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Chapter 15

Counseling Queer and Genderqueer Clients

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I like the word gay, though I think of myself more as queer.
I believe the strength in my work comes from that perspective—
my being an outsider.

—Holly Hughes

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Awareness of Attitudes and Beliefs Self-Check

1. Close your eyes and picture someone who identifies as queer. What do you see? How are your biases present in your image? Does the image change if you picture a male versus a female?
2. What people do you know who are out as queer, including celebrities or television/movie characters? How might this lack of representation impact queer or genderqueer persons?
3. How do you feel about the cultural reclamation of a previously negative or pejorative term? As this has been done similarly in African American communities (e.g., the *n*-word) and by females (e.g., *bitch*), can you understand the desire or process of doing this?

Case Study

Bianca is a 29-year-old first-generation Chicana cisgender woman. Bianca has a bachelor's degree and works at a medium-size business as a graphic designer. Bianca is proud of her educational and professional achievements but reports that her interpersonal relationships are strained. She currently lives with her partner, Thomas, in a midwestern city. Bianca's family, especially her parents and grandparents, are not supportive of Bianca's identity as a queer woman, her relationship with a Euro-American man, and her preference to focus on her career rather than start a family. Bianca presents with symptoms of depression (lethargy, negative self-talk, change in sleep/eating/activity, and increased substance use). Bianca reports that she has

been feeling depressed since college. For about 2 years she has been experiencing profound sadness, suicidal thoughts, loss of interest in life, and social embarrassment (especially when she is with her family). Bianca has also been struggling to manage her identity as a Chicana woman who identifies as queer. Bianca has attempted to connect with other lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, ally, pansexual/polysexual, and two-spirited (LGBTQI+) persons but has felt excluded because she is currently in a relationship with a heterosexual cisgender man, even though she has had multiple long-term sexual and romantic relationships with women. Bianca has decided to ask for professional help because her depression and lack of interest in life activities are affecting her relationship with Thomas, her relationship with her family, and her productivity at work.

Jesse is 45 years old and identifies as both African American and genderqueer. Jesse was married and has two teenage children from his previous marriage. His marriage ended after he came out as gay 5 years ago. He was working as a medical assistant at a local hospital but was fired after being convicted of and serving jail time for driving under the influence. Jesse's former partner is uncomfortable with his gender expression and will not allow Jesse to see their teenage children. Jesse is working with an attorney to gain custody of their children. He has no extended family, as his mother passed away about 6 years ago and he is an only child. Jesse presents with polysubstance use, including use of alcohol, marijuana, and prescription medication. He reports feeling disconnected from friends and family and feeling that no one will accept him for who he is as a genderqueer person. Jesse is experiencing suicidal ideation and reports various suicide attempts across his life span. He is connected with the local LGBT center and other LGBTQI+-specific resources. Jesse periodically attends Alcoholics Anonymous with friends he has made from the LGBT center but does not attend on a regular basis.

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Awareness of Differences

The term *queer* can be used to describe identity as a subjective mode of self-concept, which has its roots in theory and philosophy. Feminist scholar Judith Butler asserted queer theory as a logical development from poststructural feminism and other critical perspectives, including significant contributions from the philosophical work of Michel Foucault (Balick, 2011; Moore, 2013). Initially characterizing a paradigm for academic criticism based on deconstruction of heteronormative and patriarchal gender binary ideologies, queer theory and other aspects of queer subjectivity can be applied to diverse social phenomena (Carroll & Gilroy, 2001; Frank & Cannon, 2010). Tropes from feminist and critical philosophy, such as the personal being political and the role power serves in the construction of knowledge, are turned toward a consideration of how sociocultural norms saturate local and individual experiences of sex, gender, sexuality, and relationships (Moore, 2013). Commonalities across queer methodologies and practices include a critical analysis of power in the operation and performance of both dominant and marginalized affectional orientation and gender subjectivities (Zeeman, Aranda, & Grant, 2014). Practice grounded in a queer perspective also involves the deconstruction of gender and affectional orientation binaries and the perceived normativity of heterosexuality; these constructs are seen as artifacts of social power dynamics manifesting in the social construction of truth, mores, values, and knowledge. Along with the critical, deconstructive philosophies in queer theory are creative and productive modes based on valuing exploration; gender and affectional ori-

entation fluidity; and the reclamation and expression of a diverse array of gender, sexual, relational, and intersecting subjectivities (Moore, 2013).

