Training Considerations and Suggested Counseling Interventions for LGBT Individuals

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A review of scholarship focusing on counseling lesbian, gay, bisexual, and transgender individuals reveals a dearth of information regarding counseling interventions, particularly with bisexual and transgender individuals. Influences such as religious and political affiliation, as well as institutional heterosexism, can create obstacles to lesbian, gay, bisexual, and transgender affirmative counseling. Models of sexual minority development can guide counselors in providing affirmative lesbian, gay, bisexual, and transgender counseling, but some express ambivalence about these models. Suggestions for counselor and counselor preparation training are provided, along with lesbian, gay, bisexual, and transgender affirmative counseling and training scenarios and interventions.

KEYWORDS LGBT affirmative counseling, counselor preparation and training

Positive changes in societal acceptance of lesbian, gay, bisexual, and transgender (LGBT) individuals include visible sexual minority role models in the media and an increase in the availability of domestic partner benefits in academic and corporate workplaces. Despite these forward strides, many challenges remain. Younger LGBT individuals may be particularly at risk. Some have reported increased levels of suicidal ideation and attempts among sexual minority youth (D’Augelli, Grossman, & Starks, 2005; Rutter, 2008). Bernal and Coolhart (2005) noted that youths coming out must contend with an oppressive society as well as possibly homophobic family and
school environments. The coming out process appears to be simultaneously daunting and rewarding, as LGBT individuals navigate identity development in a quest for authenticity and acceptance. Schope (2004) found that closeted individuals possess a higher external locus of control and a greater fear of negative evaluation but experience less discrimination than those who are open about their orientation. Thus, while some LGBT individuals are compelled to disclose their sexual minority status, they may encounter rejection and marginalization by doing so.

An LGBT individual's geographical location and corresponding political climate (e.g., red state versus blue state) can impact the decision to come out (Rees-Turyn, 2007). Legislative initiatives to limit the rights of LGBT individuals appear to strongly affect these individuals as well as inflict psychological pain and call for an increased need for resilience (Levitt et al, 2009). Marriage amendment campaigns can have detrimental effects on LGBT psychological health (Rotosky, Riggle, Horne, & Miller, 2009). In a similar vein, organized religion can have deleterious effects on the mental health of lesbian and gay individuals (Gage Davidson, 2000). Particular religious influences, such as conservative Christian beliefs, are a primary source of oppression for gay and lesbian clients (Wood, 2000). Some have noted that many religions, including Protestant, Catholic, Islam, and Judaism prohibit homosexuality and prevent LGBT people participating in many significant religious traditions, such as ordination (Estrada & Rutter, 2006/2007; Lease, Horne, & Nobisinger-Frazier, 2005; LeVay & Nonas, 1995). Collectively, the institutions of politics and religion permeate our everyday lives and can powerfully influence attitudes toward LGBT individuals. Herek, Gillis, and Cogan (2009) defined heterosexism as

an ideology embodied in institutional practices that work to the disadvantage of sexual minority groups ... everyone is presumed to be heterosexual and when a sexual minority becomes visible, they are presumed to be abnormal and ... deserving of discriminatory treatment.

(p. 32)

Institutional heterosexism can hamper LGBT individuals in their desire and need to come out in an atmosphere of acceptance rather than of condemnation. In a study of 900 LGBT employees in the fields of education and academia, Irwin (2002) noted that homophobic harassment and treatment were common and included physical assault, ridicule, and workplace sabotage. Counselors are not immune to these influences and must vigilantly attend to their biases in order to avoid perpetuating institutional heterosexism.

The coming out process brings with it myriad challenges and rewards. Some have suggested that being closeted can cause confusion, depression, and anxiety; coming out can prompt rejection, verbal or physical abuse, expulsion from one's family's home, and even death (Jordan & Deluty, 1998, Bernal & Coolharta, 2005, Hunter, 2007). Matthew Shepard's death in 1998 is a
poignant reminder of how homophobia can foment criminal acts, including murder. Current LGBT scholarship emphasizes the anxiety and ambivalence that LGBT individuals are likely to experience prior to coming out.

