Group Counseling With LGBTQI Persons

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Group Counseling

**With**

**LGBTQI Persons**

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We dedicate this text to our husbands, Benjamin A. Jones (Kristopher M. Goodrich) and Joseph E. Tomassone (Melissa Luke), who empowered us to challenge ourselves, encouraged us when the tasks were daunting, forgave us when it took time away from them, and loved us unconditionally throughout the process.

In addition, we would like to say that this text was inspired by our clients, students, and supervisees. Our shared work with them informed a number of the concepts, interventions, and ideas included throughout this book.
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The origins of this book grew out of concern shared by both of us regarding an observed gap in the practical and scholarly publications pertaining to group work with lesbian, gay, bisexual, transgender, questioning, and intersex (LGBTQI) persons. As counselors and counselor educators, we recognize the need to train clinicians to intentionally work with LGBTQI clients. Having varied experiences in counseling and community activism, we recognize that LGBTQI persons have come to our practices at varied points in their lives and for a variety of reasons. Yet, contemporary group texts primarily identify LGBTQI persons’ presenting concerns as related to coming out, the effects of marginalization and discrimination, as well as the connection the community has historically had to the HIV/AIDS crisis. Although these texts offered conceptualization and intervention in response to these considerations, we recognized that LGBTQI persons have a wide range of other potential needs that can be addressed in group. Accordingly, this book is a first attempt to fill some of this gap so that group leaders, supervisors, and those who teach group can provide an additional structure and intentionality to the groups that they run to ensure that their services are appropriate and effective for LGBTQI persons.

Given that at least 4%–10% of individuals identify as lesbian, gay, or bisexual (Chung, Szymanski, & Amadio, 2006; Haas et al., 2010), and it remains unknown how many additional persons identify as transgender, questioning, or intersex, the demonstrated dearth of information about LGBTQI persons’ needs and experiences in the current professional literature is alarming. Not only is it probable that a group leader will work with LGBTQI group members, but the group leader is also likely to encounter a larger number of
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group members who live with and love LGBTQI persons. Thus, we approach this book with a belief that without more knowledge, awareness, and skills in working with LGBTQI persons, group leaders are at risk of stereotyping and perpetuating societal misattributions, which both can be harmful to individuals and groups. The book is also predicated on the belief that with increased knowledge, awareness, and skills, group leaders can utilize the unique properties and propensities of group work to create ameliorating structures and growth-promoting experiences for all group members, specifically LGBTQI members.

This book contains information and evidence about facilitating groups with the LGBTQI populations. We have decided to address the population developmentally, as members of the LGBTQI populations are diverse and have evolving needs at different points over the life span. The paradigm of this text is that there are various critical periods, contexts, and potential points of intervention with the LGBTQI populations that should not be pathologized. Using a focus on normative human development and the concepts of life cycles and systems, group counselors and group psychotherapists can be better prepared for this population. It is our hope that this book can be used for group counselors who both facilitate groups for LGBTQI persons as well as facilitate groups that include (but are not specific to) LGBTQI persons.

The book begins with a discussion of the history of group work with LGBTQI persons and defining the populations of people we are discussing that group leaders might work with. We review the rationale for group interventions with persons from different LGBTQI communities and whether one should decide to have them in a heterogeneous or homogenous group on the basis of presenting concern. Chapter 2 continues with different planning and group process issues that group leaders should consider in their work, such as the type of group that best serves their clients’ needs, factors that might influence the group process, and how they can best respond to those circumstances in a group setting with LGBTQI persons. Chapter 3 continues with a discussion of different ethical and legal issues of relevance with this population. The book then progresses with each chapter devoted to different segments and critical moments for the LGBTQI population. Each chapter is oriented to expand the group leader’s knowledge about certain groups and issues, self-awareness of issues that might get in the way, and skills/interventions that they can utilize within the group. This frame of knowledge, awareness, and skills has been accepted in multicul-
tural counseling practice, used in the fields of both counseling and psychology (Sue & Sue, 2013).

In Chapters 4–6, we explore developmental and gender-based groups that are more homogenous in nature. These types of groups have been constructed to increase the amount of similarity among members, to raise cohesion, and to ensure a greater ability for members to see others like they are. In Chapter 4, we address more specifically some of the issues and concerns that LGBTQI children and adolescents might face, both in school as well as in the other contexts of their lives. The interventions in this chapter have been formatted to be developmentally appropriate for group members of different ages. Chapter 5 continues with a focus on same gender adult groups for LGBTQI persons. In this chapter, we explore specific issues that they may face, including friendships, romantic relationships, education and career readiness, as well as aging. In Chapter 6, we address groups with transgender and intersex persons, who can have differing considerations from others because of their gender identity.