As a term, *queer* has historically been used as a pejorative to insult, marginalize, and discriminate against individuals who identify under the LGBTQI+ umbrella (Brontsema, 2004; Burn, 2000; University of California, Berkeley [UCB], 2015). To some, the term *queer* can be experienced as offensive and marginalizing; these feelings may be especially common in older LGBTQI+ persons who have experienced the word *queer* as an insult (Brontsema, 2004; UCB, 2015). The work of queer activists and queer theorists has aided in the deconstruction of a heteronormative paradigm that attempts to fit people into neat and exclusive boxes of heterosexual or gay. As a result, in recent years, some individuals have adopted the term *queer* to reclaim their own queer identity (Smith, Shin, & Office, 2012). *Queer* was not initially intended to be a term interchangeable with *gay* and *lesbian:* "Queer was associated with a radical, confrontational challenge to the status quo, and a constructionist understanding of sexuality and gender" (Brontsema, 2004, p. 5). The term *queer* is now understood as an affectional orientation as well as a political statement: Labeling oneself as queer can be viewed as taking a stand against hegemonic (dominant) social norms related to gender, sex, affectional orientation, and especially binary and gender conformity (UCB, 2015).

The 1980s and 1990s were groundbreaking decades for the United States with regard to both queer activism and queer theory. Queer activists in the 1980s and 1990s changed the way the LGBTQI+ community engaged with the term *queer,* which has led to the rise of queer identity in many LGBTQI+ communities. Activism surrounding several needs has increased the infusion of queer theory into LGBTQI+ issues. These events were (a) the AIDS crisis and the reactions and feelings of victimization, (b) the limitations associated with a categorization of identity beyond "homosexuality," and (c) Queer Nation's push for a reconceptualization of sexual identity (Brontsema, 2004). The term *queer* became somewhat of a newly reclaimed signifier of proud, provocative sexual identity and self-empowerment during the 20th century (Rand, 2014). Reclaiming the term *queer* can be seen as a way of promoting tolerance, regaining the right of self-definition, forging and naming one's own existence and identity, and gaining strength from past victimization in addition to challenging affectional orientation and gender dichotomies (Brontsema, 2004; Rand, 2014).

Terms used to identify gender (e.g., *male* and *female*) and affectional orientation (e.g., *heterosexual* and *gay*) are social constructs signifying a complex set of identity positions, experiences, and behavior (Moe, Reicherzer, & Dupuy, 2011). For example, society may label someone who is attracted to the opposite sex as heterosexual. Socially constructed identity categories (e.g., gender, affectional orientation) carry multiple meanings, including a context of power and privilege; they also perpetuate the notion that labeling one's gender and affectional orientation is a simple process. These labels also structure how individuals understand themselves and their position in relation to dominant and marginalized subjectivities in a social hierarchy. The dominant discourse in society reinforces a system of power and privilege through the use of identity labels; it also results in discrimination against groups espousing marginalized identities and further reifies the associated inequities (Smith et al., 2012). In addition, these simple labels are simply incorrect: Gender and affectional orientation variance exists in a continuum-based model of gender identity, gender expression, designated sex at birth, and sexual and romantic attraction. However, each of these variables is still subversive to dominant discourses (Moe et al., 2011). The gender Gumby (UCB, 2015) and genderbread person (Killermann, 2013) models serve as a depiction of the utility of continuum-based models wherein individuals may locate their gender and affectional orientation subjectivities.

The Gender Gumby and Genderbread Person Identity Models

Traditional roles related to gender identity, gender expression, sexual identity, and romantic attractions are prescribed, reinforced, and constructed by society. Traditional society

recognizes two binary genders: male and female (Killermann, 2013; UCB, 2015). The social construction of identity and language limits and categorizes individual identities and experiences into opposing binaries (i.e., gay or heterosexual, male or female). This binary does not allow for the possibility that identities outside of the gender and affectional orientation binaries exist (e.g., bisexual, pansexual, asexual, genderqueer, nonbinary, gender fluid), which therefore limits their social recognition through language.