While the need for counselors to empower LGBT clients is critical, most have never received training in working effectively with LGBT clients (Eubanks-Carter, Burckell, & Goldfried, 2005). Many counseling students feel ill prepared to work with LGBT clients, and practicing counselors have expressed a lack of adequate levels of self-awareness and knowledge concerning LGBT issues (Dillon et al., 2004). Pearson (2003) suggested that ignorance and prejudice about LGBT issues are present in the counseling profession yet seldom discussed. Some have alluded to a stark paucity in the area of affirmative counseling with bisexual and transgender individuals. Keppel (2006) noted that adequate training with bisexual clients for mental health and medical professionals is inadequate, even when training programs provide competent training around gay and lesbian issues.

For the purpose of this article, LGBT stands for lesbian, gay, bisexual, and transgender. Some authors cited here use the acronym LGB, which is simply lesbian, gay, and bisexual. The acronym LGBTQ is sometimes used in the literature to designate lesbian, gay, bisexual, transgender, and queer or questioning. LGBT will be used generally throughout the article; however, if a different acronym is used, it represents terminology used in that particular article.

The purpose of this article is to review the literature related to the multitude of issues facing LGBT individuals in the coming out process and beyond. A paucity of literature that provides suggested guidelines and interventions with sexual minority individuals across the continuum (e.g., gay, lesbian, bisexual, and transgender) necessitates higher levels of training. Scenarios demonstrating affirmative counseling with gay, lesbian, bisexual, and transgender clients will be presented, along with guidelines for training suggestions.

**SEXUAL IDENTITY DEVELOPMENT MODELS**

There are a number of different types of developmental models proposed for LGBT individuals. Cass (1979) proposed a six-stage model of homosexual identity formation in which growth occurs when lesbian and gay individuals attempt to resolve inconsistencies between the perception of self and others. Cass (1979) emphasized that gay or lesbian individuals may encounter a point at which they are "stuck," termed *identity foreclosure*. The Cass stage model is iconic and the most often cited in the literature. The more recent Cass (1984) model has been empirically tested, though some note that only a limited number of studies provide empirical support for Cass's theory (Degges-White, Rice, & Myers, 2000). Another early stage model of sexual identity formation developed by Troiden and Goode (1980) found
that gay identity is acquired in more of a graduated process over a period of time. They also suggested that gay individuals needed to bolster themselves emotionally prior to incorporating a view of self previously seen as negative. Stage models have been criticized for being overly simplistic and not recognizing the range of gay experience (Horowitz & Newcomb, 2001). Research demonstrates that a more individualized process occurs in sexual identity development (Peterson & Gerrity, 2006), and Cass's model has been criticized because it doesn't address bisexual or transgendered individuals (Lynch, 2004). Hunter (2007) suggested that sexual identity development models are not sensitive to persons from cultures other than Euro-American.

Johns and Probst (2004) found that identity formation occurs in two phases rather than multiple discreet linear stages. Some have examined the relationship of variables such as hope and optimism in the context of sexual identity development. Participants in one study who had the highest level of LGBTQ development had significantly higher scores on measures that assessed hope, optimism, and sense of purpose in life (Moe, Dupuy, & Laux, 2008). The existential nature of the Moe and colleagues study suggests important avenues for counselors to explore with LGBTQ clients. The coming out process is likely to be fraught with existential issues including meaning in life, freedom, search for authenticity, and the fear of isolation as some reject the LGBT individual.

Diamond (2005) examined fluidity and stability in lesbian sexual identity development in her longitudinal study and found that early sexual identity development and long-term sexual identity development are quite different processes that may be shaped by varying factors. This counters some of the early sexual identity models that assume that once an LGBT individual comes out, little future development occurs. A familiarity with models of sexual identity development can guide counselors and students in their LGBT competence as well as in treatment interventions. Granello (2004) suggested that identity development models for gays can represent a conceptual map that is helpful in negotiating coming out and being out challenges. As this brief review demonstrates, however, the debate around models of sexual identity development suggests that counselors use them judiciously.

