Doing Our Homework: Ethical, Clinical, and Personal Considerations in the Context of Working within Gender and Sexual Communities

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Small communities may be both geographically defined (e.g., small towns, rural areas) and/or culturally defined (e.g., disability, military, faith-based, professional, recovery, gender, sexual, and ethnic communities). Characteristics of small culturally defined communities include shared values, interests, or sets of experiences that connect its members. The challenges of working in small, culturally defined communities are numerous and include concerns and, at times, conundrums regarding healthy boundaries, issues of competence, and awareness of cultural/community expectations and mores (Schank, Helbok, Haldeman, & Gallardo, 2010).

A clinician may be a member of one or several small communities and may be faced with finding ways to navigate a professional role and simultaneous need for community support and connection. For example, a Buddhist lesbian psychologist may be faced with providing psychotherapy to lesbian clients who have recently joined and attend the only small Buddhist temple in the community. A psychologist may identify strongly with a small community but have little expertise in the form of clinical training to work with this group. For example, a transgender psychologist may have personal and cultural awareness of his, her, or their own process but may have received limited clinical experience, supervision, and training to work with a current trans-identified client. When engaging in the process of balancing these situations, it is essential to explore the ethical principles that guide our practices as psychologists.

In reviewing our *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2010) there are several ethical principles that are relevant in the context of working within the bounds of small cultural communities. These include standards reflecting multiple relationships, avoidance of harm, competence, confidentiality, and conflicts of interest. Ethical Standard 3.05: Multiple Relationships advises avoiding multiple relationships if "the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists." However, it also makes the following exception: "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical." Standard 3.04: Avoiding Harm is inherent in our work, as we are to "take reasonable steps to avoid harming clients/patients…and to minimize harm where it is foreseeable and unavoidable…."

In considering these two standards, imagine you are a gay male psychologist who is an active, long-standing member of the gay men's chorus. Your new client, who recently relocated to your city, shares his readiness and desire to connect within other gay men in ways that he feels comfortable with, namely, joining the gay men's chorus, the one that has been so valuable to you. He reports he was an active member of the gay men's chorus in his city, and believes joining the chorus now will help him develop community here and help him feel less isolated. You have several issues to consider at this juncture as you review these standards. Do you relinquish your community connection so that your client can develop his community support in the chorus? Do you discuss and establish specific boundaries that allow you both to enjoy the community that the chorus provides? Will you obtain consultation to help you consider options before addressing this issue with your client? How do you discern what is exploitative in this situation? Can you successfully maintain confidentiality, and ensure that your client receives excellent care therapeutically? This scenario highlights the tensions and opportunities for growth that arise in navigating small communities and the importance of addressing and re-visiting these types of issues.

In addition to our enforceable, ethical standards, we are also guided by aspirational principles, including Principle E: Respect for People's Rights and Dignity, which states that "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination." It states that we are to be conscious of and "respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status" in the work that we provide and asks us to "try to eliminate the effect on [our] work of biases based on those factors."

As a clinician interested in working with gender and sexually diverse communities, it is necessary to consider several clinical competency factors, namely, knowledge of group diversity, cohort variability, awareness of personal bias, and ongoing awareness of political/societal shifts that affect these

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communities. With regard to within-group diversity, sexual orientation includes, but is not limited to, gay men, lesbian, questioning, bisexual, queer, and pansexual identities. Similarly, gender identity encompasses a variety of diverse groups (e.g., binary transgender identities, genderqueer, gender non-conforming, non-gendered). Learning about each of these sexual and gender identities is essential and this learning needs to include information about the historical and social cohort from which each client originated and any disenfranchisement he, she, or they may have endured or continue to experience based on their sexual or gender identities. For example, a client who came out as trans at age 49 in 2015 may have a very different experience of community support, consciousness about gender identity diversity, familial/societal recognition, safety, and awareness of resources than a client who came out as their 15-year-old trans counterpart in the same year.

Membership in one of these gender or sexual identity communities does not inherently limit bias in our work or exempt us from ongoing clinical training and personal growth in the form of supervision, consultation, or psychotherapy in this area. Bias in the form of assumption or over-identification runs the risk of blinding us in ways that may exploit or do disservice to the client and impair the therapeutic relationship. Knowing the bounds of competency includes further recognizing that sexual orientation is not the same as gender identity, and having competence in working with sexual orientation diversity does not guarantee competence in working with gender identity diversity and vice versa.

When therapeutically engaging with these two diverse cultural communities, it is important to consider the requests you might receive from a client from these populations, your professional and cultural values regarding these requests, and whether you are competent to provide the kind of support needed. Possible requests include being a character witness in a same-sex adoption proceeding, providing a letter for transition surgery (a.k.a. gender affirming surgery), receiving an invitation to a small pre-LGBTQQ Pride gathering where your client was also invited, or being asked to attend the wedding of your long-term gay couple for whom you have been the only essential, confirming role model.

In doing your homework around developing competence in working with sexual and gender communities, you might consider the following questions: If I have an interest in working within a small community, why might I not follow through? Are my fears of offending someone getting in the way of my decision to work with gender and sexually diverse communities? Do I feel I might be incapable of working within this diverse community because I am not one of its members? Or, do I fear being dismissed as a valid provider of services to that community? Does my informed consent document imply a higher level of competency with gender and sexual identity communities than I actually possess? Does the way I present myself on my website accurately represent my level of knowledge in working with these groups? How do I appropriately yet humanely navigate shared social contexts with my clients? Is there something that is keeping me from doing my homework around developing competence in working with these small communities?

As clinicians we intentionally work to create compassionate, safe, healing, and productive therapeutic connections with our clients. Working with sexual and gender small communities affords an opportunity to continually stretch and develop ourselves ethically, clinically, and personally.

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