The gender Gumby and genderbread person models (Killermann, 2013; UCB, 2015) deconstruct the majority social narrative of the gender and affectional orientation binary, thereby allowing individuals to identify in ways that are most authentic to their lived experiences. The gender Gumby model enables individuals to identify intersecting aspects of their identities (UCB, 2015). The domains in this model influence how individuals perceive their world in terms of sex, gender identity, gender presentation, and affectional orientation, each on a separate continuum (UCB, 2015). For example, the sex continuum ranges from male on one end to female on the other. These constructs are discussed and fully defined in Chapter 14. The genderbread person model Version 3.3 (see http://itspronouncedmetrosexual.com/2015/03/the-genderbread-person-v3/) contains the same constructs: gender identity, gender expression, designated sex at birth, and sexual attraction. It additionally contains romantic orientation, which is important to separate out, particularly for asexual individuals (Killermann, 2013). The genderbread person Version 3.3 model additionally breaks down the continuum to allow for a blend and combination in each category. For example, people can rate their gender identity on two continuums: woman-ness (from 0 to complete) and man-ness (from 0 to complete; Killermann, 2013). In both models, these identity domains exist independently and are expressed independently; that is, people's gender identity and/or expression are not the same as or in conjunction with their sexual or romantic attractions (Killermann, 2013; UCB, 2015).

Just as sex and gender identity/expression are not linked, gender and its domains are not linked to an individual's romantic or sexual attractions. The gender Gumby and genderbread person models outline how individuals have domains of sexual attraction and romantic attraction, which can be the same or different. These domains are related to varying levels of femaleness/femininity and maleness/masculinity to which a person is sexually or romantically attracted. This continuum of sexual and romantic attraction is related to principles outlined by Kinsey, Pomeroy, and Martin (1948) in the Heterosexual-Homosexual Rating Scale, sometimes referred to as the Kinsey Scale. This research found that people do not fit into neat and exclusive heterosexual or "homosexual" categories (Kinsey et al., 1948) and that sexual identity is more aptly described as being on a continuum. Though the majority of men and women reported being exclusively heterosexual, and a percentage reported exclusively gay behavior and attractions, many individuals disclosed behaviors or thoughts somewhere in between (Kinsey et al., 1948). This challenges typical ideas proposed by the gender binary and provides evidence for nonbinary identities such as bisexual, pansexual, polysexual, and queer.

Kinsey et al. (1948) found that sexual behavior, thoughts, and feelings toward the same or opposite sex were not always consistent across time and could evolve across the life span. In addition to feeling various levels of sexual and romantic attraction to femaleness/femininity and maleness/masculinity, individuals may identify as having no (e.g., asexual) or little (e.g., demisexual) sexual and/or romantic attraction toward others. The gender Gumby and genderbread person models outline the fluidity of human affectional orientation and gender expression. These models challenge gender binary ideals of how society groups and defines individual sexual identity, gender identity, and gender expression; they also assist individuals in learning the complex nature of gender and affectional orientation.

Genderqueer

An individual who identifies as genderqueer is "a person whose gender identity is neither man nor woman, is between or beyond genders, or is a combination of typical prescribed gender roles and/or expressions" (UCB, 2015, "genderqueer"). This identity is related to or in reaction to the social construction of gender, prescribed gender stereotypes, and the gender binary system. The gender binary system reinforces principles of genderism, or the belief that there are only two genders (Killermann, 2013). Genderism also insists that individuals' birth-assigned sex is related to their gender identity and expression (Killermann, 2013). Genderism and genderist attitudes discriminate against transgender, genderqueer, and gender-nonconforming individuals, reinforcing the belief that cisgender individuals and those who identify as either male or female are superior and deserving of privilege. Genderqueer individuals may choose to label themselves as a direct response to genderism and the gender binary.

