

Group therapy with international LGBTQ+ clients at the intersection of multiple minority status

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Members of sexual/gender minority groups, who are also immigrants and refugees face multiple problems in adapting to their new cultures. Often their sexual interests or gender expression was stigmatised, pathologised, criminalised and persecuted in their home cultures/countries. In this article, we discuss the special problems with acculturation to their new cultures faced by such individuals in a North American milieu. They are at the intersection of multiple minority identities (i.e. ethnic, racial, religious, immigrant, refugee). We provide a model of group therapy for international LGBTQ+ clients who have been persecuted for their sexual/gender minority expressions. Clinical, professional and ethical considerations are explored for dealing with international sexual/gender minority clients in therapy. The conclusion includes recommendations for professional development and for broadening the sphere of knowledge and training in the field.

Keywords: Immigrant; refugee; sexual minority; acculturation; group therapy.

HOW DO IMMIGRANTS who are members of sexual minority groups deal with their desires for sexual and gender expression when their interests have been stigmatised, pathologised, and in some cases even criminalised by the home cultures/countries in which they were raised? How can we support LGBTQ+ clients who have been persecuted in their countries of origin because of their sexual desires and/or gender variant expressions? How can therapists help clients who have been and often continue to be multiply marginalised by virtue of their status at the intersection of sexual/gender minority, immigrant, and ethnic/cultural minority status in the North American context?

In this article, we reflect on dealing with international, LGBTQ+ clients. We then provide a model of group therapy for clients who have been persecuted in their native countries for their sexual/gender minority expressions and who now have other, multiple minority identities, (i.e. ethnic, racial, religious, immigrant, refugee). We intro-

duce clinical, professional and ethical considerations for dealing with international sexual/gender minority clients in therapy. We conclude with recommendations for professional development and for broadening the sphere of knowledge in the field.

We argue that therapists need to be aware of multiple cultural literacy issues when working with LGBTQ+ clients who are immigrants and refugees from persecution based on their sexuality/gender. Unfortunately, most mental health professionals still have minimal training in dealing with sexuality, let alone with sexual and gender minority concerns (Kleinplatz, 2012; Miller & Byers, 2010). Even more so, therapists and counselors are ill-equipped to work with LGBTQ+ clients who come to North America following victimisation in their homelands and having been forced or chose to flee. In order to be of assistance to such individuals in therapy, we will need to develop awareness of the manifold challenges facing our clients.

When sexual minority clients seek psychotherapy/clinical services, the professional needs to be able to grasp the connections, if any, among the presenting problems, the cultural context in which the individual was raised and the client's new cultural setting. Clinicians need to develop a broad and culturally competent understanding of the range and manifestations of sexual expressions rather than relying on simplistic catalogues of behaviour. Cultural literacy is an important concept in both clinical ethics and acumen (American Psychological Association, 2003, 2006; Ribner, 2012) and is especially pertinent in this situation. In order to work effectively with international sexual/gender minority refugee clients, therapists will need dual or multiple varieties of cultural competence and literacy as they pertain to various sexual/gender variant subcultures as well as familiarity with the 'normative' dominant cultures of origin of our clients.

Interpretations of sexual expressions often vary according to one's sex, gender, culture of origin, current culture, ethnicity, race, religion, etc. Nuances of sexual expressions that may seem meaningless or irrelevant to some clients can hold significant meaning, value or impact for the individual depending on the milieu. For example, regardless of the man's own identification, the sexual behaviour of men who adopt 'active' or 'passive' roles during sex between men will be interpreted differently based on the cultural characteristics of the participants, their partners and others: Some studies have found that Latino gay and bisexual men may assign different gender roles, meanings and sometimes stigma to same-sex sexual contact and behaviour as compared to North American gay and bisexual men (Carballo-Diéguez et al., 2004; Finlinson et al., 2006; Jeffries, 2009) which may or may not shift after immigration (Carrillo & Fontdevila, 2014). Similarly, sexual expressions can be interpreted differently by the clinician, based on the clinician's own theoretical biases, gender,

culture, sexual orientation, ethnicity, race, religion, etc. Sometimes bias is obvious, but sometimes subtle or veiled judgments are present. For example, gay men in stable, monogamous relationships are often presumed 'healthier' than those with other relationship styles (Parsons et al., 2013); mental health professionals often believe that practitioners of BDSM (bondage and discipline, dominance and submission, and sado-masochism) 'must be victims' of child abuse (Kolmes, Stock & Moser, 2006).

