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Jeffry L. Moe, Peter Finnerty, Narketta Sparkman & Chad Yates

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Initial Assessment and Screening with LGBTQ Clients: A Critical Perspective

JEFFRY L. MOE
Department of Counseling and Human Services, Old Dominion University, Norfolk, Virginia, USA

PETER FINNERTY
Counseling for Wellness, Kent, Ohio, USA

NARKETTA SPARKMAN
Department of Counseling and Human Services, Old Dominion University, Norfolk, Virginia, USA

CHAD YATES
Department of Counseling, Idaho State University, Pocatello, Idaho, USA

Counseling with people that identify as lesbian, gay, bisexual, transgender, queer (LGBTQ), or who are otherwise nonheterosexual or cisgender identified, should be based on a critical approach to assessment. Although general competencies have been articulated, further guidance is needed to help counselors avoid heteronormative and cisgender biases in their assessment practice. The authors provide recommendations, based on critical review of the literature, for how counselors can address biases in assessment and screening tools in work with LGBTQ clients.

KEYWORDS LGBTQ issues, prejudice, queer theory, social justice, treatment

INTRODUCTION

Social changes in the United States have resulted in increased recognition and acceptance for lesbian, gay, bisexual, transgender, queer (LGBTQ) and other gender and sexuality diverse people (Whitman & Bidell, 2014). The Institute of Medicine (IOM; 2011) estimated, by pooling data from several

Address correspondence to Jeffry L. Moe, Department of Counseling and Human Services, Old Dominion University, Norfolk, VA 23529, USA. E-mail: jmoe@odu.edu

national-level sources, that self-identifying LGBT people may make up between 4% and 10% of the adult population in the United States. Similar numbers are estimated (IOM, 2011) for individuals who do not self-identify as LGBTQ, but whose sexual-relational orientation or gender identity does not resonate with the terms *heterosexual* or *cisgender* (a person whose gender identity conforms to birth-assigned sex and gender; ALGBTIC LGBQQIA Competencies Task Force, 2013). Given these estimates, counselors will likely encounter clients and students from these populations during their professional careers. The current standard of care for work with gender and sexuality diverse people is to adopt an open and affirming approach (APA Task Force, 2009), where human sexuality and gender development are viewed as multidimensional, contextual, and occurring over the life span (Glover, Galliher, & Lamere 2009; IOM, 2011). Implementation of this standard of care supports and is supported by social and institutional openness, where individuals can experience and explore their gender and sexuality diversity needs within a safe and supportive environment (Hatzenbeuhler, 2011; Saewye, Konishi, Rose, & Homma, 2014).

Although LGBTQ activists and their allies have realized important gains in terms of social inclusion over the past two decades, there remain challenges for these historically marginalized groups. As members of vulnerable populations, LGBTQ people experience microaggressions aimed at invalidating their sexual and relational orientations (Balsam, Molina, Beadnell, Simoni, & Walters, 2011) or modes of gender expression (Patton & Reicherzer, 2010). Stressors related to being members of oppressed and marginalized groups are linked for LGBTQ people to higher rates of mental disorder (Cox, Dewaele, Van Houtte, & Vincke, 2011), suicidal ideation (Haas et al., 2010), and interpersonal violence (Poteat, Mereish, DiGiovanni, & Koenig, 2011). Safe access to qualified, competent, and affirming mental health care providers remains an important factor in the lives of LGBTQ people (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008), and professional counselors acting as competent allies can meet the wellness, developmental, and mental health needs of LGBTQ clients (Hendricks & Testa, 2012; Moe, Reicherzer, & Dupuy, 2011).

There is evidence that counselors as a professional group vary in terms of their subjective levels of competency, prejudice, and bias relative to LGBTQ clients (Israel et al., 2008; O'Hara, Dispenza, Brack, & Blood, 2013; Satcher & Schumacker, 2009). Counselors seeking to develop their skills as allies, including becoming more aware of and to challenge their own biases and sources of prejudice, can find support in professional communities dedicated to serving LGBTQ individuals and communities. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) developed two sets of competencies that counselors can use to broaden and deepen their affirming practice with and on-behalf of gender and sexuality diverse people (ALGBTIC LGBQQIA Competencies Taskforce, 2013; ALGBTIC Transgender Committee, 2010). Although tailored to the needs

of different client groups, both sets of competencies share a foundation in critical counseling perspectives such as multiculturalism, feminism, queer studies, and social justice (ALGBTIC LGBQQIA Competencies Taskforce, 2013; ALGBTIC Transgender Committee, 2010). Just as the original multicultural counseling competencies benefited from further development and operationalization (Arredondo et al., 1996), the ALGBTIC Competencies can benefit from further linking to concrete recommendations for practice.

