Spring 5-21-2022

Gap Analysis of 2SLGBTQIA+ Curriculum in Counseling Programs

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Capstone Thesis

Lesley University

April 18, 2022

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Specialization: Art Therapy

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Abstract

The purpose of this paper is to propose additional curriculum specific to marginalized populations and communities for Clinical Mental Health Counseling programs. There is a systemic lack of purposeful education on marginalized communities that student clinicians will be serving, with an emphasis on expectations of being a lifelong learner, asking the student/counselor to educate themselves. This expectation is unsustainable in the context and acknowledgment of burnout among human service providers, and does not reinforce the lens of trauma informed care that is stressed in its programming. To build strong clinicians, support must be executed systemically within its programming as an institution to ensure the readiness of the individuals in the program to be prepared to serve clients that is respectful responsible for the students, professors, and future clients. The population focus of this paper is the Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual+ (2SLGBTQIA+) community, recognizing the global present-day threats, curriculum integrated into counseling programs to educate counselors is essential in the advocacy and care of the clinicians and clients; integrated education in the already required education is a systemic support in protection against burnout for the clinicians. This addition of 2SLGBTQIA+ education is a systemic for clinicians to support this community that is reportedly proven to suffer higher rates of ACE's, suicide [attempts/ideation], and mental health needs overall.

Keywords: 2SLGBTQIA+, QTBIPOC, curriculum, mental health

Gap Analysis of 2SLGBTQIA+ Curriculum in Counseling Programs

Introduction

Queer curricula within counseling programs are integral to the lens of practicing counseling with trauma informed care is to recognize the multiplicities and intersectionality of lived experiences in marginalized communities. In order to live up to the standards and ethical expectations of the mental health counseling profession, clinical mental health counseling institutions are responsible for integrating purposeful curricula about marginalized communities. This is a systemic step in order to develop counselors with healthy boundaries who can meet their client where they are without shifting the power dynamic where the client has to teach the counselor. This inclusion lends itself to a larger intersectional theory, the Minority Stress Theory "acute and chronic experiences of trauma and stress associated with minority identity can lead to physical and psychological consequences, placing sexual minority and racial minority individuals at risk" (Ghabrial & Ross, 2018, p. 132). To build specified curriculum is to encourage and strengthen the mission of the programs to educate clinicians in the ability to be where the client is and to have culturally specific education and training. In identifying terms to uphold a baseline of terminology, the student clinicians will be able to work with and have that standard vocabulary for the community they are addressing, in this case the Queer Community. Queer historical facts bring in historical figures and representation to reaffirm that Queer history and Queerness as a concept is integral in clinical mental health programs for student clinicians and their future clients.

By acknowledging that the fields of psychology and counseling themselves are of Western idea and created from a post-colonized North America, the curriculum would open gendered conversations of pre-colonized North America and cultures outside of it. There is in

important impact of Puritan norms and Capitalism that counselors need to know that affect Queer and Trans (QT) people that lends to the erasure of Queerness and Transness. These systems that shape our society today are the constructs that have oppressed non-dominant cultures such with the 2SLGBTQIA+ community, "The system depended on a heavy emphasis on thrift and ingenuity and, above all else, on the strong repression and control of sexuality" (Albee, 1977, p. 150). Pre-Puritan Colonization recognizes that there have been the multiple genders outside of the female/male binary we know today, that were the cultural norm in many cultures for centuries around the world before Western Colonization and its subsequent colonial consequences on gender and sexuality.

Like every community, there is a language within micro-communities and identities. The term Queer itself its own identity, while also being an umbrella term for the community as a whole. The main distinction in the Queer community is the difference between sexuality and gender. Among gender, the most distinct binary is cisgender and transgender and gender nonconforming (TGNC) individuals who, "identify with a gender different from the gender assumed of them based on their sex assigned at birth…compared to cisgender people (i.e. those who identify as the gender assumed of them based on their sex assigned at birth)" (Schnarrs et al, 2019, p. 1). This introduces the difference between sex and gender, "The term sex, since classical times, has been used to designate matters related to biology and medicine… The term gender has generally been used in social or cultural contexts, in distinction from biological ones." (Diamond, 2002, p. 320). This distinction is the motive of information for the mission of this paper to include counseling curriculum and programming to ensure counselors are speaking the same language and are able to approach their clients without requiring the client to educate the counselor on their identity and community as the client.

Continuing Education Units (CEU's) are important for therapists and counselors in order to have the most recent theories to be able to integrate in their practice and further their credibility and build skills as a counselor. It is also true that therapists and counselors are over-worked, underpaid, and burnt out in the field of mental health counseling, which is a major barrier to be aware of. In a study by O'Connor et al. (2018), the burnout rates for Mental Health Professionals, they find that the "Burnout rates are high in [Mental Health Professionals], with the summary estimate of the prevalence of emotional exhaustion being 40%" (p. 97). The expectation that Continued Education Units give to counselors reinforces the urgency to continually have to do more and push boundaries of work life balance. To ask counselors to be lifelong learners without implementing curricula that supports them increases burnout. Without the support, this adds onto the additional labor of the new clinician without the practical skills of how to find these resources for themselves and their clients. Knowing that participants of counseling programs are predominately white cisgender-heterosexual (cis-het) women, not introducing marginalized populations in the curriculum of the program ultimately continues the cycle of predominately white research and a lack of intersectionality in counselors.

In order to implement therapeutic practices, unlearning polarized thinking as the clinicians and surrounding trauma of good/bad, victim/perpetrator, success/failure (Barker et al., 219, p. 194), it is integral to incorporate both systemic and individualistic views for counselors to see their clients. Recognizing the impossible ask to teach all of the lived experiences that a population might have experienced, it is a realistic expectation of curricula to have a chapter, week, or a course that is specific to a population that overviews historical influences and common shared experiences is to only strengthen the lens of counselors and therapeutic relationships. This way, the counselor is prepared when a client brings up a frequent lived

experience of that community, the counselor without the lived experience is not completely unfamiliar with the topic, as regularly explored academically with concepts like different types of attachment, abandonment, trauma, etc.

