Enhancing Cultural Competence:

Welcoming Lesbian, Gay, Bisexual and Transgender Clients in Mental Health Services

A joint project by:
Planned Parenthood Mid-Hudson Valley, Inc.,
Mental Health Association in Ulster County, Inc., and the
University of Maryland Center for Mental Health Services Research
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WELCOME

The Mental Health Association in Ulster County, Inc., and Planned Parenthood Mid-Hudson Valley, Inc. welcome you as you enhance your capacity to serve culturally diverse communities. In this tool kit you will find what you need to improve your cultural competency to better serve lesbian, gay, bisexual and transgender (LGBT) communities. You'll be able to assess where you are in the process of becoming an LGBT-welcoming mental health provider, and move forward to guarantee full citizenship for LGBT clients, volunteers, board and staff.

"The National Mental Health Association envisions a just, humane and healthy society, in which all people are accorded respect, dignity, and the opportunity to achieve their full potential free from stigma and prejudice….Justice demands that every person, regardless of disability and other characteristics such as race, ethnicity, gender, age, economic status or sexual orientation, has the right and responsibilities of full participation in society." *from the National Mental Heath Association's Values*

"…the American Psychiatric Association opposes any psychiatric treatment…which is based on the assumption that homosexuality *per se* is a mental disorder or based on an *a priori* assumption that a patient should change his/her sexual homosexual orientation…" *from the American Psychiatric Association Position Statement on Therapies Focused on Attempts to Change Sexual Orientation*

"The [APA's] Public Interest Policy Unit actively engages in shaping federal policy to promote psychology in the public interest. Issue areas include: …lesbian, gay, bisexual and transgender persons…"

from American Psychological Association's Public Policy Mission Statement

"…[NASW NCLGB responsibility to]…identify ways to eliminate homophobic social work practices…[and to]…promote the development of knowledge, theory and practice as related to gay, lesbian, bisexual [and transgender] issues…"

from the National Association of Social Workers Committee on Lesbian, Gay, Bisexual and Transgender issues

What a gift to be part of a professional network with such a vision! And, each of us has a role in making this vision a reality. Many mental health agencies and practitioners have already made great strides in honoring the diversity of those they serve. You are now about to embark on creating a safe environment for an identity group that continues to suffer severe psychological, social and legal oppression: lesbian, gay, bisexual and transgender (LGBT) people.

EXECUTIVE SUMMARY

In the course of mental health services sexuality is rarely well addressed, even though it is an integral aspect of most people's sense of self. It involves a myriad of emotions, behaviors, values, thoughts, norms, and human interactions. Yet, too often in mental health settings only the negatives are discussed – avoiding sexually transmitted diseases, avoiding exploitation, avoiding unwanted pregnancy. Important as these issues are, they exclude the healthy desire for intimacy, companionship, and relationship. This common oversimplification and marginalization is even more pronounced around marginalized sexual orientations and gender identities.

Most mental health professionals want to help all of their clients develop full healthy lives, including personal identities, relationships, and sexuality. This toolkit is designed to help bridge the gap between our current reality and providers' desire to treat all clients holistically and respectfully, including lesbian, gay, bi and transgender (LGBT) people.

This tool kit is designed to be flexible, so that readers with various interests, needs, and existing knowledge bases can go directly to what they need. The Introduction discusses the four rationales that serve as a basis for this tool kit:

Legal: In many states and smaller jurisdictions (counties, towns) it is illegal to discriminate against people based on their gender or sexual orientation in employment, public accommodations, and other arenas. A few expressly include gender identity (e.g. transgender) as well. Precise legalities vary by jurisdiction, and often include mental health services.

Ethical: Most mental health professional organizations now include sexual orientation and gender in their ethical guidelines, with language that discriminatory or insensitive treatment is unethical, and some specifically include gender identity. (See the previous section and Appendix E for excerpts from several such professional organizations.)

Outcomes: People who feel unsafe or unwelcome in mental health treatment settings are unlikely to develop the trust necessary to form a deep therapeutic alliance. The

stress of navigating unsafe feelings and experiences often results in lack of engagement, retraumatization, and refusal of crucial mental health services.

Cultural Competence: Knowledge of common health-related beliefs, experiences and concerns of LGBT people can help attune professionals to individual treatment needs. Each person's multifaceted identity and unique personal characteristics renders "cook book" approaches to any cultural group insufficient. At its root, cultural competence centers on interacting with others humanely, as unique individuals from various socio-cultural and historical contexts and communities.

The tool kit distinguishes between sexual orientation and gender identity.

Sexual orientation:

- …is distinct from sexual behavior. That is, one's sexual behavior may not match one's orientation – e.g. celibacy, experimentation, or prostitution.
- …is an inherent part of a person's core identity. Our society views heterosexuality as so normative that it is rarely even thought of as a sexual orientation, so that most heterosexuals experience their orientation as a "given," requiring little if any questioning or conscious thought. In contrast much of our society views lesbian, gay and bisexual orientation as abnormal (and even immoral), causing many LGB people to consciously think about and/or question this natural part of their core identity in ways that heterosexuals do not.
- …reflects the complexity of factors that determine to whom one is sexually attracted and with whom one falls in love. One's sexual orientation is not chosen but rather discovered as one moves from infancy through old age.
- …is not a lifestyle (gay, lesbian and bisexual people are as varied as heterosexuals in the type of lives they lead) but rather a deep part of one's self. It can be something one becomes aware of gradually or has always known.
- …is different from gender identity (see below).
- …is a scientific mystery. Sexual orientation is a complex mix of biology, psychology, culture, and many other factors. While there have been many theories and studies, we do not currently know why or how one person ends up identifying as heterosexual while another as bisexual or gay or lesbian.
- …is discriminate. Just as heterosexuals are not attracted to *every person* of the other gender, gay or lesbian people are not attracted to everyone of the

same gender, nor are bisexuals attracted to every one of both genders.

- ▼ …is varied. Some people do not identify with the labels of straight, gay, lesbian, or bi (or queer). They may choose not to label themselves, or may have different ideas/terms. One person's experience of a given orientation may be quite different from another's experience. Sexual orientation can also grow and change over the lifespan.

- ▼ …is currently referred to as lesbian, gay, bisexual, or heterosexual in common parlance. Note that the term "homosexual" is not commonly used in LGBT-positive settings. Historically, the word came into common use as a psychiatric term of pathology – when "homosexuality" was considered a mental illness. Therefore, its negative and judgmental connotations have led to its being disfavored by LGBT communities.

(Appendix C: 1, 3)

Gender Identity:

- ▼ refers to one's inner sense of being female, male, both or neither, which may or may not correspond with their biological gender.
- ▼ *Transgender* is often used as an umbrella term to encompass a range of gender identities, including transsexual, intersex, androgyne/androgynous, cross dresser or transvestite, etc.
- ▼ People who identify as "transgender" are as diverse as people whose biological or assigned gender coincides with their personal inner sense of gender identity.

The section on Mental Health Services and LGBT Identities surveys issues that illuminate how and why LGBT people are often not well served by current mental health services. Common lapses in staff behavior are summarized below.
It is common for mental health staff in various roles to…

…be unprepared and/or unable to have in depth discussions with clients about gender, sexuality;

…absorb and mistakenly apply stereotypes and prejudices in their work;

…ignore that LGBT people are diverse regarding gender, race, culture, class, disabilities etc, and that all of these interact with sexual orientation and gender identities;

…confuse sexual orientation and gender identity;

…assume/believe that a consumer's LGBT identity is a symptom of mental illness, a mental illness *per se,* and/or as indicators of sub-par development;

…assume that sexual orientation/gender identity is a core problem for LGBT clients, but never presume so for heterosexual clients;

…believe that being gay, lesbian, or bisexual is "no big deal," and that a client who wants to talk about it is using it to shy away from their "real" issues;

…constrain a client's exploration and self-discovery by the clinician jumping to his/her <u>own</u> conclusions about what the client's sexual orientation "really is" or "should be" and impressing this view on the client;

…accept prejudices and misinformation leading clinicians to advocate interventions designed to change the client's LGBT identity (e.g. Conversion/ Reparative attempts which have been discredited by major professional organizations);

…hold narrow ideas of how one "should be" LGB, and overtly or covertly pressure clients to conform (there are as many ways of being LGB as there are ways of being heterosexual);

.…use heterosexual patterns as standards for healthy personal and relationship functioning, thereby perceiving LGB people and relationships as *de facto* less healthy where they differ;

…make unwarranted assumptions about a person's values or lifestyle based on myths or stereotypes about LGBT people;

.…<u>positively</u> stereotype LGBT people out of fear of being called homophobic or due to romanticized views, which may pressure clients to hide their distress or pathology, and lead therapists to shy away from clients' problems;

…inquire about clients' sexual lives and history voyeuristically, as an exotic or erotic subject of education or titillation for themselves, rather than as it is relevant to the client's issues.

The history of pathologizing non heterosexual people in mental health settings is reviewed. Simply being "homosexual" deemed one mentally ill according to the American Psychiatric Association's <u>Diagnostic and Statistical Manual of Mental Disorders</u> until 1973, and "ego-dystonic homosexuality" was considered a psychiatric illness until 1987 (Appendix C:19-26). Homosexuality was considered a psychiatric

illness in the International Statistical Classification of Diseases, Ninth Edition (ICD-9) but not the more recent ICD-10.

Many people alive today have experienced decades of "treatment" for "homosexuality" under these earlier designations, and this may continue to affect their attitudes towards mental health care (Appendix C:27-29). A psychiatrist at an LGBT-affirmative inpatient unit said:

▼ It is especially poignant with older clients who have experienced lots of abuse in the mental health system in decades past. They are very very wary about the Mental Health system -- period, and about being out certainly. Usually they are not out at all on the unit, and are reluctant to talk about it openly. I think this is due to years misuse at the hands of the mental health system. In our LGBT support group, elderly gay and lesbian clients have talked about receiving ECT and aversion therapy (electric shocks applied to their genitalia when they respond to same sex erotica). Those with chronic mental illnesses like schizophrenia, for example, talk about not being seen as cured or the exacerbation being seen as in remission because the client "still" maintained an attraction to members of their own sex. (Appendix C: July, 1998.)

Many current mental health professionals were trained prior to 1973, or by people who were trained before that time (Appendix C:30). Some mental health professionals continue to pathologize LGB orientations. Only a few recently educated mental health practitioners still consider homosexuality a mental illness or an inferior "level" of psychological development.

Past psychiatric theory held that "homosexuality" caused mental illness or that mental illness caused "homosexuality" (Appendix C:31). From Evelyn Hooker (Appendix C:32) through more recent history (Appendix C:33-39) scientific research has consistently disproved such theories. Regrettably, prejudices often persist (Appendix C:40-42). LGBT people seeking mental health care continue to encounter mental health providers who consider their sexual orientation and/or gender identity a delusion or a symptom that will "go away" when their mental illnesses are resolved (Appendix C:43), or claim that having a same gender relationship causes or exacerbates clients' mental health problems (Appendix C:28). Pathologization of LGBT orientations/gender identities continues to be debated in prominent professional journals (Appendix C: 44, 45).

One effect of this lingering pathologization of LGBT identities is that LGBT people

have said that they are judged to be mentally healthier by mental health providers if they conform to those providers' idea of conventional (non LGBT) gender presentation in their dress, conversation, and deportment.

Transgender identities themselves are still deemed pathological via the Gender Identity Disorder (GID) diagnoses in the DSM -IV-TR (Appendix C:46, 47). Indeed, being diagnosed with Gender Identity Disorder is usually a prerequisite to gaining access to sexual reassignment surgery or hormones, and to insurance coverage for treatment. Israel and Tarver (Appendix C:48) and others make the point that the "de-pathologization" of transgender identities is making gradual progress in psychiatry and other mental health disciplines, but that it has a long way to go (Appendix C: 49). Some professionals continue to view it a psychosis or delusional system. A 1995/96 survey of 116 LGB consumers aged 18-75, across 36 states (snowball sample) the following experiences were reported (Appendix C:43):

- ▼ Therapist or psychiatrist tried to change or convert you to be straight…..23%
- ▼ Ever been verbally harassed for being lesbian, gay, or bi, by a mental health worker or professional ……… 29%
- ▼ Ever been physically hurt because you are lesbian, gay, or bi, by a mental health worker or professional…….. 10%
- ▼ Ever experienced discrimination or poor treatment in the mental health system because you are lesbian, gay, or bi……64%

The next section offers the means to create and sustain LGBT affirming mental health services. It is helpful to think about various "levels of change" that professionals and agencies can institute regarding service to LGBT clients:

Individual Practitioner:
Take initiative to examine one's own beliefs, attitudes, and behaviors toward LGBT people, and LGBT clients in particular. Honestly decide to change through information, consultation, personal reflection and taking action.

Direct Service Level:
Create daily procedures, tools, and habits in order to deliver mental health services that are LGBT-welcoming and respectful. Reinforce LGBT-affirmative values in employee training, supervision, and evaluation.

Agency Level:
Create agency-wide policies and practices that are non-discriminatory and openly welcome LGBT individuals.

Community Level: Promote LGBT tolerance in one's community and speak out against discrimination and intolerance. Forge relationships with LGBT groups and resources by attending their events, meeting to discuss common interests, supporting their efforts, and sharing resources.

Policy Level:
Support and advocate for LGBT-positive legislation and candidates on local, state, and national levels. Know the status of one's local and state non-discrimination statues regard their in/exclusion of sexual orientation and gender identity, support enforcement if they are included and support their addition if not.