One domain that appears in competency frameworks involves assessment (ALGBTIC LGBQQIA Competencies Taskforce, 2013; ALGBTIC Transgender Committee, 2010), which includes standardized assessment as well as biopsychosocial interviewing and screening for common concerns such as suicide risk (Whiston, 2014). The purpose of this article is to help counselors become informed scholar-practitioners and to deepen their assessment skills with LGBTQ clients. This includes being able to practice from a critically-aware counseling perspective so as to avoid further marginalization of gender and sexuality diverse people in society (ALGBTIC LGBQQIA Competencies Taskforce, 2013; ALGBTIC Transgender Committee, 2010). For the purposes of this article, the acronym *LGBTQ* will be used to reference clients that self-identify as such but also those that, though not identifying as LGBTQ, incorporate other aspects of nonheteronormative or transgender lived experience into their self-expression, behavior, and identities. The recommendations for initial assessment and screening, including addressing personal biases, are synthesized from critical review of the literature, both sets of ALGBTIC Competencies, and the affirming philosophy identified as the current standard of care for work with LGBTQ clients.

CRITICAL PERSPECTIVES AND ASSESSMENT

Counselors are advised to become aware of their own biases and sources of privilege to act as agents of personal and social change for clients and their communities (Prilleltensky, 2008). This recommendation serves as the foundation for critical practice with marginalized populations (Hays, 2008), including LGBTQ clients, yet can be difficult to operationalize in terms of making concrete modifications to counselors' behaviors in the field. For example, counselors are encouraged to "Understand and be aware of the historical and social/cultural context regarding the practice of assessment, particularly in relation to underserved populations, such as LGBQQ individuals/couples/families" and "Understand how assessment measurements, the *Diagnostic and Statistical Manual of Mental Disorders,* and other diagnostic tools may perpetuate heterosexist, genderist, and sexist norms that negatively affect LGBQQ individuals" (ALGBTIC LGBQQIA Competencies Taskforce, 2013, pp. 19—20). Although advocates and allies may be familiar with the perspectives from which these competency statements are

developed, such as feminist counseling or queer theory, novice allies may be confused about what awareness, understanding, and heterosexism looks like when encountered in practice. This is problematic, as counselors that fail to practice from a critical consciousness related to the historical and social implications of their professional work risk acting as de facto agents of an oppressive status quo (Hays, 2008; Prilletensky, 2008). Unaware counselors may see their primary duty as to work with individual or immediate problems and concerns, overlooking client stress resulting from oppressive social conditions. In response to concerns over the role of counselors in tacitly supporting oppressive sociocultural institutions, critical approaches to counseling have been developed to create spaces for resistance, the reclamation of marginalized experiences, and the fostering of social change (Downing & Gillett, 2011; Prilleltensky, 2008).

Critical traditions (e.g., feminism) share common premises that counselors can engage with to implement critically-aware assessment with LGBTQ populations. One premise shared between perspectives such as queer studies, feminism, and social justice is that counseling is itself a political act (Prilletensky, 2008), an institution embedded within a contingent set of power relationships (Downing & Gillett, 2011), and that counselors as social agents are never neutral to the influences of sociopolitical discourses (e.g., heteronormativity) dominant or marginalized at specific historical moments (Besley, 2002). The conversations counselors initiate, questions they ask, and assumptions that they act upon emerge from discourses embedded in culture, history, and individual subjectivity (Frank & Cannon, 2010). Individuals are active coconstructors of discourse and subjectivity, and sociopolitical power is understood as a fluid medium of mutually influential relationships as opposed to an inevitable and entrenched hierarchy (Besley, 2002). Counselors choose to support or challenge the status quo through their practices, including how well they account for their competencies and biases related to work with historically marginalized populations (Hays, 2008).

Critically-aware counselors can begin to challenge oppressive sociopolitical conditions by questioning grand or dominant narratives and universal explanations (Besley, 2002; Frank & Cannon, 2010). Rather than viewing dominant explanations as best or universal, critically-aware counselors accept that grand narratives are contingent upon the marginalization of alternate and less favored ways of knowing (Moe et al., 2011). Skepticism toward universal explanations leads to questioning the status quo and subverts attempts to identify a normative experience against which all others may be compared (Downing & Gillette, 2011). A critical view of universal or totalizing explanations also supports the premise of intersectionality, or that clients may experience oppression through occupation of multiple marginalized identities (e.g., being transgender, a person of color, and HIV positive) (Yakushko, Davidson, & Williams, 2009). Counselors practicing from a critical lens do not expect clients to prioritize their identities and

acknowledge how negotiating different identity positions may lead to added stress (Balsam et al., 2011). Finally, critical counselors understand that assessment and screening methods can facilitate documenting and organizing local, specific, and indigenous ways of knowing including clients' strengths and competencies.