As a Queer Agender student in a counseling program, there is a shocking lack of lived experience incorporated education versus systemic education of the mental health field overall. As a white person, there is a discomfort in witnessing the way that while addressing systemic oppression is addressed as a concept, there is a lack of systemic implementation that is being done, outside of theoretical discussions amongst other academics. This is problematic again in understanding the truth in that most counseling programs are predominately white cis het women, and that "the predominant focus has been on the experiences of white, middle class, heterosexual women and failed to consider the experiences of different group" (Harley, 2002, p. 226). Thus, professional and academic discussions rarely have an intersectionality of lived experienced voices in the room. Recognizing that upper education typically does become more theoretical and conceptual, a program for counseling needs to be more balanced in its mission. This field should be person-centered and about lived experiences of the individuals and communities of conversation. The mission of this capstone is to introduce curriculum concepts that can be used in action and in clinical mental health programming.

Literature Review

Historically, Queer history is still recent history and building. Systemically and federally, in the United States, there is not much in place for the protection of Queer rights, even less so on a state-to-state level. Queer United States history is still in the making and that is in large part why this writing is significant; to ensure representation in counseling the lens needs to include in Queer history and Queer visibility, not just in the independent learning of counselors. Systemic

teaching and inclusion of Queer history and lived experiences is a curriculum that counselors need to be educated on in order to ethically serve clients in this community. Queer Trans (QT) people have always existed, knowing and acknowledging that previous to the United States, Indigenous cultures, and globally, cultures have recognized gender outside of the binary of man and woman for hundreds of years, "the term Two Spirit was coined in 1990 In Winnipeg, Canada as a means of unifying various gender identities and expressions of Native American/First Nations/Indigenous individuals, the term is not a specific definition of gender, sexual orientation or other self-determining catch-all phrase, but rather an umbrella term. Two Spirit people have both a male and female spirit within them and are blessed by their Creator to see life through the eyes of both genders." (Enos, 2018, n.p.). This can be noted as evidence not only of multiple genders, but as a recognition that the representation of multiple genders predates whiteness/colonialism and needs to be currently represented in that way. Current representation of QT people is typically white-centered which is historically inaccurate and un-representative of the community as a whole. This is information that needs to be integrated into curriculum for student counselors to be able to weave affirmative therapeutic approaches with their intersectional clients, as well as to unlearn this lack of representation and covert racism for themselves as a counselor.

Queer History and Current Events

Stonewall was a pivotal moment in United States Queer History and was the inception of the marches, now recognized as PRIDE events. From a systemic lens, historically the United States, Queer history starts June 28th, 1969 with the Stonewall Uprising Lead by Marsha P. Johnson, Sylvia Rivera, and Storme DeLarverie. With visibility comes susceptibility, namely in the scapegoating with gay men with the HIV/AIDS epidemic shortly thereafter in June 1981. The

subsequent public stigmas and perceptions created from this societal scapegoating created discriminations and exclusive regulations that still exist today for gay men to donate blood. The FDA, the Food and Drug Administration, under the U.S. Department of Health and Human Services only in lieu of a Global Pandemic partially lifted regulations for [cis]men who have slept with [cis]men in April 2020. Previous to COVID-19, the regulations for [cis]men to donate blood was stigmatized since 1977 the "FDA recommended that blood establishments indefinitely defer male donors who have had sex with another male, even one time, since 1977, due to the strong clustering of AIDS illness and the subsequent discovery of high rates of HIV infection in that population" (FDA, 2020, p. 3). This regulation was partially relaxed with the emergency need for blood during the COVID-19 crisis, "The FDA has announced a relaxing of its restrictions on gay men being allowed to donate blood, in light of the coronavirus disease 2019 pandemic. Instead of 1 year, if a male has had sex with another male, he need only wait 3 months to donate blood." (Shaw; FDA, 2020, n.p.) the regulations still stand for deferral for donors, male donors cannot have had sex with another man for the past three months. For female donors, the restriction is t have not had sex with a man who has had sex with another man in the past three months (FDA, 2020, p. 8). These strict regulations on who people have sex with are current day in the regulation of same-sex, sex, and reinforcing the AIDS stigmas that same-sex practices are unclean, and untrustworthy.

There are longstanding systematic measures in place that still require the disclosure of sexuality status in order to both receive and give resources. This is no longer only affecting gay [cis] men, but bisexual, pansexual, etc. [cis]men and their partners. According to Donor Educational Material and Donor History Questionnaire part 3 I & J, anyone who sleeps with men are subject to answering outing themselves and/or their partner as Queer. Furthermore, there is

data shown that, “studies with populations at high risk for HIV and sexually transmitted infections (STIs), such as gay men, have shown that individuals who report higher levels of psychosocial health problems are more likely to engage in unsafe sex and have higher HIV and STI prevalence” (Frost, 2007, p. 637). This cyclical pattern of mental health and risky behavior only continues the stigma against gay men, as well as homosexual people in that it perpetuates the stigma that Queer people are inherently sick and need pathologizing. “The stress related to the stigmatization gay people experience has negative effects on their mental health… The added cognitive burden of concern over disclosing one’s stigma often results in problems, such as preoccupation with the stigmatized attribute, impaired long-term social relationships, negative affect, anxiety and decreased self-esteem” (Frost, 2007, p. 637) reiterating the need for [student] clinicians to be prepared for this specific stigma that may or may not need un-learning, as well as the high potential for trigger, and a comorbidity in their seeking of mental health services. This historical knowledge is essential for counseling programs to incorporate into their education knowing that again, due to this higher need of mental health in the community, recognizing historical systemic barriers that are impacting their ability participate in society and their community. The knowledge of how the system is targeting QT people, in donating blood is a further institutional medical barrier that QT have to navigate and potentially are unable to participate in at all. This has the potential to be traumatic in the case of a medical emergency, in that would have a subsequent comorbid layer of the systemic homophobia. To know these layers as the clinician, takes the burden off of the client to have to further explain through their grief and trauma. Pieces of history that have a systemic impact today, are essential to counseling curriculums, particularly for marginalized communities.