Genderqueer individuals do not conform to society's prescribed gender roles and ideas of gender conformity (Killermann, 2013; UCB, 2015). Therefore, genderqueer is a gender identity and gender expression rather than a sexual identity. In addition, some genderqueer persons identify under the transgender umbrella, whereas others do not. Someone who identifies as genderqueer may identify with characteristics traditionally labeled as masculine and other characteristics typically labeled as feminine in various combinations. Genderqueer persons can express gender nonconformity through gender expression, behavior, social roles, and gender identity. However, it is not necessary to express one's gender identity to identify as genderqueer. Genderqueer persons may also identify with terms such as *bigender, androgynous, gender fluid, gender nonconforming, gender diverse, pangender,* and/or *nonbinary.* They may also use terms such as *androsexual* (attracted to males) or *gynesexual* (attracted to females) to indicate affectional orientation, as *heterosexual* and *gay* assume a gender in their definitions.

Knowledge of Issues and Problems

Information about different groups of individuals who may identify as queer, in relation to either their gender, sexual/relational/affectional orientation(s), behaviors, or other modes of expression, can be difficult to generalize; one hallmark of living a queer perspective is the valuing of complexity, fluidity, change, and the performance of idiosyncratic or innovative subjectivities (Downing & Gillett, 2011). Research on the psychosocial and physical health of people who express same-sex sexual and relational orientations and/or who subvert gender binaries in dress, behavior, identity, or any other means exists but may be limited in its generalizability and transferability across the queer and genderqueer identities. Here we discuss overarching themes related to the physical, social, emotional, and mental health needs of queer and genderqueer individuals synthesized from the literature. Collaborative biopsychosocial assessment with queer clients can be enriched through attention to these issues (Moe, Finnerty, Sparkman, & Yates, 2015). Assuming that these issues are universal, however, should be avoided in favor of honoring the lived experiences and capabilities of queer clients.

The Institute of Medicine (IOM; 2011) sponsored a nationwide task force addressing the need for best practice standards in health care for LGBTQ individuals that developed an integrated theoretical framework for conceptualizing health issues faced by these historically marginalized populations. Members of the task force, based on a critical review and analysis of the literature, identified the following four perspectives as vital to understanding the physical and mental health care needs of LGBTQ people: minority stress, social

ecology, life span development, and intersectionality. The minority stress perspective attributes the physical and mental health disparities disproportionally impacting LGBTQI+ people to their experience of discrimination, both overt and subtle, including internalized oppression (IOM, 2011). Social ecology refers to situating queer subjectivities in interrelated contexts and discourses, in which the experience and expression of gender and affectional orientation diversity needs are textured by the interactions, mores, and expectations emergent in social relationships. The life span development viewpoint encompasses the ongoing growth and changes experienced by queer individuals as a result of aging, experiencing new roles (or the loss of old ones), and the impact of social change over the life span. The experience of identifying as queer, for example, is contextualized by social expectations for youth, young adults, middle-aged persons, and older persons in any historical moment. Finally, intersectionality involves intentional consideration of the dynamic interplay between multiple identities and subjectivities, including the operation of privilege and oppression. Expecting queer clients to prioritize their gender and affectional orientation identities over others, such as cultural or ethnicity-based identities, is tacitly heteronormative and cisgender biased, as it is based on viewing these aspects of identity as primary regardless of context or individual experiences (Moe et al., 2011).

Experiences of Bias

Self-awareness related to same-sex sexual and relational experiences or binary gender nonconformity may develop in early childhood (Cox, Dewaele, Van Houtte, & Vincke, 2010). How family and primary caregivers respond to this awareness has a lifelong impact on the sense of connection and personal well-being of people who identify as queer, with negative reactions being associated with undesirable psychosocial outcomes (Poteat, Mereish, DiGiovanni, & Koenig, 2011). It is very likely that queer persons are subject to the same degree of bullying, harassment, and abuse as other LGBTQI+ persons discussed in this book (Hines, Malley-Morrison, & Dutton, 2013; Kosciw, Greytak, Palmer, & Boesen, 2014). However, often the queer and genderqueer identities are not researched uniquely; rather, they are aggregated with LGBT data. Regardless, a nonaffirming social environment may foster a sense of isolation in children, adolescents, and adults. Isolation is a powerful contributing factor to a person's sense of self-worth, ability to cope with life challenges, and development of resiliency and overall wellness (Cox et al., 2010; Poteat et al., 2011). The effect of social context on the well-being and positive development of gender and affectional minorities (including queer people) is well documented (American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Cox et al., 2010). However, people who identify as queer may face unique challenges related to within-group social dynamics that manifest in spaces otherwise affirming of LGBTQI+ people (Moore, 2013).