Following this, Chapter 7 begins the context portions of the text. Specifically, in this chapter we explore how groups can be utilized to assist members in their disclosure or coming out process as LGBTQI. Interventions are developmentally constructed to assist members in understanding when, whether, and to whom they wish to disclose their affectual orientation or gender identity. In Chapter 8, we introduce the different contexts in which groups may take place—school, residential, and outpatient settings—and how these can influence the group counseling process for members and leaders. Using Bronfenbrenner’s (1977, 2005) frame, we introduce leaders to different interventions that can be impactful in different types of settings in which they may work.

Chapter 9 is a comprehensive chapter—authored by Hannah Bowers, a doctoral candidate at the University of New Mexico—that deals with the different types of groups available for LGBTQI couples and families. In the first portion of the chapter, she introduces groups that can be used by family members of LGBTQI persons to integrate their identity as a family member and supporter of an LGBTQI person; later in the chapter, she introduces groups that LGBTQI couples and families can utilize to explore and discuss concerns related to money, finances, expectations, and so forth.

In Chapter 10, we explore different group interventions that one can utilize for groups with LGBTQI persons who struggle with alcohol and other drug concerns. We know that addictions have
impacted this community proportionally more than others, and so group leaders must be ready to understand, and to provide specific interventions to assist, persons with this concern. In Chapter 11, we address grief and loss—a hard topic for many LGBTQI persons. Although there are similarities in experiences of loss, there are differences with LGBTQI persons concerning types of marginalization, discrimination, and lack of acknowledgment of relationships. This can compound the experience of loss and trauma, and interventions in this chapter focus on how to understand and address these issues. Chapter 12 continues with a discussion about the supervision of group work, or how supervisors can assist group leaders in providing thoughtful and intentional support in facilitating groups with LGBTQI persons.

The text ends with two chapters that have a systemic focus on intervention. In Chapter 13, we explore social justice interventions; in Chapter 14, we introduce different types of group structures for allies of LGBTQI persons. We believe in the strength and power of the group experience and how it can influence positive changes across and within members, who then can influence positive change in their lives. We provide an introduction to these ideas in these final chapters to hopefully inspire group leaders to bring about positive change in the world.

It is our hope that you, the reader, will be able to use this text as a resource and reference with your own practice of group counseling as well as group work education. We recognize that no text can comprehensively and completely span the entire domain of issues or concerns that might be present within the LGBTQI community. Instead, it is our desire to provide you with an initial reference to anticipate the unique needs and experiences of LGBTQI persons, how you can potentially address these issues, as well as where else answers might be found. We welcome you on your journey to provide intentional and effective work with the LGBTQI community, and we look forward to hearing about each of your successes!
About the Authors

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Chapter 1

Introduction and History of Group Work With the LGBTQI Population

Researchers in the fields of counseling and psychology have recently recognized that the clients they serve have multiple and diverse needs. The multicultural and social justice movements in both fields have highlighted the attention to communities that have historically been misunderstood and underserved by these professions (E. J. Green, McCollum, & Hays, 2008; Hays, Dean, & Chang, 2007; Okech & Rubel, 2007). Thus, there has been an emergent focus on different communities of clients across the range of counseling and therapeutic services that are provided. Populations of persons that have been persistently excluded from the conversation have been the lesbian, gay, bisexual, transgender, questioning, and intersex (LGBTQI) communities (Goodrich & Luke, 2010, 2011).

History of Group Work With LGBTQI Persons

Extant research has shown that group work is an effective intervention for persons seeking positive change (DeLucia-Waack, 1997; Page & Jencius, 2009). The use of group work has increased in its prevalence over recent years because of the growing recognition of its efficacy. The benefits include efficiency, therapeutic potential, and interpersonal gains for participants (Gladding, 2012; Southern, Erford, Vernon, & Davis-Gage, 2011). Although we have long
known the powerful nature and clinical potential that group experiences may have for clients, little attention has been provided to LGBTQI clients in groups. This is disturbing, as there is emergent research that has demonstrated that LGBTQI clients have increased risk of psychological, health, familial, social, and academic issues (D’Augelli, 2005; Goodrich, 2012; Goodrich & Luke, 2009; Kosciw, Greytak, Bartiewicz, Boesen, & Palmer, 2012; Mustanski, Garofalo, & Emerson, 2010; Tyler, 2008), and much of this could be prevented or mitigated through group interventions (Goodrich & Luke, 2010, 2011; Luke & Goodrich, 2013).