Significant movement was made for United States queer history with the legalization of same-sex marriage in 2015. However, globally it is criminalized in 71 jurisdictions to have private, consensual, same-sex sexual activity. The death penalty is imposed in 11 jurisdictions and implemented in six countries, Iran, Northern Nigeria, Saudi Arabia, Somalia and Yemen (Human Dignity Trust, 2022, n.p.). While the United States is exercising marginal progress, globally, queer history is still discriminated and subject to death and imprisonment around the world. To know the above information of how many countries criminalize Queer people, to the extent of the Death Penalty, is essential in having an intersectional and trauma-informed curriculum for student clinicians. This information must be included in the curriculum of non-dominant communities into counseling programs, because the process for someone coming out from a country above where the death penalty is implemented, will be drastically different than that of someone raised in, even in a non-accepting area of the United States. To recognize the lethality of coming out to a family that was raised in a country that systemically viewed homosexuality as punishable by death, needs to be recognized and known by clinicians in order to ethically support a client who wants to come out to this family. Curriculum to support this is protective of the clients, particularly recognizing that in many states, parents have access to their children's case notes if they are under eighteen years old. While the minor may recognize that it is best for caregiver(s) should be aware of information for their safety, "Research has suggested that minor clients are sometimes reluctant to enter counseling and that confidentiality is their most salient concern" (Isaacs, 2001, p. 343). It is ethically essential to recognize the responsibility to protect the client's privacy and safety ethically in the case of outing by acknowledging their culture.

The context of this global information is where curriculum can be the systemic implementation of building a stronger trauma-informed clinicians entering the field. The curriculum would focus on a historical and global overview of where this community is threatened, as well as what type of environments and systemic protections defend these communities. In order to recognize generational trauma and systemic oppression of a community, the history of a community must be emphasized; recognizing were homophobia and transphobia were systemically built is a key component to understanding of counselor's biases and systemic participation in homophobia and transphobia. To dismantle socially constructed, learned prejudices and to make systemic change, learning history of a community is integral. Beginning with Colonization and Puritan norms of the church, "1620 – Colonial Plymouth established with Puritan norms…Established gender norms that determined the nuclear family unit was the basis for all other institutions such as government or church." (Our Family Coalition, 2016). This begins the conversation about both Colonialism and the Churches harm on the Queer Community, and how outside of whiteness and religion, to recognize the student clinician's involvement in these systems, and what that means as a counselor of a Queer client.

Discussions of the first known prosecution of lesbian behavior in Colonized North America, Sodomy laws, Harvey Milk, Stonewall, HIV/AIDS epidemic, the repeal of "Don't Ask Don't Tell", the Orlando Shooting, Obergefell v. Hodges, and current events such as the recent "Don't Say Gay" Bill Effective July 1 2022, "prohibits classroom discussion about sexual orientation or gender identity in certain grade levels" (Florida House of Representatives, 2022) and Greg Abbott's (2022) OAG Opinion No. KP-0401 relayed, that under Texas law gender affirming care will constitute as child abuse. This consequently requires all licensed professionals who work with children who may be subject to abuse. Written in Texas law under

Abbott "see id. §§ 261.101(b), 261.109(a-1) and §§ 261.101(a), 261.109(a)." (p. 1) there are criminal penalties for failure to report for mandatory reporters and general public. This is integral information to have integrated into education for student clinicians so that they have the awareness of the ethical dilemmas that vary from state-to-state, and the importance of advocating for the trans community as a whole.

Bringing in current events are integral into recognizing that systemically, as far as gender and sexuality are concerned there is no equality, so that as clinicians. When a trans client is processing the trauma from this bill, the clinician should be able to recognize what they are talking about, instead of being surprised or uneducated, they know that this is not shocking, because this is not new. The weaponization of transness and criminalizing of Queer existence and liberation has been historically weaponized for centuries, to react with shock to a client is inherently dismissive of systemic truth and is harmful through ignorance. This is particularly essential for clinical mental health programs understand the impact the State of Texas making mandatory reporters and licensed professionals who have direct contact with children, clinicians are subject to criminal penalty for failure to report if a child communicates their involvement in the QT community and wanting to discuss HRT or gender-affirming surgery (Abbott, 2022). Knowledge of these laws coming into place as a student clinician is essential, to initiate the ethical conversation of outing a child to their parents, as well as the safety of their license and career. For a counseling programs to be considered objectively trauma-informed about a population, historical and current knowledge is crucial to the programming, training, and curriculum. To be able to recognize a client's fear, safety, and overall discomfort with themselves, in this case their identity with their sexuality, is the jobs of clinicians to best support their client. Thus, the institutions are responsible to teach these future clinicians the current and

historical context of a community. The responsibility needs to be on the institutions that are claiming to yield trauma-informed clinicians. Educators must inform them of the present-day traumatic events applicable to the populations and communities we are directly serving.

Institutional Programs

It is only to the strength of the programming for counselors to become familiar with shared marginalized experiences within a community, in this case the Queer community. Common shared experiences and therapeutic topics among the Queer community include outing. Being outed vs coming out, micro-aggressions with family, sexual assault, sex work, and attachment with same-sex and how that differs from opposite sex partners due to societal constructs and expectations of gender with heteronormativity. Concepts like what heteronormativity is and compulsory heterosexuality need to be discussed because unlearning compulsory heterosexuality, "the pressures to conform in a society increasingly conservative in mood have become more intense" (Rich, 2003, p. 11) is a major conversation in the Queer community, a term not recognized by most cisgender heterosexual (cis-het) people. Without being introduced to a concept, it is difficult to research it. Without being introduced to an unfamiliar population, there is a lack of awareness of how and what to be curious about, there is a lack of knowing what questions to ask. It is ethically problematic, due to the power differential between client and clinician, for a counselor to ask a client about their community due to the counselor's curiosity or expect said client to educate the counselor. If it is expected of the clinicians to be lifelong learners, it is the clinical mental health counseling program's responsibility to open this conversation. This responsibility can be actively integrated in the form of supportive curriculum to bring the information to the student clinician.