Although the assumptions of the critical counseling perspectives articulated above seem to be irreconcilable with the practice of assessment, action based on these ideas helps to reappropriate the practice of assessment for critical purposes. The purpose of assessment with LGBTQ and other gender and sexuality diverse clients moves away from the seeking of objective truth about clients' lives and becomes an effort to document how oppressive or dominant ideologies may be limiting clients' sense of agency and subjective sense of well-being. Engaging the voices and perspectives of clients, acting from their local and context-specific experience, and inviting their critique of counseling and counselors are all logical developments that arise from commitment to a critical counseling perspective. Empowering clients to reclaim stories of resilience, resistance, and liberation is also a goal of critically-aware assessment with LGBTQ clients and other marginalized groups. Counselors should also become aware, and seek to challenge, internalized biases (such as heterosexism or cisgender bias) that may influence their abilities to act as social change agents with and on behalf of LGBTQ clients.

CISGENDER AND HETERONORMATIVE BIAS

Heterosexist or heteronormative biases include tacit or explicit privileging of relationships and sexualities that conform to the patriarchal ideal of sexual relationships based on heterosexual pairings, are nominally monogamous, and intended for procreation (Downing & Gillett, 2011). Cisgender biases are based on beliefs and attitudes that emphasize rigid and deterministic gender binaries (i.e., man/woman), an emphasis on birth-assigned sex characteristics as determinants of gender identity, and patriarchal gender role conformity (Smith, 2013). Holding the view that there are inherently male personality traits (such as assertiveness) and inherently female traits (such as cooperativeness), and that demonstrating gender fluidity by expressing inherently male and female traits is a sign of severe mental illness, is another example of cisgender bias informed by patriarchy and sexism (Patton & Reicherzer, 2010; Smith, 2013). Heteronormative and cisgender biases often operate in collusion to create further oppressive beliefs and expectations. Believing that same-sex sexual relationships must include a butch (or masculine) and feminine partner, or that transgender identified people must also identify as same-sex sexual, are two examples of how heteronormative and cisgender biases operate together to marginalize gender and sexuality diverse subjectivities (dickey, Burnes, & Singh, 2012). These biases are

pervasive, emerge through socialization and interaction within a cultural context of patriarchy, heterosexism, and trans-prejudice, and operate overtly (in the form of institutionalized discrimination) and covertly (in the form of unaddressed biases and expectations) (Frank & Cannon, 2010). Research indicates that cisgender and heterosexually identified males are more likely to express prejudiced attitudes toward LGBTQ people, though people of different genders and sexual orientations may also experience LGBTQ-related biases and prejudices (Nagoshi et al., 2008).

Assessing Personal Biases

Several instruments have been developed which counselors can use to operationalize tacit or overt biases against gender and sexuality diverse individuals. The Sexual Orientation Competency Scale (SOCCS; Bidell, 2005) was designed to measure counselor readiness to work with LGBTQ populations and includes items evaluating respondents' subjective level of negative or prejudicial attitudes toward lesbians, gay, and bisexually identified people. The SOCCS is a 29-item, Likert-type scale designed to assess counselors' knowledge, attitudes, and skills for working with lesbians, gay men, and bisexually identified people (Bidell, 2005). Although a useful addition to the knowledge base, the SOCCS may be too sensitive to other constructs besides heteronormative bias and does not address cisgender bias. For example, Bidell (2005) reported that respondents self-identifying as lesbian, gay, or bisexual had higher SOCCS scores than heterosexually identified respondents. This may mean that the SOCCS is sensitive to issues of internalized prejudice or to respondents' access to affirming social environments. Measures such as the Attitudes Toward Lesbians and Gay Men (ATLG) scale (Herek, 1988) and Gay Affirming Practice Scale (GAP; Crisp, 2006) are examples of instruments that assess heteronormative and homonegative biases more specifically but define such biases narrowly in terms of attitudes toward lesbian and gay-identifying individuals. Given the many measures for related constructs such as heteronormative bias, homonegativity, homoprejudice, and homophobia, it is important for counselors to identify a priori what they are trying to assess and how this will inform their overall assessment of their personal biases. Beyond a narrow reference to self-identifying lesbian, gay, or bisexual individuals these and other similar instruments also fail to assess more subtle forms of heteronormative bias such as favoring monogamous relationships or patriarchal gender-role conformity.

Hill and Willoughby (2005) developed the 32-item Genderism and Transphobia Scale to assess individuals' attitudes toward transgender-identifying individuals. Hill and Willoughby's scale attempts to assess several closely related but distinct constructs, and though useful suffers from a lack of scale specificity in a manner similar to the SOCCS (Bidell, 2005). The Genderism and Transphobia Scale, along with most of the measures used

to account for heterosexism and homoprejudice, were developed primarily for research purposes and remain in the early stages of development. Practicing counselors hoping to begin their own ally work with LGBTQ clients can adapt short measures of internalized prejudice, such as the Internalized Homo-Negativity subscale of the Lesbian and Gay Identity Scale (Mohr & Fassinger, 2000) to quickly assess personal biases toward various gender and sexuality diverse individuals and groups. This self-assessment can serve as the basis for ongoing self-examination and consultation with others but should include multiple measures to address the different dimensions of bias operating to marginalize LGBTQ people.

