense experience of outsider identity. In thinking about working with LGBTI clients it may be helpful to think about the ways that you have experienced being an outsider and the ways you have experienced being an insider in our culture. Try to find some connection in your own life that allows you to feel like you don't fit in or are not included or valued in the same way that others are.

Think about erotic issues and intimacy issues in the therapy room

In any long-term therapeutic relationship personal feelings – what the psychoanalytic literature would call transference and countertransference issues – may develop and these may or may not become erotised. This is true regardless of the gender and sexual orientation of the client and the gender and sexual orientation of the therapist. These issues need careful consideration and

attention. Think through strategies and reactions to a situation like this before it catches you unawares. This is an important issue to discuss with your supervisor.

Think about your own race, cultural identity and religion

Ethnicity, culture and religion have powerful effects on the ways we negotiate our sexual identities and the way we perceive and relate to LGBTI people. If you have, for example, been raised in a particular religious tradition that has negative views on LGBTI issues then you will need to think seriously about how you will negotiate these beliefs.

Because LGBTI people are used to negotiating their identity in a world which assumes that heterosexuality and gender conformity is the norm, they are often skilled at picking up subtle or even unconsciously expressed judgments. So before deciding to work with LGBTI clients therapists should question their own beliefs and ask themselves if they can remain open to and respectful of LGBTI experiences in the therapy room.

If after reflection you sincerely believe that this may be a problem then you may consider referring clients to a colleague you know to be LGBTI-friendly. This is an honest and ethical decision and may not be a permanent one.

Coming out as an LGBTI specialist and an ally

If you have thought about these issues; if you have begun to see some LGBTI clients; if you have done some professional development training; it is then time to come out yourself – as an LGBTI ally.

Heterosexual allies – such as the Parents and Friends of Lesbian and Gays (PFLAG) organisations – have been important contributors to the fight for LGBTI equality and rights. Many people from President Obama through to Lady Gaga have declared themselves allies through participation in popular social media campaigns like the “It Gets Better” video project, for example.

Heterosexual allies have been important contributors to the fight for LGBTI equality and rights. Many people from President Obama through to Lady Gaga have declared themselves allies.

You can show that you are supportive of LGBTI clients by simple things like including posters in your consulting room or ensuring that your organisation has relevant literature in the waiting room. You can raise issues about LGBTI clients in meetings with colleagues or at conferences and professional associations.

Same-sex development does not proceed in an orderly, invariant, or universal manner or occur within a set, or even typical, time frame (Savin-Williams, 2005). For example, although most adolescents self-identify as gay or bisexual prior to disclosing this information to others or dating a same-sex partner, some youth enter a committed romantic relationship before self-labeling. Unlike previous cohorts of gay men, an equal proportion of contemporary young men recognize that they are gay before engaging in homoerotic sex as after (Dubé, 2000). Whereas it is very common to recollect initial same-sex attractions prior to pubertal onset, it is not uncommon for attractions to first surface in high school, or later. Indeed, the variability what some think about as ‘developmental milestones’ related to sexuality is so large that in one study the age range among all 10 ‘identified milestones’ overlapped (Floyd and Stein, 2002). Thus, sweeping assumptions about “normal” or “typical” developmental trajectories should be rejected.

— Ritch C. Savin-Williams and Kenneth M. Cohen, 2007

Some theories that might help you think about LGBTI people's lives

This is not a theoretical or academic text but it does come from the experience of expert practitioners who are well aware of research in their field. Some key ideas and theories might be helpful in framing the wisdom of the counselling room. In this section we explore some key ideas and theories about sexuality that can help inform positive counselling practices with LGBTI people. Each of the “theories” presented here are also in their own way “practice wisdom” because they have been devised by experienced clinicians or from large data pools of aggregated LGBTI experience.

As with all ideas and theories, it is important to recognise that they are just that – ideas and theories – and to keep an open-mind and engage in critical reflection. These ideas and theories are merely tools for thinking about the varieties of LGBTI experience, and should not be used therapeutically to measure ‘maturity’ or ‘progress’. Many of these ideas were developed a long time ago and reflect a much more combative understanding of the place of LGBTI people in society. It is important for therapists and others to recognise that theories and ways of thinking are

developed at a particular time and place, and by particular people, influenced by their own social locations, and life experiences and influences. However these ideas and theories remain influential, are widely available through the internet, and will be well known to some LGBTI clients.

Therapists may find that some clients use them to think about themselves – sometimes, with inaccurate or unhelpful consequences or implications, such as potentially thinking that if they are not ‘out’, that they are somehow less ‘authentic’ or ‘developed’ than others. It is particularly important to avoid fostering overly-formulaic and rigid frameworks and promoting ideas and constraints based on what is considered ‘normal’.

The sexuality spectrum

Alfred Kinsey's pioneering studies in the 1940s popularised the idea that it is common for people to have had a variety of sexual experiences. Kinsey proposed that people's sexual behavior could be mapped along a spectrum which ranged from exclusively heterosexual at one end to exclusively homosexual at the other (Figure 1).

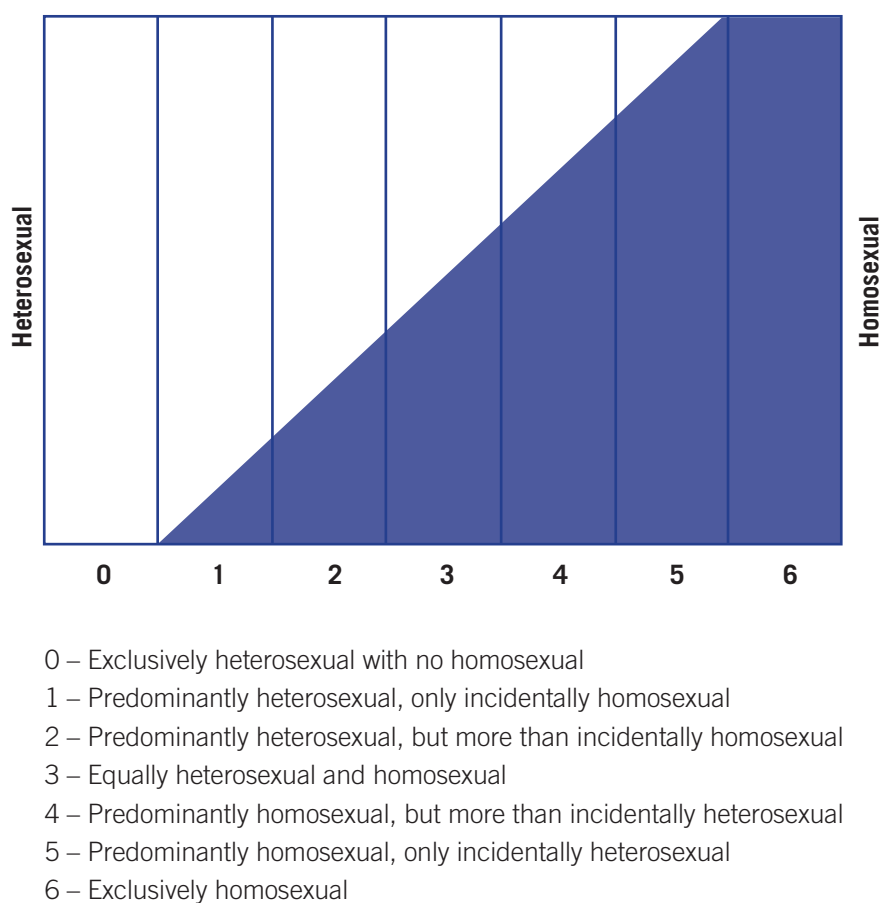
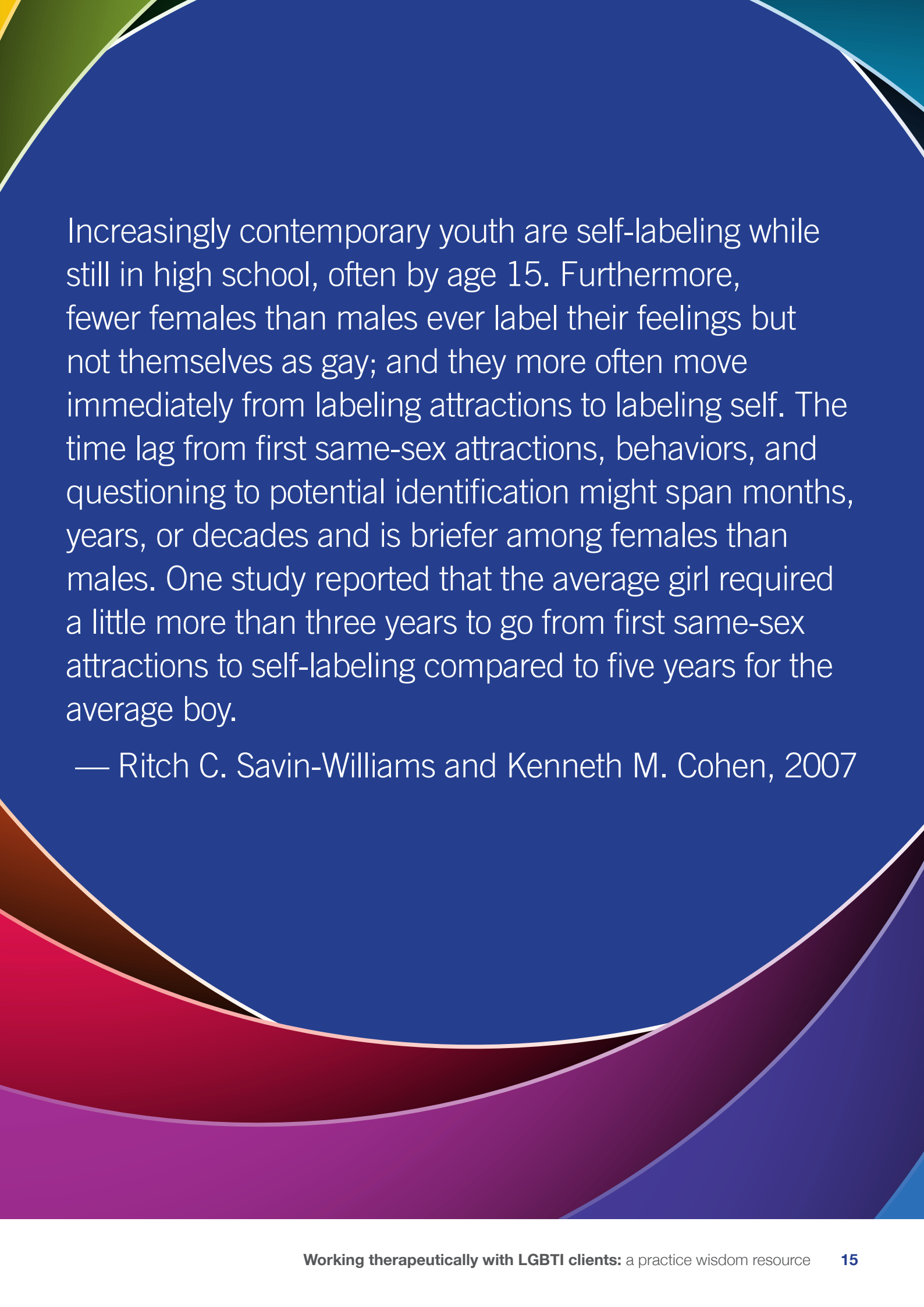


Figure 1 Heterosexual-homosexual rating scale. © The Kinsey Institute.



Increasingly contemporary youth are self-labeling while still in high school, often by age 15. Furthermore, fewer females than males ever label their feelings but not themselves as gay; and they more often move immediately from labeling attractions to labeling self. The time lag from first same-sex attractions, behaviors, and questioning to potential identification might span months, years, or decades and is briefer among females than males. One study reported that the average girl required a little more than three years to go from first same-sex attractions to self-labeling compared to five years for the average boy.

— Ritch C. Savin-Williams and Kenneth M. Cohen, 2007

This “Kinsey Scale” explained sexuality as a fluid set of practices that may vary from person to person and may vary over the course of a lifespan. However Kinsey’s model was based on surveys of sexual behavior not on an understanding of sexual identities, desires or romantic attractions and relationships. Some researchers have critiqued Kinsey’s methods, and certainly his famous 1 in 10 statistics have been superseded, but his basic contribution: that sexual behaviors should be understood as a naturally occurring variable spectrum of experience has been critical to contemporary understandings of sexuality.

Coming Out/Coming In

It was the work of Kinsey and other early sexologists who began to open up the public discussion which eventually led to the sexual liberation movements of the 1960s and 1970s. It was here that a wider discussion around sexual identity rather than just sexual behavior began to occur. One of the primary ways that these movements began to talk about sexual identities was through the idea of “coming out”.