COUNSELOR AND COUNSELOR PREPARATION TRAINING ISSUES

Assessments of cultural competence have been deemed as helpful in examining counselor knowledge, skills, and awareness with respect to ethnicity. However, no multidimensional (knowledge, skills, and awareness) assessment of counselor competence with LGB clients currently exists (Israel & Selvidge, 2003). The American Counseling Association’s Code of Ethics states, “Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse population” (C.2.a, American Counseling
As the gatekeepers to the counseling profession, counselor educators are obligated to ensure that students acquire the knowledge, skills, and awareness necessary to work affirmatively and ethically with LGBT individuals. Clients who are marginalized in several ways (e.g., gender, ethnicity, sexual orientation) may be especially challenging to counselors (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008). Furthermore, counselors who neglect to acquire knowledge, skills, and awareness in working with LGBT individuals are flirting with serious ethical breaches, including inflicting harm on a vulnerable client population.

Logan and Barret (2005) developed standards for LGBT counseling competency to aid counselors and counselors-in-training in the examination of biases and values as well as the implementation of appropriate intervention strategies. These standards have been adopted by the Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGBTIC), a division of the American Counseling Association. There is a clear need for the integration of LGBT affirmative counselor training in counselor education curricula (Dillon et al., 2004). Some have suggested that training programs that focus on LGBT affirmative counseling lack coursework with a focus on empirically informed treatments (Safren, 2005). Other mental health professionals, such as psychologists, note a lack of sexual orientation issues in their training programs, which poses a risk to vulnerable clients (Schneider, Brown, & Glassgold, 2002). Schneider and colleagues (2002) suggested that “the mental health professions … have had an inglorious history, prior to the 1970s, of participating in discrimination against LGB people” (p. 273). Counseling students should advocate for increased training standards that reflect skill acquisition with LGBT individuals.

Counselors working with transgender individuals need to be committed to educating themselves related to all aspects of gender identity, including power hierarchies that pervade gender socialization. Counselors must consider relevant factors in addition to gender, such as the capacity of the client to form positive social support systems. Also, counselors choosing to work with transgender clients need to be familiar with the Standards of Care, originally established by the Harry Benjamin International Gender Dysphoria Association, now known as the World Professional Association for Transgender Health (WPATH; World Professional Association for Transgender Health, 2001). Dr. Harry Benjamin pioneered the development of standards in the areas of sexology and gender dysphoria in 1969. The standards of care established by Benjamin provide specific guidelines for health care professionals working with transgender clients, including directives to establish readiness for surgical reassignment. To date, WPATH remains the only recognized international resource used by healthcare professionals. These standards continue to be utilized by many health care and mental health professionals. However, some believe the need for a mental health evaluation as well as the diagnosis of gender identity disorder in order to receive hormone therapy
or gender reassignment surgery is pathologizing (Lev, 2004; Sanchez & Vilain, 2009).

The next section will examine an intervention related to a training scenario. In the following section, a lesbian counseling intervention scenario is presented. The final two sections will highlight affirmative counseling interventions for bisexual and transgender clients. Therapeutic factors that are beneficial to gay and lesbian people include understanding and acknowledging the effects of homophobia, assisting clients with internalized homophobia, not assuming clients want to address issues around sexual orientation, and knowledge of local gay and lesbian resources (Israel et al., 2006).

Training and Supervision Scenario

The following scenario involves a value conflict in a counselor trainee based on religious beliefs and decisions made by her supervisor to bolster LGBT counseling competence.

Janine is a counselor education graduate student enrolled in a practicum course. Janine has been assigned to work with Frank, a 37-year-old man who lists his presenting problem as depression. Janine is instructed by her professor and supervisor, Dr. Wilson, to screen Frank for suicidal ideation, which Janine does. Frank describes episodes of depression without any indication of suicidal ideations. Subsequently, Frank tells Janine that he is depressed because the voters in their state did not pass a recent amendment that would have legalized same-sex marriage. Frank adds that he has also been affected by anti-gay-rights messages emanating from defense of heterosexual marriage protesters and highlighted by the media, coworkers, and a few of his family members. Frank says that he and his partner of 10 years are devastated by the recent campaign results as well as by the anti-gay-marriage sentiment that seems to currently pervade the country.