Staff training is central to achieve systemic change. Trainings, seminars, handouts, briefings and "refreshers" could include:

- ▼ What is and is not LGBT friendly language (e.g. using LGBT instead of "homosexual" – see glossary), and asking when one is not sure ("what name do you prefer to be called?")
- ▼ Information about LGBT mental health issues, e.g. non-heterosexual orientations are *not* pathological, though some LGB people do experience depression or anxiety due to the heterosexism they face.
- ▼ Current issues important to the LGBT community that affect your clients, such as local gay-bashing incidents, political races, same sex marriage debates, etc.
- ▼ Updates on clinical information about therapy with LGBT clients (see resources)
- ▼ Pro-active discussions about disrespect or discrimination incidents as they arise, how to handle them, and/or debriefing discussions of recent difficult situations
- ▼ Information about local and other resources useful to staff and clients
- ▼ Examination of common myths and stereotypes, their deleterious effects on all of us, and how to dismantle or resist them.
- ▼ Information about human sexual development, sexuality, sexual orientation and gender identity.
- ▼ Information about the legal, religious and social pressures used to enforce heterosexuality, and the negative impact those forces have on everyone.
- ▼ Strategies regarding how to address the needs of and contain the behavior of

staff and clients who use their negative biases, beliefs and assumptions to inflict physical, psychological, social and/or economic harm on themselves and/or others.

It is also important to incorporate LGBT awareness into *all* education and training programs. For example programs on any topic should not assume heterosexuality among all staff or clients, should occasionally include LGBT people of various back grounds in examples and case studies, and illustrations should acknowledge same-gender relationships.

Because LGBT bias occurs in organizations, problem solving is explored. Daily practices that incorporate knowledge of LGBT people and issues result in an effective process that leads to constructive resolutions. Having policies and procedures in place before an incident occurs simplifies problem solving and makes it more effective.

- ▼ Respectful resolution of problems creates enormous good will. Most LGBT people know that ignorance and bias are impossible to completely avoid, but they look closely at how such incidents are handled.
- ▼ Staff in all roles should use the same management tools to intervene when "unfriendly" behavior towards LGBT clients arises as they would if it were directed toward any other clients. For example: "We have a rule about no disrespectful language in group. That comment was disrespectful towards gay people, so it's not acceptable here."
- ▼ Anti-LGBT comments or behaviors from other clients are often a problem for LGBT people attending mental health programs where clients spend time together (e.g. groups, residential, inpatient, day programs).
- ▼ Policies must apply equitably to lesbian, gay, bisexual, and heterosexual clients. (Such as the rules about relationships, visitors, or displays of affection).

To develop LGBT-affirming therapeutic relationships, mental health providers may want to know…

- τ …that culturally competent practice (including LGBT-affirmative) is an ongoing process, not something that is achieved and then is complete;
- τ …about common prejudices, many of which come from historical and invalid assumptions within mental health professions and U.S. society at large;

- …that LGBT-affirmative staff need not be LGBT themselves to be well informed and avoid heterosexism;

- …that our society is heterosexist;

- …that people, human sexuality, and identities are much more complex than any of the labels we use;

- …that even among staff and clients of similar identities, there may be misunderstandings and friction about LGBT and other issues, which can be food for fruitful discussions;

- …that a LGBT-identified or LGBT-affirmative mental health worker may not be a good match for a LGBT client in other ways;

- …that mental health providers who are LGBT may be able to draw on this commonality in working with LGBT clients, but may also face challenges such as higher expectations, conflicting views or identities, assumed agreement and common prejudices in some LGBT communities about each other;

- …that due to the small size of many LGBT communities, an LGBT provider and an LGBT client may have overlapping social or cultural circles, and may be acquainted with more of each other's associates than a therapy dyad of differing identities or one in which both are heterosexual; and

- …of the tendency of some health-care providers (and some consumers) to view LGBT identities as beleaguered or tragic because of the challenges of living as LGBT and thereby ignore or discount the positive aspects of these identities.

(Sources include Appendix C: 7, 69-71

Mental health providers will find it helpful to know many LGBT people bring the following to their interactions:

- …the effects of their interactions with previous health providers;

- …"hyper vigilance" due to finely tuned self-protective abilities to read subtle signs of others' reactions to people's sexual orientations and/or gender identities. Such skills help people avoid or prepare for embarrassing and dangerous interactions;

- …wariness until they feel assured the clinician is both LGBT-affirmative and able to work with them in other areas (focal problems, culture, class, etc);

- τ …reluctance to let a mental health provider know they are LGBT to avoid possible rejection or intolerant reactions, even if they are comfortable with their identity;

- τ …distress about the discord their identity creates with family members who are not LGBT-affirmative, especially if they rely on family support, come from cultural or personal background that emphasize family harmony, honor, and/or filial loyalty, and/or already experience family conflict around other issues;

- τ …a sense of isolation and a lack of a comfortable community or social network, particularly if they are bisexual or transgender, are people of color, have other stigmatized "differences," and/or don't live near a large metropolitan area;

- τ …conflict or distress about their sexual orientation, due to misinformation, cultural or religious values, and/or internalized negative messages;

- τ …a need to work actively to develop a positive identity (heterosexuals usually do not have to engage so deliberately in their identity development, because they seldom encounter challenges to it);

- τ …concern about stressors resulting from anti-LGBT prejudice, e.g. losing one's job;

- τ …a need to address substance abuse that may or may not be tied to social isolation, stress, or personal conflict related to being LGBT;

- τ … pressures (and joys) unique to same-gender relationships in addition to those common to all relationships. Pressures include a lack of the social sanction, lack of relationship models, pathologization of relationships, and discrimination. Joys include deep degrees of friendship and flexibility, egalitarian roles, creative relationship models, profound intimacy and sexual communication.

(Adapted from Appendix C: 4; 15, 56, 64-72)

The need to "grow courage" to stimulate individual and institutional change is discussed, and concrete strategies to realize change are offered in the final section:

<u>Personal / Individual</u>

- ▼ Clarify your own values, priorities and intentions – passion is powerful.

- ▼ Focus on the fact that what you are seeking is a more just and humane world… you are in the right to be trying to change things.

- ▼ Look for and take advantage of everyday small opportunities to effect change. They add up and don't require as much risk.

- ▼ Accept where things are now, and reflect on where you can make changes and where you cannot. Channel your energy -- what can I do in this situation or to move closer to this distant goal?

- ▼ Don't shy away from failure, examine it and see what can be learned. Be compassionate with yourself and those who tried with you.

- ▼ Take responsibility for being personally offended at injustice when you see it happen, even if you are not a member of the group being mistreated at the moment.

- ▼ If you encounter negative reactions or hostility, acknowledge your feelings rather than denying them. Try to not retaliate but rather to channel your anger, hurt, etc into constructive action.

- ▼ Recognize and conscientiously use the power sources and privileges you do have.

- ▼ Don't bang your head too much…acknowledge your and the situations' limits.

- ▼ Be willing to step out of your comfort zone for the sake of change.

- ▼ Don't presume the worst, it rarely happens. Talk yourself out of catastrophizing, but be alert to any real risks.

- ▼ Ask what are the costs to NOT acting? To one's self, one's conscience, to others?

- ▼ Show acceptance to grow acceptance.

- ▼ Do what you need to strengthen and encourage yourself.

Interpersonal

- ▼ Find like minded people and work together to help and support each other's efforts.

- ▼ Address problems when they are small, rather than waiting for them to grow or explode.

- ▼ Hold others responsible for insensitive or unjust things they say/do, but be kind in doing so.

- ▼ Stay open to new ideas, strategies, and creativity – looking at a problem from different angles, trying different paths to the goal.

- ▼ Talk to someone outside the situation you are working on… for fresh perspective.

- ▼ Marshal resources: Gather together the information, allies, resources you need.

▼ Use a specific example (or one person's story) to show others the impact of the problem and the importance of the changes you are suggesting or working for.

▼ Think ahead of time about how you will give feedback or interrupt a negative incident.

▼ When attempting change that has real risks, talk to others about them ahead of time, especially those who may be implicated or end up involved.

Organizational

▼ Tie desired changes to your organization's mission statement and policies.

▼ Cultivate the involvement and endorsement of supervisors/managers and Board of Directors to make the changes agency-wide.

▼ Consider hypothetical problems and make response/resolution plans *before* they actually happen. Examine standing policies and procedures for gaps.

▼ When a negative incident happens, both address the acute situation at hand, and use it as an opportunity to later reflect on how it was able to happen, what could prevent it in the future, and whether the acute response was optimal.

▼ Examine what has worked or not in the past in similar change efforts and consider how those lessons may apply to your current situation, or may be irrelevant.

▼ Try to institutionalize whatever change you are working for, get it encoded in your agency's policies and usual procedures – so that it becomes "the usual."

▼ Provide staff with the information, training, coaching, and supervision that encourages the skills you want to foster in your group/agency.

▼ Talk to other practices/agencies similar to yours regarding their efforts in this area. This gives your context, comparisons and can also show skeptical others that you are not the only person/agency who cares about LGBT issues. It can also generate new ideas, networks, and resources.

▼ Ask clients and staff for feedback on changes.

▼ Join forces with self-help and advocacy groups wherever you can to share the resources, share work and share the joys.

Appendices include:

A. Exercises for Assessment and Training
B. Glossary
C. References
D. Resources & Organizations
E. Selected Bibliography on LGBT issues
F. Ethical Guideline Excerpts
G. Selected Bibliography on LGBT-affirming psychotherapy

May your journey to create a safe and welcoming environment for lesbian, gay, bisexual and transgender (LGBT) clients and staff deepen your professional skills and enrich your lives. Enjoy!

I. INTRODUCTION

This tool kit will provide you with the information, skills and strategies you need to transform your agency and your practice into a truly welcoming and safe environment for your lesbian, gay, bisexual and transgender clients. Enjoy the journey.

Four Rationales

Along with the desire to treat all people with dignity and respect, four categories of rationale make addressing LGBT issues essential for mental health providers:

Legal: In many states and smaller jurisdictions (counties, towns) it is illegal to discriminate against people based on their gender or sexual orientation in employment, public accommodations, and other arenas. A few expressly include gender identity (e.g. transgender) as well. Precise legalities vary by jurisdiction, and often include mental health services.

Ethical: Most mental health professional organizations now include sexual orientation and gender in their ethical guidelines, with language that discriminatory or insensitive treatment is unethical, and some specifically include gender identity. (See the previous section and Appendix E for excerpts from several such professional organizations.)

Outcomes: People who feel unsafe or unwelcome in mental health treatment settings are unlikely to develop the trust necessary to form a deep therapeutic alliance. The stress of navigating unsafe feelings and experiences often results in lack of engagement, retraumatization, and refusal of crucial mental health services.

Cultural Competence: Knowledge of common health-related beliefs, experiences and concerns of LGBT people can help attune professionals to individual treatment needs. Each person's multifaceted identity and unique personal characteristics renders "cook book" approaches to any cultural group insufficient. At its root, cultural competence centers on interacting with others humanely, as unique individuals from various socio-cultural and historical contexts and communities.

Sexual Orientation and Gender Identity

Definitions and Descriptions

Sexual Orientation

Planned Parenthood Federation of America's Education and Training Department describes sexual orientation as:

> … the complex interplay of a person's "affectional orientation" (who they like), "erotic orientation" (to whom they are sexually attracted) and "romantic orientation" (with whom they fall in love).

It is commonly assumed in the United States that each person's sexual orientation falls somewhere on a continuum from exclusively heterosexual (oriented to members of the opposite gender), to bisexual (oriented to members of all genders), to exclusively homosexual (oriented to members of the same gender). (Appendix C:1.) There are many other ways to conceptualize this complex aspect of human nature (Appendix C: 2). Sexual orientation is by definition an interpersonal aspect of one's identity. Sexual orientation:

- …is distinct from sexual behavior. That is, one's sexual behavior may not match one's orientation – e.g. celibacy, experimentation, or prostitution.
- …is an inherent part of a person's core identity. Our society views heterosexuality as so normative that it is rarely even thought of as a sexual orientation, so that most heterosexuals experience their orientation as a "given," requiring little if any questioning or conscious thought. In contrast much of our society views lesbian, gay and bisexual orientation as abnormal (and even immoral), causing many LGB people to consciously think about and/or question this natural part of their core identity in ways that heterosexuals do not.
- …reflects the complexity of factors that determine to whom one is sexually attracted and with whom one falls in love. One's sexual orientation is not chosen but rather discovered as one moves from infancy through old age.
- …is not a lifestyle (gay, lesbian and bisexual people are as varied as heterosexuals in the type of lives they lead) but rather a deep part of one's self. It can be something one becomes aware of gradually or has always

known.

- ▼ …is different from gender identity (see below).

- ▼ …is a scientific mystery. Sexual orientation is a complex mix of biology, psychology, culture, and many other factors. While there have been many theories and studies, we do not currently know why or how one person ends up identifying as heterosexual while another as bisexual or gay or lesbian.

- ▼ …is discriminate. Just as heterosexuals are not attracted to *every person* of the other gender, gay or lesbian people are not attracted to everyone of the same gender, nor are bisexuals attracted to every one of both genders.

- ▼ …is varied. Some people do not identify with the labels of straight, gay, lesbian, or bi (or queer). They may choose not to label themselves, or may have different ideas/terms. One person's experience of a given orientation may be quite different from another's experience. Sexual orientation can also grow and change over the lifespan.

- ▼ …is currently referred to as lesbian, gay, bisexual, or heterosexual in common parlance. Note that the term "homosexual" is not commonly used in LGBT-positive settings. Historically, the word came into common use as a psychiatric term of pathology – when "homosexuality" was considered a mental illness. Therefore, its negative and judgmental connotations have led to its being disfavored by LGBT communities.

(Appendix C: 1, 3)

Gender Identity

Gender identity refers to one's inner sense of being female, male, both or neither. For many people this inner sense corresponds with their biological gender. However, this is not always the case. A person's biological sex can be defined in various ways (chromosomes, hormone patterns, internal reproductive organs, external genitalia, and secondary sex characteristics). These often, but now always, concur with each other. When one's biological or assigned gender does not coincide with one's personal inner sense of gender identity, the person may identify as *transgender*.

Transgender is often used as an umbrella term to encompass a range of gender identities. It may include transsexual, intersex, androgyne/androgynous, cross dresser or transvestite, etc. (see glossary for definitions of these terms). People who identify as "transgender" are as diverse as people whose biological or assigned gender coincides with their personal inner sense of gender identity.