‘Coming out’ is not a theory of sexuality but it has become a primary trope in popular culture for becoming public with being LGBTI. Although some trans and intersex people may frame publically acknowledging their identities in terms of “coming out” it is primarily a concept developed and deployed by gay men and lesbian women and some bisexual people. It is important to understand the complexities which sit behind this popular idea because it has become a kind of the shorthand, “common sense”, expression that is rarely thought through thoroughly and does not fit with everyone’s experiences.

‘Coming out’ or ‘coming out of the closet’ took on particular importance with the rise of the gay liberation movement in the seventies and eighties. With the rise of a public, politicised lesbian and gay movement, ‘coming out’ became a political strategy that emphasised the need for visibility and pride in a minority sexual identity. Rather than a story LGBTI people told themselves or one another, or at most to a few close personal friends, coming out became a public political statement of “out and proud” LGBTI people.

Because of its prominence as a political strategy, and a media strategy where high profile lesbian and gay people ‘come out’ on the covers of magazines, it has come to be almost synonymous in popular culture with the range of posited complex processes that LGBTI people might go through in relation to communicating with others about their sexuality and/or gender.

In this sense it is often mistakenly regarded as a one-off triumphant process that people must or should pass

through as a right of passage to ‘resolve’ their sexuality ‘authentically’. This popular idea of ‘coming out’ is at odds with many LGBTI people’s experience for whom ‘coming out’ is an extended process and one that does not necessarily mean that they inform all people in their lives about their sexuality and/or gender. It does not take account of the experience of some LGBTI people in particular communities for whom a ‘full’ coming out is simply not desirable or possible, or for the many people who strategically ‘come out’ or not on a flexible and variable basis. Finally it doesn’t allow for many contemporary ‘coming out’ stories which occur very smoothly, with very little fanfare and no great “ah ha” moments or anything to ‘come out’ from.

The politics of coming out may indeed be important for some clients, but in the counselling context it is the shape of the coming out story, if there is one, that is important. Twenty years ago, sociologist Ken Plummer wrote of potential benefits for some of “telling sexual stories”.

“Sexual stories aid in the creation of a past, a present or a future – marking out histories, differences, unities and agendas for action.”
(Plummer 1995:78)

In a range of different contexts, not just coming out stories, these sexual stories are stories of suffering and survival. Although they may focus on discrimination and difference they are almost always stories of resilience. Plummer also made the point that there is a strong intersection between politics, community and identity in the traditional ‘coming out’ narrative and its deployment:

For narratives to flourish there must be a community to hear; that for communities to hear, there must be stories that weave together their history, their identity, their politics. The one – community – feeds upon and into the other – story.

Plummer’s model may be useful in that it shapes the ‘coming out’ story as one of resilience and survival and marks it as one connected to the process and politics of community. He also argues that ‘coming out’ like other sexual stories are what he calls forms of “intimate citizenship”. They have relevance for individual lives, they have relevance for particular communities and sub-cultures and they have relevance for society more generally.

Although there may be some common themes or pathways, individual stories heard in the counselling room are precisely that: uniquely formed narratives. One of the problems with the emergence of very public narratives of ‘coming out’ is that LGBTI people may feel further isolated if their ‘coming out’ story does not confirm to the publically celebrated model or if they don’t ‘come out’ much at all.

Maybe they grew up in a very supportive environment and never experienced their sexuality as a particularly problematic issue or something that needed to be

Those who regularly encounter individuals who may be lesbian, gay, bisexual, or transgender know from firsthand experience that the many stereotypes found in popular media that have become so deeply etched in public perception have little correspondence with actual experience. In fact, practitioners familiar with LGBT individuals find that their clients are usually quite tough, that they respond to hardships and personal tragedies with notable resiliency, are remarkably creative in devising ways of transforming hardships into opportunities, and continue to make significant contributions to society despite being denied access to environmental supports available to most other groups.

— M. S. Smith and S. W. Gray, 2009

communicated or announced to others. Young LGBTI people will now often say: “I never came out, because I was never in”.

However some clients will come from families or particular cultural or religious traditions where being other than heterosexual and conventionally gendered is much less accepted, and they are not willing to cut themselves off from family and tradition by a dramatic ‘coming out’ declaration.

Maybe professional situations demand discretion about private sexual and gender identities.

Maybe by living in a small town where it is still not safe or comfortable to ‘come out’.

Maybe being sick and tired of ‘coming out’ again and again to different sets of people and just don’t want to talk about their personal or family lives anymore.

‘Coming out’ rhetoric can be particularly problematic for bisexual people who are often treated like they have one foot in and one foot out of the closet and are critiqued for a perceived inability to “make up their mind”. But increasingly people who are bisexual have adopted a version of ‘coming out’ as a political statement that validates their identity as bisexuals.

The ‘coming out’ story is one of resilience and survival and is connected to the process and politics of community.

‘Coming out’ is never a completed process because assumed heterosexuality remains the expected norm in much of our society. Even the most publically ‘out’ LGBTI person can be constantly surprised when they must yet again declare (or not) their sexuality or gender identity in a new social or professional situation.

Some writers have also started to talk about the “coming in” process as a way of counterbalancing this emphasis on public declarations of identity. What about the more intimate development of self that occurs internally and/or with close intimate friends and family? What about the process whereby LGBTI people are welcomed ‘in’ by others that accompanies the process of being ‘out’? Such a focus turns our attention to the systemic prejudice in society which requires LGBTI people to perform the act of ‘coming out,’ and asks everyone to look at how we can make our culture a truly inclusive one for everyone: a place where no one has to be indiscriminately “out” or “in”.

Bisexual ‘identity formation’

Although ideas like the Kinsey continuum of sexuality, recognises bisexuality as one part of the continuum of sexual expression, many bisexual men and women still experience a lack of validation of their identity. The force of the public lesbian and gay movement and the prominence of its ‘coming out’ narrative have led to a widespread perception that people who say or think they are bisexuals are really gay men or lesbian women who haven’t managed to ‘come out’ yet.

Research on attitudes towards bisexual peoples shows that they confront a range of very particular negative attitudes from both mainstream society and from within lesbian and gay sub-cultures. The view that bisexuality is a transitional stage on the way to a full ‘coming out’ as lesbian or gay stigmatises bisexuals as ‘inauthentic’. Because bisexuality is regarded as an inauthentic choice, bisexual men and women are often stereotyped as ‘untrustworthy’ and because they are open to sexual experience with both men and women they can be regarded as hyper-sexual, promiscuous and therefore potentially disloyal partners (Klesse 2011).

However like other queer communities, bisexual men and women have begun to tell their own sexual stories and to claim a sexual and cultural identity for themselves.

On the basis of interviews with 20 people in the early 1990s, Mary Bradford (2004) proposed a model of what she called bisexual “identity formation” which shares a number of the characteristics of the other models of sexuality discussed in this chapter. However she proposed that in many ways bisexual identity formation can be more complex than that experienced by either heterosexuals or gay and lesbian people.

Bradford noted that, because of the historic invisibility of bisexuality in our culture, there can be a “questioning stage” during which, bisexual people can doubt their experience of both or either same-sex and other-sex attractions. She suggested that unlike lesbian and gay people who can rely on the public narrative of ‘coming out’, many bisexual people feel that they need to invent their own identity and that even when they feel comfortable with their own self-identification, they have to engage in a long process of publically maintaining this identity.

Some bisexual people might use these processes as an opportunity to take social action and they further their personal growth through activism in the bisexual and queer communities.

The unfolding of homoerotic development has been deeply influenced by the sexual revolution that has both normalised and destigmatised same-sex sexuality, particularly among youth. One consequence has been an accelerated evolution in which developmental cohorts, or generations, transform every five years and contain greater intragroup variability than during any preceding era.

— Savin-Williams, 2005

The increasing acceptance of sexual diversity and mainstreaming, rather than ghettoising, homoeroticism have allowed contemporary cohorts of same-sex attracted youth to incorporate and express life-styles, perspectives, and languages that are similar to those embraced by heterosexual youth. Stereotypes have dwindled as gay youth increasingly reveal that they vary among themselves in much the same way as heterosexual youth vary – shaped more by their gender, ethnicity, physical attributes, personality, and economic class than by their sexuality.

— Ritch C. Savin-Williams and Kenneth M. Cohen, 2007

Recent studies indicate high levels of depression and anxiety in bisexual people. One recent analysis of the peer reviewed literature concluded:

International studies that explored bisexual people separately from homosexual people showed that bisexuals have higher rates of depression or depressive symptoms than heterosexual people and, further, are at the same or higher risk for depression than homosexual people. This tendency appears to be particularly robust for women (young and adult); however, it is difficult to make any firm conclusions about sex as the data on bisexual men is much more limited, and there were few findings that compared bisexual men with bisexual women. The ARCSHS studies support the proposition that high rates of depression in Australian non-heterosexual people may be slightly inflated due to even higher rates of depressive symptoms in bisexuals. Indeed, in all four ARCSHS studies described in this section, bisexuals exhibited poorer mental health than homosexuals. (Corboz et al 2008).

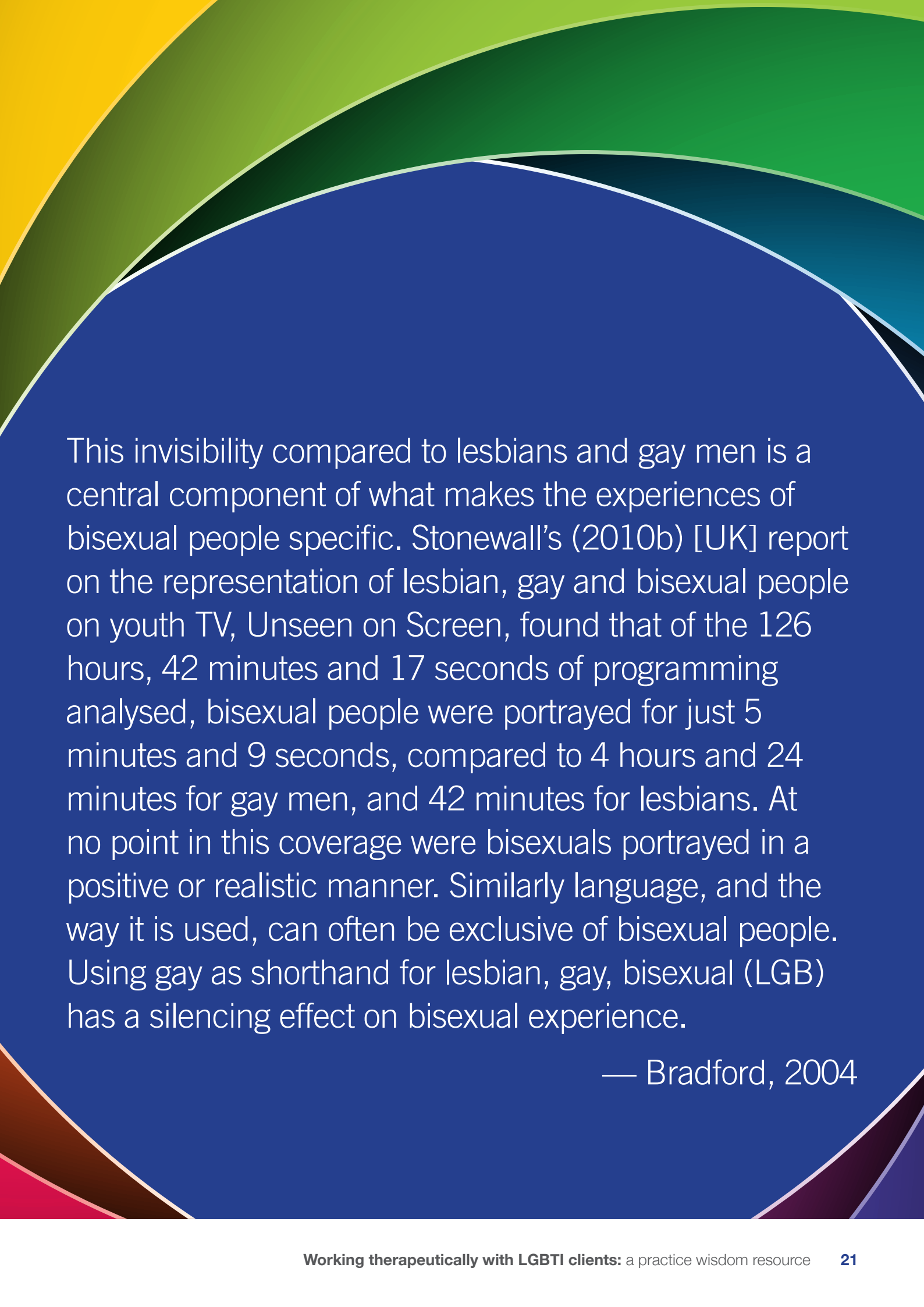
Queering the pitch

Queer Theory is both an academic and a political movement that has reclaimed the derogatory term “queer” as a way of reinvigorating thinking about the positive connections between divergent sexualities, the normal and the marginal. It also helps us to think about sexuality and gender in different ways that go beyond simple and frequently criticised ‘identity’ and ‘stage’ models.