Dr. Wilson is observing this session and notices that Janine's body language changes and becomes more closed. Janine appears to lose focus and begins to struggle in the session. Dr. Wilson decides to interrupt the session to consult with Janine. Janine proceeds to inform Dr. Wilson that she feels uncomfortable with Frank discussing the legalization of same sex marriage and lists reservations she has due to deeply held religious beliefs. Dr. Wilson decides that because Frank is in need of an affirmative counselor, she will conduct the rest of the current session in collaboration with Janine. Dr. Wilson feels that full disclosure to include Janine's stance on same-sex marriage may do more harm to Frank than to approach the session as an opportunity for growth and development.

Dr. Wilson meets with Janine after the session to discuss ways in which she can improve her LGBT competency. Dr. Wilson tells Janine that she respects her right to hold particular religious beliefs but that Janine must refrain from imposing harmful, heterosexist values on LGBT clients. Dr. Wilson
recommends some books to Janine to increase her level of knowledge and awareness. Dr. Wilson instructs Janine to familiarize herself with the Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGBTIC) LGBT competencies, developed by Logan and Barret (2005), including the need to understand the pervasiveness of heterosexism. Dr. Wilson decides Janine will work on improving her LGBT competency and will need to demonstrate her efforts in this area. Dr. Wilson assigns another student, who is further along in her LGBT competency level, to work with Frank.

GAY AND LESBIAN AFFIRMATIVE COUNSELING

While this section will address suggested gay affirmative interventions for gay and lesbian clients who are coming out, there are some caveats. The suggested interventions provided here are not exhaustive. A more comprehensive description of interventions is provided by Hunter (2007) for coming out, and Lev (2004) related specifically to working with transgender and gender-variant individuals. Additionally, counselors must recognize that there are distinct differences between the experience of gay men and lesbian women. One factor differentiating the experience of lesbians from that of gay men is the effect of sexism. When working with lesbian clients, counselors must be attuned to heterosexism and sexism (Estrada & Rutter, 2006/2007; Szymanski, 2005). When working with LGBT clients who are also culturally diverse with respect to ethnicity, disability, religion, etc., other considerations exist. Szymanski and Gupta (2009) examined the relationship between multiple internalized oppressions and African Americans with respect to sexual minority self-esteem and psychological distress. Results indicated internalized racism and internalized heterosexism were both significant negative predictors in self-esteem. Only internalized heterosexism was a positive predictor of psychological distress. Counselors who are working with LGBT clients experiencing multiple forms of internalized oppression must be highly cognizant of the insidious challenges these clients face and must diligently engage in consciousness raising for both themselves and their clients.

As a client comes closer to recognizing that he or she is gay or lesbian, internalized heterosexism or homophobia can create a negative view of same-sex relationships. Langdridge (2007) takes a cognitive stance, suggesting that an affirmative therapist will directly confront negative self-talk and thoughts while affirming positive self-talk related to sexual identity. Ross, Doctor, Dimito, Keuhl, and Armstrong (2007) employed a cognitive behavioral group intervention based on anti-oppression principles, including sessions on coming out and internalized homophobia. This intervention resulted in statistically significant reductions in symptoms of depression and statistically significant increases in self-esteem. However, the intervention did
not produce significant changes in the internalized homophobia measure. Empowering LGBT clients to overcome the effects of internalized oppression may be incredibly challenging. Thought restructuring may be limiting in altering deeply hurtful heterosexist and homophobic attitudes so prevalent in our society.