The responsibility of finding intersectional literature and non-bias history should not weigh on its students, as this research and curriculum building is the work of an educator. It is rooted in capitalistic expectations of overworking, urgency, and perfection; concepts taught in clinical mental health counseling programs to unlearn and regulate with self-care. Students of clinical mental health counseling programs are expected to perform these behaviors, while being taught that these behaviors are unhealthy and unsustainable. It is important to create specific marginalized population counseling curriculum because it opens the conversation of not just the concept of intersectionality, but it names other populations that make up intersectionality. The purposeful integration of learning about a specific population to incorporate both macro and micro perspectives and thought processes will only lend to the cultural lens of the student clinicians that they can then approach with cultural literacy to their future clients, and competently practice Trauma-Informed Care. The book Trauma Stewardship, Laura van Dernoot Lipsky explained trauma with a rippling pond analogy, "Trauma always creates a ripple effect, the same as when someone throws a stone into a still pond. The initial impact creates repercussions that expand almost infinitely, reaching and having an effect on many people who didn't experience the blows firsthand" (p. 17). It is the responsibility of the institution, to create space and purposefully include this historical and the present-day information, they are the stone in the pond, and the clinicians and future clients are the ripples. The definition of trauma informed, "occurs in a safe and client-centered environment in which service providers view and respond to maladaptive behaviors in the context of traumatic experiences." (Levenson, 2013, p. 1). The institution can bring the information to the program, that will inform the student clinicians who can then support their clients in the way they need, transforming the field. This

ripple can create lasting favorable impacts that will support the field altogether in furthering trust and recognition of counseling and human services.

Currently, the academic opportunities for 2SLGBTQIA+ inclusive therapy are limited. The California School of Professional Psychology (CSPP) within Alliant International University, offers a LGBT Mental Health Certificate "designed to meet the growing need for behavioral health professionals to develop competencies in working with lesbian, gay male, bisexual and transgender individuals, couples and families. The counseling certificate focuses on multicultural competencies specific to the intersecting identities of 2SLGBTQ clients, historical and cultural influences impacting 2SLGBTQ clients, and best practices for assessing and addressing issues in 2SLGBTQ mental health." notably, "post-graduate professionals and graduate students pursuing a degree from other universities are not eligible to enroll at this time," (AIU, 2022). That being said, Alliant International University is located in California and online. Non-students do not have the option to take these classes to be awarded the certificate.

Outside of CSPP than this, the only way to become "specialized" in 2SLGBTQ counseling, is to do individual learning and find workshops in the Continued Education Units. This again lends to systemic fallacy of the dispersal of responsibility, and white supremacist capitalistic system of higher education. Though it pretends to engage in its part of creating competent professionals. Part of the curriculum is the concept of post-grad workshops, which are out of pocket costs, essential for licensure. The structure of the requirements to be a lifelong learner, takes away its responsibility as curricula builders. The extra workload leads to faster burnout of the clinicians, particularly with the structural impacts of COVID-19, where clinicians are quitting, so subsequently the clinicians who stay have too large of caseloads, are many times expected to do more admin work and case management, and on top of this, continuing further

education. Burnout in regards to clinicians, explained by Joshi & Sharma, "Job demand resource model (Demerouti and Sanz, 2014) provides a potent basis to explain burnout as a risk factor amongst mental health practioners during COVID-19…With increase in job demand during the pandemic the practioners are facing work overload, restricted work environment, challenges to come up with effective strategies to help address concerns of different population and to keep themselves updates with the resource material which can be of help to the patients. At the same time, they are facing low job positives like enriching experiencing and building clinical competence. With job demands out numbering job positives, mental health practioners are at increased risk of facing burnout during COVID-19." (Joshi, 2020, p. 2) Not to mention these workshops, conferences, and lectures usually cost hundreds of dollars. In order to build trauma-informed clinicians and have self-care and accountability around the education for prevention of burnout and real support for their clients, institutions need to systemically support student clinicians by including marginalized cultural classes on marginalized groups, one of which arguably needs to be the 2SLGBTQIA+ community.

Ethical Considerations in Queer Counseling Approaches

While it is argued in previous literature that there is not a need for specific approaches for non-dominate communities, rather to use general approaches like DBT, Gestalt, existential approaches, the mission of this paper is to say otherwise. While affirmative therapy can be, and is regularly used with 2SLGBTQIA+ clients as well as disability-affirmative therapy, this approach is not regularly presented to clients, nor is it presented in the curriculum of most clinical mental health programs. This approach is not on Psychology Today, one of the most popularized sites for clinicians and clients under "Types of Therapy" which leads to the lack of commonplace affirmative therapy. Natasha S. Mendoza named its importance "Affirmative care

requires the practitioner to actively honor and celebrate identity while at the same time validating the oppression felt by individuals seeking services. Validation and empathy fundamentally result from increased understanding of individuals' history, cultural context, and lived experiences. Origins of the approach honored the experience of those in 2SLGBTQ+ communities…" (Mendoza, 2020, p. 31) this approach is not highlighted in programs, whereas others such as humanistic, psychoanalytic, and holistic are emphasized repeatedly in the context of being Trauma-Informed. According to this definition from Mendoza, affirmative care is ultimately and objectively trauma-informed. It is with that, that approaches to counseling would have an easy way to incorporate this into the curriculum, not as the "right" or "only way" to approach clients, but as a way to emphasize an approach that uses historical lenses for marginalized communities, other than the feministic approach that is Trauma-Informed.

This being the obvious approach to emphasize for this coursework and population, "the authors offer recommendations for affirmative care in practice with African American, Asian, Indigenous, and Latinx individuals, as well as those living in rural communities" (Mendoza, 2020, p. 31) emphasizing these approaches strengthens and integrates intersectionality. The emphasis on rural communities is equally trauma-focused in that rural communities having stronger correlations to Christianity and religion are regularly more dangerous and less representative for the 2SLGBTQIA+ community, due to this lack of safety. As a result of systemic racism and redlining resulting from the affordable housing policies in 1917 (Flournoy, 2021, p. 49), the emphasis for rural communities brings the aforementioned conversation of races and ethnicities capacity and safety living in larger cities are more expensive for families. Recognizing rural towns are typically smaller in population brings and additional ethical consideration of concern and objectively a necessary conversation where there is not an

accessible number of local therapists. Dual relationships are hard to navigate in small towns, even more-so when the clinician that is in the same community as the client. To be a QT counselor in a rural town with a client who is also QT has a much higher risk factor of dual relationship ethical obstacles. To be the therapist in a rural town who is able to hold the systemic knowledge of the marginalization that a QT person experiences, layered with the aforementioned barriers in a small rural town, will build trust and rapport. Supportive curriculum is essential in instigating these conversations for student clinicians to be prepared in navigating these difficult ethical obstacles.