Historically, when the LGBTQI populations have been addressed in the group work literature, authors have discussed specific sub-populations under the overall LGBTQI umbrella and, when doing so, have focused on particular circumstances. Overwhelmingly, these discussions have centered on coming out/disclosure groups and groups for persons living with HIV/AIDS (e.g., see Gazda, Ginter, & Horne, 2001; Gladding, 2012; Holcomb-McCoy & Moore-Thomas, 2011; Kottler & Englar-Carlson, 2010). This is problematic in multiple ways. First, this does not comprehensively represent LGBTQI experiences: Predominantly, the ways in which these groups are written about only address sexual/affectual orientation (Luke, Goodrich, & Scarborough, 2011), essentially leaving the transgender and intersex populations out of the discussion (as disclosure has not been written about considering the nuances or differences related to one’s gender identity; dickey & Loewy, 2010).

Additionally, there are many developmental concerns faced by LGBTQI individuals over the life span before, between, and after their disclosure experience. The restricted focus in the literature fails to capture the normal developmental concerns of LGBTQI individuals as they establish or maintain intimate relationships/families, encounter career or occupational concerns, and navigate other life transitions. Finally, with the pronounced focus on HIV/AIDS, one cannot help but wonder whether stereotypes about the LGBTQI community are continuing to be perpetrated within the group literature; although HIV/AIDS is a concern in the LGBTQI community, it is also a concern within the larger population as well. Moreover, having such focused conversations in only one segment of the group counseling literature limits the potential for the larger message being communicated to future group leaders.

Although Puglia and Hall (2010) recently expanded the conversation of group work issues with the LGBTQI community to include discussion of other contexts and concerns, they stopped short of exploring life span issues or representing all members of
this diverse population. Responding to this gap, in the current text we aim to comprehensively explore the needs and concerns of the LGBTQI community across the life span that can be addressed in group work. We provide you—current and future group workers—with additional knowledge and skills/interventions that can be used across group situations as well as self-awareness-building questions if something gets in the way of your work. Before we expand on this work, let’s first define the LGBTQI community we are about to explore working with.

### The Population Defined and Terminology Explained

**Affectual Orientation**

*Lesbians* (L) are women who are emotionally, physically, and intimately attracted to other women. *Gay men* (G) are men who are emotionally, physically, and intimately attracted to other men. It should be noted that the term *gay* can also be used to describe men or women who are attracted to others of the same gender, although current social trends involve greater specificity in referencing one’s own personal identity. *Bisexual persons* (B) are persons who are emotionally, physically, and intimately attracted to persons of both genders. Persons who identify as *questioning* (Q) are individuals who are exploring their affectual orientation; they are either unsure or considering the label to best describe their experience. The term *queer* (Q) might be utilized to describe some individuals who do not wish to subscribe to any previously defined label regarding their affectual orientation. Although once used in a pejorative fashion, some in the LGBTQI community have reclaimed this term to describe their identity and experience. The use of Q to describe both the terms *queer* and *questioning* has led to some confusion in the community to what the abbreviation Q means. We use the Q in this text interchangeably, as we see the fluidity of identity and identity status, something that is represented by both identity statuses that the letter is supposed to represent. Further, some persons add to the alphabet of identifications within the community. *Asexual persons* (A) are persons who lack sexual attraction or interest in sex. Finally, *heterosexuals*, or *straight* persons, are individuals who are emotionally, physically, and intimately attracted to members of the opposite sex. All these terms describe different affectual orientations or identities that a person might identify with.

There are also emerging identities that are currently in use, especially among youths within this community. One such term is *pansexual*, which describes a person who identifies as having sexual
attraction, sexual desire, emotional attraction, or romantic love toward people of any sex or gender identity. Sometimes these persons also refer to themselves as gender blind, which is meant to represent that gender and assigned sex are not significant in determining their attraction toward others, and sexual attraction is not the sole criterion for pair bonding.