Gender identity refers to the gender one experiences oneself to be -- an individual personal identity. Gender identity is entirely different from *sexual orientation* -- the interpersonal concept of the gender(s) of people one is attracted to or loves. Thus a given individual may embody any combination of gender identity (e.g. male, female, other genders) and sexual orientation (e.g., lesbian, bi, gay, heterosexual). For example it is incorrect to assume that all transgender people are gay or bisexual (although some are), or that lesbians all want to be men (although some may) – both are common myths borne from confusing gender identity and sexual orientation.

As a result of years of being misunderstood and mistreated, many transgender people have developed fear and/or mistrust of medical and mental health providers. For example, without their knowledge, many intersex people had "corrective" surgery as children in order to "fit" into one gender category or another. Another example: transsexual people often go through harsh medical and psychiatric assessments, and must be diagnosed with "gender identity disorder," in order to receive hormonal or surgical procedures to change their bodies to more closely correspond to their gender identities. Such experiences tend to foster distrust or ambivalence about health care providers.

How one identifies one's own gender and sexual orientation are personal and

complex matters. It is essential for mental health providers to be supportive and considerate of each individual, and to avoid conflating sexual orientation and gender identity. It is also important that providers avoid (covertly or overtly) pressuring people to label themselves in any particular direction. Societal, family, personal assumptions and judgments about sexual orientation and gender identity sometimes cause profound internal conflicts. Providers need to be cautious about aligning themselves with any "side" of such conflicts. People and sexuality are always more nuanced and complex than any label.

(Appendix C: 1,3)

Queer

In recent years, the term "queer" has become commonly used by some LGBT people as a positive identity label. Individuals may call themselves queer, or refer to a "queer community." There are university-based "queer studies programs" in some places. At the same time, it is also still used as a violent epithet by those who are hostile to LGBT people. In general, the reclaimed "queer" is used***:***

- ▼ as a flexible umbrella term by some people to encompass a wide range of identities that would otherwise fall under LGBT, transgender, and "not conventionally heterosexual***;***"
- ▼ to be more widely encompassing than any one of the other identity terms***;***
- ▼ to deliberately re-claim a hurtful word***;***
- ▼ more often by younger people, with whom the more firmly bounded categories of gay vs. bisexual vs. heterosexual (or male vs. female vs. intersex) do not resonate as well. Some older LGBT people cannot abide the use of the word because of their close associations between it and having experienced hatred.

Queer is also an "in house" word that may be used positively by queer people among themselves. Its use by someone outside the LGBT community is often experienced as hostility (such as when "queer!" is yelled out of the window of a speeding car and accompanied by a thrown beer bottle). Therefore, mental health providers are wise to be cautious about using "queer" unless a person or group clearly prefers it even from "outsiders." Similarly, other commonly insulting words such as "dyke," "fag," or "tranny" are sometimes used "in house" in teasing or ironically affectionate ways among LGBT people. This does not mean that this language is

appropriate for non-LGBT people to use casually. (Conversely, clinical sounding words like homosexual and sexual minority may be experienced as cold or marginalizing by LGBT individuals.) Ask about the language people feel comfortable hearing and would like you to use.

(See the glossary for information about these and related terms.)

MENTAL HEALTH SERVICES AND LGBT IDENTITIES

Note: the text in this section was adapted from Lucksted, 2004 (Appendix C: 4) and the first person quotations included are from that report. They are identified with "key informant" (KI), the person's name and the interview date.

The fact that you are using this Toolkit indicates that you are committed to providing LGBT-sensitive mental health services, and that you have an interest in helping your agency, individual practitioners, and/or yourself enhance skills in this area. The following overview of some of the roots of LGBT-insensitive practices among mental health providers is intended to identify and clarify the kinds of issues faced by many LGBT people when they seek mental health services. Please note it is not meant to imply that all providers and agencies are intolerant. Many are competent and affirming in their services to LGBT individuals and communities. However, recognizing the issues helps to illuminate the purpose and importance of positive professional practices, which are discussed in the next section.

Lesbian, gay, bisexual and/or transgender (LGBT) people who have mental health needs face abundant challenges in receiving quality mental health care. Along with the global problems of accessing affordable care, LGBT people often face anti-LGBT ignorance, disrespect, stereotypes, and hostility within mental health services. Prevailing public attitudes toward LGBT identities have improved in recent decades, yet ignorance and intolerance still linger. Table 1, below, summarizes some key points. Others are discussed in the following sub-sections.

Table 1: Common Lapses in Staff Behavior (Appendix C: 4, 5-8)

It is common for mental health staff in various roles to…

…be unprepared and/or unable to have in depth discussions with clients about gender, sexuality;

…absorb and mistakenly apply stereotypes and prejudices in their work;

…ignore that LGBT people are diverse regarding gender, race, culture, class, disabilities etc, and that all of these interact with sexual orientation and gender identities;

…confuse sexual orientation and gender identity;

…assume/believe that a consumer's LGBT identity is a symptom of mental illness, a mental illness *per se,* and/or as indicators of sub-par development;

…assume that sexual orientation/gender identity is a core problem for LGBT clients, but never presume so for heterosexual clients;

…believe that being gay, lesbian, or bisexual is "no big deal," and that a client who wants to talk about it is using it to shy away from their "real" issues;

…constrain a client's exploration and self-discovery by the clinician jumping to his/her own conclusions about what the client's sexual orientation "really is" or "should be" and impressing this view on the client;

…accept prejudices and misinformation leading clinicians to advocate interventions designed to change the client's LGBT identity (e.g. Conversion/ Reparative attempts which have been discredited by major professional organizations);

…hold narrow ideas of how one "should be" LGB, and overtly or covertly pressure clients to conform (there are as many ways of being LGB as there are ways of being heterosexual);

….use heterosexual patterns as standards for healthy personal and relationship functioning, thereby perceiving LGB people and relationships as *de facto* less healthy where they differ;

…make unwarranted assumptions about a person's values or lifestyle based on myths or stereotypes about LGBT people;

….positively stereotype LGBT people out of fear of being called homophobic or due to romanticized views, which may pressure clients to hide their distress or pathology, and lead therapists to shy away from clients' problems;

…inquire about clients' sexual lives and history voyeuristically, as an exotic or erotic subject of education or titillation for themselves, rather than as it is relevant to the client's issues.

Sexuality

Mental health services in the United States generally fail to address *sexuality* well (if at all). While sexuality is often recognized in abstract as a normal and healthy facet of adult functioning, many mental health practitioners are less than comfortable discussing sexual topics/issues with clients. In more intensive psychiatric settings clients who express sexual desires are often seen as "acting out," or the behavior is interpreted as a psychiatric symptom (Appendix C: 9, 10, KI Cookie Gant, August 1998; KI Bert Coffman, May 1998). Such negative tendencies may be heightened if the person has a sexual orientation or gender identity with which attending professionals are not comfortable (Appendix C:11, 12).

- [Providers] think sexual orientation is not important because they don't cover sexuality with their straight clients either – so why should they for GLB clients? This is even a mistake for their heterosexual clients, and more so for GLB clients because of what they have to deal with regarding society and their sexual orientation. (Appendix C: March 1998)

- The state system tends to be more patriarchal…to see patients as less adult, and therefore, less appropriate to have any sexuality. At the state hospital outpatient clinic…the staff tends to deny the sexuality of <u>all</u> patients. There's this sense of patients as children, who don't have sexuality, or that it wouldn't be good for them to be sexual. Staff don't seem to want to deal with it. For example***:*** a community residence has a rule that residents cannot have sex in the house, [but] they don't provide other guidelines or information, don't really address sexuality. More it seems they just don't want to know about it –so, not in the house. (Appendix C: 1998)

Lingering Pathologization of LGBT Identities

- Psychiatry sets lesbians and gay men up for abuse by claiming that heterosexuality is the only healthy, natural way for human beings to be…. Lesbianism / homosexuality are seen as deviations from normal development, immature phases and mental illness. (Appendix C:13)

People who do not fit into conventional heterosexual and gender roles have been pathologized for much of psychology and psychiatry's history (Appendix C:14-18). Simply being "homosexual" deemed one mentally ill according to the American Psychiatric Association's <u>Diagnostic and Statistical Manual of Mental Disorders</u> until 1973, and "ego-dystonic homosexuality" was considered a psychiatric illness until 1987

(Appendix C:19-26). Homosexuality was considered a psychiatric illness in the International Statistical Classification of Diseases, Ninth Edition (ICD-9) but not the more recent ICD-10.

Many people alive today have experienced decades of "treatment" for "homosexuality" under these earlier designations, and this may continue to affect their attitudes towards mental health care (Appendix C:27-29). A psychiatrist at an LGBT-affirmative inpatient unit said:

▼ It is especially poignant with older clients who have experienced lots of abuse in the mental health system in decades past. They are very very wary about the Mental Health system -- period, and about being out certainly. Usually they are not out at all on the unit, and are reluctant to talk about it openly. I think this is due to years misuse at the hands of the mental health system. In our LGBT support group, elderly gay and lesbian clients have talked about receiving ECT and aversion therapy (electric shocks applied to their genitalia when they respond to same sex erotica). Those with chronic mental illnesses like schizophrenia, for example, talk about not being seen as cured or the exacerbation being seen as in remission because the client "still" maintained an attraction to members of their own sex. (Appendix C: July, 1998.)

Many current mental health professionals were trained prior to 1973, or by people who were trained before that time (Appendix C:30). Some mental health professionals continue to pathologize LGB orientations. Only a few recently educated mental health practitioners still consider homosexuality a mental illness or an inferior "level" of psychological development.

Past psychiatric theory held that "homosexuality" caused mental illness or that mental illness caused "homosexuality" (Appendix C:31). From Evelyn Hooker (Appendix C:32) through more recent history (Appendix C:33-39) scientific research has consistently disproved such theories. Regrettably, prejudices often persist (Appendix C:40-42). LGBT people seeking mental health care continue to encounter mental health providers who consider their sexual orientation and/or gender identity a delusion or a symptom that will "go away" when their mental illnesses are resolved (Appendix C:43), or claim that having a same gender relationship causes or exacerbates clients' mental health problems (Appendix C:28). Pathologization of LGBT orientations/gender identities continues to be debated in prominent professional journals (Appendix C: 44, 45).

One effect of this lingering pathologization of LGBT identities is that LGBT people have said that they are judged to be mentally healthier by mental health providers if they conform to those providers' idea of conventional (non LGBT) gender presentation in their dress, conversation, and deportment.

Transgender identities themselves are still deemed pathological via the Gender Identity Disorder (GID) diagnoses in the DSM -IV-TR (Appendix C:46, 47). Indeed, being diagnosed with Gender Identity Disorder is usually a prerequisite to gaining access to sexual reassignment surgery or hormones, and to insurance coverage for treatment. Israel and Tarver (Appendix C:48) and others make the point that the "de-pathologization" of transgender identities is making gradual progress in psychiatry and other mental health disciplines, but that it has a long way to go (Appendix C: 49). Some professionals continue to view it a psychosis or delusional system.

Biased Diagnoses

Although there has been little research in this area, there are indications that mental health practitioners tend to inaccurately diagnose LGBT clients if they are unfamiliar or uncomfortable with LGBT identities. One advocate (Appendix C: 4, KI Anonymous P., September 1998) said:

▼ …an area that I think could use some serious research [is] how accurate are the mental health diagnoses given to gay people and how many of them are simply the result of subtle forms of discrimination and/or a total lack of understanding of the gay experience?"

Examples from LGBT-affirmative mental health providers support her point. Psychologist Steve Hartman (Appendix C: 4, KI May 1998) said he fears that urban gay men are sometimes inappropriately diagnosed due to clinicians' misunderstanding of their cultural patterns. For example he finds that the "acting like a queen" style of self expression (adopted by some gay men as a way of coping with stress or being humorous) is sometimes pathologized as "histrionic" or a symptom of Borderline Personality Disorder by clinicians unfamiliar with it. Similarly, psychiatrist Orren Perlman (Appendix C: 4, KI June, 1998), has observed that some mental health professionals mistakenly consider people who identify as bisexual as having a

Personality Disorder, assuming (in error) that a bisexual person's attraction to men and women *de facto* indicates poor personal boundaries.

In this era of "medical model" mental health care there is also the danger that an appropriate mental health diagnosis will be assumed to tell the whole story. For instance a mental health provider may diagnose a person with depression or an anxiety disorder, conceptualize it only as a biochemical imbalance, and fail to inquire about or address stressors such as homophobia, family hostility after coming out, struggles with gender identity, or other psychosocial problems which may have created and/or exacerbated the person's distress.

Disregard and Discrimination: First Person Experiences

A paucity of information and familiarity with LGBT people and issues makes mental health professionals susceptible to believing harmful stereotypes – such as that all gay men are HIV positive, bisexual people are all sexually promiscuous, or that people of color are never "really" LGBT but must have been coerced or co-opted by white LGBT people. Such ignorance can lead otherwise competent mental health providers to make serious mistakes. For example Avery, Hellman, and Sudderth's 2001 survey (Appendix C:52) of clients of outpatient and inpatient mental health care, found that LGBT respondents were more than twice as likely to report dissatisfactory care than heterosexual and gender congruent respondents.

▼ As I was going along, most often my therapists didn't know anything about being transgender. I had to educate them. It really bothered me, and changed the whole therapy dynamic and takes away from the trust you feel, and the time spent on <u>you</u>, and why you are there.

▼ First I saw a psychiatrist, just for meds. He'd ask something, but then would quickly go on to other topics if I brought up anything that made him uncomfortable – anything gay. For example, he'd ask how my family was, but when I'd say something about my difficulties with my mom being so homophobic, he'd just be like "So! When should we have our next appointment?"

▼ At the clinic, my last six months were a constant battle because of the support group my therapist wanted me in. I tried it for more than the recommended trial and still decided it was definitely not for me. But I was never able to make my therapist see how totally unhelpful that all-straight group was, especially given the

open hostility of one straight female member who blamed me (and all gays) for the fact that she had AIDS. My therapist never got it and just kept harping on me for not being good at making friends.

- ▼ It took me a long time to build my life back up again after that [a disastrous phone call to family made at the insistence of her social worker]. I believe the social worker did not really have any idea about the issues of a family totally disowning someone for being gay – how strong homophobia is, and that it is not going to be 'cured' by a phone call.