Biases in Standardized Assessments

Scholarship on heteronormative and cisgender bias within standardized assessments has been lacking. Chernin, Holden, and Chander (1997) evaluated six common psychological assessments for heteronormative bias. Chernin et al. found that the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Strong Interest Inventory (SII; Harmon, Hansen, Borgen, & Hammer, 1994) were examples of assessments that were free from heteronormative and cisgender bias. This assertion, however, is based on the face that these instruments are gender and relationship neutral. Although an improvement over instruments that assume same-sexuality or transgender experiences are pathological, validating these instruments explicitly with LGBTQ populations is needed. Chernin et al. stated that the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Hathaway et al., 1989) contained several types of heteronormative and cisgender bias. For example, items on the MMPI-2, Scale 5 (Masculinity-Femininity) contained examples of what Chernin et al. referred to as connotation bias, where nonheteronormative or cisgender modes of beings are viewed as negative or undesirable. Within the context of the MMPI-2 assessment domains, this negative connotation implies that identifying as transgender is pathological (Chernin et al., 1997). Additionally the MMPI-2 includes the word *homosexuality* alongside descriptions of pathology, illustrating contiguity bias or that homosexuality can be seen as related or contiguous to a pathological state (Chernin et al., 1997).

The Sexual Addiction Screening Test-Revised (SAST-R; Carnes, Green, & Carnes, 2010) is a common measure used to screen for compulsive or addictive sexual behavior that has been partially normed with a clinical sample of gay-identified men. Despite the attempt to create an inclusive measure of sexual addiction, several items on the SAST-R appear to contain heteronormative bias, such as items asking respondents if they have ever been ashamed of their sexual behavior. Conflating shame or guilt with problematic sexual compulsivity is an example of connotation and contiguity bias (Chernin et al., 1997), and along with these deficits the SAST-R has not been normed with

lesbians, bisexual people, or transgender people. Carnes et al. (2010) stress that assessing for general features such as loss of control, sexual preoccupation, affective disturbance, and high-risk behavior such as unprotected sex remain consistent in conceptualizing sexual addiction across populations. Critically-aware counselors should reflect on how and by or for whom sexual addiction has been defined, and whether screening for it resonates with the worldviews of gender and sexuality diverse clients.

Chernin et al. (1997) stated that more assessments need to be reviewed for instances of bias and, when possible, adapted to be effective with LGBTQ clients. Moradi, Mohr, Worthington, and Fassinger (2009) suggested that counselors and researchers reduce heteronormative bias during assessment through (1) selecting assessments appropriate for the LGBTQ community, (2) investigating the psychometric properties of culturally adapted or new assessments, and (3) ensure that assessments accurately measure conceptualizations and constructs related to LGBTQ clients. This includes not assuming that assessments validated with clients claiming a specific identity (e.g., lesbian) are themselves universally applicable to other LGBTQ populations. Within LGBTQ communities, issues pertaining to being a person of color, bisexual, or transgender are often overlooked (Meyer, 2010; Smith, 2013).

SELF-IDENTIFICATION AND DISCLOSURE

One way that counselors may be tacitly operating from heteronormative or cisgender bias involves expectations that clients will self-label their sexuality or gender identity using identity markers such as gay, lesbian, or transgender. Counselors should reflect upon what makes it important to invite clients to label their sexualities and gender identities. Viewing the adoption of and consistent use of such labels as the only sign of mental health and well-being for gender and sexuality diverse people obscures how self-labeling as LGBTQ is done in relation to dominant categories (e.g., heterosexual) that are themselves assumed to be normative or preferred (Frank & Cannon, 2010). Past models of sexual identity development have been critiqued for being too reliant on intrapsychic explanations and for failing to incorporate consideration of sociocultural contexts (Moe et al., 2011). The empirical support for linear, stage-based identity development models is inconclusive regarding the number of stages and what the normative goal of identity development should be. Models that emphasize the influence of context on development (Glover et al., 2009), the intersection of multiple identities (Yakushko et al., 2009), and that do not proscribe a single normative experience for LGBTQ clients help to challenge deterministic, intrapsychic, and individualistic models that some LGBTQ clients may find constraining rather than affirming.