For some it is used as a handy, gender-neutral shorthand for all the members of the LGBTI alphabet. Others use the term queer to distinguish new thinking about a politicised sexual identity from an assimilationist or rights rhetoric of the LGBTI movement.

One thing that queer reminds us about, in the counselling room, is that difference can be positive and that traditional psychological approaches, that have historically prioritised ‘adjustment’ and fitting in, are problematic, not necessarily accurate, and that can have their own unintended negative consequences or implications. For some, queer identity is not about fitting in; it is about exploring alternative visions of the world and the way it should be and moving away from binary or rigid conceptualisations.

Queer also highlights a contested and open idea of identity-in-process that doesn’t fit neatly into easy schemas of identity development. It also draws attentions that sexual identities intersects with, and are inseparable from, a range of others such as those based on race, class and gender. It is a critical perspective which acknowledges that diverse sexuality and sexualities may provide particular vantage points to look at and think about these intersections.



This invisibility compared to lesbians and gay men is a central component of what makes the experiences of bisexual people specific. Stonewall's (2010b) [UK] report on the representation of lesbian, gay and bisexual people on youth TV, *Unseen on Screen*, found that of the 126 hours, 42 minutes and 17 seconds of programming analysed, bisexual people were portrayed for just 5 minutes and 9 seconds, compared to 4 hours and 24 minutes for gay men, and 42 minutes for lesbians. At no point in this coverage were bisexuals portrayed in a positive or realistic manner. Similarly language, and the way it is used, can often be exclusive of bisexual people. Using gay as shorthand for lesbian, gay, bisexual (LGB) has a silencing effect on bisexual experience.

— Bradford, 2004

Thinking about gender and changes and variation in gender

Despite prevailing cultural understandings that male and female gender identities are fixed and easily assigned, psychologists, physicians and social theorists have shown that gender identity and expression is best seen as a flexible socially-constructed spectrum rather than as a fixed binary classification. In this guide we refer to trans people to indicate a variety of people who seek to affirm a gender identity, or expression, different to their sex assigned at birth. This includes transsexual people who will employ a range of medical interventions to effect this affirmation and a diverse group of other transgendered people who express their gender independence in a range of ways. Facebook now provides over 50 different alternatives when asking people to list their preferred gender.

Unfortunately the psychological literature often still uses terms and concepts such as “gender dysphoria” and “gender identity disorders” as the primary ways of describing the experience of people with non-traditional gender identities and their relationship to their assigned sex and bodies. Gender independent, gender diverse or gender variant are better ways of describing the experiences and identities of trans people without such pathologising language. As recently as 2010 the World Professional Association of Transgender Health (WPATH) felt it necessary to produce a major statement drawing attention to this:

The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative.

In their most recent Standard of Care guidelines WPATH make the important distinction between gender non-conformity and gender dysphoria as a psychological condition:

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex. Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Only some gender nonconforming people experience gender dysphoria at some point in their lives.

If “coming out” is a primary metaphor used in relation to lesbian and gay people to talk about developing sexual identity processes, “transitioning” is a common expression in relation to changing gender identity processes.

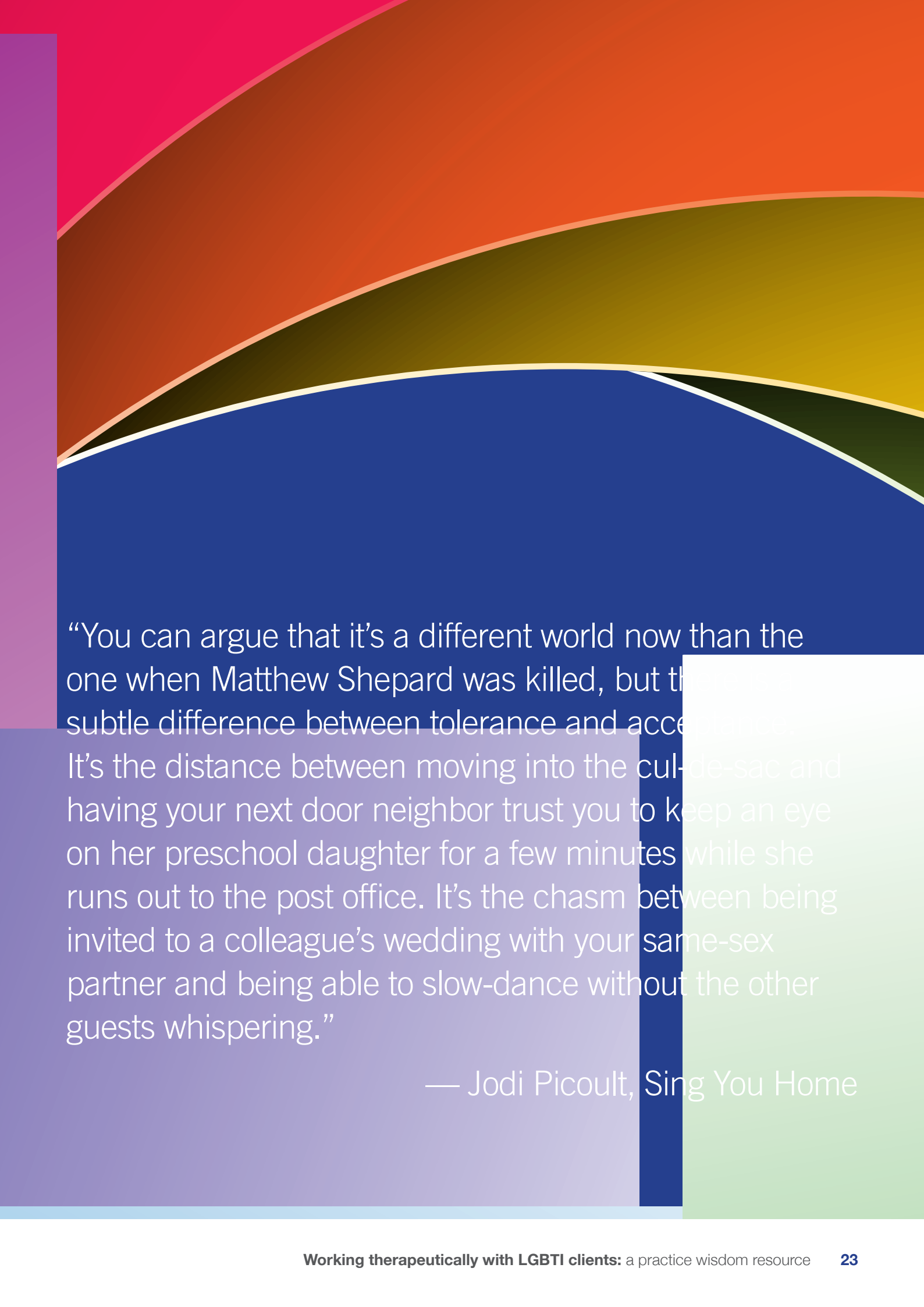
Transitioning is a process whereby trans people move to live in a way that affirms their gender identity rather than the gender they were assigned at birth. Transitioning takes on a range of different expressions for individual trans people. Most trans people will undergo a ‘social transition’ where they express their gender more freely and openly, disclose their gender identity to others and inform them of their preferred pronouns and name. Some will take hormones that will assist them in either feminising or masculinising their bodies in accord with their affirmed gender identity. Some will also undergo surgery to further assist a physical transformation in line with their gender identity. However not all trans people will take hormones or engage in surgical procedures, some choose to live as their affirmed gender without medical intervention. Some might refer to themselves as genderqueer or transqueer because they prefer to take on a range of gender expressions and roles which they do not want to be categorised as traditionally male or female.

Genderqueer clients need support in their choices to identify in ways which do not fit male female gender binaries as they commonly have particular problems negotiating social systems which seem to demand definite and binary gender choices. They may even sometimes feel pressure from other trans or LGBTI people to choose a particular gender expression. Clinicians need to be attuned to the variety of gender fluidity, expressions and choices and not inadvertently pressure clients to make a particular choice.

Trans people will also present with a variety of sexual orientations and these are independent of their gender identity. It is important that practitioners do not make assumptions about trans people's sexual choices or likely attractions. Many trans people will be heterosexual while some others will be gay, lesbian, queer or bisexual.

Transitioning is not just a physical or external process, it is a process whereby trans people become increasingly at home with their affirmed gender identity. Sociologist, Aaron Devor, in 2004, has expressed this in a 14 stage model. It is useful in delineating some of the ‘stages’ that some trans people might go through but like all such conceptual models it is limited and far from universally applicable. It incorrectly assumes that there is a final stage of trans identity formation, which is achieved through medical intervention.

Devor introduces two potentially useful ideas when discussing his model: the importance of witnessing and mirroring. He posits that in any processes of identity formation we may need to be seen by others for who we are – witnessed – and to see ourselves and our possibilities in others who are like us: through a process of mirroring. This may be acutely important for trans people who often feel unseen for who they are because their physical identity in the world does not match their own affirmed identity.



“You can argue that it’s a different world now than the one when Matthew Shepard was killed, but there is a subtle difference between tolerance and acceptance. It’s the distance between moving into the cul-de-sac and having your next door neighbor trust you to keep an eye on her preschool daughter for a few minutes while she runs out to the post office. It’s the chasm between being invited to a colleague’s wedding with your same-sex partner and being able to slow-dance without the other guests whispering.”

— Jodi Picoult, *Sing You Home*

Devor's posited 14 stages suggests that periods of what he conceptualised hesitation, delay and identity comparison occur even after trans people come in contact with ideas about transgender or transsexual identities and experiences. Devor himself noted that this is not always the case and that trans people position themselves in various and flexible ways and after their discovery of transgender identities.

The 'stages' that Denver conceptualised included periods of: preferences for activities commonly associated with the gender that was not assigned at birth; first doubts about the suitability of the originally assigned gender; seeking and experimenting with gender identities; learning about the existence of transsexual people and transexualism; seeking further information; further exploring transexualism and starting to disidentify with originally assigned gender; increasing identification as transgender and increasing disidentification with original assigned gender; seeking further information and looking for changed circumstances; telling others about a changed gender identification; researching, planning and undergoing sex and gender transitions; post-transition life, including managing stigma and being involved in advocacy in some way.

Gender is one of our most entrenched social constructs, and as feminism and men's studies have shown it is also deeply problematic. Even in the most enlightened families and social circles we grow up with a set of embedded gender cues that are rigorously tied to our assigned birth sex. So no matter how deep seated the inner cues experienced by trans people are, there is an inevitably difficult process making sense of them in the context of our social conditioning.

Further, although the social visibility and acceptance of trans people has improved dramatically in recent years, trans identities are still not publically celebrated and validated as readily as lesbian, gay and bi identities. This means that opportunities for witnessing and mirroring trans identity are often less apparent than those available to lesbian, gay and bi people.

Trans people who seek medical interventions also have to negotiate an often confusing and expensive medical system which further exacerbates the experience of stigma and adds a unique layer of stress to transition processes.

All these factors increase the stigma, minority stress and lack of public understanding that people experience before, after and during transition.

The deeply embedded social resistance to an open discussion about, and acceptance of, gender variant experience has recently been described by trans scholars as "cisgenderism".

Trans scholar and psychologist Gavriel Ansara and others have adopted this term to describe the systemic forces in society which mitigate against the recognition of trans and intersex experience:

Cisgenderist ideology involves multiple, intersecting assumptions that construct people's own designations of their genders as less valid than those made by external authorities. Cisgenderist ideology constructs the world as having only two valid genders and sexes, thus ignoring societies in which there are more than two official gender categories. Cisgenderist ideology also ignores people who may self-identify with the adjective intersex, the most widely preferred term internationally for people whose bodies are often excluded by medical norms that recognise only "female" and "male" bodies. Cisgenderist social norms treat biological sex as an authoritative category distinct from gender, assuming that gender maps fit uniformly onto sex. Based on these assumptions, a cisgenderist perspective also assumes that gender is universally experienced as a permanent and intrapsychic identity, rather than as a shifting relational status, and that each "normal" person has a single "real" gender that does not shift across the lifespan (e.g., all boys grow up to be men, and boys who grow up to be women must have "really" been girls all along)." (Blumer, Ansara & Watson 2013)

This perspective challenges us to think carefully about our own assumptions in regard to gender expression, gender roles and gender identity. It moves beyond any essentialist understanding of gender and embraces what sociologists and psychologists would call a "constructionist" point of view: that gender and sexuality emerge in individual lives and are part of a broad set of interacting social, cultural, psychological and biological conditions. Because of its broad embrace this is a particularly helpful framework for client-centered psychological interventions because it does not preclude choices or prescribe specific solutions.