For example, gender and affectionally divergent youth of color reported feeling misunderstood by older LGBTQI+ people (Giwa & Greensmith, 2012). This sense of feeling invalidated or misunderstood arose partially as a result of the adults expecting the youth to identify with and express their gender and affectional orientations through identity markers such as lesbian or gay (Giwa & Greensmith, 2012). It should be noted that the participants, despite describing this sense of disconnection, still felt that LGBTQI+ service providers were more competent and affirming in general compared to non-LGBTQI+-identifying providers (Giwa & Greensmith, 2012). Thus, people expressing queer and genderqueer subjectivities may feel isolated, judged negatively, or otherwise invalidated in groups and communities that embrace ethnic majority, binary, and/or heteronormative identities (Stone, 2013). This informs the therapeutic alliance, as queer clients may struggle

to trust that their counselors, even those identifying as allies and/or LGBTQI+, will be authentically affirming and valuing of their lived experiences.

Life span considerations for queer individuals include being able to share their gender, sexual, and relational fluidity with family members (whether of origin or intent) and potential life partners (Moe et al., 2011). Adopting and expressing a queer identity after identifying as heterosexual, lesbian, bisexual, and so on may cause awkwardness and confusion among close friends and loved ones as the new identity is negotiated socially. Intimate partner violence has also been studied in queer-identified individuals. Queer individuals appear to experience rates of intimate partner violence comparable to cisgender and heterosexually identified couples (Ard & Makadon, 2011). The experience of intimate partner violence for queer and other LGBTQI+ people is nuanced by a lack of affirmation from intimate partner violence response providers, a lack of relationship recognition in many communities and states, and fear of having their sexualities or gender identities involuntarily disclosed to others as result of seeking help (Ard & Makadon, 2011; Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011). Older adults who identify as queer may face significant challenges to maintaining their standard of living, as services (such as group homes) for elders may expect or enforce strict codes of behavior based on heterosexism and patriarchal gender-role conformity; individuals presenting as ambiguous in any way in terms of affectional orientation or gender identity may be turned away from such facilities (Erdley, Anklam, & Reardon, 2014). Seeking out and connecting with other people who affirm queer values is an important wellness practice across the life span for people who identify as queer (Moe et al., 2011).

Queer-identified persons are infrequently included under the LGBT umbrella. The term *queer* sometimes serves as an umbrella term for LGBT-identified persons but is also a unique political and social identity that is not included in the LGBT spectrum. One person may identify as LGBT and queer, and another person could identify as queer and not under the LGBT identities, depending on personal identification preferences. Traditional paradigms regarding affectional orientation and gender insist that an individual must identify with a group (e.g., heterosexual or gay, male or female) without allowing for fluidity. This is sometimes reinforced in lesbian and gay communities through the nomenclature and language used to define an individual's affectional orientation or gender. For the counseling field to improve services for LGBTQI+ persons and advocate for social justice issues related to this group, counselors themselves must develop an awareness of the power of language and grouping on individual identities (Smith et al., 2012). In the case of queer-identified persons, cultural norms, traditions, grouping, and naming have reproduced a gender binary, which creates socially constructed either/or identity categories. These categories cannot accurately describe the fluidity of human sexuality or gender identity. This inaccuracy leads to the exclusion and marginalization of sexually diverse and gender-nonconforming individuals.

Queer-identified persons are also often misunderstood and marginalized, culturally and in mental health services. The deconstruction of heteronormative values, the gender binary, and genderist attitudes enable counselors to dismantle heteronormative mental health practices and research (Smith et al., 2012). Greater awareness of the affectional orientation and gender binary can enable well-intended counselors to construct their own understanding of affectional orientation, gender, and client status(es) (Burnes et al., 2010; Harper et al., 2013). Interrogating the construction of gender binary principles is essential for counselors and the field of counseling to gain an understanding of affectional orientation and gender minority concerns (Smith et al., 2012). This deconstruction will ensure that counselors develop a greater awareness of their own assumptions, values, and biases related to the affectional orientation and gender binary. This will assist in developing

practice-appropriate interventions for affectional minority and gender-nonconforming clients (Smith et al., 2012). Increased understanding of the queer community requires that counselors and mental health professionals educate themselves about and advocate for efficacious services for queer-identified persons.