An integral part of intersectional counseling is understanding one's privileges. White QT counselors must understand it's gains from and involvement in marginalization. To recognize both the marginalization, and the privilege that white QT people have is to understand both the liberation of the community, as well as its erasure. Stonewall was led by a QTBIPOC Drag Queens and a Black Lesbian (Matzner, 2015, p. 2). More often than not when asking about Queerness, the representation and general knowledge is white celebrities. Acknowledging whiteness as a protective factor that leads to the representation overall and systemic change for trans people overall. Performative allyship does not make an organization fully QT safe, however the uprise in conversations about respect for a community like the trans community can be argued to be correlated to the overall white representation of the 2SLGBTQIA+ community. QT people are generally represented by white masculine/androgynous people, leads to an innate power and privilege that the QTBIPOC community does not. The white representation of trans people overall is a power over the BIPOC community that has to be acknowledged in the counseling approach to a QTBIPOC person. This privilege needs to be named and discussed for white Queer student counselors to recognize that while the client and clinician are both in the

Queer community, that there is a power difference that shapes the lived experiences of the non-white client in a different way than the white student clinician.

Furthermore, representation of queer characters in media is historically and currently problematic in its characterization, "LGBTQ people have consistently been stereotyped as comic relief, villains and/or criminals, mentally and/or physical ill, and victims of violence. These stereotypes remain prevalent and may contribute to ongoing societal homophobia and heterosexism" (McInroy & Craig, 2017, p. 34). This overall negative representation of the Queer tragedy does not lend to the systemic support that is Queer Liberation and Queer Joy. This societal standard lends to the clinician approaching a QT client with an already assumed level of tragedy, and lends to further covert assumptions and generalizations of the client. While these assumptions may not be cognizant, the societal standard is there, and leads to a bias that needs to be address in a curriculum for clinicians to better support their Queer clients. The general acceptance and visibility of the 2SLGBTQIA+ community is majorly driven in whiteness leading to further marginalization and erasure within its own community. To be within a community that was founded by race, and being erased because of race is a history that must be named and acknowledged by clinicians for QTBIPOC clients. The harm of a minimizing comment that "people are more accepting now" to a client who is specifically and regularly erased in their own community can be argued as a microaggression.

Specific to the 2SLGBTQIA+ community, "affirmative clinical practice must acknowledge and counter the oppressive contexts in which clients experience care. Understanding and empathizing with the felt discrimination, otherness, microaggressions, and victimization experienced by individual clients is critical to the role of the affirmative practitioner" (Mendoza, 2020, p. 32) bridges the gap of the clinician, are outside of the

community of the client. Contrasting, this approach must be used carefully and purposefully as there in an increased and inherent risk of tokenizing and reductionistic patterns that may arise by seeing the client as only this identity, "treating a client as though they identify strongly with a particular culture when they do not may produce the effect opposite to what practitioners seek, which is to better empathize with the person seeking service…In the attempt to create space and give voice to expertise about a given culture, we certainly run the risk of creating tension. There is a boundary we will not cross—namely, we do not intend to reinforce stereotypes" (Mendoza, 2020, p. 32). To hold multiple truths as the clinician while this part of this person and their race/ethnicity/gender/sexuality systemically affects them in a societal and systemic way. These clients are an entire person with multiple parts outside of this identity. Likewise, therapeutically, this part of them may not be part of their therapeutic goal and the contract the client and clinician have formed together. Restating Mendoza, not reducing someone to a stereotype after having learned about the community they are a part of. Recognizing that not every QT person is going to have a depth of knowledge of Queer history, and they may rarely if ever bring up their Queerness, Queer history, or queer artists while art making. Affirmative care is the integration of meeting the client where they are at, in that when they bring these topics of their community to the table, the clinician is prepared and educated, otherwise their identity and community is not to be named by the clinician first. This gives space for the client to name the challenge they are facing, is directly connected with their identity or community. This approach is demonstrated in a Trauma-Informed approach with sexual assault therapists, for clients who have been sexually assaulted and do not label themselves as a victim, it is common practice of the counselor to not call them a victim of sexual assault, and use the language that the client is using.

Therapeutic Relationships

Curriculum can be integrated from this lesson from Mendoza and Trauma-Informed skills with clients who have experienced sexual assault, of the concept of intent vs. impact with an intersectional lens for the 2SLGBTQIA+ community. This curriculum could integrate practical skills such as repairing with a client as a counselor who has caused unintentional harm. As previously mentioned misgendering someone, "Misgendering" is the name given to the practice of referring to a trans person using gender markers other than those they identify with" (Flint et al, 2021, p. 1) is a necessary conversation of repair for a student counselor to practice inside and outside of their professional work. Purposeful spaces in curriculum to integrate the practice of repair in misgendering a client who has recently come out, and how to maintain trust and rapport after a rupture. Trust and rapport are concepts that are over-arching in the curriculum and conversations of clinical mental health programs. As one of the most integral parts of being a clinician, "On the whole, building and maintaining patient rapport leads to positive client outcomes" (Leach, 2005, p. 263). It is recognized that with the importance of this trust and rapport comes the significance of maintaining it, and consequently the potential ruptures in the therapeutic dynamic.

