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

Authors

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I. INTRODUCTION

Theoretical Framework and Background

This document is intended to provide counseling and related professionals with competencies for working with Lesbian, Gay, Bisexual, Queer, Intersex, Questioning and Ally (LGBQIQA) individuals, groups, and communities. Those who train, supervise, and/or educate counselors may also use these competencies as a framework for training, practice, research, and advocacy within the counseling profession in order to facilitate trainee growth towards LGBQIQA competence. Transgender people are not addressed in the current document as the document *American Counseling Association's (ACA) Competencies for Counseling with Transgender*

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

The central role of social justice in the lives of LGBTQIQA individuals, groups, and communities can be explained well by understanding the Minority Stress Model (Meyer, 2003), which greatly influenced the work in these competencies. The Minority Stress Model describes that individuals who hold minority status (LGBTQIQA identities) experience daily stressors above and beyond the day to day stressors that everyone experiences (alarm doesn't go off, flat tire, annoying coworker, etc.). These stressors result from the pervasive nature of oppression within our societies, and they result in an increase in overall stress for individuals with minority status. The intensity of such stressors can range from *microaggressions* up to and including the *threat or actuality* of physical violence, even death. *Microaggressions* are defined within the context of racism as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, Esquilin, 2007, p.271; Sue, 2010). The authors believe the spirit and letter of this definition apply equally to LGBTQIQA individuals, groups, and communities.

Historically, the mental health community has pathologized LGBTQIQA individuals, groups, and communities. However, the authors believe that struggles arise not as a result of individual dysfunction, but as a result of a natural response to increased stress of living in an environment that is hostile to those who hold a particular identity. It is for this reason, that the authors believe that it is important to extend the role of counseling and related professionals beyond the confines of their individual practices or settings to address the systemic issues that are responsible for these added stressors. In accordance with the ACA Advocacy competencies (2003), the authors of this document believe that it is important to advocate with and for LGBQIQA individuals, groups, and communities in order to continue to promote their empowerment and a more socially-just society. Thus the following competencies incorporate these perspectives into each area as a focal point for work with LGBQIQA individuals, groups, and communities.

LGBQIQA Language and Definitions

The language used throughout these competencies is an attempt to recognize and utilize the most common, current, and inclusive language that is in use as well as is consistent with the language found commonly in scholarly literature. There are limitations with how inclusive and empowering certain terms are due to their historical use. For example, the terms lesbian, gay, and bisexual are commonly understood in terms of the gender binary. However, there are individuals who utilize these terms but have a more broad and inclusive understanding for themselves (e.g. bisexuals who are affectionally oriented to a wider range of gender identities and expressions beyond just "woman" and "man"). Additionally, language is constantly evolving, and therefore

the language used in this document will become outdated over the course of time. The terminology included in Appendix A does not fully address the wide diversity of language in use across North America, much less the remainder of the world. There are many terms that are in less frequent use and are not present here due to the limitations of the scope of this document, such as *omnisexual, two-spirit, woman loving woman, men who have sex with men, genderqueer*, etc. The authors acknowledge the use of these terms and any others that are not present in our work, and encourage the use of language by LGBTQIQA individuals, groups, and communities that are empowering or that challenge the current limitations of language.

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

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

regional and local differences, as well as the diversity of the make-up of group membership (geographic, intersecting identities, philosophical identities/ideas, etc.) from one group to the next are important to consider when working with any particular community. As is the case in working with individuals, understanding these differences is paramount to honoring, respecting, and understanding the particular community with which one works.

Current Issues and Stances on LGBQIQA Counseling

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

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

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

The authors also acknowledge the limits of research with LGBQIQA populations due to bias as well as lack of studies normed on the LGBQIQA population, sp(t)-2(i)-2(onWby)20(,)-10(t)h3(r)3(e)4(sonWby

Overall Organizational Structure

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

I. Introduction

II. Competencies for working with Lesbian, Gay, Bisexual, Queer and Questioning Individuals

III. Competencies for working with Allies

IV. Competencies for working with Intersex Individuals

V. References and Resources

VI. Appendix

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

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

Intersex and Allies Sections

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

In this work, there were clear commonalities among some of the concerns and issues that would need to be addressed among Lesbian, Gay, Bisexual, Queer and Questioning Individuals. However, the authors felt that individuals who are Intersex or Allies have unique concerns that could not necessarily be subsumed into the main body of the document (following the 8 CACREP areas). Instead, these sections are addressed separately to allow the appropriate focus on the unique differences of these two groups. Although the authors believe that this document will add an important piece to understanding what it means to work with these two groups, we also acknowledge that each of these groups deserves the full attention that the Transgender Competencies document provided for transgender individuals. While it was outside of the scope of the work of this taskforce, the authors strongly encourage expansion of the Allies and Intersex sections in the future.