- ▼ Some of them see something bad in the gay community and (1) they stereotype us by assuming that we're all like that just because we're gay. Then (2) they don't even <u>think</u> about how many really bad problems are going on that impact the gay community and cause the things they're seeing – how homophobia, AIDS, problems with families, isolation, all that, affect people -- how these bad things they see (promiscuity, drinking) come about….

(Appendix C: 4, KI, July 1998)

<u>Denial</u>

Many mental health programs ignore the existence of LGBT clients, even to the point of assuming and even asserting that all clients (and staff) are heterosexual (Appendix C:54). This fallacy allows programs and mental health systems to avoid addressing the needs of LGBT clients and employees by simply denying that LGBT people exist. Since "It is important for those who provide treatment to recognize all of a person's life, not just selected parts of it" (Appendix C: 54), such denial leads to neglect and outright abuse. As a long-time mental health worker and peer advocate, Audrey Grifel (Appendix C: 4 ,KI, March 1998) stressed,

- ▼ Around mental health providers there are many things about people that aren't acknowledged. For a long time your ethnicity was not at all. So sexual orientation is one of many parts that just don't exist [in the system]. There is no visibility in the mental health system of people who are LGBT, and so no affirmation – at a time when people…are in the system because they need affirmation.

Drawing on her career as a mental health professional in the public sector, key informant Anonymous L. (Appendix C: 4, March 1998) concluded, "[LGBT consumers] are approached clinically from a <u>heterosexual</u> mode, mistreated by the public mental health system…. They get treatment for their mental illness, but <u>not</u> as a whole person.

It's really very damaging…and creates a profound sense of isolation for LGBT people who are clients."

Discrimination & Harassment

Concrete manifestations of ignorance or bias are anecdotally common in many mental health settings, although exactly *how* common has not be well quantified. The more subtle expressions of ignorance or ignoring can be seen throughout the policies and practices of many mental health providers, and often leave LGBT clients feeling excluded and un-welcome. For instance since people in same-gender relationships are not currently recognized by marriage law (nor are unmarried people in mixed-gender romantic relationships), intake forms that ask if one is "married, single, widowed, or divorced" leave no room for them. Other LGBT clients have mentioned administrative and clinical chart notes refusing to denote same-sex significant others as family members when it comes to visitation, accompaniment, or social support.

Similarly, some providers or programs may disregard the fact that "coming out" (see glossary) is a highly personal process. Several key informants described programs with anti-discrimination policies that fail to recognize hidden homophobia that can engender LGBT clients, such as, requiring them to be "out" to all staff and clients. Other programs demand that LGBT people stay closeted and fail to extend support when disclosure brings about harassment. Forcing or forbidding disclosure disempowers the individual and disregards his/her judgments and preferences about what is safe and comfortable. It can also create intense conflict for a person unsure of his/her sexual orientation or gender identity.

▼ Just recently in our group a 23 year old Latina woman in chronic treatment, in a residential program, was outed by a person she thought was a friend, and who she had told she was a lesbian in confidence. The friend went to the whole house, and the woman was harassed a lot and was very upset. We spent most of the afternoon meeting of our group helping support her. (KI Bert Coffman, May 1998)

If LGBT people feel unwelcome, refuse to disclose when required to, or experience hostility after forced disclosure, they are not only denied safe and respectful services, they can be denied services entirely. Conversely, some have observed that

confidentiality is sometimes misused to avoid talking about LGBT topics openly:

- ▼ This center is unlike some places where people just don't talk about sexual orientation except to their therapist in private…. Partly this may be because of confidentiality but also I think it's because the staff don't want to deal with it, hear about it. Confidentiality can be misused as a way of sanctioning making sexual orientation a "dark secret" versus a real need to keep confidentiality…so the person will feel safe. (Appendix C: August, 1998)

Egregious instances of hostile discrimination or harassment against LGBT people receiving mental health care are rarer than the manifestations of ignorance and ignoring described above. Nonetheless, they are profoundly harmful and can create widespread and long lasting fear, distrust and feelings of insecurity among LGBT clients and potential clients. Various first person accounts tell of mental health providers saying frankly homophobic things to them, and of overhearing violent sentiments from them ("fags will all burn in hell"). Some tell of being isolated on an inpatient unit because staff loudly stated LGBT client would sexually abuse any roommate (Appendix C: 55). Others report being flatly denied services because of their sexual orientations and gender identities. In some places staff have been reported to let anti-LGBT verbal abuse (name-calling, provocation) from other clients continue indefinitely, and sometimes even joined in.

Nancy Nystrom's 1997 (Appendix C:56) survey of gay men and lesbians found that 46% reported receiving mental health care that they experienced as homophobic. Similarly, in a 1995/96 survey of 116 LGB consumers aged 18-75, across 36 states (snowball sample) the following experiences were reported (Appendix C:43):

- ▼ Therapist or psychiatrist tried to change or convert you to be straight…..23%
- ▼ Ever been verbally harassed for being lesbian, gay, or bi, by a mental health worker or professional ……… 29%
- ▼ Ever been physically hurt because you are lesbian, gay, or bi, by a mental health worker or professional…….. 10%
- ▼ Ever experienced discrimination or poor treatment in the mental health system because you are lesbian, gay, or bi……64%

Examples from other first person accounts elaborate on these statistics:

▼ Q: What was it like being out of the closet as a lesbian at the hospital?
A: A lot of staff were after me, grabbing my butt and kissing me. I thought they were gross. A lot of them tried to hook me up with men (Appendix C:57).

▼ I'm happy that I didn't come out in the place I was in. I overheard my doctor talking in the common area and he was making very homophobic comments. You don't always have to fear how the other patients will react, you also have to fear the doctors" (Appendix C: 4, August 1998).

More studies need to be done to discern how rare or widespread such mistreatment is. However, many LGBT consumers consider harassment and mistreatment likely when they attend a new mental health program and prepare for it (Appendix C: 55, 58-61), constituting an additional stress from the places and people they are going to for help.

Peer Intolerance often goes unaddressed

In mental health settings where clients spend time and interact closely with each other (groups, day programs, residential, inpatient), LGBT people risk disrespect and harassment from other clients. Although there are no research documents that show the extent or prevalence of this problem, it is common enough that many LGBT people in mental health care say they expect it. Staff often ignore this problem which clients experience as staff condoning such abuse. The problem of peer intolerance also may extend to mental health consumer self-help groups or consumer-run agencies being inhospitable to LGBT people.

▼ Patients in the system also panic – there is LOTS of homophobia and transphobia, and attacks and harassment. And the staff will usually ignore it, condone it by their inactivity." (Appendix C: 4, June 1998)

Family Stress

People who identify as gay, lesbian, bisexual, or transgender cannot necessarily rely on family support as many families reject their LGBT members. "Coming out" (see glossary) to family and close friends can be an intensely stressful dilemma that is not a one time event for most LGBT people. Many LGBT people want to be honest with those closest to them and/or find the constant effort to hide one's identity to be exhausting.

On the other hand, many LGBT people have good reason to believe certain family members will be unsupportive, rejecting, hostile or violent. While many LGBT people do come out to family in the first several years of their awareness of an LGBT identity, many do not. Some never come out, and may experience tense or distant family relationships as a result. Many who come out to family find acceptance, while others face years of strained relationships and conflict. Mental health practitioners can therefore best assist their LGBT clients by inquiring about family relationships, asking about being out and family support/stress, and not pre-judging clients' choices about these issues. Additionally, some family members hold stigmatizing attitudes about mental healthcare.

▼ I, for example, came out to my family 13 years ago and was immediately disowned. Despite efforts to contact them, cards and gifts sent, etc, I have never seen another single member of my family again, even though my sister, nieces and mother live only 35 miles away. I was told that I would be arrested for trespassing if I tried to visit them. Although extreme, this is not entirely atypical of the [LGBT] consumers' experience at the Alliance." (Appendix C: 4, February 1998)

Effects

The issues described above cause many LGBT individuals to spend tremendous energy managing their identity, self presentation, fear, anxiety, and the negative reactions from the people that they would hope to receive help and support: mental health providers, peers, and family. For some people with tenuous self-concepts or conflict about their identities, such experiences can constrain personal exploration and increase/induce self-hatred (Appendix C: March, 1998). "For individuals diagnosed with serious mental illness who are LGBT, homophobic attitudes among providers of mental health services and mental health programs which are heterosexist…create barriers to recovery and detract from the effectiveness of treatment and support services" (Appendix C:62, pp. 1-2).

CREATING AND SUSTAINING LGBT-AFFIRMING MENTAL HEALTH SERVICES

While no individual mental health professional or agency can eradicate homophobia or society's narrow gender rules, we each can play an important role in ensuring that the LGBT (and questioning) individuals that we encounter receive the highest quality of care. Toward that end, it is helpful to think about various "levels of change" that professionals and agencies can institute regarding service to LGBT clients:

Individual Practitioner: Take initiative to examine one's own beliefs, attitudes, and behaviors toward LGBT people, and LGBT clients in particular. Honestly decide to change through information, consultation, personal reflection and taking action.

Direct Service Level: Create daily procedures, tools, and habits in order to deliver mental health services that are LGBT-welcoming and respectful. Reinforce LGBT-affirmative values in employee training, supervision, and evaluation.

Agency Level: Create agency-wide policies and practices that are non-discriminatory and openly welcome LGBT individuals.

Community Level: Promote LGBT tolerance in one's community and speak out against discrimination and intolerance. Forge relationships with LGBT groups and resources by attending their events, meeting to discuss common interests, supporting their efforts, and sharing resources.

Policy Level: Support and advocate for LGBT-positive legislation and candidates on local, state, and national levels. Know the status of one's local and state non-discrimination statues regard their in/exclusion of sexual orientation and gender identity, support enforcement if they are included and support their addition if not.

These levels are not mutually exclusive. Activities in one often benefit others, and

levels blend into each other. Below, we focus on the Agency, Direct Service, and Individual Practitioner levels in more detail.

▼ When people are GLB-identified and do come to an affirmative unit, they report that it does make a difference. Not that they wouldn't get as good clinical care somewhere else necessarily, but rather it's their comfort level. Trust. They can settle down and work. (Appendix C: 4, September 1998)

Agency Level Strategies

(Appendix C: 1)

Mental health providers can take organizational-level steps to provide a sound infrastructure for policies and procedures that are fair and LGBT-affirming. Since mental health services are delivered through many different types of organizations and situations, some of the ideas below may be of greater or lesser relevance to you.

1) Include mental health consumers, especially those from groups whose needs you are trying to better address (e.g. LGBT people) in your agency and program development efforts.

2) Communicate the human and practical benefits of becoming more LGBT-affirming to all levels of your agency (board, management, support staff, direct care). These benefits include increased client referrals from new sources, attracting new supporters / donors, gaining community recognition, hiring and retaining good employees, better outcomes with LGBT individuals and families.

3) If you are the Director, recognize that your visible leadership will provide the vision, consistency, and support necessary to establish and maintain the LGBT-affirming changes you and your team are working to create in your organization.

4) Make diversity a stated goal of your board and management, in writing and with a plan for increasing all types of diversity (race, ethnicity, age, gender, sexual orientation, and disability among others). Nominate/hire board and staff members who welcome LGBT people as clients and co-workers and support this goal.

5) Empower a management team or diversity committee to make a feasible action plan that identifies specific objectives, time lines and responsible staff – creating ownership and shared responsibility/workload.

6) Create an LGBT community advisory committee including LGBT people from a cross section of ages, races, genders, ethnicities and cultures to strengthen coalition

efforts, connect you with local resources, enhance sensitivity and ensure that LGBT voices are built into your change process.

7) Add sexual orientation and gender identity to your organization's anti-discrimination or equal opportunity statement. Potential employees and "customers" look for this in brochures, web sites, job descriptions, etc

8) Make firm, doable plans to educate management, board, and staff about facets of the LGBT communities you serve, and the benefits of serving them well.

9) Advertise directly to the LGBT community (e.g. LGBT newsletters or newspapers, fliers in LGBT bookstore) and/or add the "welcome" triangle to all marketing. Such steps let LGBT people know that you are an ally and that they are welcome at your agency.

10) Build coalitions and working partnerships with your local LGBT community.

11) Publicly advocate for LGBT human rights issues. This builds your credibility, enhances trust and reinforces messages of respect.

12) Ensure your personnel policies help foster a welcoming environment for employees and (indirectly) clients, including: job descriptions that mention valuing diversity; staff/volunteer orientation that includes non-discrimination information; performance criteria rewarding affirming efforts; benefit coverage for domestic partners, etc.

13) Ensure that your agency policies and procedures for documenting and resolving incidents of harassment, unfair treatment, threats, etc., include anti-LGBT incidents on equal par with others, and train the board, management and staff in their use.

14) Appreciate everyone's efforts, provide timely feedback on progress made toward goals, facilitate constructive problem solving when obstacles arise, and recognize successes to sustain the agency's efforts and morale.

An example of a LGBT-affirming mental health program's promotional brochure:

> The LesBiGay and Transgender Affirmative Program is a component of Heights-Hill's multicultural services. It is designed for lesbian, gay, bisexual, and transgendered individuals with chronic mental illness. Treatment is directed by a team of licensed professionals sensitive to the concerns of this varied clientele. Interventions are geared to help address the stigma associated with homosexuality, transgender issues, and mental health, and to foster a deeper sense of heritage and community…..Heights-Hill believes that effective treatment must go beyond traditional psychotherapy approaches by providing services that are relevant to a culturally diverse population. The LesBiGay and Transgender Program is a unique

and essential service that can help lesbian, gay, bisexual, and transgender individuals with chronic mental illness bridge the social and cultural gap that they commonly experience in the traditional mental health care setting.