Intersex experience

Intersex is an umbrella term that describes people who have natural physical variations that differ from conventional ideas about 'female' or 'male' bodies. These natural variations may include genital, chromosomal and a range of other physical characteristics. People are born with many different kinds of bodies. Although intersex people are often confused with trans people, the term intersex refers to a diversity of physical characteristics. Most intersex people identify simply as women or men but they are deeply affected by our medical, cultural and psychological understandings of gender.

Early on I am told to get in line after a morning bell, girls in one line, boys in another. I walk past the girls feeling this strange, powerful gravity of association. Yet some part of me knows I have to keep walking. As soon as I look towards the other line, though, I feel a feeling of differentiation that confuses me. I don't belong there, either. I stop between them. The nun I realise is staring at me, she's shouting at me. I don't know what to do. She grabs me, she's yelling at me. I'm not trying to disobey, I'm just trying to fit in. My silence starts to infuriate her, and she starts to hit me ... [My mother is called] She jumps out of her car, she hurls herself at this nun. She rips me away from her, rescues me. She warns the nun never to touch me again. She takes me home and she's trying to understand what happened, but I have no real language to describe it.

— Trans film director, Lana Wakowski

Children can be born with a large range of sex characteristics. These natural variations may include genital, and a range of other physical characteristics. Studies have suggested that this occurs in 1 in 2000 live births but numbers may be as high as 1 in 100 births because many will initially go undiagnosed.

Intersex bodies which manifest with a range of physical, hormonal and chromosomal variations challenge traditional understandings of sex, gender, gender assignment and the medicalisation of gender. As such, intersex people have had a long struggle to claim their rights to self-determined gender expression and human rights.

Even well-meaning physicians have often insisted on invasive and unnecessary surgery to “normalise” young intersex bodies and to “naturalise” a given gender assignment. However this surgery, apart from being imposed without choice, often leads to long-lasting, painful after-effects and is usually completely unnecessary from a health perspective.

Intersex people, therefore often grow up with a deep sense of shame about their bodies and a sense that they have no control over their gender expression.

When working with young intersex clients it is critical that they are assured that their bodies are a natural human variation and that they do not have to make particular choices to conform to common understandings of gender or gender expression. They do have the options of negotiating particular medical interventions at some point if they feel this will affirm their chosen gender identity.

Many intersex people will identify simply as a man or a woman but intersex people also now identify with a range of gender expressions and self-designated gender identities which go beyond a male female binary.

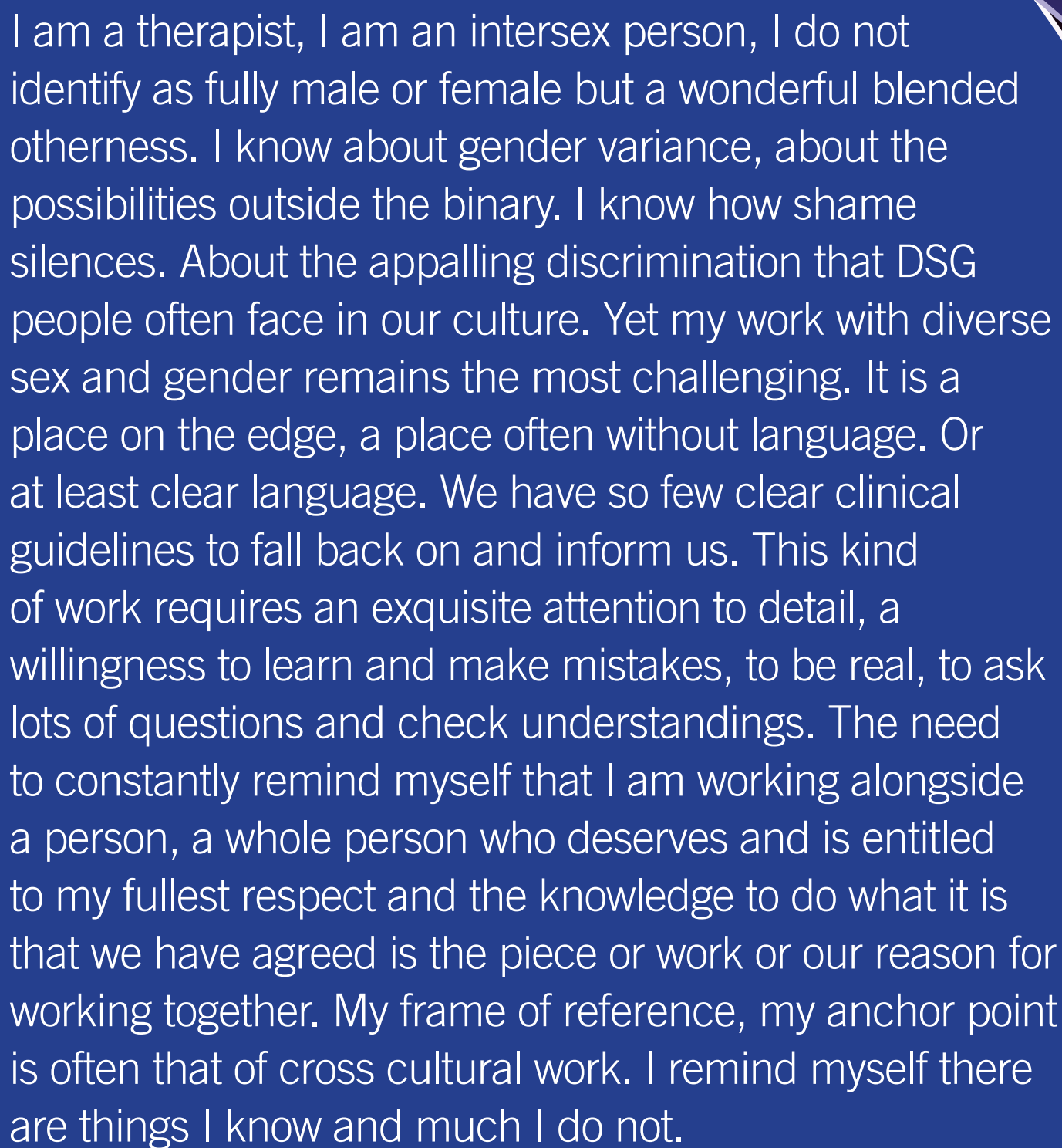
Treatment models and understandings of intersex identity have changed a lot in the last decade and Alice Dreger has described this as a movement from a “Concealment-Centered Model” to a “Patient-Centered Model”.

In the “Concealment-Centred Model” being intersex is treated as a problem or a rare medical abnormality that needs to be concealed or masked through medical intervention. This is done so the child might have a “normal” life. Underlying assumptions governing this model include beliefs that ambiguous or varied physical gender expression will lead to suffering and lack of social integration and ought to be avoided. Parents and physicians under the sway of this model believe they have an obligation to intervene to protect their intersex child. In this model assigning a child’s gender is a mathematical calculation based on a set of clinical hormonal tests and unnecessarily pathologises intersex variations as ‘Disorders of Sex Development’.

In the “Patient-Centered Model” intersex bodies are seen as a relatively common natural variation and any medical intervention is regarded as a personal matter of choice and only to be undertaken where clear physical health concerns dictate this as necessary. Gender expression is regarded as a broad continuum and is not a simple calculation that is medically assigned. Intersex children and adults are regarded as autonomous subjects who can determine their own gender identities and expressions and make choices about their medical needs. This is something that can happen over time and change with their growing understanding and evolving needs. The underlying assumption in this model is that intersex people have the right to self-determination and that any unnecessary interventions by parents or physicians early in life may irrevocably interfere with those rights.


Although contemporary health care practices have changed, many intersex clients will have grown up having been traumatised and shamed through their experience in a concealment-centered medicalised system of care. But like other LGBTI people they will have developed a set of personal resilient strategies in response to the discrimination and impositions that they have faced. These clients will need deeply affirming person-centered therapeutic work to support them in developing lives of confident self-determination that validates their resilience and acknowledges their pain.

Intersex people will make a range of choices in their sexual partners and sexual orientation is independent and unrelated to their physical sex characteristics or chosen gender identity. Many will be heterosexual and some will be gay, lesbian, queer or bisexual. Whatever their sexual orientation, intersex people may well present with a range of issues around sex because the concealment-centered model tends to have contributed to a sense of embarrassment about their bodies.



I am a therapist, I am an intersex person, I do not identify as fully male or female but a wonderful blended otherness. I know about gender variance, about the possibilities outside the binary. I know how shame silences. About the appalling discrimination that DSG people often face in our culture. Yet my work with diverse sex and gender remains the most challenging. It is a place on the edge, a place often without language. Or at least clear language. We have so few clear clinical guidelines to fall back on and inform us. This kind of work requires an exquisite attention to detail, a willingness to learn and make mistakes, to be real, to ask lots of questions and check understandings. The need to constantly remind myself that I am working alongside a person, a whole person who deserves and is entitled to my fullest respect and the knowledge to do what it is that we have agreed is the piece or work or our reason for working together. My frame of reference, my anchor point is often that of cross cultural work. I remind myself there are things I know and much I do not.

— Mani Mitchell



The critical roles of biphobia and monosexism in participants' mental health experiences were apparent in their responses. Bisexuality is often dismissed or disallowed at a structural level, to the extent that participants felt they were constantly required to justify or explain their sexual identity: “[Y]ou’re either straight or you’re gay/lesbian. [People] don’t see that there are other possibilities” ... Bisexual identity was structurally disallowed for transgender and transsexual participants in particular, as in the example of gatekeepers to gender identity services: “The general stereotype is that if you’re bisexual, you’re probably not transsexual, you’re just confused. And that if you really are a transsexual and you really are a woman, then you should only be attracted to men, otherwise this is all bullshit” .

— Ross, et al., 2010

Working well with LGBTI clients

What LGBTI clients want from therapists

Clients present with a range of issues in their lives when coming to a mental health service or therapist.

In talking with a new client about their experiences, issues of sexual or gender diverse identities may emerge in different ways. Clients may mention in passing that they are gay, lesbian, bisexual, transgender, queer or intersex.

Clients may describe difficulties, because of social pressures, prejudice, or instances of discrimination they have experienced because of being LGBTI. They may describe relief and personal satisfaction of having worked through these issues in the distant or recent past. For some clients, realising and sharing with others their sexual orientation, intersex status or gender identity may have been relatively easy.

For some clients issues about sexuality and/or gender identity construction and affirmation might be foregrounded as a set of powerful current emotional experiences, for others these process may not seem particularly relevant or to be largely in the past.

Whatever way the client presents, one of the most important things to remember is that sexuality, sex and gender are only part of a person's life.

Sometimes therapists feel somewhat in a bind or unsure what to do.

On the one hand we want to appear supportive and open to engaging with issues to do with sexuality, sex and/or gender, but on the other hand honing in on these issues with too fine a focus leaves a range of other connected issues in their lives underexplored.

Sometimes in our enthusiasm to appear supportive we can over-emphasise the story of sexuality while under emphasising other important areas that need attention. This is the same for gender and sex, in our eagerness to affirm a person's gender identity, we may not seek to explore connections and meanings the client's exploration of gender has with other issues. But equally, any lingering discomfort around issues of sex, sexuality and gender may lead therapists to skate too quickly past these issues when at first glance they do not seem to be related to pressing presenting issues.

Clients' own awkwardness in talking about aspects of their sex, sexuality and/or gender, which may arise from

internalised negative social attitudes and shame, can further complicate striking the right balance.

So respectfully dealing with issues of sexuality, intersex status and gender identity in people's lives involves fine-tuned listening, to gather the nuances of their story and their range of presenting issues, experiences and beliefs.

Whether homosexual, bisexual or heterosexual, and whether intersex, or transgender or cisgender, working with LGBTI clients demands the development of empathy – finding a way into understanding LGBTI people's experience.

Most LGBTI clients are not going to present saying: "I want to talk about my sexuality" or "I want to talk about my gender" or "I want to talk about being intersex".

Most LGBTI clients will present saying: "I am feeling more anxious than usual" or "I'm feeling quite depressed lately" – in other words most LGBTI clients will present with the same range of everyday, chronic and acute, issues as other clients.

LGBTI clients want to be able to talk freely about the totality of their lives. So if it is relevant they will want to talk about their current feelings around sex, sexuality and/or gender but equally they may not want to talk about that at all or until later in the process when a deeper level of trust has been established.

Because many LGBTI people have learned to live with the stresses of being different over a long period of time, they may not be aware of the toll that this experience of chronic low-level stress creates. So a client may enter therapy, or some other counselling relationship, thinking that they do not need to talk about their sexuality, intersex difference or gender identity. But slowly both the client and the therapist may discover – together – that the residual effect of this stress is a big part of a presenting problem such as depression.

Like any complex emotional issue, these sorts of discoveries occur in an open supportive therapeutic relationship where the client leads the discovery.

Therapy is relational

The most obvious point to make about working therapeutically with LGBTI clients is that psychological work of any kind emerges out of a trusting relationship between client and therapist.