It should be noted that the term *homosexual* is not used in this book to describe individuals who are emotionally, physically, and intimately attracted to persons of the same sex. The rationale behind this decision is that the term *homosexual* has been seen as medical in nature, reflecting the historical pathologizing of the LGBQ population. Although some individuals within this community might utilize the term to describe themselves, more recently many members of this community have made decisions to more specifically identify themselves (e.g., L, G, B, etc.), both publicly and privately. Our decision to not utilize this term reflects the current social and political trends. Note that these trends may change over time, and personal identity belongs to the beholder. Thus, it is important to take cues from one’s own clients when using terminology to refer to and describe one’s clients in group or individual session (Sue & Sue, 2013). Further, we would caution the group leader to refrain from labeling a client before the client self-identifies, as there is often a distinction between sexual identity and behavior (e.g., a client who identifies as straight but describes having sex with persons of the same gender).

Additionally, please note our use of the term *affectual orientation*. Historically, some authors have utilized the terminology *sexual preference* when describing the LGB community (Puglia & Hall, 2010). We find the use of this term to be dated and offensive. Preference indicates that people have a choice about their affectual identity; there is a large academic canon that demonstrates that this idea is inaccurate. We find the term *sexual orientation* similarly dated and reflecting institutionalized sexism and patriarchy, as it connotes a greater importance on sexual behavior within intimate relationships than on affectual connection, and it implies that the former is normative. There is literature that ascribes gendered differences in the causal connection between sexual and emotional intimacy, with men generally reporting greater emotional intimacy following sex, whereas women report greater emotional intimacy leading to sexual desire (Heiss, 1962). Thus, we prefer the term *affectual orientation*; though it is inherently reflected in the youth community vernacular, it has not yet been commonly used in the literature. Nonetheless, for space constraints and clarity, we have opted to utilize the
term *affectual orientation*, as it reflects emerging cultural conditions and is the current phrasing utilized by the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC), a division of the American Counseling Association (ACA), in its most recent counseling competencies (ALGBTIC LGBQQIA Competencies Taskforce, 2013; a copy of this set of competences can be found at the following ACA web page: http://www.counseling.org/docs/competencies/algbtic_competencies.pdf?sfvrsn=3).

**Gender Identity**

Transgender (T) is a general term to describe persons who vary from conventional gender roles. Most typically, this describes people whose gender identities do not match the sex they were assigned at birth. This is an umbrella term describing a large population of persons. This includes transsexuals (people who identify as members of the gender opposite to what they were assigned at birth), cross-dressers (people who identify as one gender but wear the clothing of the opposite sex; often they identify as heterosexual), drag kings and queens (performing artists of either gender or affectual orientation who wear clothing and/or makeup for special events/occasions), *genderqueer* (a term used by individuals who wish to identify outside the gender binary of male and female), androgyne (people who do not fit clearly into typical gender roles), bigender (people who move between gender roles), third gender (individuals who are categorized as neither male nor female), *two-spirit* (an umbrella term for Native Americans who fulfill mixed gender roles traditionally found in Native American/Canadian communities), and other individuals. Intersex (I) individuals are persons who were born with reproductive/sexual anatomy, or chromosome combinations, that do not fit typical definitions of male or female (Intersex Society of North America, 2008). Although there are dozens of conditions and circumstances that can result in intersex identities, a common manifestation is incongruence between internal and external reproductive anatomy. In the past, such individuals have been referred to as *hermaphrodites*, but this term is now understood as pejorative and outdated.

Additionally, readers should note that, increasingly, members of the youth community have begun to utilize the term *gender fluid* to describe their identity. This term is best described as people who identify, or feel, that they are a dynamic mix of boy and girl, male and female. People who claim this identity might always feel like they are a mix of the two traditional genders, but they may feel more
male one day and more female another. Again, gender fluidity has nothing to do with affectual identity, but it refers to people’s identity or feelings in the moment about their gender identity.

Each of the terms mentioned earlier describes individuals outside of the dominant gender binary of male or female. Thus, many people utilize the term gender nonconforming to capture the larger experience. There are, of course, individuals who do identify within the socially accepted male and female roles. These persons are referred to as gender normative, as they fulfill the norms and expectations of gender roles in the broader society. More recently, the term cisgender has been adopted to describe individuals whose gender identity matches the gender they were assigned at birth (e.g., a person assigned the gender male at birth who also identifies as male). Each of the terminologies cited earlier is used to describe one’s gender identity.

Differences Between Affectual Orientation and Gender Identity

Oftentimes, we find that clinicians confuse the language between affectual orientation and gender identity. This may in part be a reflection of how often the professional literature references the collective LGBTQI community (or similar variations: LGBT, LGBTQ, etc.), when in reality it is referring to specific issues related to affectual orientation and not gender identity. This is problematic, as these are two different socially constructed identities with their own meanings and history within the larger LGBTQI population.