How are therapists to deal with clients at the intersection of these multiple minority statuses and what can mental health professionals learn from our clinical experience, described below, for their own work with LGBTQ+ clients, across different settings? First, it is helpful for therapists and other professionals to learn about the meanings of sexual and gender minority expressions in clients' countries of origin, how other immigrants have resolved conflicts while in North America and the clients' desires and options for sexual expression in the new culture. Second, therapists must consider and ask themselves what roles they wish to assume in relation to disadvantaged clients.

In all clinical work, we recognise that therapy is characterised inherently by power differentials (Brown, 2004; Pope, Sonne & Greene, 2006). The discrepancies in our roles become all the more crucial in dealing with clients who have literally been exiled from their communities due to their sexuality/gender. Therapists must consider whether the role of alleged, clinical neutrality is helpful or harmful to clients who might benefit from our advocacy. In the paradigm presented below, we choose to provide information, resources and concrete support to clients in order to assist them in navigating multiple barriers to safety. For example, clients need information as to securing income, housing, medical care, food, clothes and legal counsel. Rather than denying our power differential, in our group, we acknowledge and use it to empower our clients. We are aware of the

peril of disavowing or silently denying the reality that refugees – especially sexual/gender minority refugees – may perceive us as gatekeepers. Providing supporting documentation to complete clients' immigration applications may be an appropriate and essential service to our clients. We choose to address our positions and how we can use them to empower our clients to help themselves. It is up to individual professionals to determine what role(s) they choose to assume given the power differentials of the clinical/counseling relationship. Our experience suggests that each therapist must grapple with this concern before working with clients at the intersection of multiple minority status. Issues of privilege surface, for example, in dealing with the coming out process.

Since homosexuality was removed from the *DSM* in 1973 (APA, 1980), North American clinicians have been implicitly encouraging clients to come out to themselves, their friends and families, co-workers, etc. However, paradoxically, this may not necessarily be in the best interests of these clients. In our group paradigm, we remain ever vigilant to be respectful of the choices made by our clients. As clinicians, our first impulses are to respect the client's own readiness to acknowledge their own sexual/gender expressions. Psychologically, it is important to help clients sort through the many layers of identity and behavioural expressions of their LGBTQ+ inclinations and to come out as they wish. Unfortunately, for refugee Canadians this wish remains a luxury. The very same individuals who were forced to flee their homes and families upon being 'caught' in forbidden sexual relations are now required to identify publically as sexual or gender minorities in order to qualify before a board of inquiry for refugee and citizenship status. They are typically torn by conflicting emotional allegiances to self-determination and freedom even when their public disclosures might have adverse consequences for family and partners left behind. Alternately, mere suspicions on the part of

family and neighbours may now be confirmed such that these clients can never return to their loved ones for fear of further ostracism, danger and retribution, whether to or from their families. In fact, the price of their freedoms may place their loved ones who remain in their home countries in significant danger. North American therapists should temper their beliefs in the value of openness and authenticity, considering the consequences of these options for these individuals. Moral neutrality is not a realistic option in dealing with clients facing such dilemmas. These considerations may be worth pondering not only for therapists dealing with sexual minorities from Africa or Middle-Eastern countries but also those from rural Alberta or Alabama.