See page 46 for a concise agency assessment tool to help you recognize areas of success and identify priorities at the management (above) and direct service (below) levels

Daily Direct Services: Policies and Practices

Physical Environment

What one sees and hears in an office or facility makes a strong impression. Practitioners and agencies who want to welcome the LGBT community, clients, and employees (potential or current) need to consider the physical "face" their organization presents when people walk in the door:

- ▼ If there are community resource pamphlets available on tables or racks, do they include the LGBT community?
- ▼ If posters or artwork include people, do they depict a diverse range? Do some of them show same gender people together? Families with two parents of the same gender?
- ▼ What reading material is available in the waiting room? Does it include LGBT publications?
- ▼ Do staff want to display a "welcome triangle" or "safe space" card in visible locations (on a door, at the front desk, in consultation rooms, rest room) to signal their supportiveness? See http://www.league-ncr.com/safe.cfm or http://www.northwestern.edu/lgbt/safespace.html for examples.
- ▼ Sound is also important: Do staff use LGBT friendly language that others overhear? Does the radio play a station that allows homophobic remarks on the air? Or one that includes artists popular with the local LGBT community?

Questions and Forms

Do the intake and assessment questions, procedures, or forms you use send heterosexist messages? Four common issues:

Married, single, widowed, or divorced?

Many intake and patient information forms ask if someone is “married, single, widowed, or divorced,” yet in most places same-gender couples cannot be legally married. Therefore, such questions serve to alienate gay, lesbian, or bisexual people. Many people in same-gender relationships will not point out the inadequacy of the question. Instead they may reply “single” (their legal status), “married” (if they consider themselves so even though it may not be legally recognized), or they may not answer.

Such language might be necessary in some narrow circumstances when information about a person’s legal status is actually needed. However, most mental health settings ask “marital status” questions to assess a person’s family structure and support network. More useful and accurate information would be gathered by using more precise and inclusive language:

- ▼ Do you have a spouse or partner?
- ▼ Are you in a romantic relationship?
- ▼ Who are your most important support people?
- ▼ Who do you consider your family?
- ▼ With whom do you live?

Gender

Most intake interviews and clinical forms ask if one is male or female. This leaves out most transgender people who consider their gender to be either androgynous, male to female, female to male, “trans,” or something else. Some transgender people may identify as male or female and be fine with the question, perhaps even bothered by someone needing to know if they are “trans” versus having been born the gender they report.

Alternative question: What is your gender?

Asking about Sexuality and Sexual Orientation

Most mental health agencies and practitioners do not discuss sexuality with their clients unless an obvious problem arises. This is unfortunate, since sexuality is an integral aspect of most people’s sense of self, and affects to other facets of clients’ lives (mood, quality of life, family relationships, self esteem, etc.). Part of creating LGBT-

affirming *(and* heterosexual-affirming*)* mental health services and practices involves addressing sexuality in all its complexity.

A person's sexual orientation can not be presumed. Often, mental health practitioners allow clients to decide if/when to disclose their sexual orientation. While often respectful and empowering to the client, such consideration should not be used as an excuse allowing the uncomfortable practitioner to convince him/herself it is acceptable to avoid this or related topics. In other instances, a practitioner may decide to ask a client his/her sexual orientation. "What is your sexual orientation?" is a fine question, if rather blunt. Occasionally one will run into a client who does not know the term "sexual orientation." More useful questions are:

- ▼ Do you have romantic feelings about men, women, both, or neither?
- ▼ Do you have sexual relationships with men, women, both, or neither?

Who is Family?

Because many LGBT people have been disowned by their families of origin, they have created alternative family connections. At the most basic, all staff should know not to be dismissive or shocked when clients have a same-sex significant others and want them to be treated as "family". LGBT-affirming providers include same-sex partners as a matter of course, and are knowledgeable about the legal or institutional policy details of unmarried partners regarding proxies or registrations. Similarly, same-gender parents should be invited and included in all "family" programs and events regarding their children's care. Further, the fact that some LGBT people remain close to former partners and consider them – and other close friends – to be "family" should be embraced. Many LGBT communities refer to this as one's "family of choice."

Staff Education

Thoughtful and ongoing education for all staff and volunteers is crucial to maintain a safe and welcoming atmosphere for LGBT people. Everyone needs training, including clinicians, direct-care staff, board members, administrators, volunteers, receptionists, billing clerks, public affairs employees, housekeeping, etc. Trainings, seminars, handouts, briefings and "refreshers" could include…

- What is and is not LGBT friendly language (e.g. using LGBT instead of "homosexual" – see glossary), and asking when one is not sure ("what name do you prefer to be called?")

- Information about LGBT mental health issues, e.g. non-heterosexual orientations are *not* pathological, though some LGB people do experience depression or anxiety due to the heterosexism they face.

- Current issues important to the LGBT community that affect your clients, such as local gay-bashing incidents, political races, same sex marriage debates, etc.

- Updates on clinical information about therapy with LGBT clients (see resources)

- Pro-active discussions about disrespect or discrimination incidents as they arise, how to handle them, and/or debriefing discussions of recent difficult situations

- Information about local and other resources useful to staff and clients

- Examination of common myths and stereotypes, their deleterious effects on all of us, and how to dismantle or resist them.

- Information about human sexual development, sexuality, sexual orientation and gender identity.

- Information about the legal, religious and social pressures used to enforce heterosexuality, and the negative impact those forces have on everyone.

- Strategies regarding how to address the needs of and contain the behavior of staff and clients who use their negative biases, beliefs and assumptions to inflict physical, psychological, social and/or economic harm on themselves and/or others.

It is also important to incorporate LGBT awareness into *all* education and training programs. For example programs on any topic should not assume heterosexuality among all staff or clients, should occasionally include LGBT people of various back grounds in their examples and case studies, and illustrations should acknowledge same-gender relationships.

See Appendix A for specific training / discussion exercises and the Appendix D for other resources

Programming

Fully integrating LGBT issues into all the services and promoting safety is necessary for creating LGBT-affirming mental health care. The section above discussed inclusion / integration regarding intake and assessment queries. Similarly, one can ask whether the therapeutic opportunities one offers are inclusive, and that LGBT identities are a part of every group of people that we serve. More broadly, one might ask whether a program and its staff talk with clients about sexuality in all its forms as a positive aspect of adult life as well as a potential problem. LGBT clients need to feel that they are assumed to be present and are welcomed in all aspects of a service.

▼ They [members] know that they don't have to make any great announcement… And I think this carries over to discussions in groups. People talk about gay and straight relationships, both easily. In more mainstream places that I've worked people are much more closeted and have to worry about disclosure and what they discuss much more. (Appendix C: 4 July 1998)

At the same time, it is often useful to consider whether one's practice or agency can offer any LGBT-specific programming, e.g. social activity, support or discussion group, a peer program, a resource book, etc. Many marginalized people find it fortifying to have occasional access to spaces where they can relax among people known to be of the same group or supportive.

▼ Another absolutely crucial issue is increasing the opportunities for [support] groups and for social opportunities with other LGBT consumers. People feel so alone, have to be so secretive…. Even if a person doesn't come to a gathering or a group. Just seeing the publicity that it exists makes people feel less alone and more supported. And, potentially they'll come later. (Appendix C: 4 May 1998)

Problem Solving

LGBT bias occurs in organizations*.* Daily practices that incorporate knowledge of LGBT people and issues results in an effective process that leads to constructive resolutions. Having policies and procedures in place before an incident occurs simplifies problem solving and makes it more effective.

▼ Respectful resolution of problems creates enormous good will. Most LGBT people know that ignorance and bias are impossible to completely avoid, but they look closely at how such incidents are handled.

▼ Staff in all roles should use the same management tools to intervene when "unfriendly" behavior towards LGBT clients arises as they would if it were directed toward any other clients. For example: "We have a rule about no disrespectful language in group. That comment was disrespectful towards gay people, so it's not acceptable here."

▼ Anti-LGBT comments or behaviors from other clients are often a problem for LGBT people attending mental health programs where clients spend time together (e.g. groups, residential, inpatient, day programs).

▼ Policies must apply equitably to lesbian, gay, bisexual, and heterosexual clients. (Such as the rules about relationships, visitors, or displays of affection).

Individual Practitioners: Continuing Self Education

(adapted from Appendix C: 4)

For a mental health agency of any size or structure to create and maintain positive therapeutic relationships with LGBT clients requires awareness on multiple levels, from policies to décor. At the same time, individual practitioners in all roles and from all helping disciplines can (and should) take personal responsibility to build their own competencies. Iasenza (Appendix C:3) provides several concrete suggestions for doing so:

▼ Educate yourself: read, attend events, follow issues, take action to be an ally.

▼ Explore sexual orientation and gender identity issues in your own therapy and peer groups.

▼ Consult formally with members of the groups you are trying to learn about, individually or through workshops and other training opportunities.

▼ Seek supervision regarding clients about whose identity groups you need to further develop your competence.

▼ Speak up when you see discrimination, insensitivity, gaps in knowledge and action.

▼ Look for and create opportunities for self, colleagues, and students to gain information and experience.

▼ Address atmosphere issues in your workplace.

▼ Examine your language use and behavior for heterosexual assumptions.

▼ Reflect on your reactions and feelings as you attempt and do these things.

Please see Appendix G for a review

of the published literature about psychotherapy with LGBT clients.

Other suggestions from various sources are included in Table 2 below:

Table 2: Ideas Toward LGBT-affirmative Practice

To develop LGBT-affirming therapeutic relationships, mental health providers may want to know…

- …that culturally competent practice (including LGBT-affirmative) is an ongoing process, not something that is achieved and then is complete;
- …about common prejudices, many of which come from historical and invalid assumptions within mental health professions and U.S. society at large;
- …that LGBT-affirmative staff need not be LGBT themselves to be well informed and avoid heterosexism;
- …that our society is heterosexist;
- …that people, human sexuality, and identities are much more complex than any of the labels we use;
- …that even among staff and clients of similar identities, there may be misunderstandings and friction about LGBT and other issues, which can be food for fruitful discussions;
- …that a LGBT-identified or LGBT-affirmative mental health worker may not be a good match for a LGBT client in other ways;
- …that mental health providers who are LGBT may be able to draw on this commonality in working with LGBT clients, but may also face challenges such as higher expectations, conflicting views or identities, assumed agreement and common prejudices in some LGBT communities about each other;
- …that due to the small size of many LGBT communities, an LGBT provider and an LGBT client may have overlapping social or cultural circles, and may be acquainted with more of each other's associates than a therapy dyad of differing identities or one in which both are heterosexual; and
- …of the tendency of some health-care providers (and some consumers) to view LGBT identities as beleaguered or tragic because of the challenges of living as LGBT and thereby ignore or discount the positive aspects of these identities.

(Sources include Appendix C: 7, 69-71

Table 3: LGBT Identity and Social Issues that People May Bring to their Interactions with Mental Health Services & Practitioners:

- …the effects of their interactions with previous health providers;
- …“hyper vigilance” due to finely tuned self-protective abilities to read subtle signs of others’ reactions to people’s sexual orientations and/or gender identities. Such skills help people avoid or prepare for embarrassing and dangerous interactions;
- …wariness until they feel assured the clinician is both LGBT-affirmative and able to work with them in other areas (focal problems, culture, class, etc);
- …reluctance to let a mental health provider know they are LGBT to avoid possible rejection or intolerant reactions, even if they are comfortable with their identity;
- …distress about the discord their identity creates with family members who are not LGBT-affirmative, especially if they rely on family support, come from cultural or personal background that emphasize family harmony, honor, and/or filial loyalty, and/or already experience family conflict around other issues;
- …a sense of isolation and a lack of a comfortable community or social network, particularly if they are bisexual or transgender, are people of color, have other stigmatized “differences,” and/or don’t live near a large metropolitan area;
- …conflict or distress about their sexual orientation, due to misinformation, cultural or religious values, and/or internalized negative messages;
- …a need to work actively to develop a positive identity (heterosexuals usually do not have to engage so deliberately in their identity development, because they seldom encounter challenges to it);
- …concern about stressors resulting from anti-LGBT prejudice, e.g. losing one’s job;
- …a need to address substance abuse that may or may not be tied to social isolation, stress, or personal conflict related to being LGBT;
- … pressures (and joys) unique to same-gender relationships in addition to those common to all relationships. Pressures include a lack of the social sanction, lack of relationship models, pathologization of relationships, and discrimination. Joys include deep degrees of friendship and flexibility, egalitarian roles, creative relationship models, profound intimacy and sexual communication.

(Adapted from Appendix C: 4; 15, 56, 64-72)

Growing Courage and Making Changes

Heterosexism is so deeply embedded in American culture that it is experienced as a “given,” the “default” mode of how everyone “naturally” is. Misconceptions are bound to follow, e.g., “homosexuality is unnatural…perverse…immoral…sick…corrupt… evil… sinful…willful…changeable… etc.…” And yet, we know that LGBT affirming practices and programs improve clinical outcomes, reflect professional standards, prevent damage to clients, help clients feel welcome, develop safe therapeutic alliances, and uphold the value of each unique individual and culture.

Becoming an agent for change can be uncomfortable. Unhealthy fear can seem paralyzing. “What will happen if I challenge the status quo?...What if I fail?... Will I be seen as a radical troublemaker?...Will people think that I’m LGBT?...” It can be reassuring to know that no one does this perfectly. Holding ones own and others’ anxiety in compassion is an essential step toward growing the courage necessary to walk through the anxieties that impede action.

As we know from our work with clients, personal (and systemic) change requires profound courage, the willingness to look deeply at oneself (and one’s agency) and to explore new approaches. Patience, persistence and flexibility are essential, especially when one’s carefully thought out new approaches run amok (as they tend to do). Lasting change results from an accurate assessment of the current situation, starting with what the assessment finds, and using small steps to reach the desired larger goal. (Great leaps forward almost never succeed and usually result in back sliding and backlash.)

Practical, effective tools are as essential as courage to effect systemic change. In November of 2005, Planned Parenthood Mid-Hudson Valley, Inc. and the Mental Health Association in Dutchess County, Inc. sponsored a full day workshop “Looking In and Reaching Out: Becoming an Ally for Lesbian, Gay, Bisexual and Transgender Clients” (presented by Alicia Lucksted). As part of that workshop, participants were

asked to brainstorm strategies to help them grow courage and gather tools. Their ideas reflect the wisdom of experienced social change agents, and are summarized below for your use. See the Resources appendix for more ideas and sources.