Assessment and scholarship should be based on infusion of multidimensional, continuum-based models of sexuality and gender identity (Glover et al., 2009; Moe et al., 2011). This includes documentation of sexuality and gender narratives that clients find personally relevant and empowering (ALGBTIC LGBQQIA Competencies Taskforce, 2013; Patton & Reicherzer, 2010). Clients that self-identify as LGBTQ can be invited to share their developmental process, which may or may not resonate with published models of gender and sexuality identity development. Frameworks that incorporate multiple dimensions, such as the layer-cake model of bisexual identity development (Bleiberg, Fertman, Friedman, & Godino, 2005) allow more freedom for clients to describe their gender and sexuality diversity needs without being compelled to self-identify with a label that may not be personally relevant. Extending the discussion of gender and sexuality development to work with heterosexually or cisgender-identified clients is another way for counselors to subvert heteronormative or cisgender bias, as doing so decenters heterosexual or cisgender experience as default categories.

Counselors who overemphasize self-labeling with an LGBTQ identity may also place inappropriate, or inconsistent, emphasis on client disclosure of their gender and sexuality diversity to others. Disclosure and openness about one's same-sex attraction or transgender identification appears to be associated with positive mental health outcomes (Legate, Ryan, & Weinstein, 2012). Preemptory or involuntary disclosure, however, may result in feelings of crisis or in perceived loss of control and subsequently may act as a barrier to help seeking (Ard & Makedon, 2011). People that do not openly identify as LGBTQ may be committed to nonidentification as a mode of political resistance and subsequently view disclosure of their gender and sexuality diversity in a more nuanced and contextual manner (Downing & Gillett, 2011). Legate and colleagues (2012) found that disclosure of their sexuality or relational orientation was related to well-being for a sample of lesbian, gay, and bisexual respondents when it occurred in environments supportive of individual autonomy, but that initial disclosure was negatively related to well-being in closed or controlling environments. Empowering clients to navigate their own disclosure process based on awareness of their local systems (e.g., coworkers or family members) is considered best practice (ALGBTIC LGBQQIA Competencies Taskforce, 201; ALGBTIC Transgender Committee, 2010). This includes creating the therapeutic environment for disclosure without forcing said disclosure for clients (ALGBTIC LGBQQIA Competencies Taskforce, 2013; Senreich, 2010). Revising intake paperwork to represent gender and sexuality diverse relationships, identities, behaviors, and presenting concerns in tandem with broaching these issues during the assessment process helps to signify that counselors are allies who are willing and open to discussing these topics.

SCREENING

Counselors routinely screen for suicide risk, alcohol or other drug abuse, and for intimate partner violence (Whiston, 2014). Along with these common indices of psychosocial health, counselors working with LGBTQ clients should screen for internalized prejudice; whether conceived as internalized homonegativity, homophobia, or trans-prejudice/trans-phobia, research indicates that internalized prejudice is associated with mental disorder and suicidal ideation for gender and sexuality diverse people (Frost & Myer, 2009; Newcomb & Mustanski, 2010). Screening for internalized prejudice can facilitate effective crisis response and can also provide opportunities for open and affirming messages to be communicated to clients.

Internalized Prejudice

Internalized homo- or trans-prejudice includes negative global attitudes about gender or sexuality diversity, discomfort with disclosure of sexual orientation or gender identity, and discomfort with and isolation from other LGBTQ individuals (Henricks & Testa, 2012; Newcomb & Mustanski, 2010). Phenomena related to internalized prejudice, whether associated with negative self-appraisal or attitudes directed at LGBTQ groups, plays a major role in the psychosocial adjustment of LGBTQ people (Haas et al., 2010). Several measures have been developed to assess internalized prejudice with different groups of LGBTQ clients, and counselors should select measures validated with populations that match their clients' backgrounds and modes of identification. Mayfield (2001) developed the Internalized Homo-Negativity Scale (IHNS), a 21-item scale to measure internalized homonegativity with gay men that includes self-directed gay affirmation or homopositivity as a related construct. The specificity to male experiences of internalized homoprejudice limits the usefulness of the IHNS with other LGBTQ people. The 52-item Lesbian Internalized Homophobia Scale (Szymanski & Chung, 2001) has been normed with samples of lesbian-identified women and provides a multidimensional perspective on internalized prejudice. The internalized homonegativity subscale of the Lesbian and Gay Identity Scale (LGIS; Mohr & Fassinger, 2000) is a five-item subscale measuring internalized homonegativity that has been used independently from the LGIS while maintaining psychometric rigor (Moe, Dupuy, & Laux, 2008). The Internalized Homo-Negativity (IHN) subscale of the LGIS is also useful in that it has been validated with samples of males and females. This scale has not been validated with transgender persons. One potential drawback of this measure involves the use of the word *homosexual*

to signify lesbian, gay, or bisexual people. This could be an example of contiguity bias (Chernin et al., 1997), where a respondent's negative reactions to a historically pathologizing label are conflated with his or her attitudes related to potentially more affirming identity positions (e.g., lesbian, gay, or bisexual).