II. Competencies for Counseling Lesbian, Gay, Bisexual, Queer, and Questioning Individuals

A. Human Growth and Development

Competent Counselors will:

A. 1. Understand that biological, familial, cultural, socio-economic, and psychosocial factors influence the course of development of affectional orientations and gender identity/expressions.

A. 2. Affirm that LGBQQ persons have the potential to integrate their affectional orientations and gender identity into fully functioning and emotionally healthy lives and relationships.

A. 3. Identify the heterosexism, biphobia, transphobia, homophobia, and homoprejudice inherent in current lifespan development theories and account for this bias in assessment procedures and counseling practices.

A. 4. Be aware of the effects internalized homophobia/biphobia/transphobia may have on individuals and their mental health.

A. 5. Notice that developmental periods throughout the lifespan (e.g., youth, adolescence, young adults, middle adults, older adults) may affect the concerns that LGBQQ clients present in counseling.

A. 6. Recognize how stigma, prejudice, discrimination and pressures to be heterosexual may affect developmental decisions and milestones in the lives of individuals regardless of the resiliency of the LGBQQ individual.

A. 7. Know that the normative developmental tasks of LGBQQ youth, adolescence, young adults, middle adults, older adults, may be complicated, delayed, or compromised by identity confusion, anxiety and depression, suicidal ideation and behavior, academic failure, substance abuse, physical, sexual, and verbal abuse, homelessness, prostitution, and STD/HIV infection.

A. 8. Understand that the typical developmental tasks of LGBQQ older adults often are complicated or compromised by social isolation and invisibility.

A. 9. Understand that affectional orientation is not necessarily solid, it is or “can be” fluid, and may change over the course of an individual’s life span.

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

B. Social and Cultural Diversity

Competent counselors will:

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

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

expression, religion/spirituality, class, ability, etc.) and their accompanying developmental tasks. This should include attention to the formation and integration of the multiple identity statuses of LGBQQ individuals.

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

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

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

B. 12. Recognize that spiritual development and religious practices may be important for LGBQQ individuals, yet it may also present a particular challenge given the limited LGBQQ positive religious institutions that may be present in a given community, and that many LGBQQ individuals may face personal struggles related to their faith and their identity.

C. Helping Relationships

Competent counselors will:

C. 1. Acknowledge that affectional orientations are unique to individuals and they can vary greatly among and across different populations of LGBQQ people. Further, acknowledge an LGBQQ individual's affectional orientation may evolve across their lifespan.

C. 2. Acknowledge and affirm identities as determined by the individual, including preferred labels, reference terms for partners, and level of outness.

C. 3. Be aware of misconceptions and/or myths regarding affectional orientations and/or gender identity/expression (e.g., that bisexuality is a “phase” or “stage”, that the majority of pedophiles are gay men, lesbians were molested or have had bad experiences with men).

C. 4. Acknowledge the societal prejudice and discrimination experienced by LGBQQ persons (e.g., homophobia, biphobia, sexism, etc.) and collaborate with individuals in overcoming internalized negative attitudes toward their affectional orientations and/or gender identities/expressions.

C. 5. Acknowledge the physical (e.g., access to health care, HIV, and other health issues), social (e.g., family/partner relationships), emotional (e.g., anxiety, depression, substance abuse), cultural (e.g., lack of support from others in their racial/ethnic group)), spiritual (e.g.,

their theoretical approach for working with LGBQQ individuals given the paucity of research on efficacious theoretical approaches for working with LGBQQ individuals.

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

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

C. 17. Demonstrate the skills to create LGBQQ affirmative therapeutic environments where disclosure of affectional orientation is invited and supported, yet there are not expectations that individuals must disclose their affectional orientation.

C.18. Continue to seek awareness, knowled 2(dua)4(l)-26(l)-2(s)0019eut3d [(di)-2a2(i)-2((l)-2(s)-17 0 Td a)-

D. 3. Recognize within-group power differentials and oppression among LGBQIQA

group process. Counselors should seek appropriate supervision and/or consultation in order to foster ethical practices.

D. 13. Understand the potential benefits of flexibility and cr

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

E. Professional Orientation and Ethical Practice

Competent counselors will:

E. 1. Utilize an ethical decision-making model that takes into consideration the needs and concerns of the LGBQQ individual when facing an ethical dilemma.

E. 2. Utilize a collaborative approach with LGBQQ individuals to work through ethical dilemmas that impact the professional relationship when appropriate.