While repairs between client and clinician are important therapeutic directives that are worthwhile, and ruptures are a natural part of a therapeutic relationship, it is of utmost importance and priority to ensure that the counselor is not disrupting trust and rapport due to ignorance. This ignorance is bypassed by purposeful curriculum in clinical mental health programs, as well as the intentional therapeutic repair to then model and discuss intention versus impact with the client. This lack of awareness of how to repair a misgendering, both professionally and casually, can be incorporated into curriculum through role-plays, as well as open discussions of experiences of having misgendered someone. A repair with a client after a

misgendering is necessary to ensure trust and rapport with client and clinicians because "misgendering disrupts the more general social identity process of verification in which others fail to authenticate a person's gender identity" (McLemore, 2016, p. 54) thus, the client is not feeling seen or respected. Conversations on exploring discomfort is a common practice in clinical mental health programs. With this structure already in place, it should be easy to integrate into a curriculum specific to the discomfort around misgendering someone, which must include the lens of the misgendered client, and how to go about repair, while holding discomfort.

Working through the concepts outside of only [counter]transference, curriculum would need a focus of internalized and overt microaggressions, gaslighting, tone-policing, centering the clinician, and random equivalence all under the umbrella of working with QT clients. Examples of historical ignorance and gaslighting as the above "shock" directed at this anti-trans bill in Texas (Abbott, 2022), conversations about centering the clinician's emotions and bias', and when the clinician is engaging in random equivalence with the client to create rapport. Specific conversations of experiences such as coming out [later in life], same-sex parents, couples who are transitioning, religious trauma and living with religious families, and internalized homophobia/transphobia are again important conversations to be initiated for exploration in a space that does not hold the client responsible for being a teacher. To incorporate curriculum in systemically, is to foster safe exploration of topics, so that the future clinician can then later hold these stories with the proper space and education to give to the client.

Benefits of Art in Queer Culture

Historically, art has been a safe space for Queer people to exist, as well as a space that advocacy and visibility has been celebrated for centuries, through the systemic lack thereof for support or recognition. Society itself was dangerous for Queer people to exist, but as a Queer

person existing in the art world was safe, providing a unique space and therapeutic experience. Namely, there is Claude Cahun (born 1894) and Marcel Moore (born1892), Robert Rauschenberg (born 1925), David Hockney (born 1937), Robert Mapplethorpe (born 1946), Catherine Opie (born 1961), Beauford Delaney (born 1924) Mickalene Thomas (born 1971), Zanele Muholi (born 1972), and Isaac Julien (born 1960). Art for the Queer community has historically given the ability to thrive in a microculture, while being marginalized in the entirety of the culture; a unique experience to the Queer community to be within and without privilege.

Art making is inherently apart of Queer culture and Queer history, as it has been pivotal in visibility and reclamation of spaces; The Pink Triangle "Silence = Death" created by six activists – Avram Finklestein, Brian Howard, Oliver Johnston, Charles Kreloff, Chris Lione, and Jorge Soccaras – founded the "Silence = Death" project in New York City in 1987 (Smithsonian, n.d.) to "design a poster about AIDS, to try to push the community into political action" (Finklestein, 2017), and Gran Fury's "Kissing Doesn't Kill: Greed and Indifference Do" 1989 similar to Silence = Death, as a combination of art and advertising to bring awareness of the AIDS/HIV epidemic's effect on Queer people. Art is historically and inherently therapeutic in its activism for the Queer community. "Gay-affirmative psychotherapy developed over a period of many years following the declassification of homosexuality by the American Psychiatric Association in 1973" (Cerbone, 2011, p. 301) but there is not direct art therapy for Queer populations outside of affirmative approaches. While the book, *Creative Arts Therapies and the LGBTQ Community: Theory and Practice* by Briana MacWilliam "aims to fill the current gap in literature, education, and training to build best practices in working through creative arts therapy with the LGBTQ community" (MacWilliam et. al, 2019, p. 10) MacWilliam acknowledges "the vast majority of creative arts therapists report a lack of training in delivering therapy to the

LGBTQ community and feel unprepared to work with this population." (MacWilliam, 2019, p. 9). To have a curriculum in place, with art therapy directives specific to a population like the 2SLGBTQIA+ would lend seamlessly to the community itself, acknowledging what art has done systemically for Queer Liberation.

With this lens, it is easy to argue that not only is art-making part of Queer culture, but Queer healing. Art therapy is imperative to Queer healing and mental health, "what is more, there seems to be a limited use of each modality's artistic inclination to explore and understand the issues that impact the LGBTQ community as well as lack of training in the use of specific creative arts therapy interventions to address their clinical needs." (MacWilliam, 2019, p. 9). Recognizing that approaches such as affirmative counseling are already built and confirmed as therapeutically beneficial, as well as how art has historically informed the systemic visibility and political movement for Queer people in the United States, the responsibility of creating trauma-informed clinicians falls onto the institutions that claim to do so. The responsibility cannot only be on the clinicians, particularly new clinicians who were only just students. This lack of incorporation of technique and approaches that are already built is active ignorance on the institutions part as in this research it has been found to already be built, so that other mental health counseling programs are applying these approaches and have created certificates for it specifically. "Creative Arts Therapies and the LGBTQ Community: Theory and Practice", edited by Briana MacWilliam, et al., is in the Lesley Library, lending again that the resources are at the institution, and not being utilized. This is where systemic curriculum within a clinical mental health counseling program could specifically integrate Art Therapy, and how art has advocated specifically to a community in a therapeutic and systemic way. The curriculum would be focused on advocacy and liberation through the arts and representation for the Queer Community.

This history would tie the curriculum into more of an Arts-Therapy curriculum, looking into symbolism and color theory with concepts such as artist Gilbert Baker's creation of the rainbow flag and the color symbolism associated to each color, lavender ceremonies, and Gran Fury's Silence = Death Pink Triangle, AIDSgate, Read My Lips (Boys), and Kissing Doesn't Kill: Greed and Indifference Do. (d'Addario, 2011). Recognition of these artists and color symbolism will allow student clinicians to be more purposeful with art-making with these populations, to offer colors and symbols and/or to recognize them in their client's work. Being able to offer Queer representation to a client expressing a lack of representation such as Gran Fury, Robert Mapplethorpe, or Keith Herring, from education and training, and to give resources of strong historical representation is to continue to build that trust and rapport, and emphasize the commitment as a clinician that the client is being heard.