Similar to internalized homoprejudice, internalized trans-prejudice occurs when transgender individuals incorporate negative societal perspectives based on cisgender bias and patriarchal gender determinism into their self-concept. Internalized trans-prejudice has been associated with negative psychosocial outcomes such as depression and difficulty coping with stressful life events (Hendricks & Testa, 2012; Sevelius, Keatley, & Gutierrez-Mock, 2011). There is a need for screening tools that adequately and specifically measure internalized trans-prejudice among and between groups of transgender-identified persons such as male-to-female (MTF), female-to-male (FTM), and people who are multiple gender identified (ALGBTIC Transgender Committee, 2010). Cursory adaptation of protocols and approaches validated for use with lesbian or gay male individuals may further marginalize aspects of transgender clients' lived experiences, and in keeping with an open and affirming standard of care, counselors' questions should encourage client self-direction and disclosure rather than impede it (Hendricks & Testa, 2012).

There is a dearth of measurements that assess internalized prejudice clients may experience due to the intersection of minority stress from multiple identity positions, including ethnicity, culture, and socioeconomic status along with gender and sexual-relational orientation (Meyer, 2010). One such measure is the LGBT People of Color Micro-aggressions Scale (LGBT-PCMS), an 18-item self-report scale that measures microaggressions that adult ethnic minorities who are also gender and sexuality diverse experience along three subscales (Balsam et al., 2011). This scale assesses an interaction of sexual-relational orientation and ethnic/racial status that most studies and scales fail to take into consideration. The developers of the LGBT-PCMS reported strong internal consistency for this instrument, as well as construct validity regarding correlations to psychological distress and orientation/gender identity variables (Balsam et al., 2011), but the usefulness of the LGBT-PCMS as a screening tool in clinical settings is unproven.

The array of instruments used to measure internalized prejudice suffer from lack of specificity in construct definition, may be too long or complicated for screening purposes, or may lack psychometric rigor. Furthermore most published instruments were developed for usage with gay men and have not been validated with other populations. Adapting questions and short measures from other scales may serve as a starting point for further assessment. Counselors that screen for internalized prejudice using a

more refined scale, such as Mohr and Fassinger's (2000) five-item subscale, may broach the topic of intersecting identities and minority stress issues by adapting questions from the scale developed by Balsam et al. (2011). Assessing the relative importance of gender and sexuality diversity issues related to clients' presenting concerns, how comfortable clients feel with their gender(s) or sexual-relation orientation(s), and gauging how these factors may fluctuate depending on the clients' contexts (e.g., family or work) would help counselors-as-allies incorporate consideration of internalized prejudice into their overall assessment approach with LGBTQ clients (Moe, Perera-Diltz, Sepulveda, & Finnerty, 2014).

Suicide Risk

Suicide risk, and rates of suicide attempts and completions, have been shown to be more prevalent for LGBTQ people (Haas et al., 2010). Despite this, established measures of suicide risk assessment such as the Suicide Assessment Scale (Niméus, Hjalmarsson Ståhlfors, Sunnqvist, Stanley, & Träskman-Bendz, 2006) have not been validated expressly with LGBTQ populations, are assumed to be generalizable across populations, and are tacitly based on a gender and sexuality diversity neutral paradigm. Chu and colleagues (2013) developed the Cultural Assessment for Risk of Suicide (CARS) to incorporate consideration of minority stress, including sexual minority stress specifically, into assessment of suicide risk with marginalized populations. The CARS was found to have adequate reliability, specificity, and convergent validity relative to other measures of suicide risk (e.g., the Beck Hopelessness Scale; Chu et al., 2013). Questions designed to assess minority stress did improve the ability of the participants' overall CARS scores to predict past suicide attempts, but the effect size difference with or without these questions was small (Chu et al., 2013).

If a client indicates experiencing suicidal ideation, hopelessness, can articulate a suicide plan, or other common risk factors associated with suicide attempts a counselor should engage in a more thorough risk assessment (Whiston, 2014). Experiencing rejection by loved ones, harassment, violence, or experiencing high degrees of internalized prejudice are associated with stress and depression for LGBTQ populations (Cox et al., 2010). The suicide risk assessment can also be augmented with questions inviting clients in distress to articulate how their sexuality or gender identity influences their feelings of hopelessness or helplessness. Thinking critically, counselors should not assume that people who are not exclusively heterosexual or cisgender always experience their sexualities, relationships, and gender identities as impinging on their abilities to cope with suicidal ideation. Counselors should seek to help clients reclaim moments where their successful negotiation of heterosexism, cisgender bias, and homo- or trans-

prejudice helped to foster clients' own sense of self-worth, competence, and resilience.