North American LGBTQ+ communities pride themselves on featuring sexual diversity and, therefore, often value a sense of belonging. Paradoxically, what becomes salient rather quickly is the monolithic nature of the LGBTQ+ world, as perceived by people who feel conspicuously alien. What emerges is not a sense of belonging to a diverse community – on the contrary, it is a sense of the monolithic nature of the sexual minority world and a new and different sense of being 'other', again. For example, LGBTQ+ immigrants in our group (below) are startled by the assumption that they have the option or are even expected to or look for new partners online. In their countries, meeting people or potential partners takes place by happenstance or may be arranged secretly by disguised members of the LGBTQ+ community. Some had no access to the Internet in their home countries because such services are not available or due to poverty. In these countries, many are fearful to even consider going online to find partners because these sites are under scrutiny by government officials. Furthermore, online and real life norms in North American LGBTQ+ cultures, particularly in the gay world, include an emphasis on body image (Morrison, Morrison & Sager, 2004; Nichols, 2014; Tucker 1998). These new norms con-

flict with previously acquired values, which may include modesty, privacy and valuing of the whole person rather than his or her appearance when choosing a partner.

In practice, this conflict means that being true to themselves may entail a sense of alienation rather than belonging. Precisely the clients that we might hope could draw strength from a gay identity in gay community feel disenfranchised by racism. For example, Black men who have come to Canada to escape persecution based on sexual minority status now encounter racist assumptions about their penis size, skin colour, alleged aggressiveness and the assumption that they always want sex (Wilson et al., 2009). That is, they encounter multiple oppression where least expected.

This problem of multiple sources of oppression follows LGBTQ+ immigrants in society at large as well as within therapy (Greene, 1997). In communities of their fellow immigrants, they fear prejudice and reprisals upon coming out because of their LGBTQ+ status; in LGBTQ+ communities they fear discrimination due to their ethnic and racial minority status. For therapists, navigating through the intersectionality of multiple sources of oppression requires interrogating one's own assumptions about sexuality, gender, and ethnicity. The clients' reconstruction of healthy sexuality from within their own frames of reference will require therapists' own capacities for sensitivity and empathy, even or especially when they do not correspond to our own world views. Therapists who are dealing with LGBTQ+ clients who have recently come out to themselves must be prepared to encounter the concept of sexual orientation and its cross-cultural meanings. For many clients whose worldviews come from outside white-Eurocentric traditions, homosexuality is considered the transmissible 'White disease' presumably contracted via sexual contact with Caucasians. Many in our group report their families' admonitions about continuing along this path and their recommendations that the client seek out treat-

ment, for example, antibiotics to 'cure their homosexuality' or if necessary, psychiatric help. Clients recognise the prejudice against them but this intellectual awareness does not prevent internalised homophobia. The job of therapy in this instance is to inquire and deconstruct this package of beliefs and their impact upon clients (Pope, Sonne & Greene, 2006). It is often difficult to balance respect for the clients and the norms and values which characterise their upbringing while simultaneously challenging the notion of sexual or gender variations as necessarily immoral, criminal or pathological. Here, our goal is to support clients in reconstructing a narrative of healthy sexuality, which fits them and their values while observing aloud that this is a difficult process.

A considerable amount of our work in group therapy consists of processing trauma and grief. Some losses can never be overcome. If this picture seems dismal, it can be, although it can also be deeply meaningful and ultimately rewarding. As therapists, we are trained to refrain from rather than to dwell in sorrow. Conspicuously, the *DSM-5* (APA, 2013) has decreed that we are to treat depression two weeks after a major loss rather than allowing for six months of mourning upon of a death of a loved one as permitted in previous editions of the *DSM*. That is the 'grief exclusion' for depression upon of the death of a loved one has been eliminated (APA, 2013). The implications for those who have suffered multiple, traumatic losses (e.g. family, culture, home, belongings, identity, language, health, safety) include the sense of being utterly misunderstood and their lived experiences distorted, including sometimes by therapists. Diagnosing these clients who exhibit symptoms of trauma due to their experiences, with PTSD is a beginning (please note that not all clients in this cohort suffer from PTSD. Some resilient individuals do not meet criteria for PTSD even after a traumatic experience). Nevertheless, for those clients affected, it is not enough to create the space for sheer sorrow and loss, that is, for grief.