Affectual orientation refers to the emotional, physical, and romantic/intimate attraction between two individuals. People who express that they are lesbian, gay, bisexual, straight, asexual, or questioning are expressing their affectual orientation. Gender identity has to do with the way in which people self-identify their gender; this may be biologically based, socially constructed, or a combination of these or other factors (Goodrich, 2012). People who refer to themselves as male, female, transgender, transsexual, queer, questioning, or a variety of other gendered terms under the broader transgender umbrella are expressing their gender identity (Carroll & Gilroy, 2002; Carroll, Gilroy, & Ryan, 2002; Ellis & Eriksen, 2002). Note that people can question their affectual orientation and/or their gender identity. Sometimes, a person may even be questioning both. This has to do with the social construction of both identities as well as the historical and cultural ways that both identities have been marginalized by our broader culture. It is important when talking about identities within the broader LGBTQI population that one is familiar with the distinctions between affectual orientation and
gender identity as well as how these identities intersect. Additionally, although there are similarities of needs and concerns across each of the identities, there are also some differences as well. When identifying one’s competence and ability to serve members of this population in a therapeutic setting, specifically in group work, clinicians must be specific and clear about whom they can work with and what they are able to give to their clients.

Other Populations

Two populations not yet addressed include allies and advocates; sometimes these communities are added within the larger grouping of letters to represent these populations, and sometimes they are not. These persons can be of any affectual orientation and/or gender identity, but the defining feature of these individuals is that they associate with or among LGBTQI persons. Allies are typically seen as people who stand with, befriend, and give voice to the experience of individuals from nondominant groups. Advocates are similar to allies, except they typically move beyond association or friendship and actively join the cause of seeking equity, justice, and fairness for marginalized groups. Heterosexual individuals can be allies or advocates for members of the LGBTQI population; LGB individuals may be allies or advocates for transgender or intersex persons, or vice versa. It should not be assumed, however, that just because people do, or do not, share the same identity or larger group membership that they identify or are willing to serve as allies or advocates for other persons. As with any other group membership, there can be larger within-group differences than between-groups differences in the LGBTQI community (Sue & Sue, 2013). The history and politics of the groups, discussed later, do impact some of the reasons why persons may or may not be willing to ally or advocate with other LGBTQI persons.

Risk of Assumptions

As there is a broad spectrum of identities, as well as terms, that people can utilize to define themselves, group leaders need to be cautious before making assumptions about their group members’ lives (Sue & Sue, 2013). People express their identities in their own ways, and this cannot be easily or comprehensively described by a textbook definition. Issues such as identity often highly depend on culture and can be constructed in many different ways in various societies. In fact, just as identity is often understood as fluid and evolving, so too are the language and terminology used to represent individuals’ experiences. One important misconception we
wish to clarify is the false assumption that a person can only be one thing: either a nondominant affectual orientation or nondominant gender identity. Our clinical work and life experiences have demonstrated that this idea is far from true.

Every person has an affectual orientation and a gender identity. A person can identify as gender normative (or cisgender) and gay, lesbian, or bisexual. Additionally, a person can identify as transgender or intersex and straight. There remains, however, a heterosexist bias within both the medical and therapeutic systems that persons who identify as transgender must be seeking a corrective experience to address their affectual orientation (DeCuypere, Knudson, & Bockting, n.d.; Reicherzer, 2008). Medical policies and diagnostic criteria have been created in the past to ensure this purpose, allowing individuals who express a desire to change their assigned sex only if their changed sex ensures that they are then heterosexual (such as in previous editions of the Diagnostic and Statistical Manual of Mental Disorders; see DeCuypere et al., n.d.; Reicherzer, 2008). It should be noted, however, that persons who identify as transgender can also identify as lesbian, gay, or bisexual (DeCuypere et al., n.d.). Although we see such assumptions as clearly heterosexist and transphobic, they nonetheless have existed and prevented such individuals from transitioning to a different gender if the transition would result in their being considered lesbian, gay, or bisexual; clinically, this may also have understandably led a number of transgender clients to lie to clinicians to ensure that they would be eligible to receive medical documentation for hormones or surgeries. Thankfully, this has changed with the emergence of new diagnostic criteria within the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013; also see DeCuypere et al., n.d.). The distinction between an intersection of affectual and gender identities (often graphically represented as x- and y-axes) can be confusing to persons living in the dominant society that has only recently come to accept affectual orientation for persons who subscribe to more dominant gender roles. This is, however, many persons’ lived experience and should not impede on the clinical care they receive from group leaders.