Intimate Partner Abuse

Intimate partner abuse (IPA), which can include emotional abuse, physical violence, and other means of domination and control, affects the relationships of LGBTQ people at comparable rates to heterosexual and cisgender people (Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011). LGBTQ people face added obstacles to care and problem resolution when experiencing IPA, including overt and covert forms of discrimination and prejudice (Ford, Slavin, Hilton, & Holt, 2013). One specific stressor identified in the literature involves fear of having their sexuality, relationship status, or transgender identity involuntarily disclosed (Ard & Makadon, 2011). Personnel involved in IPA response and prevention may not consider the relationships of LGBTQ people to be valid or may hold other prejudicial beliefs such as viewing IPA as a phenomenon that only occurs between heterosexual partners where the male is the perpetrator and the female is the victim (Ard & Makadon, 2011). This rigid or stereotyped view of IPA may be inculcated into the culture of an agency, resulting in further marginalization of LGBTQ people (Ford et al., 2013). Screening for IPA with LGBTQ clients may also be more difficult as identifying the perpetrator and the victim in abusive situations can be less clear (Carvalho et al., 2011). Negotiating other sources of minority stress due to their sexual and relational orientation(s) or gender identities, including past experiences of violence, further compounds access to care for LGBT people (Carvalho et al., 2011).

Screening for IPA among those seeking professional help is a common yet controversial standard of practice (Rabin, Jennings, Campbell, & Bair-Merritt, 2009), and to date few screening tools have been validated for use with LGBTQ clients specifically (Ford et al., 2013). Counselors that have sensitively documented clients' sexual and relational orientation(s) and/or gender identities should broach the topic of IPA (Ford et al., 2013). Commonly used screening tools include the Hurt, Insult, Threaten, and Scream (HITS) protocol (Sherin, Sinacore, Li, Zitter, & Shakil, 1998), the Women Abuse Screening Tool (WAST; Brown, Lent, Brett, Sas, & Pederson, 1996), and the Partner Violence Screen (PVS; Feldhaus et al., 1997). Each tool has strengths and weaknesses; the WAST has superior psychometric properties compared to the HITS and PVS but has not been validated for use with male or transgender-identified people (Rabin et al., 2009). The PVS has been validated for use with cisgender males and females and with individuals from Anglo German, Latino, and African American heritages; however, the PVS has not been validated for use with transgender populations (Rabin et al., 2009). Counselors working with lesbian or bisexual women may consider using the WAST due to its more robust psychometric properties with these

groups. Given that the HITS protocol has a complex scoring method, counselors may want to use the three-item PVS to help broach the topic of IPA, and follow-up a positive response to any item with a more detailed IPA assessment.

Alcohol and Other Drug Use

Research on rates of problematic substance use among LGBTQ populations is contradictory, with some studies indicating that rates are higher than the general population whereas other studies find equivalent rates (IOM, 2011). Research on this topic suffers from oversampling of individuals at bars and clubs known as local hubs for the LGBTQ population (IOM, 2011) and often fail to account for factors such as minority stress or internalized homo- or trans-prejudice. One measure for screening alcohol abuse, and that has been validated with diverse populations (but not LGBTQ people per se) is the CAGE protocol (for cut down, angry, guilty, or eye-opener) (Dhalla & Kopec, 2007). Reisner, Mimiaga, Mayer, Tinsley, and Safren (2008) reported an internal consistency value of .69 with a small sample of men who have sex with other men (MSM). This value is lower than commonly reported consistency estimates for the CAGE (Dhalla & Kopec, 2007) but indicates that the CAGE has some reliability as a measure for use with MSM. The CAGE is also limited due to underperforming as a tool for screening severe alcohol use, and for lack of sensitivity to problem drinking with women. The 10-item Alcohol Use Disorders Identification Test (AUDIT) performs better as a brief screen for severe forms of problem drinking and has better reliability and validity evidence for use with women. Broyles, Gordon, Sereika, Ryan, and Erlen (2011) found in their instrument validation study that responses to a brief, 3 question version of the AUDIT (the AUDIT-C) could predict antiretroviral treatment (ART) adherence in a diverse sample that included MSM men. Although noteworthy for including MSM as part of their validation study, variables associated with LGBTQ health outcomes such as internalized homoprejudice were not factored into consideration.

One of the most widely used screening tools for alcohol and other drug abuse is the Substance Abuse Subtle Screening Inventory-3 (SASS-3I), a 93-item scale validated for use with clinical and nonclinical populations (Laux, Piazza, Salyers, & Roseman, 2012; Lazowski, Miller, Boye, & Miller, 1998). The SASSI-3 contains both theoretically derived and empirically derived items, which increases the ability of this scale to detect problematic substance use issues with clients that may be in denial about their problematic usage (Laux et al., 2012). Unlike the CAGE or AUDIT, the SASSI-3 is valid for screening for other drug abuse along with alcohol abuse (Lazowski et al., 1998), making it more versatile with populations with higher rates of other drug use such as crystal methamphetamine. Using the framework proposed by Chernin et al.