Counselors can assist LGBT clients who are coming out with helpful resources, including LGBT organizations and relevant Web sites. Counselors can help to normalize sexual identity for LGBT clients by providing this information, even if clients are not ready to join LGBT clubs. Hunter (2007) noted that when making referrals to LGBT groups, counselors should be cognizant of referring clients to specialized groups based on their ethnicity or religion. As clients move into accepting their gay/lesbian identity, she or he may come out to trusted friends. Counselors at this stage of development need to help clients examine the pros and cons of making disclosures. Gay affirmative interventions provided in this article will assume that clients are engaging in a developmental process that is more likely to be fluid than linear.

Lesbian Affirmative Scenario
Angelina is a 26-year-old Caucasian female. She was raised in a conservative Christian family in the Midwest. Angelina is quite close to her parents and four siblings. Angelina dated boys occasionally in high school, and she had a sexual experience with a girl about whom she felt very conflicted. Angelina obtained a bachelor's degree and is working for a local company and is doing quite well. Angelina has been seeing Donna for about six months. She has introduced Donna to her family members as a “good friend.” Angelina is experiencing a desire to come out to her family and a few friends but fears rejection, particularly from her parents. She has heard her parents discuss marriage amendment legislation in a highly negative way. Angelina is referred to a gay affirmative counselor because she wants to know how to come out to her family and whether she should take that risk.

The counselor begins by assisting Angelina with exploring the reason she's considering to come out at this time, the potential risks that she has identified with her decision, and whether her religious background plays a part in her current decision to come out or not come out. In addition to counseling, the counselor suggests joining a coming out support group so that she can experience hearing others' coming out stories. The counselor continues to work with Angelina to develop a coming out plan for each person she wants to come out to. The counselor suggests that Angelina begin with coming out to those individuals perceived as the least “risky” so that she may gain exposure to her coming out process and begin to gauge and understand her feelings related to coming out, along with her feelings in response to their reactions. This also allows her to bring these
experiences back to counseling for further processing and exploration while hopefully preparing her for coming out to those she views as the highest "risk." The counselor understands the importance of Angelina disclosing her sexual orientation at a pace that feels comfortable and safe for her. The counselor and Angelina also discuss the possibility that her individual coming out plan(s) may change depending on the response from those she tells. The counselor and Angelina continue to work on her beginning stages of coming out to others.

Transgender Affirmative Counseling

The dearth in available scholarship and models for transgender affirmative counseling suggests that counselors working with transgender clients obtain pertinent information and guidance from other sources, such as clinical mentors who possess this expertise. Support groups are especially helpful for transgender persons in expressing their identities and feeling a sense of acceptance (Hunter, 2007). Support groups can provide role models who have successfully completed sexual reassignment surgery for those considering that option.

Kirk and Belovics (2008) stated that counselors should refer to transgender persons using “he” or “she” even when not in the client’s presence, and if a counselors are unsure about a client’s gender identity or how they wish to be addressed, they should ask in a respectful manner. Counselors must not assume that all transgender clients are seeking services related to sexual orientation. “Members of the transgender community are united by the fact that they are discriminated against because of their gender expression” (Sánchez & Vilain, 2009, p. 202). Counselor training programs, as well as continuing education standards, need to address issues that are particular to transgender clients, some of whom may choose surgery to reconcile their physical selves with their gender identity.

If a transgender client is contemplating sexual reassignment surgery but has limited knowledge, she or he needs concrete information about surgical requirements as well as information about hormonal therapy, cosmetic surgery, and other resources (Hunter, 2007). Clients seeking evaluation for hormone therapy or sexual reassignment surgery may resent the pressure to receive therapy and see therapy as an obstacle and present challenges to counselors due to this dynamic (Lev, 2004). Transgender clients need accurate feedback related to how well they pass as the new gender and how to cope if identified as transgender by other people (Hunter, 2007). Sanchez and Vilain (2009) stated that the American Psychological Association has not published standards of care to guide therapists with transgender clients. The paucity of scholarship in this area suggests that transgender expertise is limited in the counseling field. Advocacy on an institutional level is necessary tool to rectify this situation.
Transgender Affirmative Scenario