Although this is true for all clients it is particularly important to remember when working with LGBTI people, nearly all or all of whom will have had some history of rejection and prejudice in their lives.

For people who grew up feeling different, and or rejected, and who may have internalised negative societal judgements about being LGBTI, being able to explore their lives in a safe non-judgemental space is the first requirement for productive therapy to occur.

Whether the therapist or counsellor is homosexual, bisexual or heterosexual, and whether intersex, or cisgender or transgender, working with LGBTI clients demands the development of empathy – finding a way into understanding the LGBTI experience. Empathy comes from finding something in ourselves that we can use to understand the client's issues - something that we have experienced in our life, that might give us some idea of what it might be like for our client.

Therapists working with LGBTI people need to demonstrate their knowledge and understanding, rather than a shared sexual or gender identity, but there are a variety of ways to create connection to clients and sometimes it will be appropriate to use “we” language to express solidarity.

Establishing a framework with your client

Part of developing this empathic, relational experience is establishing an explicit framework at the beginning of the process and sending clear signals throughout.

Again this involves standard procedures used with any client: introductory negotiations about what the client wants to get out of the sessions and some disclosure of the therapist's approach. Although practitioners are rightly wary of inappropriately talking about themselves, shifting the attention to themselves, or making a therapeutic relationship personal, some recent research (Borden et al 2012) suggests that both personal and professional disclosure can be important elements in therapists establishing trusting, effective relationships with LGBTI clients. This research suggests that LGBTI clients may be more likely to trust those who give both a personal and professional introduction that discloses elements of their psychological approach and their background.

Because many LGBTI people have grown up not disclosing their sexuality, sex or gender, what is said and

unsaid can be very significant in their lives. So using explicit language and asking explicit questions is important in signaling that the therapist is open to exploring areas that may have seemed unspeakable in other contexts.

In listening to LGBTI people's stories the therapist can play an important role in helping the client acknowledge and name both strong and difficult emotions and the quality of resilient responses that emerge in their narratives.

An important part of working empathically and affirmatively with LGBTI people is paying careful attention to the language that clients use.

LGBTI people adopt a range of terms and labels to describe themselves, their lives and their identities.

Many men who present and talk about sexual attraction or relationships with men will be comfortable referring to themselves as gay. Likewise many same-sex-attracted women will label themselves as lesbian or gay. But the therapist should never assume this is the case.

Some deliberately choose to avoid labels such as gay or lesbian or bisexual. Some, particularly younger people, may want to use the more inclusive term queer or not use labels at all. Some women and men still prefer the term homosexual. Some women don't like lesbian and will prefer gay or dyke.

Trans and intersex people will also label themselves in a variety of ways: trans, transgender, transsexual, genderqueer, intersex, FTM, MTF, female, male, gender fluid and many more.

There are a range of personal reasons that people adopt or reject certain labels to describe their own behavior and identity and these choices are important to recognise and honour.

It is important to recognise that people's choice of different labels does not necessarily reflect anything about their state of comfort with their sexual identity. For example, someone who says “I don't regard myself as gay just because I am having this relationship with a man,” may be expressing an understanding of fluid sexual identity and/or a strong bisexual identity.

Similarly, be particularly attentive to the pronouns used by trans clients in referring to themselves. Most will use the pronoun appropriate to their assumed gender but some may choose gender neutral pronouns such as “they” or “zie”.

Trans people refer to social and medical transitioning processes in different ways. Take your lead from the

You are who you are, and the view I always took when I went into Parliament is that I would be completely open about who I am and not hide that at all. I think you have to demonstrate that kind of dignity in the face of criticism or offensive disrespect, not just for yourself but because of how other people fare. I think it is important to show people who are marginalised that they are OK, not just by what you say but also how you behave. When you stand up and speak, someone who experiences racial abuse or homophobic bullying hopefully see that ‘it’s not about me, but it’s about them.’ They are OK and they do not have to put up with it.

— Labor politician, Penny Wong

client and refer to transition processes in the way they do. For example, some will speak of “changing” gender while others will talk of “aligning” or “correcting” their gender identity. Therapeutically, what’s important is to pay attention to what that means for the client.

As with all clients, relationship terms also need to be attended to. While perhaps most clients will use the term “partner” some will use other terms such as “lover”, “girlfriend” or “boyfriend”. With the advent of same-sex marriage some LGBTI people prefer to use husband or wife for their same-sex spouse. You should not assume that the use of any of these terms implies a corresponding acceptance of the traditional gender roles often associated with such relationship terms.

If after sustained and careful listening, if there is any doubt about getting the language right in relationship to someone’s sexual and/or gender identity, intersex difference and experiences, or relationship status it is best to simply ask directly.

Naming experience

Not long ago homosexuality was known as “the love that dare not speak its name” both because of the prejudice attached to gay and lesbian sex but also because a public language did not widely exist to talk about gay and lesbian lives. This is also true for bisexual, trans and intersex people whose public visibility and rights have also slowly evolved. It is only relatively recently that LGBTI people have been publically telling their stories in far greater numbers. Finding their own story and creating a unique personal script which goes against many of the dominant scripts in our society is an important part of what is often called the “coming out process” and is also an important part of what some refer to as “coming in” to themselves.

Therapy with LGBTI clients involves helping clients develop stories and scripts for living that validate their experiences and identities, which are in many ways different to the dominant narratives of sex, sexuality and gender.

Part of this story telling and naming of experience involves working with the dialectic of distress and resilience that is part of LGBTI people’s lives. Different clients will have reacted to this dialectic in different ways and differently over time. Some may be very aware of the negative effects of the prejudice and discrimination that they have experienced, without acknowledging their often resilient navigation of such difficult circumstances. Others will be very focused on their own strength to resist dominant narratives of oppression and might find it hard to acknowledge the hurt they have experienced in their lives.

In listening to LGBTI people’s stories the therapist plays an important role in assisting the client acknowledge and name both the depth of trauma and the quality of resilient responses that emerge in their narratives.

While many therapists try to remain generally neutral in the counselling room, sometimes working with LGBTI clients (as with other people who have experienced marginalisation and prejudice) requires making your empathy and support explicit, because many LGBTI clients may have grown up without the support of allies or peers.

Sometimes it will be important for the clinician to say, “What happened to you wasn’t okay. It shouldn’t be like this.”

Deciding when, whether and how to adopt such an explicit tone with a client will depend on a number of individual circumstances. Just as with other clients, clinicians need to pay careful attention to potential interpersonal dynamics and “transference” processes and decide when and if such an intervention will be heard and useful for the client.

It is often important for LGBTI clients to hear explicit statements of support for LGBTI people’s rights and explicit condemnation of social prejudices in the context of therapy.

Going beyond a standard model of non-judgemental empathy can be important with some LGBTI clients so they can hear – maybe for the first time – this explicit message of support. This may then open up other spaces in the therapeutic encounter: What is it like for the client to hear that message of support? How does the client make sense of this experience? What impact does it have on them? How do they change patterns of behaviour knowing that support is available?

Even clients who present with very successful lives and demonstrate significant satisfaction of their LGBTI experiences and/or identities may reveal emotional vulnerabilities as they explore and revisit their experiences of facing prejudice or ignorance. Because LGBTI people encounter expressions of prejudice and discrimination from a very early age and continue to encounter it throughout their lives they can often carry residual distress into their later lives even while simultaneously demonstrating pride in their LGBTI lives.

The counselling room may be the only opportunity that these clients have of retelling their story: naming both the difficulties they experienced and the ways they have overcome the barriers that culturally negative attitudes set against LGBTI people’s self-regard.

In working with clients’ experience it is often important for them to name these experiences and explore their emotional tone. Sometimes in these situations it might be helpful to name the experience: “That sounds like it was

I have never had a satisfactory explanation to me of how my loving relationship with my partner in any way damaged the institution of marriage or would if marriage were available to us, damage that relationship, or diminish it or degrade it in any fashion whatsoever ... A loving relationship of tenderness, of gentleness and affection, and fidelity and support is a beautiful thing and anyone who would disrespect it is not a kind person.

— Justice Michael Kirby

deeply hurtful for you.” This can provide an explicit sense of validation for the client and an acknowledgment that their pain is recognised by another – a pain that they may have hidden from themselves and others in an effort to remain strong in the face of social negativity.

Explicitly naming and celebrating achievements with the client begins the equally important process of exploring their repertoire of coping and personal-development strategies.

Adopting a sociological as well as a psychological analysis

Part of the reason why the negotiation of early LGBTI people’s experiences often remain emotionally powerful, even into later life, is that prejudice and discrimination is still a reality.

Even the current very public debate about same-sex marriage is a fraught public spectacle. It is energising for LGBTI people to see broad public support developing for the reality of their loving relationships, but the debate has also become a site for the repetition of deeply offensive rhetoric about LGBTI people, their relationships and their families.

This constant experience of being treated a site of public debate and confrontation is inevitably wearing for many LGBTI people. It can induce a range of emotions from anger, to sadness, to buoyant fighting spirit.

Because the psychological lives of LGBTI clients are so integrally related to the social negotiation of attitudes around sex, sexuality, gender and gender expression, helping professionals must adopt a sociological as well as a psychological analysis.

So in working with LGBTI clients it is important to not only explore and name the many powerful emotional realities experienced, it is particularly important to also explore the social causes and implications of their experience. It is important to place experiences of such things as belittlement, hurt and rejection, in their social context.

It is important to explicitly acknowledge that many LGBTI experiences of hurt, rejection and social isolation arise from the mechanisms of socially entrenched patriarchy, heterosexism and fear of difference.

From a psychological point of view a clear sociological analysis assists any lingering sense of victim-blaming that can be a part of internalised homo/bi/transphobia or prejudice. But it is also part of making the counselling room an explicitly, safe, affirming environment and an acknowledgement that prejudice and discrimination is a social problem that everyone must address by taking a stand.

Naming and mapping social networks

Because the experience of both distress and resilience involves the negotiation of a variety of both problematic and supportive social relationships, explicitly exploring a client’s social networks is important.

For many LGBTI people the first experience of difference, rejection or isolation is within their family of origin. Equally those who enjoy supportive families this is a tremendous boon to successfully negotiating an LGBTI identity. So talking about, and mapping, the story of family is often an important and useful part of working with LGBTI clients.

Some therapists have found it helpful to use techniques like Genograms where clients draw a family tree and map and discuss their relationships as well as emotional relationships and emotional inheritance. Mapping on paper can be helpful in externalising the story of the client’s relationships with their family and friendship networks. Both the strength of particular bonds and connections as well as feelings or experiences of isolation and difference can be explored in these types of activities.

Partly because families of origin have often been sites of rejection, many LGBTI people have developed strong groups or families of affiliation through tight, supportive friendship networks within LGBTI and wider communities. It is important for therapists to recognise that these “families of choice” are often more important to and more supportive of LGBTI people than families of origin. It is therefore important to map the nature of these social networks and include them in any diagramming of “family”.

Because many LGBTI people have felt the need to conceal their intersex status, or sexual or gender identities, at different points in their lives, the nature of who they are, how they behave, and how they relate to others may be markedly different in a range of different social situations and social circles. Social prejudice and practices of concealment may mean the development of very different personas among family, in professional situations and among intimate friends. So mapping the quite different ways that social relationships are negotiated in these different situations can be important.

Culture and ethnicity

We have already made the important point that sexuality sex or gender is only one of the focal elements of an LGBTI person’s identity. People are also deeply influenced by their race, ethnicity, socio-economic background and culture.

In a multicultural country like Australia it is important to recognise that there are a range of overlapping attitudes to LGBTI issues. While there has been a great advance in the liberalisation of general attitudes to sexuality and gender expression in the Australian community as a whole, there

are still specific sub-cultural groups who maintain very traditional attitudes influenced by religion and ethnic cultural traditions. In addition, many families from cultures that are often relatively more supportive of diverse sex, sexuality, gender and living arrangements are themselves often not.

The proscription against LGBTI people's lived experiences and identities in some ethnic communities is stronger than in others. In these communities decisions about relationships, marriage and family are deeply inter-related and any deviation from traditional cultural practices can be seen to have repercussions not just for the individual but for the extended family network. While many Australians in ethnic communities have supported LGBTI offspring and siblings, therapists should be aware that cultural traditions often influence the negotiation of sexual identity and or gender expression.

Pride in an ethnic tradition, and participation in community rites and practices, can be critical sources of strength for many LGBTI people and it is important not to merely focus on ethnicity as a potential site of conflict.

Some LGBTI people will react to strong cultural proscriptions with outright rejection of these traditions. This often comes at the steep cost of isolation from their family and community. Other LGBTI people will not be prepared to risk separation from their family and community and may decide to adopt a variety of strategies that mean a traditional westernised "coming out" is not desirable or possible. For some declaring their LGBTI identity publically may even result in threats to their life or physical safety.