Physical Issues and Health Care

LGBTQI+ populations, including queer and genderqueer individuals, present with significant health disparities in the United States and globally (Haas et al., 2010). Negative physical health outcomes manifesting with greater prevalence across gender and affectional orientation variant groups include higher rates of HIV/AIDS and other sexually transmitted infections as well as greater risk of injury due to physical assault (IOM, 2011). Individuals with genderqueer and/or transgender identities and modes of expression, especially those with intersecting ethnic minority heritages, appear to be at the highest risk for interpersonal violence; deprivation due to poverty; financial insecurity; and the development of chronic health care conditions, including HIV seroconversion (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). Access to competent and affirming providers of physical health care is also an important social justice issue for queer populations, with the real or perceived threat of prejudicial behavior on the part of providers being a factor in the decision of LGBTQI+ people to seek care (Carvalho et al., 2011).

The evolution of marriage equality laws to recognize non-heterosexual couples is a welcome structural development in terms of ensuring that queer clients are able to share insurance, to share information, and to act as decision makers in critical health care situations on behalf of their partners and spouses (Erdley et al., 2014). However, insurance coverage for gender transition and health care providers who are open, affirming, and competent relative to gender and affectional orientation variance are still relevant issues for LGBTQI+ persons.

Potential Mental Health Challenges

As previously delineated, individuals who identify as LGBTQI+, or whose behavior and experience does not conform to strict heterosexuality and/or binary gender-role conformity, appear to experience higher rates of mental disorder and stress than their heterosexual and cisgender counterparts (Haas et al., 2010; IOM, 2011). This includes higher rates of suicidality, depression, and anxiety (Haas et al., 2010), all conditions seen as related to minority stress and internalized prejudice (Balsam et al., 2011; Cox et al., 2010). These manifestations of mental distress appear to be common across LGBTQI+ groups and to be exacerbated further by social alienation and isolation (Mink, Lindley, & Weinstein, 2014). Trauma appears to be experienced at higher rates by LGBTQI+ groups, with the highest rates experienced by people who identify as transgender or genderqueer as well as LGBTQI+ people of color (Balsam et al., 2011). Accurate assessment of minority stress, internalized prejudice, and trauma that accounts for societal heterosexism and cisgender prejudice is an important standard of care for counselors seeking to provide services to queer individuals (IOM, 2011; Moe et al., 2015; Patton & Reicherzer, 2010).

In terms of unique aspects of queer individuals' mental health and ongoing development, Stone (2013) reported queer individuals place high value on being able to remain in a state of experiential fluidity regarding their gender and/or sexual-relational orientation(s) and identities in order to avoid a sense of feeling stuck or trapped. That is, challenging and questioning personal identities, relationships, and experiences (even positive or affirming ones) was seen as a motivating force by participants and as a healthy indicator of the queer individual's ability to avoid stagnation (Stone, 2013). Cherishing fluidity in identity and experience, as

well as innovation in gender, sexual, and relational expression, may be both a strength and a potential source of stress for clients who identify as queer in terms of striving to enact an idealized queer subjectivity. It is also important to note the strengths and capabilities of queer individuals in any discussion of mental health and well-being: It is important to honor the achievements of members of this population and to counter the overpathologizing of nonbinary persons. Self-identifying queer, genderqueer, and other nonbinary-conforming individuals have been an integral and visible part of sociopolitical movements to address heterosexism, patriarchy, and cisgender prejudice, especially in previous generations when other identity markers (e.g., gay) were used less or not at all (Lee, 2013).