Lisa is a 30-year-old African-American female. She entered counseling with reports of depression and previous suicidal ideation. When inquiring about her family history, the counselor learns that the only biological members she remains in contact with are an aunt and a sibling. She then discloses living in a group home as a teen due to being kicked out and then removed from the home at age 16 after coming out as a lesbian. She also has a history of substance abuse. The counselor explores the reasons Lisa is seeking counseling at this time along with her treatment goals. Lisa talks about depression and describes her symptoms. She then adds, "I think I should finally talk to someone about my gender issues too." Lisa reports feeling like a boy as far back as she can remember. She reports not wanting to wear female clothing or engage in female typical behavior. She describes always feeling different and uncomfortable around girls growing up. She also shares that all of her romantic interests and sexual experiences have been with females. When asked if she considers herself to be lesbian identified, she hesitates, and replies with uncertainty. She then talks about feeling more and more uncomfortable as a biological female and that most recently she has started binding her breasts to appear male. She also reports that sex has become less enjoyable over recent years with her female anatomy and that the only way she can engage in sex is if she imagines herself as a male. Lisa reports feeling uncomfortable with her biological gender both privately and publicly on a daily basis. She then discloses to the counselor a possible interest in taking the hormone testosterone and transitioning to male. The counselor also discovers that Lisa prefers to be addressed as male and that he started using the name Lee in a small circle of friends. The counselor informs Lee that he will need an evaluation from another mental health professional as well, if he decides to pursue sexual reassignment counseling. Lee agrees on continuing to work with the licensed counselor on the reported symptoms of depression and underlying issues related to substance abuse. The counselor also educates Lee on the process of gender reassignment. The counselor provides Lee a copy of the World Professional Association for Transgender Health Standards of Care used by mental health professionals working with transgender individuals who are interested in transitioning to the opposite gender. Lee reports an interest in eventually having "top surgery" (removing his breasts) but not genital reassignment surgery. The counselor refers Lee to a transgender community support group to help him begin to build an ongoing support system. The counselor also refers him to literature and documentaries previously suggested by other transgender clients for additional assistance with his process. Lee and the counselor continue to work together on the mental health issues related to his gender identity for months. While in therapy, the counselor assesses Lee's level of emotional preparedness, personal support, and overall stability prior to recommending hormone therapy. Once the
counselor and Lee agree that he is ready to begin the hormone therapy, the counselor will write a letter of recommendation for him to take to his medical health care professional specializing in surgical reassignment surgery. Lee will be encouraged to continue counseling for added support while beginning hormone therapy and to deal with issues related to beginning a life as a heterosexual male and coming out to the people who know Lee as Lisa.

Bisexual Affirmative Counseling

Society continues to dichotomize sexual orientation into gay or straight categories (Bradford, 2004; Keppel, 2006; Hunter, 2007). Keppel (2006) suggests that the terms “same-sex,” “same-gender,” “other-sex,” and “other-gender” will be perceived by clients as being friendlier and demonstrating a broader range of thought related to sexual orientation. Because bisexual individuals may not be validated by either heterosexuals or gays and lesbians, counselors need to emphasize that attraction to people of both genders is normal (Hunter, 2007). The stigma against bisexual individuals may be even more pronounced with people of color, who likely have even fewer role models (Bradford, 2004). Counselors need to provide referrals for bisexual clients to discover positive bisexual role models, such as community organizations and Internet sites. Bradford (2004) recommends the Bisexual Resource Guide (www.biresource.org) as a helpful resource.

Hunter (2007) stated that “bisexual women and men rarely report having equal attractions to women and men” (p. 53). Hunter further suggested that emotional attractions and sexual attractions can vary by gender, thus a bisexual woman may feel more emotional closeness toward women but more sexually attracted to men. Bradford (2004) noted that when a bisexual partner desires to experiment with other-sex relationships, the couple relationship and level of attachment is likely to be negatively affected. Counselors working with bisexual individuals and their partners need to be educated regarding the impact and complexities of dual attraction. As with transgender affirmative counseling, the limited amount of scholarship in this area suggests that alternate sources of information be accessed, such as Internet sites and mentors with bisexual counseling expertise and knowledge.