Although therapists may be able to provide useful coping skills for dealing with flashbacks, nightmares, and phobic reactions, it is crucial that we not add to their existential aloneness by insisting that they cheer up, accept our reframes or find the positive in their stories (Stolorow, 2007). It is often difficult for therapists to simply be present and to receive clients' stories of unending pain but it may provide the most authentic avenue towards healing.

Therapy often involves unpacking and validating clients' experiences by facilitating emotional expression surrounding the conflict among sexuality, gender, cultural values, race, religion, language and socioeconomic status. Clients are gently encouraged to turn inward to deal with their emerging feelings. Therapy can create a safe environment in which clients can process their losses, integrate their impact and choose new directions, sexual and otherwise.

Therapy at the margins: Counselling LGBTQ+ clients with multiple minority status

Our work focuses on clients whose sexuality has been marginalised. Sometimes they identify as members of sexual/gender minority groups though in other cases, it is their sexual expression which has been most salient to them, regardless of identity status. Many of them have sought out counselling/therapy precisely in order to deal with their desires for sexual or gender expressions which have been pathologised, criminalised or otherwise persecuted within their communities of origin and painfully, too often, within their families of origin. As health professionals, we regard our clinical work as encompassing not only trauma-informed 'treatment' but advocacy on the part of those who have been silenced because of their sexuality. We have worked with the broad spectrum of sexual expressions and recognise the importance of situating this work in our own sociocultural and professional contexts. We live in Ottawa, Canada (MN and PK) and in San Francisco

(CM). Among us, we speak seven languages and were each born in a different country.

The bulk of the remainder of this article will illustrate the work of the first author (MN) with LGBTQ+ clients who are new immigrants, refugees and who seek asylum in Canada. Canada is among the few countries in which sexual minority status is protected by the constitution, that is, the Canadian Charter of Rights and Freedoms (1984). Gay marriage has been legal since 2005. Our immigration board affirms that people may seek refuge based on persecution of sexual and gender minorities in their homelands (e.g. Cambodia, Uganda, Zimbabwe, Cameroun, Iran, Lebanon, Saudi Arabia, Nigeria). As the capital of Canada, an officially bilingual (i.e. French and English) country, Ottawa is a heterogeneous city with many recent immigrants. There is a diverse but small LGBTQ+ village in the downtown core.

Group therapy for LGBTQ+ refugee clients in a community health care setting

It is in this relatively liberal context that this work is situated. I (MN) co-facilitate a group for sexual/gender minority immigrants, refugees and asylum seekers in a community health center in Ottawa. The group is government-funded and free of charge for its participants. My co-facilitator, who is a social worker, and I speak four languages (English, French, Arabic and Armenian) and the group switches among languages as desired by participants. It is an interpersonal, trauma-informed, strength-based approach to therapy. Therapy is focused around potentials and resiliency factors of clients who are dealing with the intersections of sexual, gender, cultural, ethnic and other identities and multiple trauma. The recognition of a lack of counselling services to support LGBTQ+ refugees and immigrants created the impetus to form the group and reach out to this extremely isolated, cohort of refugees. Group sessions are scheduled once per month for two hours. On average, indi-

viduals participate in the group for five to 10 sessions. Outreach is conducted via flyers, social media, word-of-mouth and community engagement.