(1997) the SASSI-3 could be viewed as an exemplary heteronormative and cisgender bias neutral assessment, however it has also not been expressly validated for use with LGBTQ populations and may conflate internalized prejudice, minority stress, and substance abuse risk. A brief screening tool like the AUDIT-C could be integrated into initial assessment with members of LGBTQ communities, and positive indicators could be followed up with a longer measure like the SASSI-3. Validation studies with LGBTQ clients for gender and sexuality diversity blind screening tools like the CAGE or AUDIT-C are needed.

FUTURE DIRECTIONS

Standardized biopsychosocial assessment interviews should be modified to better serve the purpose of accurately and critically documenting issues, problems, and strengths that LGBTQ clients may present with for counseling. Revising intake documentation with a critical lens helps to subvert tacit heteronormative and cisgender biases, such as adherence to binary modes of self-identification or the conflation of biological sex, gender role, and gender identity. Broaching conversations about sexuality, gender identity, and demonstration of an open and affirming attitude to client self-identification and to complex experiences of identity, behavior, attraction, and expression, help clients to gauge their counselors' subjective comfort with and acceptance of gender and sexuality diversity. Incorporating affirming dialogue on gender and sexuality diversity, and reviewing intake documentation to make it more inclusive and affirming, helps to mitigate omission and representational biases that impact the ability of client to find counselors competent for work with LGBTQ clients.

Although brief tools that are neutral to issues of sexual orientation and gender identity can be found and incorporated into critically-aware assessment practices, scholars need to validate these instruments with the various LGBTQ populations. Researchers should also consider developing tools normed specifically with these stakeholder and client groups and that rely on inquiry designed to create rich and authentic depictions of lived experiences represented by LGBTQ individuals and communities. Assessment and screening practices should help document ranges of functioning beyond simple categorization or diagnostic labeling. Scholars could incorporate most of the recommendations for assessment provided in this article into case studies with key informants from LGBTQ groups. Issues of representation are also important considerations for addressing hidden heteronormative and cisgender biases in research and scholarship. Coconstructing the research approach with non-scholar participants, such as is done with action research methods, is a logical development from engaging in scholarship with a critical perspective. Inviting LGBTQ clients to define, document, measure, and

challenge the frames, assumptions, and conclusions attached to a specific research endeavor serve to disrupt the binary expert/subject hierarchy.

This article was developed to support further operationalization of the ALGBTIC competencies, specifically in the domain of assessment. Scholarship on the other competency domains would be a valuable addition to the literature in a similar way as efforts to expand on the multicultural counseling competencies (Arredondo et al., 1996). Program evaluation protocols based on the ALGBTIC competencies (ALGBTIC LGBQQIA Competencies Task Force, 2013) should be designed to assess the impact of training upon practice as interest in providing affirming counseling to LGBTQ people grows. The generalist nature of the ALGBTIC competencies, and the critical epistemology upon which the competencies are based, creates space for further competency development with other groups such as LGBTQ people of color or people who are Intersex. Individual counselors seeking to ally with LGBTQ populations, whether in counseling relationships or as community advocates, need to seek out professional support for mutual encouragement, consultation, and accountability.

Further documentation of the impact of affirming counseling upon the resolution of mental health concerns of LGBTQ clients, their families, and allied communities is still a needed research area. Studies that rely on ecological or environmental assessment are also needed, given more recent findings on the role that oppressive and marginalizing social environments play in the development and health of LGBTQ people (Hatzenbuehler, 2011). Integrating the recommendations detailed in this article should lead counselors to broach the topic of gender and sexuality diversity and to be aware of and to challenge their own heteronormative and cisgender biases. Along with these two practices, counselors can assess how important issues related to gender and sexuality diversity are to clients' presenting concerns, how comfortable clients are with their gender identity and or sexual-relational orientation, and whether clients' experiences of importance and comfort change across contexts such as work, family, or school (Moe et al., 2014).

CONCLUSION

Competency is developed and maintained as a result of education, training, supervised experiences, and continuing exposure to clients within contexts of practice (e.g., schools or agencies). Counselors are ethically responsible to develop general competencies, including in referral, for work with a variety of client types and presenting concerns including the needs of LGBTQ clients (American Counseling Association, 2014). Whether as part of a general scope of service provision, or as a specialist commitment to work with LGBTQ populations, counselors must incorporate critical self-awareness into their assessment practices to subvert tacit or overt biases. Challenging one's own biases can be difficult, especially where counselors are isolated or even

discouraged from developing competence with stigmatized client populations. Addressing biases in assessment and screening requires awareness of how socio-cultural and political dynamics inform the lives of LGBTQ people. Cultivating critical self- and other awareness involves willingness to examine, and to challenge, biases and assumptions that if left unchecked may reinforce heterosexism and transgender prejudice in counseling. Counselors that develop critical awareness will be better prepared to provide sensitive and effective service to LGBTQ clients.

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