E. 3. Consult with supervisors/colleagues when their personal values conflict with counselors' professional obligations related to LGBQQ individuals about creating a course of action that promotes the dignity and welfare of LGBQQ individuals.

E. 4. Seek consultation and supervision from an individual who has knowledge, awareness, and skills working with LGBQQ individuals for continued self-reflection and personal growth to ensure that their own biases, skill, or knowledge deficits about LGBQQ persons do not negatively impact the helping relationships.

E. 5. Use language, techniques and interventions which affirm, accept , and support the autonomy of intersecting identities and communities for LGBQQ individuals.

E. 6. Recognize the emotional, psychological and sometimes physical harm that can come from engaging clients in approaches which attempt to alter, “repair” or “convert” individuals’ affectional orientation/gender identity/expression. These approaches, known as reparative or conversion therapy lack acceptable support from research or evidence and are not supported by the American Counseling Association or the American Psychological Association. When individuals inquire about these above noted techniques, counselors should advise individuals of the potential harm related to these interventions and focus on helping clients achieve a healthy, congruent affectional orientation/gender identity/expression.

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

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

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

E. 7. Continue gaining specialized training/education through professional workshops, reading relevant research, and staying up to date on current events for LGBQQ individuals and the LGBTQIQA community.

that the use of particular career theories may not have been normed for LGBQQ individuals, and that interventions based on such theories will need to be assessed for their efficacy.

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

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

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

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

F. 7. Understand how experiences of discrimination and oppression related to affectional orientation and/or gender identity/expression at work may be compounded when other

G. Assessment

Competent Counselors Will:

G.1. Become informed (via empirical and theoretical literature and supervision/consultation with LGBTQIQA communities resources) of the spectrum of healthy functioning within LGBTQIQA communities. Appreciate that differences should not be interpreted as psychopathology, yet they often have been interpreted in harmful ways to LGBTQIQA

of diversity issues impacting the development, norming, administration, scoring, interpretation, and report writing dimensions of the assessment process.

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

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

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

G.13. Become aware of professional education and resources of assessments tools adapted and/or created for LGBQQ individuals/couples/families and how those may be used in conjunction with multicultural and advocacy models to address the whole person and all of their intersecting identities.

G.14. Review intake paperwork, intake forms, interview methods, initial interventions, screening in the assessment measures to ensure use of inclusive language, w lfter methodsmi4( )-.

H. Research and Program Evaluation

Competent Counselors Will:

H.1. Be aware that the counseling field has a history of pathologizing LGBQQ individuals and communities (e.g., studies of homosexuality as a “disorder" and research agendas that

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

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

III. Allies

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

Section I – Counselors Who are Allies

In addition to being competent working with LGBTQIQ individuals, counselors who are allies will demonstrate behaviors and attitudes that may be outside their role as counselors. Counselors who are allies of the LGBTQIQ community will observe the following guidelines (adapted from http://www.mnsu.edu/lgbtc/resource.html):

AWARENESS:

A competent ally will:

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

KNOWLEDGE:

A competent ally will:

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

I. 3. Know and understand how socio-cultural, political, and economic climates and the resulting institutional practices, laws, and policies affect the LGBTQIQ community.

I. 4. Know and understand how LGBTQIQ individuals experience their intersecting identities within their own development and their communities.

SUPPORTING INDIVIDUALS' DECISIONS ABOUT COMING OUT:

A competent ally will:

I. 5. Acknowledge that the process and extent of coming out should be the decision of the individual.

I. 6. Validate the potential struggle of LGBTQIQ persons as they navigate their coming out process through such techniques as empathic listening and reflective feedback.

I. 7. Allow LGBTQIQ persons to define and place in perspective their own developmental process.

I. 8. Take proactive measures in seeking out a competent and experienced supervisor/consultant with expertise working with LGBTQIQ individuals, use remediation efforts to develop expertise and competence, and make adjustments in providing services as needed.

FACILITATE SUPPORTIVE ENVIRONMENTS:

A competent ally will:

I. 9. Encourage and promote an atmosphere of respect through such actions as displaying LGBTQIQ-supportive periodicals, books, or posters in the office, or providing take-home LGBTQIQ-oriented literature.

I. 10. Acknowledge, appreciate, and celebrate differences among individuals and within groups (e.g., acknowledging the intersecting identities of a Gay, African-American male of the Muslim faith).

I. 11. Use inclusive and respectful language (e.g. using the term partner rather than specific terms like spouse, wife, husband, boyfriend, or girlfriend in general situations and using specific terms to honor personal choices when directed to do so by the individual).