Participants originate from countries in Africa, the Middle East, Asia and South America. They speak English, French or Arabic. This open group has been active since January 2014, and we have had 25 diverse clients, ranging from 18 to 60 years of age. On average, individuals attend the group for five to 10 sessions. The majority identify as gay men, plus there are also a few lesbians and trans people. An average of eight participants attend each group session. For additional support, participants have access to individual therapy and coaching to present their cases to the Canadian Immigration and Refugee Board (IRB). To date, 15 participants have accessed to individual therapy sessions with MN. Our goals include making it safe to speak about the previously forbidden and to create a welcoming environment for participants. Each of the participants has been threatened, humiliated, abused, subject to verbal, physical and sexual harassment, including torture and imprisonment based solely on their sexual expressions – or merely the desire to express their sexuality/gender, in environments where such expression might have been grounds for execution. Presenting problems vary amongst group members. The focus of each session is participant generated and thus dependent on who attends a given session on a particular day. Most focus around difficulties and complications related to coming out processes at the intersection of LGBTQ+, ethnic, cultural, immigrant, refugee and other minority status. Other sessions centre on grief; feelings of isolation and rejection due to nonconformity with North American models of being gay, lesbian, bisexual and trans; and difficulties finding cultural communities. Participants share difficulties experienced with immigration and barriers to access to social justice. Some sessions have focussed on ‘diseased’ sexuality, discrimination, privileges and trauma.

Many ethnic minority clients come from countries where accessing psychological services is stigmatised. In this instance, LGBTQ+ refugees and asylum seekers of colour have no choice but to access these services to satisfy the requirements of their refugee applications. They may feel forced to attend mental health services without any justification or explanation given to them by the government. In my practice with this population, the stigma around mental health services is discussed and usually focuses on the context in which clients have internalised feelings of fear, shame and avoidance towards mental health services. Our job is to validate these feelings while also educating clients about therapy processes. I reflect with the clients on their personal narratives and sociocultural values concerning mental health. Furthermore, I describe the nature of the relationship between clients and therapists, as well as, the purpose of having such services in North America.

Sessions usually begin with a review of group norms and guidelines, established by participants, including the importance of confidentiality, privacy, and respecting differences. The session is divided into three phases: checking-in, middle phase, and checking-out. During checking-in, clients are encouraged to introduce themselves, using the desired pronouns, that is, he/she/they, and to share a story experienced during the week. The middle phase usually is focused on support, and maintains a ‘here-and-now’ focus. Finally, checking-out is focused on sharing outcomes of therapy and on newly acquired skills. For example, clients are encouraged to report what they are taking away from the session.

A case scenario: Excerpt from the middle phase of a group therapy session

In a particular session, questions were raised about the dominant discourses of coming out in North America, that is, what does it mean to ‘come out’? How might it fit for people from different cultures? What impact might

this discourse have on people with multiple minority status? Group members described feeling loss, isolation and confusion about the 'right' way to come out. They expressed dismay over the lack of role models from their countries of origin to guide them in the process of coming out. They voiced their disappointments about losing their cultural identities if they chose to fit into predominant coming out scripts. They felt pressured, whether directly or indirectly, by the LGBTQ+ community in Ottawa to look and act in certain ways to fit in and in order to feel a sense of belonging. They indicated that the price of conventionality would jeopardise their values and beliefs regarding dating, disclosing their orientations, and feeling pride about being part of the LGBTQ+ community. Being conventional would save them from isolation and loneliness – but at a price. Trans participants reported feeling doubly isolated because of the stigma attached to being trans people of colour, and the lack of coming out scripts for trans people.

Group cohesion helped to provide a safe space for members to share their feelings of isolation and loneliness. Despite individual differences in trauma experience and unique narratives of survival, mutual acceptance and respect provided the required atmosphere of trust and belonging to permit exposure of vulnerabilities. The group dynamic allowed members to validate the shared feelings of isolation and loneliness. For example, members appeared attuned to each other's experiences, exhibiting mutual empathy, compassion and encouragement. Participants moved from being active observers to active supporters. This transition was an important milestone in the group process because it helped participants shift the tone of the interaction, which became softer and less volatile. Members thereby added to their growing capacities to cope with feelings of isolation and loneliness. To activate this shift, my co-leader and I asked participants to identify and share what strengths they rely on to continue coping with their circumstances in Ottawa.