There is also an assumption that transgender or intersex persons will want to change their gender to reflect the dominant gender identities within the larger society. This is also not true for all clients. Many clients who identify under the larger transgender umbrella are comfortable not living in the gender binary and have no desire to change (World Professional Association for Transgender Health, 2011). Thus, there is a growing population of transgender persons
who classify themselves as *gender queer* or a number of variations of this term (Ellis & Eriksen, 2002; Reicherzer, 2008). This self-identity is in some ways political but also demonstrates that they do not (and do not wish to) live within the gender binary. Additionally, intersex individuals seek recognition that they were biologically born not reflecting the gender binary of male or female (Intersex Society of North America, 2008). Thus, group leaders need to be prepared that not all their clients will fit neatly into socially and culturally constructed gender roles, and leaders must learn to be comfortable with that.

**Historical and Social Issues Impacting the LGBTQI Community**

Although they are viewed as a united community of persons with similar identities and causes, this has not been (and perhaps is not) the case within the diverse LGBTQI communities. As noted by multicultural scholars Sue and Sue (2007), there are larger within-group differences than between-groups differences. The history of the LGBTQI population includes times of conflict and strife because of political and social challenges faced by different members of the population at different times (Bronski, 2011).

Although lesbians were known to have supported gay men when HIV/AIDS was first being discovered, they were angered to find that at that same time they did not necessarily have the full support of gay men within the gay rights movement. This caused political and social tensions between the two communities (Bronski, 2011). Additionally, bisexuals have often found themselves marginalized in the larger queer rights movement because of a lack of understanding about their affectual orientation and fear over outsiders’ (e.g., heterosexuals’) perceptions related to choosing a partner of either sex/gender (and how that might impact the gay and lesbian communities; Carroll, 2010). Similarly, transgender and intersex persons have also faced transphobia within both the larger culture as well as the LGB community because of a lack of understanding of gender identity and fear of straight/gender normative perceptions of others in the community. Only within the past decade have intersex persons found a collective voice and, largely through the Internet, have intersex persons been able to access information, supportive resources, and one another. We have seen how the current debate about same sex marriage (better known as marriage equality) has further caused political and social tensions within the LGBTQI community, as transsexuals who transition from their...
assigned gender to their identified gender are able to marry their significant other (if their transition leads to a heterosexual relationship), whereas other members of the LGBTQI community still cannot marry in many states in the United States. We have seen this cause anger and tension within some LGBTQI advocacy groups and lead to misunderstandings.

This is, of course, not a comprehensive list of historical and social issues impacting the LGBTQI community but is a primer for persons unfamiliar with this larger community of persons. These historical and social issues are important for group leaders to be aware of, as they may think a group made up of the differing segments of the LGBTQI community will face similar issues or will have no issues in getting along. As shown earlier, this may not always be the case. As we believe that the group is a microcosm of society, historic alliances and tensions across LGBTQI populations have the potential to be enacted within the group. This should not, however, stop a group leader from opening a group up to members across the LGBTQI community; in subsequent chapters, we discuss how this can be intentional, helpful, or healing. It is important to know, however, underlying issues that could come to the surface of an LGBTQI group and to be aware that, like any other group of people, there are differences.

One final point of discussion that has recently received attention is issues related to sexual orientation change efforts (SOCE), more commonly known as reparative or conversion therapy (Goodrich & Meng, in press; Goodrich, Rutter, & Moran, 2011). This has been a historical issue faced by LGBTQI persons in counseling, with counselors or therapists attempting to change one’s affectual identity to better match heterosexual identity. It should be noted that SOCE are harmful for LGBTQI persons and have been discredited by researchers and scholars. Most counseling organizations have taken professional stands against the practice of SOCE, including the ACA, American Psychological Association (APA), American Psychiatric Association, and American Association of Marriage and Family Therapists, among others. Counselors specifically should be aware that the ACA Governing Council adopted a statement opposing reparative therapy in 1999, and within the most recent ethics code, ACA (2014) discusses the need for counselors to utilize empirically supported treatment in their work with clients (Standard C.7.a.) and to not provide techniques or modalities when evidence suggests the potential for harm (Standard C.7.c.), even if the service has been requested; SOCE have not been empirically validated by research to