I. 12. Be a safe and open-minded person to talk with by facilitating open and honest discussions about LGBTQIQ issues.

I. 1.3 Object to and eliminate jokes and humor that put down or portray LGBTQIQ people in stereotypical ways.

I. 14. Counter statements regarding affectional orientation or gender identities which are not relevant to decisions or evaluations concerning LGBTQIQ individuals (e.g. Responding to statements such as, "Well you know he's bisexual, but that doesn't matter as long as he does his job" or "Well you know they are a female couple raising a child so they may not have the resources a 'normal' couple has").

I. 15. Encourage continuing education and professional development activities regarding LGBTQIQ topics.

I. 16. Confirm with LGBTQIQ staff their willingness to consult on LGBTQIQ issues with other staff members.

I. 17. Refrain from referring all LGBTQIQ issues to LGBTQIQ staff/faculty because they may not have any expertise in LGBTQIQ issues and/or their expertise may not be limited to LGBTQIQ issues. Promote an atmosphere where all individuals are encouraged to know about LGBTQIQA identities.

I. 18. Be purposeful in recruitment and retention of staff and faculty who identify as LGBTQIQA.

I. 19. Include affectional orientation and gender identity/expression in discussions of diversity and promote an atmosphere in which LGBTQIQ identities are desired in a multicultural setting.

I. 20. Advocate with administrators to require competency in-working with LGBTQIQ individuals (e.g., staff, faculty, students, or clients).

I.21. Acknowledge that a safe and supportive environment may enable LGBTQIQ people to openly share their identity, among other benefits. However, the decision of when, how, and who to come out to should always be made solely by the individual.

I. 22. Recognize that polices ensuring non-discrimination based on affectional orientation, gender identity, and gender expression are the responsibility of the agency/organization and not the LGBTQIQA individual.

I.23. Ensure that all clinical-related paperwork and intake processes are inclusive and affirmative of LGBTQIQ individuals (e.g., including “partnered” in relationship status question, allowing individual to write in gender as opposed to checking male or female).

Section II – Competencies for Counseling Allies

This section is specific to a counselor working with individuals who identify as an ally. Allies include friends, family, significant others, colleagues/ associates, mentors , those who seek counseling before they identify as allies and may be heterosexual, cisgender and/or members of the LGBTQIQ Communities (e.g., a Cisgender, Bisexual Woman who is a Transgender Ally), particularly when the individual holds an identity that has traditionally been marginalized in the LGBTQIQ Community. As such, this document refers to the identity labels that are self-assumed, rather than externally applied. Additionally, ally development varies from individual to individual, and should be considered when counselors conceptualize working with an individual on issues related to what being an ally means (considering the counselor's and individual's own development). Due to the fact that there are more available resources for heterosexual allies, more information is available about their development [see resource list for Heterosexual Ally Development Model (Poynter, 2007)]. For example, according to this model,

the first status of Ally Development includes that the individual does not hold an identity of ally and/or negative beliefs/attitudes towards LGBTQIQ individuals. This document addresses issues that relate to the various statuses of ally development and covers a wide range of situations that counselors might encounter in working with individuals related to their role as an ally. Additionally, due to the lack of research on allies in general, this document seeks to begin a dialogue and encourage future research in this area.

Competent Counselors will:

I. 23. Recognize the important contributions of allies to their respective LGBTQIQA Communities and the importance of the support they provide to LGBTQIQA Individuals.

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

I. 25. Recognize that allies also have a coming out process and that this process has implications for them and their identity. For example, many heterosexual cisgender allies may ask themselves for the first time about whether or not to disclose their identity, what the potential risks for doing so in each setting they enter are, and potentially lose privilege as a result of coming out as an ally.

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

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

I. 28. Help cisgender heterosexual allies explore oppression they may face in LGBTQIQA Communities, such as use of derogatory terminology like “fag hag”, “fruit fly”, etc. or in experiences of others disregarding their identity through statements like “You know you will come out eventually” or negative statements about heterosexuals, such as referring to them as “breeders” or referencing them as the enemy, or myths and stereotypes of cisgender heterosexual allies (e.g. every straight woman wants a gay best friend to shop with, etc.)

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

I. 30. Help allies to be aware of national, state, and local community resources for LGBTQIQA Communities (e.g. local Parents and Friends of Lesbians and Gays (PFLAG) Chapter, community LGBTQIQA Resource center, LGBTQIQA Events in the area, Gay, Lesbian, Straight Education Network (GLSEN), etc.).