Counseling Skills and Techniques

To those familiar with the critical epistemologies (e.g., feminism) from which queer theory was developed, it should come as no surprise that the discourse of evidence-based practice (EBP) is also an object for deconstructive engagement along with heteronormativity and gender binary thinking. The framework of postpositivism, rooted in modernism and so-called scientific objectivity, promotes the seeking of unitary and universalist truths and related value-free causal explanations for phenomena (Balick, 2011). Information that is quantifiable, created using postpositivist methodologies such as the randomized controlled clinical trial, is privileged in the EBP perspective because of the apparent removal of both the observer and the observed from consideration of the knowledge claims supported by such research endeavors (Balick, 2011; Zeeman et al., 2014). Therefore, queering the discourse of EBP and reclaiming potentially useful knowledge and awareness are the goals in reviewing the existing research; expressly critiquing the operations of heteronormative and gender binary assumptions in the creation, implementation, analysis, and interpretations of research will help reveal the validity of the research. Just as a queer view of identity does not deny the valuing of nonqueer identities (Moore, 2013), a queer response to EBP does not reject the scientific method; rather, claims based solely on a postpositivist frame are considered incomplete without consideration of power, history, relationships, and other sources of context (Burnes et al., 2010; Harper et al., 2013). Thus, the paradigm of EBP, applied uncritically and differentially, itself can be used to support tacit and explicit heteronormativity and transgender prejudice (Smith, 2013; Zeeman et al., 2014), as has been done in the past (Daley & Mulé, 2014).

Another important consideration involving uncritical adherence to the EBP viewpoint is related to which populations and presenting concerns have any empirically supported counseling and psychotherapy approaches validated for work with queer and other LGBTQI+ individuals. According to the *ACA Code of Ethics* (American Counseling Association, 2014), counseling interventions that do not rest on a scientific and theoretical foundation for work with populations to which clients belong, and/or the presenting concerns of clients (e.g., social phobia), should be represented as developing or innovative. Assessment instrument reliability and validity, intervention efficacy studies with LGBTQI+ populations, and the development of therapeutic responses for specific presenting concerns are all underdeveloped domains in the existing knowledge base largely as a function of historical heteronormativity and transprejudice in the academy (Singh & Shelton, 2010). This is especially problematic given the apparent differential expectations for what kind of evidence is considered sufficient to justify continued use of diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* whose criteria for gender dysphoria and some paraphilias appear to be informed more by social norms than by scientific evidence (Daley & Mulé, 2014).

To counter the potential for misappropriation of the EBP worldview, counselors working with queer individuals (and other gender and affectional minorities) can seek to

enrich their awareness of valid approaches. Along with standards for evaluating quantitative research, such as reliability, validity, and generalizability, counselors can apply standards related to qualitative methodologies (e.g., trustworthiness, credibility, transferability) to an evaluation of counseling approaches. Counselors can use this combined approach when working with queer clients and developing a case conceptualization and related evaluation of EBP: (a) Is gender and/or sexual diversity related to the reason queer individuals are seeking counseling? (b) What are the presenting concerns, and how are these concerns informed by heterosexism and cisgender privilege? (c) What evidence (both quantitative and qualitative) exists to support counseling for the presenting concerns with any populations? (d) What evidence exists to support counseling with the specific populations with which queer individuals identify? and (e) How does a particular counseling approach resonate with the lived experiences of queer individuals, including tapping into their competence, strengths, and coping abilities (Moe et al., 2015; Zeeman et al., 2014)?

Scholars have sought to strengthen the empirical and theoretical synthesis of counseling models with affirmation of LGBTQI+ communities, including those identifying as queer. The framework of cognitive–behavioral counseling, an approach with breadth and depth of empirical support for a diverse array of presenting concerns, can be tailored to address issues specific to the lives of queer clients (Martell, 2014). Techniques such as challenging rigid or dichotomous thinking, engaging in and altering self-talk to be more self- and other affirming, thought stopping, behavioral rehearsal and experimentation, and reframing can be utilized to counter the influence of internalized prejudice and related minority stress concerns (Martell, 2014). Third-wave cognitive therapies based on mindfulness, such as acceptance and commitment therapy, can help deepen the ability of queer-identified clients to be more present oriented and confident in negotiating their values across the full spectrum of social contexts (Stitt, 2014). Paradigms based on cultivating a rich therapeutic rapport, such as relational-cultural theory (Patton & Reicherzer, 2010), are theoretically consonant with the queer values of engaging with the worldview, self-expression, and self-concept of individuals negotiating their life experience in an oppressive sociocultural milieu (Moe et al., 2011). Self-disclosure, immediacy, authenticity, radical valuing, and accurate empathic awareness are all appropriate counseling techniques for both fostering a sense of therapeutic alliance and subverting the potential objectification of the client (Patton & Reicherzer, 2010).