In looking at the complex interactions between these different sites of identity it is critical to acknowledge the multiple positive and negative influences that these communities have in people's lives. Pride in an ethnic tradition, and participation in community rites and practices, can be critical sources of strength for many LGBTI people and it is important not to merely focus on ethnicity as a site of conflict. Those who decide to distance themselves from these communities, to live a more open LGBTI life, will often need to work through complex issues of grief and loss.

An LGBTI person's race or ethnicity may also cause problems with their integration into the LGBTI communities. Non-anglo LGBTI people have described the experience of a double sense of difference: not feeling at home in their ethnic communities because of their sexuality or gender expression and not feeling at home in

the LGBTI communities because of potential racism or ethnocentrism.

Carefully exploring these complex relationships, and weighing up the relative costs and benefits that come with participation in various aspects of all these cultures and communities, is a critical part of coming into a full sense of selfhood as an LGBTI person of colour or an LGBTI person of ethnic origin.

Talking about relationships

Like heterosexual, LGBTI relationships are incredibly diverse and LGBTI clients will present with a range of relationship issues.

But until recently LGBTI people's relationships were largely not the subject of public discussion and there was less expectation that they would conform to social norms such as exclusive, long-term monogamy. So although many LGBTI couples have relationships similar to the ideal of heterosexual marriage, many have been involved in more fluid and open relationships.

So it is important that therapists understand that even though there is a very public campaign occurring for marriage equality before the law, the shape of individual long-term LGBTI relationships may vary even more than heterosexual relationships do and may not resemble a traditional marriage.

As we have emphasised throughout this booklet it is important for the counsellor to listen to how clients describe their relationships and the types of terms they use.

The validation of clients' relationships is important for LGBTI clients because some still feel that they cannot readily talk about their partner in some contexts, or walk arm in arm down the street.

Since the emergence of the public LGBTI movements it has been much easier for many LGBTI people to be open about their partnerships and to talk readily about them with colleagues and a wide range of others.

The validation of clients' relationships is important for LGBTI clients because some still feel that they cannot readily talk about their partner in some contexts, or walk arm in arm down the street. So part of the therapeutic process may simply involve providing a supportive space to talk openly about their life with a loving partner.

LGBTI clients might well present with a range of common issues around forming and maintaining relationships,

and these may revolve around intimacy, sex and communication. Many of these issues will be similar to problems experienced by other clients but often the way they are experienced will also be influenced or exacerbated by the tensions and stresses of the remaining negative social attitudes towards LGBTI peoples.

Talking about sex

We shouldn't assume that sex will be more or less important for LGBTI clients when compared to other clients. But, because their sex life is intimately connected to their minority identity, feelings such as embarrassment or guilt may have become embedded in their attitudes to sex. For those from religious backgrounds, some may experience feelings of shame or 'sinfulness'.

Many practitioners don't necessarily ask, as openly and as often as they perhaps could, about clients' sex life. Sex is an important area of personal development for many clients and simply checking – "Are you happy with the sex life that you've got?" can be an important part of talking about a client's life experience.

Some therapists maintain that sex rarely comes up in therapy but often this is not necessarily because clients do not have sexual issues. It may be because they need supportive questioning to feel comfortable talking about their sex life.

Some therapists working with LGBTI clients feel comfortable discussing most aspects of LGBTI people's lives but are less comfortable talking about sex. Some therapists adopt an "I'm fine but I don't want to know the details" approach about discussions to do with sex in general. But often you have to be able to talk about details if that's part of what arises as an issue. So it is important to think through some of these areas and perhaps discuss them with a supervisor if you find yourself not well equipped to talk about sex.

Some therapists maintain that sex rarely comes up in therapy but often this is not necessarily because clients do not have sexual issues. It may be because there is mutual avoidance. Clients may need supportive but gentle questioning to feel comfortable talking about their sex life. Public negotiation and discussion of sex and sexualities of all kinds is still often complex and somewhat difficult. So often clients will not raise issues relating to their sex lives because of internalised shame or guilt – the very issues that might need to be brought into the open in the counselling room.

Clients will talk about sex in a range of ways. Some will be more attuned to it having a role in developing intimacy in a relationship. Others might describe it as "play" or adventure. These types of cues in client language are important in helping understand and unpack people's attitudes to sex and the role it takes in their lives and relationships.

As with non-LGBTI clients, many LGBTI clients will have mundane sex lives but some may have explored a range of broader sexual practices that mainstream culture might judge as "kinky". There is a fairly large "leather" sub-culture among gay men, for example, and many of these men engage in consensual B&D, role-play and other sex play. It is important to be open to conversations about this type of sex if it is relevant to the client's issues or well-being. It is important to be non-judgemental and open to people talking about sex.

Outside the therapy room – advocacy and referral

As we have already noted, because LGBTI people will usually present to therapy having experienced some level of discrimination in their lives, the establishment of a warm supportive relationship between therapist and client is particularly important.

For the counsellor, part of the dual process of assisting the client through distress and naming resilience that we have referred to throughout this resource often requires showing practical as well as emotional and support.

If the LGBTI client has experienced victimisation and isolation in their social interactions with a heterosexist culture it can be important that they recognise the therapist not just as a supportive listener but also an embracing advocate.

Depending on the circumstances of the individual and of the therapeutic relationship, this may involve providing information and support on some practical matters as an advocate. Certainly an awareness of other practitioners, resources and agencies who have expertise or resources in these areas and who can provide such practical support is essential for a therapist or counsellor who is serious about equipping themselves to work with LGBTI clients.

Gay identities continued to function as positive anchorage points that brought affirmation to [these young people's] sense of self and...illustrates young people's capacity to reframe lesbian and gay identities as points of affirmation and pride and to reject homophobic discourses that often accompany their first encounters with these identity frames. Lesbian and gay identities were not always discussed as cohesive or comfortable subject positions as some participants conveyed a reflexive awareness of the constraints of these identity frames. This ... finding emphasises young people's capacity to critique the apparent usefulness of sexual categories. It shows young people participating in a wider questioning about the utility of existing sexual 'taxonomies' for framing their individual lives, sexual attractions and relationships.

— Willis, 2012

Working with LGBTQI subgroups and special issues of concern

LGBTI young people

The social conditions for acceptance of LGBTI people have improved dramatically in western cultures in recent years. So much so that some researchers are now proposing that we are in a “post-gay” world where the default position for young LGBTI people is acceptance. Research in Australia (Hillier, 2010) and overseas (Savin-Williams, 2009) indicates that same-sex attracted young people are ‘coming out’ at an increasingly younger age. It is now common for young LGBTI people to self identify in their early or mid teenage years. Even though this is the case for some young people, many still struggle with our dominant cultures’ remaining negative stances towards non-heterosexual sexuality and non-cisgender identity, and many are still experiencing discrimination and bullying in their schools, communities and families. Intersex differences are also still commonly seen as ‘not normal’ and widespread ignorance remains.

Some studies have suggested that up to 80% of LGBT young people are aware of their sexuality or gender identity by the age of 15 years, and the highest risk of suicide is when a young person has ‘come out’ to themselves but not to anyone else. This has implications for psychological support of all young people, regardless of their presenting issue: each young person who sits down in front of you might be struggling with issues related to their sexuality or gender identity, and by not asking about this you could be missing a central issue that is increasing their risk of suicide.

The tendency for LGBTI people to self-identify and to ‘come out’ to peers at an earlier age has a range of both positive and some potentially negative effects. It may be a liberating experience for the individual or it may place them in a more vulnerable position, if they are subjected to peer-bullying or abuse, or negative responses from their families. Defending themselves emotionally and physically can then become both a very bruising experience as well as the first experiences of claiming a resilient identity.

We began this resource by reminding counsellors that any client who presents for any issue may be an LGBTI client. It is particularly important to state this simple fact again in regard to working with young people. Many counsellors effectively assume that their young clients are likely to be heterosexual by putting the onus on young

people to ‘come out’. A young person who is confused or struggling with their sexuality, gender or the possibility or consequences of being intersex because of social stigma will not self-identify as LGBTI without the counsellor providing the scaffolding to make this a safe disclosure.

A young person who is concerned about possible negative reactions, or who is struggling with socially fraught attitudes to LGBTI sexualities, sexes and gender identities may or may not feel comfortable in self-disclosing early on in the therapeutic relationship. They will need explicit signs that this is a safe place for such disclosures. These include physical signs such as posters in your office or waiting room which indicate a commitment to LGBTI equality and inclusion. It includes explicit invitations to begin the discussion in the way that the therapist frames their questions.

At least initially keep your questions gender neutral and don’t assume that someone is likely to be, or likely not to be in a relationship. Ask about this directly but carefully: “Who are the important people in your life at the moment?” or “Are you in a relationship at the moment?”. It is also often supportive to explicitly speak in a way that indicates that you do not assume that a partner would be of a particular gender such as: “Have you got a girlfriend or boyfriend?” This immediately breaks the dominant paradigm of assumed heterosexuality and gives permission to talk about diverse sexual expression.

Asking that question to, say a 14-year-old girl who is questioning her sexuality: “Let’s talk about relationships, do you have a girlfriend or a boyfriend?” gives permission for a safe disclosure and might open up a range of conversations: “Well actually I don’t, but if I had a choice I’d prefer to have a girlfriend”. Or it could be a really homophobic heterosexual young man, who says “What on earth are you talking about, what the fuck? I’m not a fag.” So that also presents a wonderful opportunity to have a conversation with that young man to find out where he learnt these attitudes and to work with him on his homophobia. Asking questions like this are relevant for all young people not just for LGBTI young people.

Quite apart from issues to do with sexuality, sex and gender, many young people will be uncomfortable with the whole process of seeing a counsellor or entering a mental health service for the first time. But a skilled

counsellor can use this to open up broad areas for discussion and to carefully work to build the young person's respect and trust.

All practitioners will have their own approaches to beginning therapy but often it is a good idea when initially working with young people to ask very broad and varied questions. You could begin:

"Today's about me getting to know you a bit, and hearing what it is you would like to talk about and what might be helpful. I'll ask you a bunch of questions, some will apply to you and some won't but I want you to know that I'm happy to talk about whatever you'd like to bring up today and if you don't feel comfortable talking about some things that I ask about that's okay too."

This type of interaction sets the scene at the start and enables the therapist to ask a range of questions which may seem odd or intrusive in another context. If the client has not given a clear answer about their relationships then you can still ask directly about their sexuality: "Are you usually attracted to guys, girls or both? Or have you not really experienced much attraction so far?" and they can place themselves on the continuum somewhere.

Talking about gender identity can be a little more tricky because someone who is not familiar with ideas about gender variation may well not understand the question. But you can open up discussions with a range of questions like: How are you feeling in your body? How do you feel about how others react to your body? Do you feel comfortable being a boy/girl? How do you feel about where you'd place yourself in terms of your gender? How are you feeling about your gender? Some people find gender expectations difficult to handle, is this the case for you? These types of questions signal that you are prepared to talk about gender in an open way and can provide opportunities to explore further issues with trans people or with other young people who find the constraints of gender in our culture difficult to navigate.

Sometimes LGBTI young people may need strategic advice as well as emotional support. If they are planning to but worried about disclosing their identity to friends and family, the counselling room may provide a "rehearsal" space for this. It is important to talk through this as a process, to highlight that even if some people react negatively these attitudes often change over time and to try to discern the right moment for the process to occur. Young people sometimes feel pressured to 'come out' because they have seen television shows where characters 'come out' or read articles in the media about celebrities 'coming out' and they experience it as a kind of social obligation. A counsellor can play an important role here in assuring the young person that there is no particular rush to confirm their sexual or gender identity and that it is up to them to engage in this, or not, at times of their own choosing.

Some therapists have found it useful, if that is what client thinks might be helpful, for the client to invite a family member to a joint therapy session in order to inform them about their LGBTI identity within the supported space of the therapy room. This may be a good idea if the client is experiencing a lot of anxiety about the process and/or is expecting a negative reaction; on the other hand, those kinds of concerns might be an indication that talking with family members would not be a good idea, for that client, at that time.

'Coming out' for lesbian and gay people is becoming easier and more common but 'coming out' as a trans person is still very difficult and tends to cause a range of issues within families. The disclosure of trans identity is in some ways both more problematic and a deeper imperative than for other LGBTI people. Because of lower levels of trans visibility and trans understanding in our culture, declaration of trans identity may be met with a deeper shock or even incomprehension. But if a trans person is to more fully engage with and communicate their identity, this is likely to involve a number of visible choices that cannot be easily concealed or segmented in their lives. So it is especially vital that a young trans person who is about to talk to their family about their gender identity for the first time is fully prepared for and supported in this process.

LGBTI older adults

Just as LGBTI young people will have a range of particular issues that relate to both their stage of personal development and the social era in which they grew up, older LGBTI adults may also present with a range of particular issues.