Personal / Individual

- ▼ Clarify your own values, priorities and intentions – passion is powerful.
- ▼ Focus on the fact that what you are seeking is a more just and humane world… you are in the right to be trying to change things.
- ▼ Look for and take advantage of everyday small opportunities to effect change. They add up and don't require as much risk.
- ▼ Accept where things are now, and reflect on where you can make changes and where you cannot. Channel your energy -- what can I do in this situation or to move closer to this distant goal?
- ▼ Don't shy away from failure, examine it and see what can be learned. Be compassionate with yourself and those who tried with you.
- ▼ Take responsibility for being personally offended at injustice when you see it happen, even if you are not a member of the group being mistreated at the moment.
- ▼ If you encounter negative reactions or hostility, acknowledge your feelings rather than denying them. Try to not retaliate but rather to channel your anger, hurt, etc into constructive action.
- ▼ Recognize and conscientiously use the power sources and privileges you do have.
- ▼ Don't bang your head too much…acknowledge your and the situations' limits.
- ▼ Be willing to step out of your comfort zone for the sake of change.
- ▼ Don't presume the worst, it rarely happens. Talk yourself out of catastrophizing, but be alert to any real risks.
- ▼ Ask what are the costs to NOT acting? To one's self, one's conscience, to others?
- ▼ Show acceptance to grow acceptance.
- ▼ Do what you need to strengthen and encourage yourself.

Interpersonal

▼ Find like minded people and work together to help and support each other's efforts.

▼ Address problems when they are small, rather than waiting for them to grow or explode.

▼ Hold others responsible for insensitive or unjust things they say/do, but be kind in doing so.

▼ Stay open to new ideas, strategies, and creativity – looking at a problem from different angles, trying different paths to the goal.

▼ Talk to someone outside the situation you are working on… for fresh perspective.

▼ Marshal resources: Gather together the information, allies, resources you need.

▼ Use a specific example (or one person's story) to show others the impact of the problem and the importance of the changes you are suggesting or working for.

▼ Think ahead of time about how you will give feedback or interrupt a negative incident.

▼ When attempting change that has real risks, talk to others about them ahead of time, especially those who may be implicated or end up involved.

Organizational

▼ Tie desired changes to your organization's mission statement and policies.

▼ Cultivate the involvement and endorsement of supervisors/managers and Board of Directors to make the changes agency-wide.

▼ Consider hypothetical problems and make response/resolution plans *before* they actually happen. Examine standing policies and procedures for gaps.

▼ When a negative incident happens, both address the acute situation at hand, and use it as an opportunity to later reflect on how it was able to happen, what could prevent it in the future, and whether the acute response was optimal.

▼ Examine what has worked or not in the past in similar change efforts and consider how those lessons may apply to your current situation, or may be irrelevant.

▼ Try to institutionalize whatever change you are working for, get it encoded in your agency's policies and usual procedures – so that it becomes "the usual."

▼ Provide staff with the information, training, coaching, and supervision that encourages the skills you want to foster in your group/agency.

▼ Talk to other practices/agencies similar to yours regarding their efforts in this area. This gives your context, comparisons and can also show skeptical others that you are not the only person/agency who cares about LGBT issues. It can also generate new ideas, networks, and resources.

▼ Ask clients and staff for feedback on changes.

▼ Join forces with self-help and advocacy groups wherever you can to share the resources, share work and share the joys.

APPENDICES

H. Exercises for Assessment and Training
I. Glossary
J. References
K. Resources & Organizations
L. Selected Bibliography on LGBT issues
M. Ethical Guideline Excerpts
N. Selected Bibliography on LGBT-affirming psychotherapy

Appendix A : Exercises for Assessment and Training

Included in this appendix are helpful exercises. Each exercise includes directions and guidelines. The Appendix also includes three outlines for educational workshops that use the exercises in different combinations.

Exercises:

1. Assessing your Organization's LGBT Friendliness
2. Trash that Myth
3. Definitions and Terminology Discussion
4. Heterosexual Questionnaire
5. Moving Survey
6. Examining Stereotypes

Assessing your Affiliate Friendliness

To enhance your LGBT work it's helpful to annually identify the steps you've already taken to create a safer and more welcoming environment for LGBT people, and to notice the steps that need more attention. Put a check mark in the small triangle to indicate your completion of each step. Date completed __________

1. We have the support of our Executive Director .
2. We have the support of our Management Team.
3. We have created a diverse and on going LGBT Advisory Committee.
4. We currently elect LGBT board members.
5. We annually educate our board and keep them informed.
6. We annually train all staff and volunteers to be LGBT friendly.
7. Client forms have been reviewed and are LGBT sensitive & gender neutral.
8. We are market and advertise directly to LGBT people.
9. Our sites are visibly welcoming to LGBT people.
10. Our education and training programs include LGBT awareness.
11. We have built coalitions with the LGBT community.
12. We publically advocate for LGBT rights.

Trash that Myth Exercise

Purpose: The purpose of "Trash that Myth" is to help participants differentiate misconceptions from accurate information about LGBT people in a non-threatening way.

Directions:

1. The attached myth-facts sheets are formatted in large type with one statement per page so that you can directly copy them (as is) for use in this exercise. You'll need one copy of each.

2. You'll also need an open trash can.

3. Place the trash can in the middle of the room.

4. Give each participant one or more of the myths/fact sheets, so that all are distributed.

5. Ask the person whose sheet is #1 (then #2, #3, etc.) to read her/his statement aloud, and to state whether or not the statement is a myth or a fact.

6. Then ask the group whether or not they agree. Use the process points on the facilitator's answer key (included below) to generate discussion and help the group separate the myths from the facts.

7. If the participant's statement is a myth, ask him/her to "trash" it by dramatically crumpling it or tearing it up and throwing it in the trash can. If it is a fact, tape it up so that the group is left with the facts clearly in view at the end of the exercise.

8. Repeat for all of the statements.

Materials Needed:

1) Myth – Fact sheets to copy and use

2) Facilitator's Answer Key

3) Trash can

4) Masking tape

Feel free to use the information included in the myth/fact statements and answer key in other ways: as springboards for discussion, as "lecturette" material for clinical issues, compiled as an informational fact sheet handout, transformed into overheads, etc.

1) **Everyone has a sexual orientation.**

2) Homosexuality is not natural.

3) **If a person has sex with someone of the same sex, it means they are lesbian or gay.**

4) Alfred Kinsey found that after the age of 12, 37% of all men had at least one homosexual experience.

5) **Simply being homosexual deemed one mentally ill according to the APA's Diagnostic and Statistical Manual of Mental Disorders until 1973, and "ego-dystonic homosexuality" was considered a psychiatric illness until 1987.**

6) Homosexuality causes mental illness, & mental illness is a cause of homosexuality.

7) **Bisexuals are equally attracted to men and women, & are confused about their sexuality.**

8) **The average age of coming out for lesbian, gay & bisexual people is 15.**

9) **“Transgender” refers to people who do not fit within traditional gender roles.**

10) Transgender identity is still deemed pathological *per se*, and a diagnosis of Gender Identity Disorder is usually a prerequisite to gaining access to somatic treatments (e.g. sexual reassignment surgery, hormones).

11) **Gay men dress like women, lesbians dress like men, & cross dressers are rarely heterosexual.**

12) **Gay men want to be women and lesbians want to be men.**

13) Gay and lesbian relationships don't last.

14) **The vast majority of adults who have sex with children are heterosexual males.**

15) Gay men and lesbians try to recruit straights.

16) In a 1997 survey of LGB therapy clients, 64% reported that they had experienced discrimination or poor treatment in the mental health system because they were lesbian, gay or bisexual.

17) **28% of LGBT students drop out of school because of assault, verbal abuse and isolation.**

18) **LGBT youth are at least 4 times more likely to attempt suicide than their peers.**

19) **There tends to be a higher incidence of depression among LGBT people than among heterosexual people.**

20) Intimate partner violence does not occur between same sex partners.

21) **LGBT people have played a significant role in human history.**

22) **Many mental health providers are uninformed about issues and concerns of LGBT clients, and don’t know about resources that could benefit them.**

23) **Parents, families and friends of LGBT people created organizations in support of sexual minorities.**

Trash That Myth

Facilitator's Answer Key

1. Everyone has a sexual orientation.
Fact. Sexual orientation is like an inborn inner compass, which attracts a person toward others of the opposite gender (called heterosexual), same gender (called homosexual) or both genders (called bisexual). Some people experience no sexual attraction. This orientation is called asexual. Studies among mammals indicate that about 10% are exclusively heterosexual in their behavior, 10 % are exclusively homosexual in their behavior, and 80 % are on a continuum of bisexual behavior (72).

2. Homosexuality is not natural.
Myth. Funk & Wagnall's Standard College Dictionary defines natural as "...occurring in nature..." Homosexual behavior occurs in nature in all types of nature's creatures (73).

3. If someone has sex with someone of the same sex, it means they are lesbian or gay. Myth. A person's sexual identity, whether they identify themselves as heterosexual, bisexual or lesbian/gay, may or may not be consistent with their behavior. Many people who think of themselves as heterosexual have had sexual interactions with people of the same gender, and many people who think of themselves as lesbian or gay have had sexual experiences with someone of the opposite gender (72).

4. Sexuality researcher Dr. Alfred Kinsey found that after the age of twelve, 37% of all men had at least one same gender sexual experience.
Fact. It is natural for people to experiment with their sexual feelings. 90% of these men chose basically opposite gender sexual behaviors after these experiences. (Remember that *behavior* is a choice, and *orientation* is an attraction upon which one may or may not choose to act.) (72)

5. Simply being "homosexual" deemed one mentally ill according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders until 1973, and "ego-dystonic homosexuality" was considered a psychiatric illness until 1987.
Fact. Since LGBT sexualities that do not fit into conventional heterosexual and gender roles, they have been pathologized for much of psychology and psychiatry's history. (references 14-18). This history still lingers today, among LGBT people who experienced decades of "treatment" for "homosexuality," and the history of psychiatric abuse of which younger LGBT people are acutely aware (27-29*)* The notion that "homosexuality" *per se* is a mental illness also remains among some mental health providers trained before 1973, and some younger mental health providers (30).

6. Homosexuality causes mental illness, and mental illness is a cause of homosexuality. **Myth.** There is a long professional history of theorizing that "homosexuality" causes mental illness or vice versa (31) and LGBT people still sometimes encounter these beliefs when they seek mental health services. Some LGBT people who seek mental health care still encounter some mental health professionals who consider that their sexual orientation and/or gender identity is a delusion or symptom that will "go away" when their mental illness is resolved (43). Although scientific research has consistently disproved this myth (33-39), some mental health providers claim that having a same gender relationship causes or exacerbates clients' mental health problems (28), and pathologization is still debated in prominent professional journals(44,45)

7. Bisexuals are equally attracted to men and women, and are confused about their sexuality. **Myth.** Most bisexuals have a stronger attraction toward one gender or the other, while recognizing their attraction to both. Remember the continuum among the 80% of bisexual mammals, and that an individual's inner compass can be attracted to any point along that scale. Many bisexual (and lesbian and gay) people feel confused for a time during their "coming out" process. This "confusion" is a normal response to the messages they've heard all of their lives that there is something wrong with what they clearly feel. Their feelings are clear. The confusion comes from society's messages about what they feel (72)

8. The average age of coming out for lesbian, gay and bisexual people is 15.
Fact. Most people (including heterosexuals) are aware of their sexual orientation as young children, although they might not have words for it and some reach awareness at later ages. LGB people have usually been aware of their sexual orientations an average of six years before coming out to anyone (telling at least one other person). Coming out is not a single event, and LGB people must continually make decisions about in what situations and to whom it is safe to come out (74).

9. "Transgender" refers to people who do not fit within traditional gender roles.
Fact. This is a broad, encompassing term used to describe individuals whose gender identity and expression does not coincide with their assigned gender roles or biological gender. Examples include cross dressers and people who feel that they were born the "wrong" gender *(International Foundation for Gender Education, 2002, www.ifge.org)*

10. Transgender identity is still deemed pathological *per se*, and a diagnosis of Gender Identity Disorder is usually a prerequisite to gaining access to somatic treatments (e.g. sexual reassignment surgery, hormones).
Fact. The DSM-IV-R defines Gender Identity Disorder as "a strong and persistent

cross-gender identification which is the desire to be, or the insistence that one is, of the other sex", accompanied by "persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex." A psychiatric diagnosis of GID is usually a prerequisite to gaining access to somatic treatments (e.g. sexual reassignment surgery, hormones).

11. Gay men dress like women and lesbians dress like men, and cross dressers are rarely heterosexual men.
Myth. Some gay and lesbian people cross dress but most do not, just as some heterosexual people cross dress and most do not. In fact 80-90% of cross dressers are heterosexual men. We can't tell someone's sexual orientation by how they dress. *(International Foundation for Gender Education, 2002, www.igfe.org)*

12. Gay men want to be women, and lesbians want to be men.
Myth. Most gay and lesbian people are quite comfortable with their gender identity. *(International Foundation for Gender Education, 2002; www.igfe.org)*

13. Gay and lesbian relationships don't last.
Myth. Gay and lesbian relationships last about as long as heterosexual relationships. Many gay, lesbian and bisexual people have life long committed relationships (75).

14. The vast majority of adults who have sex with children are heterosexual males.
Fact. One FBI study showed that 98% of all adults who have sex with children of either gender are heterosexual males (76).

15. Gay men and lesbians try to recruit straights.
Myth. Gay men and lesbians do not seek to coerce or convert anyone and are usually quite cautious about "coming on" to anyone whose sexual orientation they don't know, for fear of upsetting the person. In contrast, small numbers of heterosexual people sometimes do assert that having sex with someone of the opposite gender will "straighten out" a gay or lesbian or bi person. This reflects social mores and some laws that try to enforce heterosexuality. *(Lambda Legal Defense and Education Fund, 1997-2002, www.lamdalegal.org)*

16. In a 1997 survey of LGB therapy clients 64% reported that they had experienced discrimination or poor treatment in the mental health system because they were lesbian, gay or bisexual.
Fact. Nancy Nystrom's 1997 (56) study also found that 23% reported that a therapist or psychiatrist tried to change or convert them to be heterosexual, 29% reported being

verbally harassed for being lesbian, gay or bisexual by a mental health professional, and 10% reported being physically hurt by a mental health worker or professional

17. 28% of lesbian, gay, bisexual and transgender students drop out of school because of assault, verbal abuse and isolation.
Fact. Few schools protect LGBT youth from abuse in the halls, with disastrous results LGBT teens have successfully sued school districts for failing to protect them. As word of this gets out, more schools are taking actions to protect LGBT youth and thereby prevent lawsuits (77).