The framework of narrative therapy (Saltzburg, 2007) is based on deconstruction of counseling and psychotherapy as a social practice, which makes this approach theoretically and stylistically consistent with the poststructural philosophy on which queer theory is based (Saltzburg, 2007). Elements of narrative therapy, such as restorying, situating thoughts and beliefs in social discourse, and externalizing discourse(s) limiting the well-being of clients, are well matched to the lives and experiences of queer individuals. Externalizing heteronormativity, patriarchy, and cisgender prejudice as sociocultural discourses may in fact be second nature to clients already identifying as queer, and counselors should privilege the competence and strengths of queer clients related to coping with and resisting oppressive discourses. Strengths-based counseling and psychotherapy models, such as solution-focused brief therapy, are also helpful for reclaiming the successes, capabilities, and innovations that queer-identified individuals engage to not only cope with oppression but thrive as fully realized social agents (Mink et al., 2014). Identifying strengths and successes with queer clients can be helpful given the history (and current use) of stigma, overpathologizing, and medical discourse to objectify queer people as deviant or abnormal (Daley & Mulé, 2014; Moe et al., 2015).

The Competencies for Counseling LGBQQIA Individuals (Harper et al., 2013) and Competencies for Counseling Transgender Clients (Burnes et al., 2010) are frameworks that contain process guidelines for affirmative practice that should be synthesized with other

counseling models. Standards such as cultivating self-awareness around heterosexist and cisgender biases, incorporating inclusive and client-affirming language in documentation as well as spoken dialogue, and seeking complementarity in the evidence used are all informed explicitly by queer theory and should be applied to any counseling situation with people who identify as queer (Burnes et al., 2010; Harper et al., 2013). Each framework is based on critical review and integration of available theoretical and empirical evidence on affirming counseling with LGBTQI+ populations.

Conclusion

Ongoing research and theory construction is still needed to validate counseling and psychotherapy approaches with queer individuals and groups, especially in terms of theory built on the foundation of queer peoples' values, strengths, and lived experiences. This chapter has predominantly considered queer subjectivity as one of many viewpoints relating to gender and affectional orientation, but a queer perspective can also be infused into consideration of the needs, experiences, and identities of heterosexual or cisgender individuals as well. Illustrating the operation of power in how individuals manifests their affectional orientation or gender identity, for example, may be liberating for any human; it can be quite oppressive for any person to negotiate a unique or minority identity in a patriarchal, heteronormative, and binary gender deterministic social ecology. Embracing the diversity within and between identity categories (including heterosexual or cisgender identities) creates space for continued innovation in the collective understanding of sexuality, relationships, affectional orientation, gender, and their myriad intersections and forms of expression in human development.

Questions for Further Discussion

1. What might it mean to Bianca to identify as queer? How about Jesse as genderqueer?
2. What types of bias and discrimination are Bianca and Jesse facing?
3. What are the possible reasons why Bianca and Jesse are experiencing physical/mental health symptoms?
4. What competencies does a counselor need to be able to work effectively with Bianca and Jesse?
5. What potential counseling interventions may be effective for these cases?

Resources

1. Review the following gender training tools online:
   a. Gender Gumby: http://www.pdxqcenter.org/wp-content/uploads/2013/02/gumby%20pp.pdf
   b. Gender Pokey: https://catchingwine.files.wordpress.com/2013/11/gender-pokey1.pdf
   c. Genderbread person version 3: http://itspronouncedmetrosexual.com/2015/03/the-genderbread-person-v3/
   d. Gender unicorn: http://www.transstudent.org/gender
2. Learn more about the genderqueer identity at http://genderqueerid.com/.
3. Read about the overlap of affectional orientation and genderqueer identity at http://itspronouncedmetrosexual.com/2012/02/sexual-orientation-for-the-genderqueer/.

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