As a gay person of colour and immigrant, I can relate to the sense of loneliness and isolation. North American discourses of coming out are not usually inclusive towards other cultural communities and do not consider the additional stress of immigration processes of LGBTQ+ people of colour. As a multiple minority person, I have re-evaluated my own values and belief systems and have adopted a Canadian way of being a gay man. I feel I have been fully acculturated into Canadian society. As a therapist, I have had to be cautious not to project my views of acculturation onto group participants by minimising their experiences related to coming out and feelings of isolation. I have had to be careful so that clients could express their needs and desires without feeling judged yet again, but this time by the therapist.

Sharing stories of strengths and resiliency was beneficial to many participants but not to all members. The session ended with diverse opinions regarding the outcomes of such sharing. A consensus emerged around applying their new skills to future experiences.

Ethical, professional and clinical considerations in dealing with clients' of multiple minority status

Clinical work with sexual minority clients requires de-centering from the therapist's own sexuality and welcoming others' sexual expressions through clients' own lenses. The open acknowledgement of diverse sexual expressions requires cultural literacy on behalf of the therapist. Cultural competence is doubly important when clients are at the intersection of multiple minority status. For my clients being a member of a sexual minority group is at the nexus of their identities in ethnic, racial, sociopolitical and/or religious minority groups. (Other refugees may have a different primary identity, but sex, sexuality and gender identity should not be forgotten). Some individuals present expressing distress or dissatisfaction over their sexual expressions. They are in conflict

with either their social, cultural and/or religious values or norms, or they may have learned that there is a 'right' way to be sexual or to express sexuality. Culture shapes identities, sexualities, sexual scripts, and sexual boundaries of individuals within a given context (Mahay, Laumann & Michaels, 2000; McGoldrick, Loonan & Wohlsifer, 2007). One's sexual expressions often reflect socially constructed sexual norms as well as individual beliefs and preferences, which do not always mirror those instilled by the society. However, many sexual minority people who are also members of ethnic minority groups face the conflict of maintaining a sense of belonging and visibility in both their ethnic and sexual minority communities. Many LGBTQ+ people of colour experience a sense of isolation because they face homophobia in their 'home' community and simultaneously, discrimination in the gay communities (Greene, 1997). The sting of this set of rejections or multiple threats thereof is doubly painful and bitterly ironic for those who hold multiple minority status.

It is important that therapists appreciate the extent to which members of sexual minority groups struggle to gain social acceptance and civil rights internationally, at home and abroad. Some are blocked in the struggle, while others, for example, have gained the legal right to marry. Knowledge of the regional political development allows facilitation of better relationship dynamic between therapist and clients. The endemic disapproval of sexual minorities continues globally. Many countries in the Middle East and Africa criminalise homosexuality (Ungar, 2002). Often, the death penalty is used to punish offending individuals in some Middle-Eastern and African countries (Itabrahay & Zhu, 2013).

Many immigrant LGBTQ+ clients have accepted the messages conveyed by family, media, religious institutions, etc., in their cultures of origin that if they could relinquish their sexual/gender proclivities and instead, accept normative sex, their problems would vanish. It is crucial to view clients

as experts in their own sexuality. In so doing, we empower them to delve into exploring and questioning their own sexual values, attitudes, and emotions. We simultaneously help to create a trusting and non-judgmental therapeutic atmosphere. Although clinicians may be uncomfortable, skeptical or even overly confident about their understanding of the full range of sexual expressions, clinicians have professional and ethical obligations to be familiar with sexual diversity.