Beauregard & Long (2019) mention in their article *Attuning to the needs of LGBTQ Youth" within the "Creative Arts Therapies and the LGBTQ Community: Theory and Practice*, "The use of language and knowing how to talk/inquire about sexual orientation and gender identity in treatment can be challenging for therapists of all skill levels, particularly when youth and their families are not in alignment around identity and language (Brill & Pepper, 2008; Nealy, 2017; Ryan, 2009)" (p. 121). This is the language that should be incorporated in curriculum for clinical programs. Courses that teach topics such as power, privilege, and oppression are taught in an insightful way about the clinician themselves to address their bias'. This is not to argue that this is not a powerful lesson and part of the curriculum, it is to say that there needs to be inclusion of both. To be able to have a course in which the verbiage is used as standard, is only of the support of the client and clinician rapport, as well as the psychoeducation to clients who are un-learning their own biases and internalized homophobia/transphobia. To

host this curriculum is essential in dismantling systemic oppression from a psychoeducation standpoint on all layers, that are systemically supportive of the 2SLGBTQIA+ community.

Addressing biases and potential countertransference is essential to the work of mental health counselors, as well as becoming linguistically accurate for the communities' counselors are more regularly working with. Curriculum specific to a marginalized community addresses the topic of ignorance and how not educating mental health counselors in marginalized communities is harmful to clients, both within and out of the community. I akin this the dispersal of responsibility capitalism asks of the individual to use compostable napkins and paper straws while monumental corporations do not change their practices to ensure clean, ecofriendly production. In order to make systemic change, it needs to come from the top down, the responsibility, and systemic change cannot be made solely by the individual. Mark Connolly from Accelerating Systemic Change in STEM Higher Education puts it simply, "systemic change occurs when change reaches all or most parts of a system, thus affecting the general behavior of the entire system. However, systemic change is often difficult to envision, let alone encourage, because people generally find it easier to focus on the parts than on the systems that connect those pieces" (Connolly, 2017), it's easier to ask the individual to buy a metal straw, it's easier to ask the clinicians to be lifelong learners. It must be acknowledged as well, that the education system is broken in that the professors are overworked; as most professors in are working multiple jobs. This is to say, that institutions must systemically support professors in order to have these specific curriculums. This support must come from hiring more professors with lived experiences, in order to respect both the professors, and students, recognizing that they are all clinicians who need to have these conversations, for the safety and care of the clients.

In line with the safety and care of Queer and Trans clients, a curriculum that recognizes and educates the student clinicians on the power of confidentiality in a client who has come out, is using a new name and identified their legal name as their deadname, using their pronouns, to encourage the sense of self and social identity all while saying they are not ready to come out to their parents. Social identity is important to foster as a clinician with recognition that "deriving a sense of importance from one's stigmatized identity may have the potential to act as a psychological buffer against enacted stigma" (McLemore, 2016, p. 54), an important aspect of identity work withing therapy and rapport building. With practical practice and curriculum of how to write a note in this case of an ethical conundrum knowing the client can ask for their notes. To protect the client and not out them, while affirming their social identity needs to be part of the ethics curriculum that is already built in, as well as in the practicing of writing notes that is regularly practiced in the program's supervision.

This curriculum could provide formats of writing referrals, and how to talk to medical professionals and find gender affirming medical care in the local area. It is important to integrate how to navigate medical literacy, for transgender clients specifically, into counseling curriculum because, "research shows that trans people, both those who undergo and do not undergo medical transition, are held accountable to medicalized narratives of gender non-conformity across social contexts and institutions" (Johnson, 2016, p. 466) Topics of medical advocacy with local hospitals, and conversations of the ethical oppression then of an adolescent coming out, as a counselor in Texas post July 2022 versus other states. Without oppressive state measures, the protocol and rights as a counselor to ensure the client has access to medically affirming medications and surgeries. This would be the place to educate and bring in the safety of these medical steps, not only in a mental health conversation of suicide prevention and

depression/anxiety management, but the safety that HRT and surgeries are not “abusive” (Abbott, 2022) or harmful toward the adolescent’s growth. This knowledge is integral for any family counseling as well, for parents who may hold bigoted and oppressive views disguised as “safety precautions” for their child. To be able to dismantle this type of ignorance in an affirmative and educated way as a counselor, it is necessary to abolish bigoted and harmful stigmas against marginalized communities.

The transgender community relies on the mental health field for medical care. The concept of medical transition and hormones in practical form is integral, as well as the internal biases that need to be confronted as clinicians that not all trans and gender non-conforming [TGNC] individuals are going to want surgery. This is an ethical topic that would behoove of a program to purposefully integrate, instigating the question of internalized transphobia in that the immediate assumption would be that a TGNC client is going to have surgery. McLaren points out, “Most transgender representation is therefore overly simplistic and lacking nuance in that it almost always features characters that either desire (or have already completed) some sort of medical transition” (McLaren, 2021, p. 173). Student clinicians need the supported conversations within curriculum to not assume that their client who is TGNC is going to want surgery or hormones. This conversation that can be integrated into clinical mental health program curricula, in conversations of not assuming and checking biases that happen in the classroom anyway. These topics of learning are already being taught, the lens and questions are being asked of the student clinicians in other classes such as the ethics class, it behooves of the programming, to have integrated curriculum in order for these questions to be transpired for the specific marginalized communities that the student clinicians will be working with. To have introduced

these questions to the students in the classroom, supports the future client from potential harm of ignorance from the clinician, and ultimately the program that did not host these spaces of insight.

Methods

Approaching this research was to look into the gaps of resources, and discovering the needs that have not been addressed. In doing so, the concepts of LGBTQ counseling, accredited programs, workshops, trainings, and certificate programs needed to be established. Looking into the Lesley Library to establish already done work in order to avoid duplication of work, as well as to include peer reviews directives and writing from QT counselors and academics.

Studying the coursework and syllabi of clinical mental health programs, and researching existing curriculum for each week in order to understand how each would be taught. Reflecting on assignments from Lesley University, the task was to expand these impactful assignments under the lens of the 2SLGBTQIA+ community. Using the power of what is already built as educators and clinicians, embracing the concepts of a focused population(s) and systems of oppression within the community are systemic options that an institution can integrate and reinforce in that this will create lifelong learners. This gives foundations to the students to be able to know the questions to ask of themselves in relation to other populations and minorities, as well as a format of how to be a lifelong learner; how to research and dismantle their ignorance towards a group of people as a clinician.