The older the client is, the more likely it is that they will have suffered significantly under the kind of discrimination or persecution that LGBTI people experience, which was especially prevalent in the 40s, 50s, 60s and into the 70s. Therefore be aware in working with older LGBTI adults, that they are likely to carry some scars of that experience. However as we have repeatedly suggested throughout this resource the experience of LGBTI discrimination and oppression is almost always matched with a story of struggle or of personal resilience which allows the individual to navigate that social terrain.

This involves listening carefully to clients narrate their own experiences of daily life: both their current lives and the experiences of their past. This again involves a delicate balancing act of supportively unpacking examples of difficulty and distress while affirming and celebrating the stories of resistance, courage and resilience that shape LGBTI people's lives.

Not all older LGBTI people will have experienced significant personal discrimination but all will be aware of the social climate which was far from accepting of LGBTI

people's lives. It is important not to make unfounded assumptions about what their lives were like and to listen carefully to their stories.

As older LGBTI people grew up in social conditions that did not facilitate openness about being LGBTI, many will have adopted guarded behaviour that concealed elements of their identity and experiences from colleagues, peers and family members. Because they may have led quite concealed lives and become adept at holding things close, and segmenting their lives, exploration in therapy may be difficult. It may also mean that early experiences of discrimination or bullying may now present very powerfully because the therapeutic relationship facilitates disclosure and discussion of the effects of these experiences and this may be one of the first times that these experiences have been spoken about openly.

In spite of social conditions many LGBTI older adults will have led defiantly open lives and will have at some point decided to refuse the social strictures around their identities and experiences. It is important in hearing about these clients' lives to celebrate the strength that they found in carving out their LGBTI identities.

Older LGBTI adults may have led concealed lives and become adept at holding things close so early experiences of discrimination or bullying may now present very powerfully because the therapeutic relationship gives permission for disclosure and discussion.

LGBTI older adults will be experiencing a range of issues similar to their non-LGBTI counterparts. This is a time of transition and the full range of emotions associated with major life changes and ageism in society will confront them just as they will any other older person. However they will still also be facing discrimination and related issues to being LGBTI. These, combined with any residual issues relating to their being LGBTI, and the discrimination they have experienced in the past, will make navigating these new transitions more difficult. Working with LGBTI older adults is a layered process which involves working coherently with narratives of the past, narratives of the present and narratives of the future.

Some older LGBTI adults may have successfully adapted a need for or a strategy of concealment and led lives which segmented their professional life from their social life. They may well be happy with maintaining a degree of privacy about their LGBTI identity and experiences, and this may be an important part of their resilience strategy. These kinds of choices need to be respected as a valid part of this person's life journey and no less a valid way of embracing LGBTI personhood.

Counsellors should also be aware of the needs of older trans people. Transitioning can occur at any stage of the lifecycle and it is not uncommon for trans people to decide to transition later in life. Particular issues that older trans people may face in transitioning later include the negotiation of their "new" identity in well-established professional and personal social networks. Issues of continuity and change become particularly important in this context.

HIV and AIDS

HIV/AIDS has been a critical dimension of the experience of many LGBTI people for the last thirty years. It has of course been a particularly important part of gay and bisexual men's experience. In Australia two thirds of new diagnosis still occur in men who have sex with men and it is estimated that about 10 % of Australian gay men are HIV positive. In larger urban communities, such as Sydney and Melbourne, the percentage of gay men infected with the virus would be much higher.

But the impact of HIV/AIDS on the lives of LGBTI people goes well beyond these statistics. The emergence of AIDS in 1983 occurred at a time when the early lesbian and gay rights movement was starting to achieve visibility and impact and at a time when community activist and commercial sub-cultures were well developed. Ironically, the emergence of HIV/AIDS had both positive and negative impacts on the LGBTI community. While a generation of gay activists were lost to illness and death, before the intervention of life-saving drugs in the late nineties, the emergence of strong activist networks and government funded health programs meant community infrastructure was ultimately strengthened.

Research has shown that people with HIV are more likely to suffer from depression than the general population. This is not surprising given both the shock of diagnosis with a life threatening illness and the stigma still associated with HIV.

However this increased visibility also came at a cost, and the early media coverage of AIDS was not sympathetic. This created an atmosphere of fear and stigma which still lingers and this may well be a powerful memory for those people with HIV who lived through those times.

Medically, HIV is now regarded as chronic manageable disease and most people with HIV can be effectively treated with daily doses of anti-retroviral drugs. This allows most people with HIV to continue to live active healthy lives. However some people, especially those with long term HIV infection, continue to experience a variety of persistent physical and mental health issues.

Research has shown that people with HIV are more likely to suffer from depression than the general population. This is not surprising given both the shock of diagnosis with a life threatening illness and the stigma still associated with HIV. There is also some evidence that the virus itself has subtle effects on brain chemistry even in individuals who are successfully treated with anti-retroviral drugs. A small minority of clients with long-term infection may still present with AIDS related dementia.

For older gay men, whether they are HIV positive or not, HIV/AIDS is likely to still be an emotionally significant experience and many will have lost many friends to the disease. As they grow older this loss of key members of their friendship networks may become increasingly significant.

Most people with HIV continue to have an active sex life and as treatments improve and people live well longer, maintaining a healthy sex life becomes increasingly important. Safe sex strategies such as condom use have meant that people with HIV have usually become used to negotiating their sexual relationships with both HIV sero-positive and HIV sero-negative sex partners. But the presence of the threat of infection can still create mental and physical issues for both partners, and can interfere with a healthy sex life. It is therefore particularly important that therapists ensure they address sexual and health issues in a sex-positive framework when dealing with clients with HIV.

Mental health professionals should also be aware that gay men may also negotiate a range of sexual strategies based on the HIV status of their partners. Sero-concordant partners (either two HIV negative or two HIV positive people) will often negotiate unprotected sex based on an understanding of their status. This demands a high level of trust, particularly where both partners are HIV negative.

With advances in drug therapies, some activists and HIV organisations have advocated “treatment as prevention”. These programs encourage early drug treatment for all people with HIV on the basis that the more people who have undetectable viral loads (i.e. suppressed virus in their system due to drug treatment) the fewer new infections there will be. This prevention strategy is still the subject of much research and debate, so it is important that therapists remain up-to-date with the latest information because it is part of the range of calculated risk approaches being taken by individuals and talked about by community groups. Talking openly and non-judgmentally about these and other risk-taking and risk-reduction strategies may be an important area of working with HIV positive clients.

Evidence from some recent surveys suggests that HIV/AIDS is not a significant concern of younger gay men. In fact recent statistics indicate a rise of unprotected sex and new diagnosis in men under 25. Therefore it may be

important to raise issues of safer sex when talking with younger gay men.

HIV/AIDS may be an issue for any LGBTI client, particularly for gay men. Therapists should be conscious of the different roles that HIV will have played in the lives of men of different ages and the different issues that it may raise whether they are themselves HIV positive or HIV negative.

Many gay men have been living well with HIV for 20+ years so uncovering their survival strategies and the stories of community support is yet another example of the dual strategy we have been recommending of working through distress while celebrating resilience.

Lesbian women and other members of the straight and queer communities played critical support roles in the formation of the early organisation of HIV/AIDS organisations. So many LGBTI people, not just gay men with HIV, may present with stories of this struggle. It is important to note that although men who have sex with men are still the majority of those with HIV in Australia, including other LGBTI people have also contracted the virus.

What do we know about LGBTQI people and suicide?

A range of studies have shown that LGBTI people have an increased risk of suicide compared to those in the general population. How do we understand this risk, and what do counsellors need to know about assessing this risk in LGBTI clients and working with LGBTI clients with suicidal ideation?

Suicide must be understood not just as ending a life but also as ending pain. So the key to understanding LGBTI people's suicidal ideation is understanding the types of pain or traumatic experiences in their lives that have become so seemingly unbearable that they feel they no longer want to live.

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We have already described the mixture of distress and trauma and resilience that shape many LGBTI people's lives and in assessing their risk for suicide it is the complex relationship between these factors that may be crucial.

Exposure to discrimination and prejudice, and the likely internalisation of negative societal attitudes about being LGBTI, can lead to many LGBTI people commonly experiencing both acute and chronic stressors which put them at risk of suicide. These potentially traumatic experiences must be looked at in the context of concomitant development of tools for resilience. As many LGBTI people grow up with an ongoing sense of difference and an experience of discrimination they are forced to develop a series of complex strategic coping skills. Their internal resilience is often quite strong – they cope because they have to; they become hardy in the face of opposition. However this sometimes comes at the cost of developing strong external resilience – being able to trust and rely on others for support. So at times of acute stress, when internal resilience is exhausted they may have a sense or experience of not having enough external support to rely on. This is often particularly so for people who have experienced rejection from family of origin and significant others.

Exploring LGBTI people's repertoire of intrinsic and extrinsic resilience is an important part of general mental health work with this group but it may have particular relevance in understanding suicide risk and in building protective factors with clients who are at risk.

Because of the recent media coverage of young LGBTI people and suicide, many people imagine that this is the common story of LGBTI people and suicide: a young person who is struggling to 'come out' and cannot envisage a better future because they are bullied, rejected, and isolated. However LGBTI-questioning and LGBTI people of all ages are at increased risk for suicide. Often people who have successfully negotiated sexual identity and/or gender expression earlier in life confront stressors later in life which bring on suicidal ideation or actions.

Often these LGBTI people describe being exhausted by a perceived sense of remaining strong and proud in the face of ongoing experiences of prejudice and discrimination. Sometimes these people have entertained suicidal thoughts or made suicide attempts earlier in life and an acute stressor such as the end of a relationship or the loss of a job may begin a process of entertaining those same thoughts again.

In working with LGBTI people it can be important to explore this potential narrative. Have they ever felt so low that they have entertained suicidal thoughts? What was it at that point in their lives that gave them strength to continue? Are those protective factors still active in their lives? If not, why not, and how could they be re-activated?

While internal psychological factors are important, a range of social and contextual factors are also critical to understanding and working with LGBTI people who are at risk of suicide.

Gay advocate and educator Eric Rofes in 1993 wrote an influential book about LGBTI people and suicide called 'I Thought People Like that Killed Themselves' which takes its title from a quote about homosexuality by King George V. This indicates the strong cultural association between LGBTI people and suicide that have been emphasised in literature and film. For a long time, both suicide and same-sex sexuality were regarded as deviant, both were seen to result from flawed character, both were a criminal act, both were supposedly abhorrent to God. Although these attitudes and associations have changed dramatically in recent decades there are still lingering cultural associations between LGBTI people's lives and suicide. These attitudes have become internalised by some LGBTI people, particularly those who have grown up when these attitudes were more prevalent.

So some LGBTI clients with strong suicidal ideation may have internalised a sense that: "This is our lot". This can be compounded by experience of suicide within their circle of friends and acquaintances. As suicide is higher in LGBTI populations, LGBTI people will know more friends who have suicided and this is also a known risk factor for suicide.

This again points to the importance of developing a clear picture of LGBTI clients' social networks and resources as part of exploring their narratives of identity.

While it is important to be attuned to the variety of ways that suicidality can be a part of LGBTI people's life narratives it is also important to be aware that there are many LGBTI people who are no more at risk for suicide than any other client. Due to the negative cultural associations of LGBTI people and suicide it is important that this topic is handled sensitively within the context of exploring a range of mental health issues and behaviours.

Working with LGBTI families

Families are commonly central to the well-being of LGBTI people just as they are for their heterosexual counterparts. As with heterosexual clients, families may be a source of both distress and support.

Many LGBTI people have very good support from, and relationships with, their families of origin and extended family members. However because LGBTI people have often had to negotiate difficult experiences with their family of origin, it is not uncommon for LGBTI people to have ongoing problematic relationships with these family members. They may have experienced, and may still experience, disrespect, and at times, rejection from family members. This stress and difficulty associated with families of origin makes it more common for LGBTI people to talk about their close friends, partners and ex-partners as their "family of choice" which fulfills a special function in their lives.

In spite of an increased risk of suicide attempts among LGB compared to heterosexual respondents, those reporting suicidal behavior are a clear minority of the LGB individuals who have been studied, estimated at 12–19% of gay/bisexual males, and a smaller percentage of lesbian/bisexual women. Relatively little research has been done on factors that protect the large majority of LGB people from suicidal behavior. Analysis of data from a statewide survey of 6th, 9th, and 12th grade students in Minnesota found three factors to be significantly protective of reported suicide attempts in youth with same-sex sexual experience: family connectedness, perceived caring from other adults, and school safety. A nonrandom study of self-identified young and middle-aged LGB adults in New York City found connectedness to a gay/lesbian community and positive sexual identity were associated with greater social and psychological well-being.

— Haas, et al., 2010

LGBTI families take many different shapes and it is essential to listen to the client's story as everyone's family, including heterosexually-based families, are very different. Contemporary families are very diverse. With the divorce rate at around 40%, many people have multiple parents for example, and most adults are likely to have had more than one long-term partner.