18. LGBT youth are at least 4 times more likely to attempt suicide than their peers.
Fact. Even though LGBT youth represent only about 10% of the population, they represent about 30% of all teen suicides (78).

19. There tends to be a higher incidence of alcohol/substance and depression among lesbian, gay, bisexual and transgender people than among heterosexual people.
Fact. People who are subjected to alienation, discrimination and violence are more likely to become depressed, and some may "self medicate" with alcohol and other drugs, than are people who are not subjected to such treatment (79). Overall, LGBT people as a group experience more of these negatives and do have higher average rates of these illnesses.

20. Intimate partner violence does not occur between same sex partners.
Myth. Just as intimate partner violence occurs in heterosexual relationships, it also occurs in same gender relationships, in about the same proportions. *(New York State Coalition Against Domestic Violence, 2001)*

21. LGBT people have played a significant role in human history.
Fact. Significant contributions have been made by Socrates, Plato, Sappho, Michelangelo, Eleanor Roosevelt, George Sand, Oscar Wilde, and Chopin to name a few – and many others whose names are not famous (76)

22. Parents, families and friends of LGBT people have created organizations in support of sexual minorities.
Fact. PFLAG (Parents, Families and Friends of Lesbians and Gays) is the largest and can be reached through its web site at www.pflag.org

(end of Myths-Facts Facilitator's Key)

Definitions and Terminology Discussion

1) Look through the Glossary appendix of this Tool Kit. Xerox, copy, or paraphrase a set of terms and their definitions that you think are most important to the people who will be participating in your exercise. You probably do want to include the following among those you choose: sexual orientation, gender identity, homosexuality, heterosexism,

2) Give participants a "Glossary" hand out and ask them to look it over.

3) Guide the group in a discussion of the glossary. Some suggestions for discussion questions and prompts are below:

- Are there any definitions that aren't clear, or that you still have questions about?
- Ask the group to discuss the distinction between sexual orientation, gender identity, and sexual behavior.
- Draw out the difference in the message that is sent if one refers to another person as "homosexual" vs. referring to them as "gay" or "lesbian"
- Ask the group to share some examples of heterosexism and homophobia in language, from their professional experience (e.g. asking all women their husband's or boyfriend's name assumes everyone is heterosexual).
- Emphasize the power that language has to not only convey information but also to convey emotion, welcome, or discomfort with a topic.
- Ask the group why it may be important to understand the "family of choice" concept.
- Ask the group to distinguish between a woman who has sex with women and a lesbian.
- Ask if there are other terms that participants have questions about.

Training Options for Martin Rochlin's "Heterosexual Questionnaire"

(developed by Planned Parenthood Mid-Hudson Valley New York)

Before beginning any version of this exercise, explain to the group that statistically somewhere between ten and 20 percent of the people in the room are lesbian or gay, and that some are bisexual. Ask that everyone please pretend to be heterosexual for the purposes of this exercise.

The heterosexual questionnaire turns on its head basic heterosexist assumptions and misconceptions about what it means to be lesbian or gay by reversing some of the questions most commonly asked of lesbian and gay people. The tool can be used in a variety of ways to provide heterosexuals with a personal sense of how lesbian and gay people may feel when asked such questions, illuminate the assumptions behind the questions, and generate discussion about the validity of questions like these in therapeutic settings, for example:

To simulate an early individual therapy session (e.g. when taking client's history, or when client discloses sexual orientation), ask participants to work in "interview" pairs, and request that one partner interview the other with questions one through nine, then switch so that the interviewed partner becomes the interviewer for questions ten through eighteen. Ask participants to note how they feel when asked the questions.

Process points:

- → Ask group how they felt being asked the questions and list responses on newsprint.
- → Ask what they thought of their interviewer's ability to understand and accept them as they are, and list responses.
- → Ask whether or not the questions led to any concern that the interviewer may be uncomfortable with their heterosexual orientation, or wish to change it.
- → Review above responses and ask the group if they felt they could develop a therapeutic alliance with their interviewer.
- → Ask whether or not they would return to this interviewer.

Close the exercise by asking the group to identify:

- ▼ which (if any) of these questions are relevant in treatment;
- ▼ why the use of questions like these may be detrimental to therapy; and
- ▼ effective ways to address clients' concerns about their own or another's sexual orientation (list on newsprint).

Go around the room and ask participants to name something that was meaningful for them, and something they would consider doing differently as a result of this exercise (list on newsprint).

To simulate a therapist addressing sexual orientation in a group therapy session, explain that the trainer represents the therapist, and will ask some group member a question that they must answer aloud in front of the group. Ask participants to note how they feel when asked the questions. Invite the other group members to participate in the group at will. Then, ask two or three group members a question or two, and ask them to further explain and clarify their responses. Make no effort to intercede on the behalf of the members you question.

Process points:

- → Ask those questioned how they felt being asked these questions in front of group members and list responses on newsprint.
- → Ask what they thought of the therapist's ability to understand and accept them as they are, and list responses.
- → Ask those questioned about the degree of safety felt in the group, and how they saw the therapist's role in creating safety. (List responses.)
- → Ask whether or not the questions led to any concern about being accepted by other group members.
- → Ask how group members who identify as heterosexuals felt about witnessing others asked to justify their heterosexual orientation.
- → Review above responses and ask the group if they felt they could develop a therapeutic alliance with the therapist and the group.
- → Ask whether or not they would return to this group.

Close the exercise by asking the group to identify:

- ▼ which (if any) of these questions are relevant in treatment;
- ▼ why the use of questions like these may be detrimental to therapy;
- ▼ effective ways to address clients' concerns about their own or another's sexual orientation (list on newsprint); and
- ▼ how a co-therapist might have interceded to create safety for everyone involved.

Go around the room and ask participants to name something that was meaningful for them, and something they would consider doing differently as a result of this exercise (list on newsprint).

To simulate client interactions in a group therapy session, tell participants that they are all clients in a group therapy session, and they may participate in the group at will. Ask for a volunteer to play the role of "curious client." Ask "curious client" to ask a battery of the questions of one group member. The trainer (therapist) watches the

interactions and does not intercede. Ask participants to note how they feel as the session unfolds.

Process points for above approaches:

- → Ask the client who was questioned how s/he felt being asked these questions in front of group members and list responses on newsprint.
- → Ask s/he about the degree of safety felt in the group, and how s/he the therapist's role in creating safety. (List responses.)
- → Ask whether or not the questions led to any concern about being accepted by other group members.
- → Ask how group members felt about witnessing one group member asked by another to justify her/his heterosexual orientation.
- → Review above responses and ask the group if they felt they could develop a therapeutic alliance with the therapist or the group.
- → Ask whether or not they would return to this group.

Close the exercise by asking the group to identify:

- ▼ which (if anything) in the client to client interactions are helpful in treatment;
- ▼ how client to client interactions like these may be detrimental to the group's process;
- ▼ effective ways to address clients' concerns about their own or another's sexual orientation (list on newsprint); and
- ▼ how the therapist could have interceded to create safety for everyone involved (list on newsprint);

Go around the room and ask participants to name something that was meaningful for them, and something they would consider doing differently as a result of this exercise (list on newsprint).

Heterosexual Questionnaire

(adapted from Martin Rochlin, Ph.D.)

1. What do you think caused your heterosexuality?

2. When and how did you first decide that you were heterosexual?

3. Does your heterosexuality stem from a neurotic fear of others of the same gender?

4. If you've never made love with someone of the same gender, isn't it possible that all you need is a good gay or lesbian lover?

5. To whom have you revealed your heterosexual tendencies? How did they react?

6. Why do you heterosexuals feel compelled to seduce others into your lifestyle?

7. Why do you insist on flaunting your heterosexuality? Can't you just be what you are and keep it quiet?

8. Knowing the problems they'd face, would you want your children to be heterosexual?

9. Since the vast majority of child molesters are heterosexuals, do you consider it safe to expose your children to heterosexual teachers?

10. Despite all the societal support marriage receives, the divorce rate is spiraling. Why are there so few stable relationships among heterosexuals?

11. Why do heterosexuals place so much emphasis on sex?

12. Considering the menace of overpopulation, how could the human race survive if everyone were heterosexual like you?

13. Could you trust a heterosexual clinician to give you a physical exam without becoming sexually aroused?

14. How can you become a whole person if you limit yourself to compulsive, exclusive heterosexuality and fail to develop your natural, healthy homosexual potential?

15. There seem to be very few happy heterosexuals. Techniques have been developed which might enable you to change if you really want to. Have you considered aversion therapy?

16. The vast majority of criminals, welfare recipients and other irresponsible or antisocial people are heterosexual. Why would anyone hire a heterosexual for a responsible position?

17. Why are heterosexuals so promiscuous?

18. Do you make a point of attributing heterosexuality to famous people to justify your own heterosexuality?

Moving Survey Exercise

Equipment Needed:

One sign saying "Certain" and a second saying "Uncertain" (8.5 x 11 paper or larger) and tape.

Explaining the Exercise to Participants:

- ▼ The purpose of this exercise is to get people out of their seats and thinking about w LGBT issues directly apply to mental health work, and their own personal views.
- ▼ I have taped one sign on the wall at one end of the room, and the other at the other end, so that the two signs represent the ends of a continuum and there is open space for people to stand anywhere along that continuum, against the wall.
- ▼ This is voluntary. Hope that everyone will participate, but don't have to.
- ▼ No one will be embarrassed, put on the spot, or asked to defend their opinions. In fact, you won't be expected to say anything unless you really want to.
- ▼ As I read each statement move to the spot on the continuum where you feel you belong, for whatever reason. Just stand there until everyone is settled.
- ▼ I'll then ask if anyone wants to make a comment about their place on the continuum, but you don't have to.
- ▼ Purpose is just to hear what each other is thinking and reflect on own feelings, clarify where you stand. No comments or discussion about other's place or views.
- ▼ You may move as others talk if you wish, if a remark makes you reconsider.
- ▼ If don't feel you can stand where you'd really like to due to social pressures, at least think to yourself why you'd stand there and why. But do try to be truthful and candid.
- ▼ Ask participants to Volunteers will be asked come up to the continuum wall.

Instructions for the Leader:

1. Before the exercise, choose 4 scenarios from the list below, or create your own.
2. Have the signs posted as explained above

3. Explain the exercise to everyone (see above)
4. Ask volunteers to come to the front of the room.
5. Read the first scenario, followed the prompt 'How Certain to Uncertain are you about how you would react in this situation" and wait until everyone has found their spot. Often it helps to repeat the scenario and the prompt.
6. Gently ask if anyone wants to make a comment, but emphasize that they don't have to. Hear out the comments with acceptance and without further comment.
7. Then go on to the next scenario
8. When you've done all 4 scenarios (or however many you choose), lead everyone in a short debriefing:
    - Ask participants how they found the exercise. Any surprises?
    - Ask those who chose to watch rather than participate what they observed.
    - Thank everyone for their participation.

<u>Potential Scenarios to Choose From</u>

These were created from real situations happening in real mental health settings (mostly in Maryland). Feel free to create your own based on common challenges in your type of work, your setting, geographical area, etc.

▼ During discharge planning, a client asks you if the program you're referring them to is safe for gay men, or if he should expect harassment.

▼ At intake a lesbian client asks to list her ex-partner as her next of kin.

▼ You overhear a co-worker commenting to another that LGB people will all burn in hell when they die.

▼ A coworker asks you for help in finding an outpatient therapist who is supportive of bisexual people, for a client who asked.

▼ You walk into a common area to find one patient calling another a "fucking dyke" during a disagreement.

▼ The Metropolitan Community Church, a Christian denomination that has mostly LGBT members, asks if your agency would like their chorus to give a performance for staff and clients during the winter holidays.

▼ A new client person is admitted who has undergone sexual reassignment surgery and asks to have his/her own room because of past difficulties with roommates hostile to transgender people.

- ▼ A new openly LGBT staff member invites you and other staff to his/her home for a barbeque.

- ▼ A client in the process of gender transformation is dressing and living as a woman but has not yet been able to legally change her name from her previous (male) one, and some staff are insisting on calling her by her former/male name against her request.

- ▼ A staff person or client wants to come out (as LGB or T) during your program's community meeting

- ▼ Your co-worker's client confides to you that his/her counselor has been saying disrespectful thing about the client's sexual orientation during their counseling sessions, but the client feels afraid to object to the counselor (your co-worker).

Examining Stereotypes Exercise

Equipment Needed: flip chart (large pad of paper) & easel, markers, tape

Purpose: To facilitate participants' examining how stereotypes affect everyone, focusing on mental health and LGBT stereotypes.

At each step, record responses on the flip chart, taping full pages to the wall or wherever possible so everyone can see. It is helpful to have one person lead this exercise while a second person writes things down.

1. Ask the group: What are the common stereotypes about people who receive mental health care?

- Get people to call them out, list on the flip chart paper.
- You can emphasize that it does not have to be things they believe, but just what are the ones out there.
- Prompt brainstorming for a few minutes until you have a good list

2. Then ask: What are the common stereotypes about lesbians, gay men, bisexual and/or transgender people?

- Again, get people to call them out, write on a different piece of paper…keeping both up and visible.
- Again, you can emphasize that it does not have to be ones they believe, but ones they've heard of.
- As a prompt, ask about each group separately: gay men, bisexual men, bisexual women, lesbians, and transgender people.

3. Go back to the consumer stereotypes page. Ask the group:

- What do you think of these? (hopefully they'll say they are false and hurtful)
- Where do they come from? Where do people learn them? Hear them?
- What do these stereotypes do to people who seek or need mental health care?
- How do these stereotypes affect your work, your job?
- Record their answers on a fresh sheet of the flip chart

4. Then turn to the LGBT stereotypes and carry out the same exercise:

- What do you think of these?
- Where do they come from? Where do people learn them? Hear them?
- What do they do to people who are LGBT?
- What do they do to heterosexual people?
- How do they affect you and your job?