In the process of researching already created curriculum, affirmative counseling became unavoidable in which so much of this work has already been done, as far as research for clinicians of marginalized communities, “It requires practitioners to actively affirm and honor identity while at the same time validating the oppression felt by the individual seeking services. Offering further clarification (in the context of transgender care), Austin and Craig (7) asserted

that affirmative clinical practice must acknowledge and counter the oppressive contexts in which clients experience care" (Mendoza, 2020, p. 31). The concept of the therapeutic affirmative approach is integral in creating curriculum for student clinicians, the curriculum must be based off and utilize the language and the goals. Applying the core concepts of affirmative approaches provides the format for a clinical mental health counseling curriculum for marginalized communities.

The concept of lifelong learners is a continuation of the overall white privilege of the mental health field in that the required CEU's to reinforce this lifelong learning and to maintain a license can be and usually are hundreds of dollars. These are continued barriers to become an LPC, Registered Art Therapist (ATR) particularly for the marginalized individuals who graduate from clinical mental health programming. As an institution, it is their responsibility to give these clinicians the tools to be able to lead with curiosity and critical thinking. The CEU's contribute to the bureaucratic barriers, particularly for QTBIPOC candidates, more so in rural areas where there are not as many of these workshops available as larger cities. To have courses formatted upfront and curate these questions and integrating intersectionality of a marginalized community opens up the questions of further intersectionality as it will begin to inevitably intersect with the student/candidates lived experience.

Discussion

From the systemic curriculum and the student clinician, one recognizes the impact and needs for education on the 2SLGBTQIA+ community knowing "transgender people are subject to discrimination as well as physical and sexual violence because of the stigma attached to their gender presentation and identity, and these experiences are tied to anxiety, depression, substance abuse, suicidal ideation, and suicide attempts" (McLemore, 2016, p. 54). With these

considerations, it is arguable to great courses to foster this education and curriculum. Adjacent to courses like Power Privilege and Oppression, taught at Lesley University, and required as an elective, a professor of the community teaches an eight-week course on this community and trauma-informed approaches, history, and ethical clinical considerations. This is a solution both the lack of specified marginalized cultural education, as well as the employment of marginalized clinicians, and representation for the students in the courses. Recognizing how white cis woman dominate the field is, this is a direct systemic support of marginalized populations that is alongside the mission of many institutions. This systemically supports student clinicians, to learn from a professor with lived experience of the course they are teaching, and provides a safe space to learn ethical considerations of a population/community without harming the clients. For this purpose, this course is covering the 2SLGBTQIA+ community. These weeks are broken into categories that have potential for a general layout of other marginalized communities, but certain weeks are specific for the 2SLGBTQIA+ community, and would be replaced accordingly for other topics/populations. The weeks are broken up into Sexualities & Genders, global queer history, Intersectionality; QTBIPOC, Intention vs. Impact *as counselors*; how to repair with clients, Art liberation with Queer Community, Affirmative Counseling approaches, and Medical Advocacy and Confidentiality.

It would behoove of the university to integrate these courses in clinical mental health counseling programs due to the known increased mental health risks that are carried throughout the individuals in the 2SLGBTQIA+ community. Bettergarcia et al., (2021) confirmed this in *Training Mental Health Providers in Queer-Affirming Care: A Systematic Review" recognizing that* "Due to these increased mental health risks, queer individuals are more likely to seek out therapy and other psychological services compared to heterosexual individuals" (p. 365).

Knowing that this community is seeking out mental health services at a higher rate, only elucidates the matter of needing more purposeful education and curriculum for student clinicians.

Acknowledging the need for applicable resources for 2SLGBTQIA+ curriculum and tools amongst the clinical mental health field, a therapy deck is an accessible way for clinicians to initiate insightful concepts with themselves about individuals of a community, as well as their own biases. A therapy deck also acts as a way for a clinician to recognize shared experiences individually, as to not center themselves in the moment and co-opt a space. Therapy decks are making headway in specific communities. Most notably Dr. Ebony, Licensed Psychologist has created multiple decks, the first Self-Exploration Card Decks for Black Men, Women, and Teens, alongside journals (Butler, 2020). She has created packs for adults, and family work. Dr. Ebony's work is a concrete example of systemic implementation of resources not only for marginalized communities, but clinicians as well.

Reflective of Dr. Ebony's deck and many others, there are three images that represent three categories. Dr. Ebony's categories are broken down into mindset, habits, and triggers. This deck from Dr. Ebony is recognition of non-dominate communities creating specific tools for their lived experiences and therapeutic benefit. A deck for the queer community could have cards that utilize thought provoking quotes from Queer History representatives such as Marsha P. Johnson, Sylvia Rivera, and Stormé DeLarverie. Dr. Ebony's cards are split in half, with the top having a question related to the topic, and the bottom providing a normalization, affirmation, or a task. For example, a Habit card says, "Where do YOU fall on your list of priorities…Task: Do something today that places you as the top priority" (Butler, 2020). A Queer Deck could be modeled using this format, a boundary card could be "When Stormé DeLarverie first decided to perform in drag for the Jewel Box Revue, "somebody told me that I couldn't do it, and that I

would completely ruin my reputation, and…didn't I have enough problems being Black? I said, I didn't have any problem with it. Everybody else did." (Lo, 2021) with a task underneath it that reads, "Identify three parts of yourself, that you would not change for anyone. Thank those parts of yourself and do something that engages them today." This is an integration of Queer History, Queer Representation, Black representation, Gender Non-Conforming representation, all in the format of a self-reflective question about boundaries, and the sense of self for the reader. This deck would give opportunity for the clinician and the client, to discuss parts of the self with the potential to incorporate parts theory with Interpersonal Family Systems therapy from Richard C Schwartz. Beneficially, the naming of the important Queer historical figure can start the independent research of the clinician who does not know this person, and can start their own further education of the Queer Community and history for themselves, future clients, and advocacy otherwise.

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