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

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

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

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

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

I. 36. Help allies, who are members of the LGBTQIQ communities themselves, to find a healthy balance between advocacy for others and advocacy for themselves. Also acknowledge that advocacy activities may take place on the micro, meso, and/or macro levels (See ACA Advocacy Competencies in the reference list).

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

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

- XY gonadal dysgenesis
- XY gonadal agenesis
- Cryptophthalmos
- Smith-Lemli-Opitz
- 4p syndrome
- 13q syndrome
- Mayer Rokitansky Kuster Hauser syndrome (MRKH)
- Mixed adrenal dysgenesis
- Maternal ingestion of certain medications (particularly androgenic steroids)
- Lack of production of specific hormones, causing the embryo to develop with a female body type regardless of genetic sex
- Lack of testosterone cellular receptors

How common is Intersex?

The instance of intersex anomalies has been estimated to be between 1 in every 100 to 1 in every 4500 (1 in 2000 is cited most often). This means that it is likely that more babies are born intersex than those born with cystic fibrosis, the incidence of which is one in 2,500.

What happens when a child is born intersex?

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

Concealment v. Client-Centered Models

The concealment-centered model comes from a stance that intersex is an abnormality that needs to be concealed and/or augmented, while the patient-centered model

	(CONCEALMENT -CENTERED MODEL)	(CLIENT -CENTERED MODEL)
What is intersex?	Intersex is an anatomical **abnormality** which is highly likely to lead to great distress in the family and great distress for the person who is intersex. Intersex is pathological and requires medical attention.	Intersex is an anatomical **variation** from the "standard" male and female types; just as skin and hair color vary along a broad spectrum, so does sexual anatomy.
Are intersex genitals a medical problem?	Yes. Untreated intersex is highly likely to result in depression, suicide, and possibly homosexual orientation. Intersex genitalia must	No. Intersex genitals are not a medical problem. They may signal an underlying metabolic concern, but they themselves are not

	be “normalized” if these problems are to be avoided. (Note: There is no solid evidence for this position, and there is evidence to the contrary.)	diseased; they just look different.
What should be the response to the discovery that a child has been born intersex?	The correct treatment for intersex is to “normalize” the abnormal genitals using cosmetic surgical and hormone technologies, and so on. Doing so will eliminate the potential for psychological distress.	The whole family should receive psychological support, including referrals to qualified counselors

more inclusive of people who are intersex include terms such as “omnisexual” and/or

(E.g., although the “I” for people who are Intersex is often included, the needs and concerns of people who are Intersex are not usually included in the work of the LGBTQIQA community.)

J. 18. Be aware of the official stance of the American Counseling Association in regard to people who are Intersex (Resolution to Protect Intersex Children from Unwanted Surgery, Secrecy and Shame, April 1, 2004).

J.19. Empower parents to advocate and resist oppression from medical communities and help them to talk directly to their child’s doctor themselves without the counselor present.

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Appendix A

Definitions

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

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

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

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

ALLY: The term ally as used in this document refers to a counselor or a client who provides therapeutic or personal support respectively, to a person or persons who self-identify as LGBTQIQ. Allies include friends, family, significant others, colleagues/ associates, mentor, those who seek counseling before they identify as allies and may be Heterosexual and Cisgender, and/or members of the LGBTQIQ Communities (e.g. A Cisgender, Bisexual Woman who is a Transgender Ally). Additionally, in this document we reference pejoratives used against allies (particularly Heterosexual and Cisgender allies), to

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discussion that is rarely had about the experiences of allies within LGBTQIQA communities and to urge LGBTQIQA communities to become more inclusive, but also urge the reader caution in how these terms are used so that they do not further injure others.

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

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

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

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

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

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

GAY: A man who is emotionally, physically, mentally and/or spiritually oriented to bond and share affection with other men. Also used sometimes as an umbrella term, referring to individuals who identify as Lesbian, Gay, Queer, and/or Bisexual.

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

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

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

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

HE/SHE/ZE: He/she/ze are pronouns that are used to refer to one's gender as either male, female, or gender neutral respectively.

HER/HIR/HIS: Her/hir/his are possessive forms of personal pronouns referring to gender. The term "hir" is included as the possessive form of a gender-neutral pronoun to identify a transgender, gender-queer, transsexual, cross-dresser, or otherwise gender non-conforming person. The terms "her" and "his" are used as the possessive form for people who identify as female and male respectively.

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

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

HETEROSEXUAL: This is a term that is used to describe as an individual who is emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with those of the "opposite" sex. While most people are familiar with this term, the authors felt it important to note that many people

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

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

RACISM: Racism refers to oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted towards people because of their race or ethnicity. It alfor

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