Working with clients who identify as LGBTQ+, kinky (i.e. who have non-standard sexual interests), or who engage in consensually non-monogamous relationships and other variant sexual/gender expressions requires that therapists go beyond our own backgrounds, training and comfort zones to develop cultural competence and literacy. Graduate schools rarely even acquaint mental health professionals with the vocabulary to communicate effectively with sexual minority clients. It is incumbent upon the professional and not the client to provide the knowledge of sexuality *per se* and atypical sexual expressions required to be comfortable and skillful therapists. Therapists should undertake continuing education and supervision to heighten cultural competence and to learn new skills to supplement clinical work. For example, to foster cultural literacy, clinicians should attempt to be familiar with the terms used commonly among LGBTQ+, consensually nonmonogamous, and kink communities (Moser, 1999). We need to learn about professional blind-spots so that we can focus on the clinical needs of sexual minority members. Strikingly, although there is a burgeoning literature on LGBTQ+ refugees (e.g. Lewis, 2014; Shuman & Bohmer, 2014; Shuman & Hesford, 2014; White, 2014), it is not to be found within the mental health professional domain.

Increasing didactic knowledge is necessary but not sufficient. Sexual Attitude Reassessment/ Restructuring (SAR), that is, experiential learning designed to help trainees explore 'their own feelings, attitudes, values, and beliefs regarding

human sexuality and sexual behaviour' is a required component in the training of certified sex therapists (AASECT, 2014). Therapists who intend to work with sexual minorities may wish to include a SAR as a component of their professional development, too.

Even more is required of therapists in dealing with clients at the intersection of sexual/gender and other minority status: Understanding of and reflecting upon multiple minority statuses and contextual factors such as race, ethnicity, social class, language, religion, geographical location, sexuality and gender can assist clients in becoming self-aware and feeling empowered (Wynn & West-Olatunji, 2009); strengthen the therapeutic alliance (Nerses & Paré, 2014); and prevent alienation of clients from therapists when the former are most vulnerable (Gitterman, 2001). When therapists validate and normalise the dilemmas inherent in multiple minority statuses, we create a safer atmosphere for self-disclosure, and empower clients to reveal sexual thoughts, feelings and behaviours.

Creating a safer atmosphere for this population is crucial. In reflecting on our experiences with this population, we found the following elements/steps helpful:

1. Discuss openly issues related to racism and oppression with clients.
2. Discuss the stigma surrounding mental health concerns and validate clients' feelings.
3. Therapists must be aware of the terms they utilise when referring to clients' pronouns, names, gender markers and sexuality.
4. Confidentiality of clients. We encourage participants to keep confidential what is shared in the group. We discourage unintentional 'outing' of members particularly if participants with similar ethnicity meet in their ethnic community for different events. We provide a case scenario to the members regarding this issue.
5. Awareness and knowledge of international LGBTQ+ issues. By acknowledging

what takes place in their home countries, we reveal our genuine interests in their stories.

6. Therapists must acknowledge their own, individual privilege and how it may play a role in creating a safer atmosphere for less privileged and marginalised group members.
7. We have received many requests from external community partners, members, or professionals to join our group to witness processes of LGBTQ+ Newcomers and refugees. We are very cautious about these requests and we approach them sensitively. We appreciate their desires to support LGBTQ+ Newcomers and their interests in refugee matters. However, external observers can create a sense of voyeurism and may jeopardise the safety of group processes.

These recommendations are not exhaustive. We also, encourage professionals to reflect on the policies and procedures of their agencies, which address LGBTQ+ newcomers refugees' issues.

Conclusion

The group therapy illustration above suggests several implications for clinical practice. When working with sexual minorities, consider going beyond just treating dysfunction and distress; consider the value of incorporating advocacy into our professional roles. For example, approaches to working with LGBTQ+ immigrants, refugees and asylum seekers must emphasise and facilitate collaboration with other community agencies serving this population.

Expanding knowledge and expertise about working with ethnic sexual minority clients remains a necessary step in creating inclusive practices. We can advocate for a new focus on research which takes into account the effects of marginalisation, oppression, family dynamics, collective identities, and migration on sexual minority individuals who hold multiple minority statuses. In the end, it is up to the individual therapist to attain training and for clinical training

programmes to provide this necessary training. The client should not be expected to train the therapist, though unfortunately, that is too often the case.

Working with diverse clients helps therapists to learn and grow in their clinical work; it is crucial that therapists not rely on clients to teach them and lead the way.

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