Bisexual Affirmative Scenario

Carrie is a 29-year-old Caucasian, bisexual female. She began receiving counseling five months prior with reports of depression following a break up from her three-year relationship with her partner. She is working with her counselor around coping with the loss of the relationship, her home, shared pets, and their planned future that included adopting a child. Carrie describes a strong support system of friends reaching out to support her during the
breakup. Over the past month, Carrie appeared to have an improved mood and reported feeling more hopeful about her future. She even started engaging in previously enjoyed activities again and reported beginning to date.

When Carrie returns to her next counseling session, she appears sad, and she has been crying. She informed the counselor that she started dating a great guy and that she really likes him. She adds that she's been feeling really upset and confused by her former partner's reaction. Carrie discusses bringing a male date to a friend's barbecue she knew her ex-partner would not attending. She then describes an overwhelming feeling of not belonging. She talks about never before feeling so alienated from her friends and how painful the experience was. She reports "my so-called friends were treating us like outsiders." She described pulling the host aside to ask what was wrong with everyone, and being told, "We all thought your date was going to be a girl," and, "What are you, straight now?" Carrie goes on explaining to the counselor how they treated her as if she had betrayed them and that she ended up defending her bisexual orientation to people she never thought would treat her that way. She reported leaving after experiencing an overwhelming sense of discrimination from her friends.

Carrie then reported feeling angry and explained that her ex-partner, who is lesbian identified, is now being invited to all of the activities with this circle of friends, along with her new girlfriend. Carrie states that her family is now more accepting of her and has already invited her and her boyfriend to more activities in this brief period of time than she was invited to in the three-year period with her girlfriend. Carrie describes feeling overwhelmed and confused by all of her emotions and reports an increase of her depressive symptoms. The counselor helps Carrie to identify all of the loss she has recently experienced and to validate the difficulty and confusion of being rejected by her family when in a nonheterosexual relationship but accepted by her friends but now being rejected by her friends and accepted by her family for being in a heterosexual relationship. Since Carrie is vacillating between different stages of grief, the counselor supports Carrie by being with her in her process and being very nondirective for many sessions. Carrie spends several sessions trying to understand the reported conditions placed on her acceptance based solely on her sexual orientation. At one point, she begins to date another woman and finds herself experiencing the distancing from her family again but now also from her previously identified circle of friends. During a recent session, she stated that she was now being told by some of these "friends" that she is not a "real lesbian." The counselor refers Carrie to a bisexual support group given the unique struggle described of feeling discriminated against by sexual majority and minority communities. The counselor continues to work with Carrie on her symptoms of grief and loss and assists her with identified self-esteem issues related to who she is. The counselor works with Carrie for several sessions to assist her with recognizing that her sexual identity is just one part of her whole identity.
as a person. The counselor also assists her with exploring new groups of friends and how to talk with her family about her feelings related to their conditional acceptance.

CONCLUSIONS AND IMPLICATIONS FOR TRAINING

LGBT scholarship is clear about the need for more training to bolster competence in counselor educators, counseling students, and licensed counselors. Counseling programs currently provide an inadequate amount of training in this area (Eubanks-Carter et al., 2005; Keppel, 2006). Counselor educators who are themselves informed about current issues related to LGBT clients will be in the best position to mentor and guide counseling students through the clinical training process. The multicultural counseling movement, initiated by Arredondo, McDavis, and Sue (1992), perpetuated an enduring need for counselors to address cultural issues in counseling with respect to competencies in knowledge, skills, and awareness. Counselor educators, licensed counselors, and counseling students need to attain a similar level of competence in LGBT knowledge, skill, and awareness. Counselor educators and licensed counselors can seek mentoring and collaborative opportunities from practitioners with demonstrated expertise in LGBT affirmative counseling. Counselor educators can invite these experts to speak in counseling courses. Outcome based research, as well as best practice articles in the area of LGBT counseling, can all further the limited body of scholarship that currently exists, particularly with bisexual and transgender individuals.

REFERENCES