Increasingly LGBTI people are having and raising children in a range of different circumstances and counsellors need to be attuned to a number of issues that can arise working with LGBTI individuals or couples who are parents. There are many thousands of same-sex couples in Australia who have had children. Although most of those couples are women, an increasing number of gay men are also parenting and having children. Like different-sex couples, same-sex couples have children in their families as a result of birth, adoption, fostering, and through parenting as part of step and blended families.

Across Australia, children born into the relationship of two women will have both women registered on their birth certificates as their full legal parents, which means that such children have legally recognised family relationships with their birth and their non-birth mothers' families. Increasingly, legislative changes mean that children who are born into the relationship of two men via surrogacy also have both men recognised as being legally responsible as parents.

Research indicates that same-sex parented families often experience high levels of social support and recognition, including from school, service providers and the wider community. There have also been very significant changes in Australia, in the last decade, which have opened up equal access to fertility services and which have recognised same-sex couples as couples and the families of same-sex couples as families. However, there are still widely disseminated and dominant ideas that a 'real' family or a 'proper' family is biologically-based and heterosexual: that a non-biological mother or father is somehow not a 'real' parent. These ideas have not caught up with the contemporary shape of Australian families, and nor have they caught up with the legal definitions of family in Australia. For example, although non-biological/non-birth mothers in a lesbian relationship are now legal parents, many non-birth lesbian mothers still find that they are not always readily recognised by peers and service providers as a 'real mother'. This can happen in subtle ways: someone congratulating just the pregnant person or someone asking the non-biological mother what kind of role she will play in the child's upbringing.

Once again it is vitally important that the therapy room becomes a place of recognition and does not repeat the experience of non-recognition that many couples may have experienced in regard to their families and their roles as parents.

So if two women, or two men, have had a child together, and have intended to have a child together, no matter what the biological circumstances of the conception, both of those people need to be recognised and valued as parents of that child.

Although research indicates that many same-sex parents and their families have close connections and experience high levels of support and respect from their families of origin, often the intersection of these new family units and the couples' traditional families of origin may also be a cause of tension. Families are usually the site of celebration when a couple have a child but in the case of LGBTI couples, having a child might exacerbate tension with their parents or siblings. LGBTI couples will, for example sometimes put off telling their family they are pregnant for fear of a negative response, which doesn't happen as often with heterosexual couples. Clients may want to talk about experiences like this, so it's important to hear this but also to encourage them to talk about people who are able to recognise them as a family and to reflect that back.

As we have stressed before, language is key to negotiating helpful therapeutic relationships with LGBTI people and it is particularly important when talking about families and children of LGBTI couples.

For example, assume that two women, or two men, bringing up a child are simply the child's mothers or simply the child's fathers. It is usually not necessary for the counsellor to ask who the "biological parent" is. If this is a pertinent issue it will emerge organically from the discussion.

Lesbian couples will often use a known sperm donor who may or may not play an active part in the child's upbringing. Avoid referring to this person as a 'father' or a 'biological father' unless that is the term of choice that this couple has adopted. The majority of men who provide sperm to single or lesbian women to conceive a child do not relate to, and are not related to by, these children and families as a parent. A minority of sperm providers do take on a co-parenting role, and many others are involved in the child's and family's life as a significant and close friend, so terms used will vary.

In using these terms allow yourself to be led by the client and listen carefully for their signals regarding the relationships they have mapped out.

Many bisexual, trans and intersex people are parents too and their families also come in a range of shapes and structures.

The social and legal development of LGBTI families is a fast moving area and even some LGBTI people are not all fully aware of their rights and obligations in this new environment. This can become even more difficult when

The picture painted by recent research is mostly a continuation of a story from earlier research – that families with two lesbian parents (biological, social, or step) exhibited a number of strengths. Research has repeatedly shown that lesbian parent couples have high levels of shared employment, decision making, parenting, and family work, in part in the service of an egalitarian ideology. Lesbian couples also averaged higher satisfaction with their relationships with each other and with each others' parenting. Lesbian mothers had a strong desire for children and devoted a great deal of time and thought to choosing parenthood, and they tended to equal or surpass heterosexual married couples on time spent with children, parenting skill, and warmth and affection.

— Biblarz and Savci, 2010

couples with children separate. In some instances there is then a tendency to revert to and even try to promote very conservative notions of biological motherhood in negotiating shared custody, even when parenting has been fully shared up until that point. In these instances it is important for counsellors to be aware of the legal frameworks which may assist their clients as well as the psychological frameworks for affirming their rights and meeting their responsibilities.

LGBTQI clients, religion and spirituality

LGBTI clients are likely to have complex relationships to religion and spirituality. Religious institutions have been particularly homophobic and have often led the case against changes in LGBTI rights legislation. This is currently true in the case of the fight for marriage equality.

LGBTI people who come from families with strong religious traditions will often have experienced religious prohibitions against diverse sexualities and gender expression as a key cause of family conflict.

However it is important that counsellors don't make assumptions about an LGBTI client's relationship to religion or spirituality. Some will have a strong sense of spirituality, others will find meaning through other frameworks, some will be involved in organised religions, others will be very antagonistic to official religious structures.

If they have had a strong religious background, in a more fundamentalist religious tradition however, this has probably made their self-acceptance processes more difficult. Don't underestimate how long lasting and intrusive the residual effects of these strong religious strictures may be in people's lives.

Some clients may present after being part of a Christian fundamentalist "ex-gay movement" which claims to "convert" same-sex attracted people to heterosexual lifestyles. There is no evidence that this is possible and most often these clients end up being further traumatised and often will present with experiences similar to victims of other kinds of abuse. Clients often struggle with the guilt and the shame instilled by this kind of treatment over a number of years.

If an LGBTI client has been deeply religious, their sense of conflict may not be merely about the religious prohibitions against LGBTI expression. One of their key formative experiences may well have included the sense of a relationship with a loving God that was then clouded by these harsh institutional prohibitions. So walking away from a faith tradition because of their rigid views on sexuality or gender identity is not just a choice between

their own self-expression and their family or community but it's a choice between a new sense of self and their relationship with their "maker". It is also walking away from something that has at times been deeply nourishing. This produces a very complex set of deep psychological, emotional and social ruptures which need to be negotiated.

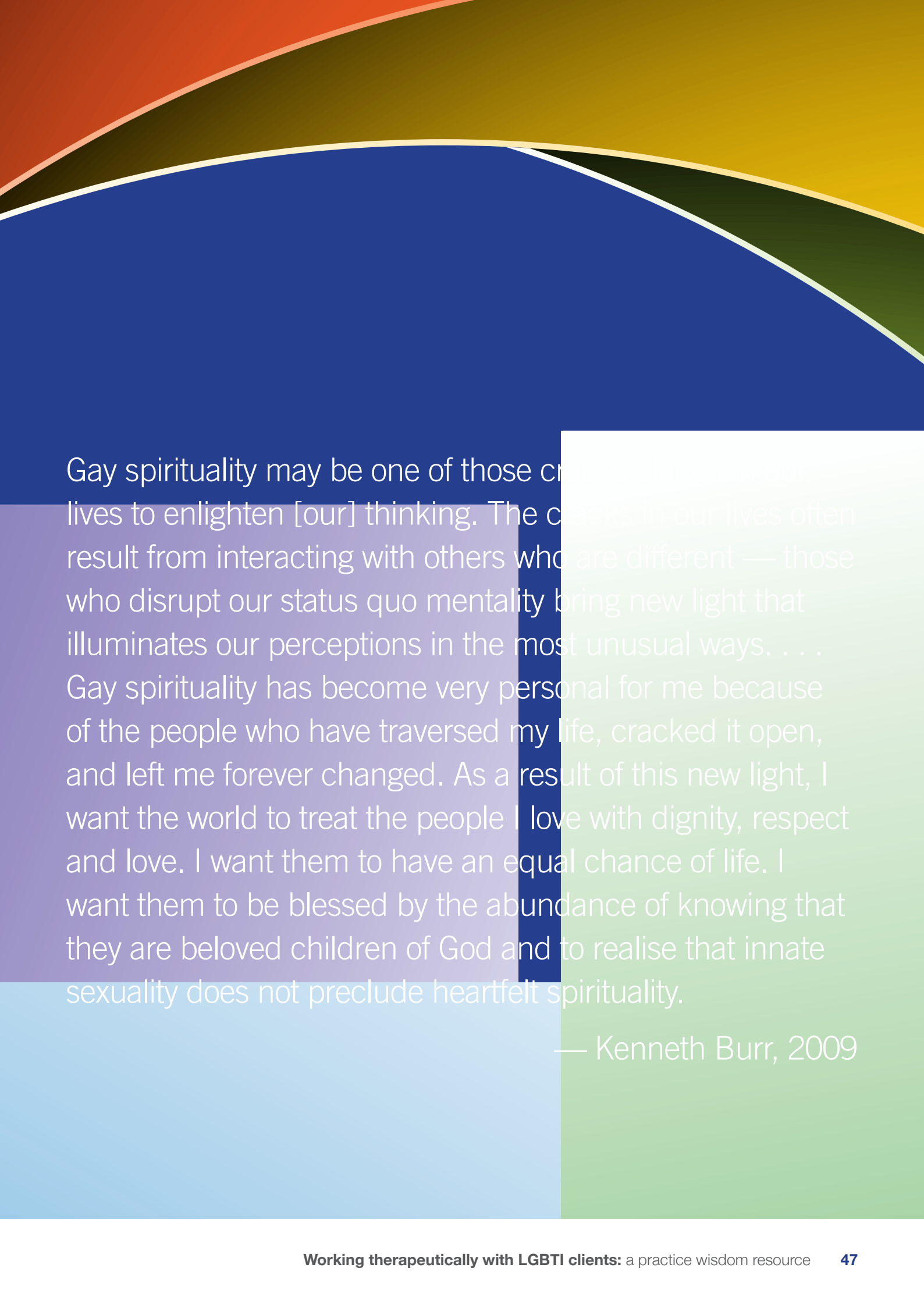
The LGBTI 'coming out' process could be seen by some as a unique spiritual process. This can be a useful framing of experience for some LGBTI people, particularly those who have come from a religious background.

In deeply religious families and faith communities, religious beliefs and values go beyond mere patterns of behaviour. They are part of a deep personal identity and pattern of conditioning, so transitions away from this identity will involve a degree of deep distress and struggle, even if it is done freely, and with determination, to explore a new LGBTI identity.

Even though many religious authorities may present this transition as an 'either or' 'choice', between religious affiliation and sexual expression, there are more nuanced ways of integrating spirituality and sexuality and most religious communities now have groups or communities that are LGBTI affirming. Counsellors should make themselves aware of options in different faith traditions that they can use as referral points.

It is also helpful to distinguish between religion and personal spirituality. In leading a self-affirming LGBTI life some religious people dispense with all connection to the spiritual and then they find that there is something missing and they experience a real grief in this absence. Simultaneously, there may also be resistance to exploring alternative forms of spirituality because both religion and spirituality have become associated with a bruising experience of rejection.

Spirituality is essentially the search for meaning, and does not necessarily have to be associated with traditional religious paths. Some LGBTI people, who have had no association with traditional religion, may present to therapy because they come to feel that a critical "something" is missing in their life and they need to forge new ways of connecting with, and creating meaning in their life. It can be important for this search for meaning, purpose and connection to be recognised as a personal spiritual process. But as we have recommended before, language is critical and therapists need always to be guided by the narrative that the client is creating. So the choice of terms



Gay spirituality may be one of those cracks placed in our lives to enlighten [our] thinking. The cracks in our lives often result from interacting with others who are different — those who disrupt our status quo mentality bring new light that illuminates our perceptions in the most unusual ways. . . . Gay spirituality has become very personal for me because of the people who have traversed my life, cracked it open, and left me forever changed. As a result of this new light, I want the world to treat the people I love with dignity, respect and love. I want them to have an equal chance of life. I want them to be blessed by the abundance of knowing that they are beloved children of God and to realise that innate sexuality does not preclude heartfelt spirituality.

— Kenneth Burr, 2009

like “spirituality” needs to arise organically in the course of the therapeutic exchange if it is to be useful.

Some people regard the LGBTI ‘coming out’ process as a unique spiritual process. At its deepest it might be viewed by some as a type of death/rebirth process: leaving behind the socially negative constructs that inhibit self-affirming LGBTI identities. It might also be viewed as a spiritual process where a person’s spirit, or inner psychological resources, drives this formation of a new strong sense of self and a new search for sexual connection and/or gender identity. So, depending on the client, this can be a useful framing of experience for some LGBTI people, particularly those who have come from a religious background. But like all such metaphors this is only useful if it arises organically from the clients’ experience and with the language and concepts they use.

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National LGBTI Health Alliance

PO Box 51, Newtown 2042 NSW Australia

www.lgbtihealth.org.au

General enquiries: info@lgbtihealth.org.au