5. Concluding Discussion

- Notice parallels between the two sets of papers… ask for comments.
- Ask for thoughts on how both sets of stereotypes affect a program like this.
- Ask for thoughts on how we can dismantle them, at least in the sphere you all share who have come together for this exercise.

4-hour Inservice Training Outline

Appendix C: 1

If you want to do your training in-house, the following outline offers one model for your use. It is followed by two other different outlines.

The goal of this four-hour training is to increase awareness of LGBT mental health issues, enhance staff comfort level, increase sensitivity to diversity dimensions and improve cultural competence in working with LGBT clients.

Recommendations

1) This training has been most effective when provided to fewer than 20 people at a time.
2) The amount of time spent on each section will vary from group to group. Enjoy the teachable moments as they arise.
3) Providing snacks and a conducive training space are always helpful.

Time needed: 3-4 hours

All the suggested handouts are provided within this toolkit, as outlined below. You will need an easel, newsprint pad, markers, masking tape and a trash can. You may want to use your agency's standard training evaluation tool to assess the training afterwards.

1) Opening: the facilitator(s) introduces self, gives overview of training and states training goals.

2) Ice breaker: Ask participants to share an experience, either personal or professional, that they have had with a lesbian, gay, bisexual or transgender person. Once everyone has spoken, ask for overall comments or observations. To aid this discussion, some "process points" are included below for the facilitator.

- ▼ most of us have met someone, or have family members who are lesbian, gay, bisexual or transgender

- ▼ many of us have already seen LGBT clients
- ▼ LGBT people come from all backgrounds
- ▼ there's a range of comfort level in the room--some of us are quite comfortable, some feel a little hesitant, and it's all alright, we can work with it together.

3) Trash that Myth Exercise

See earlier in this Appendix for the instructions and materials for this exercise.

4) Definitions and Terminology Discussion

See earlier in this Appendix for the instructions and materials for this exercise.

5) Heterosexual Questionnaire used as a group exercise

Divide the group into pairs. Explain that we are going to explore what it feels like to be asked questions by someone who doesn't understand your sexual orientation and makes assumptions about you. Give each participant the "Heterosexual Questionnaire" handout (see earlier in this appendix). Ask them each to choose three or four questions to ask their partners and listen to his/her responses, then switch. Ask participants to take each question seriously and try to answer them honestly.

After 10-15 minutes in pairs, reconvene as a large group for discussion.

Discussion points:

- ▼ how did it feel to be asked these questions?
- ▼ was it easy to justify your sexual orientation to another person?
- ▼ did the questions seem bizarre when placed in this context? how so?
- ▼ what are some of the assumptions that underlie these questions?
- ▼ are any of these questions important in providing clinical services to a heterosexual person? why or why not? (If it's not related, don't ask it.)

Applying this exercise to future work: When you're about to ask an LGBT client a question, first substitute the word "heterosexual" in your mind before you ask it. How does the question sound? Positive? Respectful? Insulting? Ridiculous? That is probably how it will sound to the client as well.

6. Q&A: Leave at least 15 min at the end of your inservice to allow open discussion. The facilitator might ask participants for any remaining questions, things the workshop made them think about, or topics they'd like to address before concluding.

7. Conclusion: Going around the circle of participants, ask each person to respond to the following open-ended statement: "This training inspires me to..."

8. Evaluation: You may want to have ready your agency's usual inservice evaluation form to gather feedback, or to have created one expressly for this inservice. Both positive and negative feedback can be valuable in shaping future trainings or discussions.

(end of 4-hour Inservice Training outline)

90-minute Staff Workshop on LGBT Issues in Mental Health Services

(from (2))

Preparation:

- ▼ Informal discussions beforehand with staff to assess needs, wants, focus
- ▼ Presenters need to decide who will take what roles ahead of time
- ▼ Nice to plan from the beginning to have a follow up meeting among presenters.

1. Introductions (15 min)

A. Purpose in doing this workshop is to share information about issues that gay, lesbian, bisexual, and transgender people face when they receive services in mental health programs like this one. We know that there are a wide variety of opinions and feelings about LGBT people and issues, and a lot of professional expertise in this room. So, the purpose is not to tell anyone how to think. Instead, we are holding it because all the major mental health professionals' organizations recognize that professional conduct includes showing respect for and offering good services to LGBT people as to anyone. So, by sharing this information today we hope you can incorporate it into your own best professional work in ways that you see fit.

B. Agenda Review: for the next 90 minutes we'll be doing a variety of discussions and exercises, with time for additional questions at the end. Nonetheless, if you have a question as we go along please feel free to ask. If it's something that will take some time to answer or discuss, we may save it for the end.

C. Personal Introductions: Presenters if unfamiliar to participants, or and go around and have everyone introduce themselves.

2. Terminology Discussion (15 min)

To make sure we're all speaking the same language, and to begin talking about ways to show respect and sensitivity, we'll discuss some terminology.

(See earlier in this appendix for directions guiding a discussion of terms and definitions)

3. Moving Survey (20 min)

(See earlier in this appendix for directions regarding this exercise)

4. Topics for Short Discussion (30 min total with introduction)

Drawing from the information in this toolkit, you pre-workshop discussions with stakeholders or participants, and your own professional experience and other training, lead time-limited discussions on 3 or 4 of the topics below. Often it works well to ask participants to choose what is most interesting to them, but other presenters may prefer to choose themselves ahead of time. Each should last only about 5 minutes.

See attached summary points on each topic listed below, to assist in your facilitating the brief discussions; they follow this outline.

A. Healthy adult human sexuality is not addressed well in most MH programs
B. Staff homophobia and lack of information not addressed in most programs
C. Consumer – consumer intolerance and harassment re LGBT is condoned, not addressed
D. Programs have little information/resources about LGBT affirmative resources in community or for own programs
E. Personal religious beliefs vs. professional conduct and community welfare
F. We don't have any LGBT clients
G. Transgender people / issues

5. Remaining Questions and Conclusions (10 minutes)

Allow time for participants' remaining questions, but also reserve time to make a few concluding statements yourself. Some ideas are below:

▼ How LGBT-affirming a setting is has serious effects, on client's perceptions of (physical and emotional) safety, on their engagement with care and their outcomes, everyone's stress levels, on the atmosphere for all.

▼ This 90-minute workshop was not designed to give answers. Rather it is a beginning not an end. Hopefully it will spark further discussion.

▼ Each person and agency can decide what, if anything, it wants to develop further in this area – what self-examination it might want to engage in, what changes it might want to make.

▼ Thank everyone for being interested and open to considering these ideas.

Topics for Short Discussion: Summary Information

To assist facilitators in leading this section of the 90minute Staff Workshop

1. Healthy Adult human sexuality is not addressed well in most MH programs

- For many people love, affection, and sexuality are important parts of their life
- In MH settings, there is often a message that patients should not have such needs and desires at all
- Rather, sexuality of any type is seen as a problem – don't get HIV, don't get exploited or hurt, don't get pregnant.
- All are important, but viewing sexuality only in the negative contradicts helping people create holistic health and a full life. What about positive aspects?
- Even MORE not addressed well when talking about LGBT people – more stigma and ignorance
- **Ask** for an Example: Long-term care people go for years without being touched except in clinical way. Same sex couple sanctioned heavily for kissing during visiting time.

2. Staff homophobia and lack of information not addressed in most programs

- Consumers often experience staff as afraid of LGBT people, hostile to them, try to avoid, don't treat people well
- Stereotypes crop up in policies and practices, assumptions that continue un-questioned – often this topic is not even on the radar.
- Knowledge and training re LGBT issues is usually not covered by staff orientation or performance expectations.
- Staff who do raise issue or point out a problem are sometimes criticized
- Working together is important, need good atmosphere to do good work.
- Ask for Example: Staff assume a lesbian patient will likely try to seduce roommate; exhibit religious judgementalism, don't know about LGBT resources in their region that could help clients.

3. Consumer – consumer intolerance is condoned, not addressed

- LGBT patients report harassment and belittling from other clients in their unit or program as common in some places
- The find that staff often look the other way, say nothing – which they perceive as agreeing with it, condoning it, allowing it to happen
- Creates tension and fear, just like other types of harassment.
- Ask for Example: Patient tells one person she's a lesbian, it gets around, person is stared at, others act like afraid of her, men challenge her to have sex with them, threaten her.

4. Programs have little information or resources about LGBT affirmative resources in community or for own programs

- Do staff know about local LGBT issues? Know where to get information, consultation, and assistance when they want/need it?
- Are they able to ask co-workers and supervisors?
- Are any LGBT community resources made available for staff and client education and use?
- This can include both clinical resources (an outpatient therapist friendly to bisexuals) and wider resources (social groups, support organizations)
- Are LGBT issues invisible? Talked about at all?

5. Personal religious beliefs vs. professional conduct and community welfare

- Some people (staff, consumer, others) sincerely hold personal beliefs that are negative toward LGBT identities. Yet many professional ethics codes say it's wrong to discriminate.
- In helping-profession settings, what is the right balance between personal belief and professional conduct when they conflict?
- Clients come to program for help, need to feel accepted and supported, not judged or condemned. Need to be able to bring whole self to treatment / recovery. Yet others have a right to their beliefs
- Often best to consider this issue before it comes up. How is it handled for other instances of conflict between values and client needs (such as perhaps regarding abortion or divorce)?
- Works best if is discussed calmly and openly… in supervision, treatment planning meeting, etc. Referral? Switch assignments? Education?
- Ask for Example: Staff who refuse to work with certain groups? Who are made to feel belittled for own views?

6. We don't have any LGBT clients, so why do we need to know this stuff?

1. If a practice/program never has any LGBT clients, they might inquire into their reputation in the LGBT community – are people staying away? Afraid to be known as LGBT when clients? LGBT people live in every community, so it would be unusual to never have any LGBT clients.
2. Might there be LGBT clients who are not comfortable being known as such? LGBT people are often very skilled at remaining "closeted" when it feels necessary.
3. Often even people who are NOT LGBT suffer disrespect and discrimination because others harass them if perceived might be or could be gay. Creates hostile atmosphere for everyone, having to police one's self so as to not seem to fit someone's unknown stereotypes.

4. Ask for Example: When staff or clients speculate about someone's orientation or gender identity, what is the tone of that speculation? Are there signals that this is a safe welcoming place to be out?

7. Transgender people / issues

- Gender identity seems to be an even more emotional topic than sexual orientation for many providers – ties us in knots. Why? Perhaps because we assume gender to be a simple binary (male / female) and trans people show the much more complex reality.
- Most mental health settings have gender segregated facilities -- bathrooms, changing rooms, residential wings, men's / women's groups – this creates the question of "where to put" transgender people. This can often be talked about respectfully with a trans client. However, it is a good idea to think about the issue before needing to address the needs of a specific client.
- Issue of pronouns – staff in all parts of program need to ask if don't know the person's preference for name and pronoun, and respect it. Supervisors often don't enforce ethics codes when involve religious beliefs, even though code is clear
- Transgender people get harassed more than non-transgender people who are LGB. What is ok in this setting?
- Community resources for staff and program
- Ask for Example: How would staff react if openly trans person came as client?

(end of 90-minute Staff Workshop outline)

45-60 minute Discussion Outline

This workshop was originally created to present to the *clients* of several mental health programs. Staff at these programs thought that their clients would benefit from discussing LGBT issues in a non-threatening way. However, it is likely useful for other constituencies as well.

1. Introductions (10 minutes)
   - ▼ Personal introductions of the facilitator if needed.
   - ▼ Introduction of the purpose of the workshop: to share information about LGBT identities and issues, in general and in this program.

2. Stereotypes Exercise (see earlier in this Appendix for directions: 10 minutes)

3. Terminology Discussion (see earlier in this Appendix for directions: 10 minutes)

4. Topics choice and list, short presentations and discussion (20 minutes total)
   (See this section of the 90-minute workshop, directly above)

5. Questions and Answers from the audience (10 minutes)

Appendix B: Glossary

(Appendix C:1)

Androgyne/Androgynous: people who present themselves in a gender neutral manner or who combine outward characteristics that are typically thought of as "masculine" or "feminine". Androgynous people may identify as male, female, a third gender, or no gender.

Bisexual: A person who is attracted to people of both genders or of either gender. Some bisexually identified people say that gender is irrelevant to their attraction or choice of romantic partners. Others say that gender is quite salient and they are attracted to men and to women for different reasons or at different times. Bisexual does not mean that the person is necessarily involved with both men and women at the same time.

Closeted or *"being in the closet":* not disclosing, or actively hiding or disguising, one's sexual orientation or gender identity. Like "coming out," it may be situational and/or change over time. A given person may be "closeted" at work, but quite "out" socially.

Coming out: the process of acknowledging to someone that you are gay, lesbian, bisexual and/or transgender. It often begins when one first recognizes/acknowledges the identity to one's self ("I came out to myself in college") and then often continues with disclosure to others. This is a non-linear process -- an individual may be "out" in some situations or to certain people but not to others. Various situations (a new job, a new friend) may cause the person to consider whether or not they will "come out," when, and to whom. The term is short for "coming out of the closet" Also used to communicate having come out to someone… such as "I am out to my mother but not my dad" (see *closeted* as well)

Cross dresser (*transvestite*): A person of any gender and any sexual orientation who wears clothing that is not usually associated with his/her socially assigned gender roles.

F to M: A "female to male" transgender or transsexual person. That is, someone who transitioned or is transitioning from living as a girl/woman to living as a man.

Family of choice: because many lesbian, gay, bisexual & transgender people remain "closeted" from their biological families or have been rejected by them to some degree, many develop supportive friendship networks that function as family. Clinicians' sensitivity about whom the client views as family is essential to providing quality care.

Gay: A person who is attracted to people of the same gender. This term is used mainly in reference to men (*gay men)*; however it is sometimes used as an inclusive term to encompass both men and women. Gay may also be used as an adjective to denote

same-sex sexual orientation.

Gender: One's biological, social and /or legal status as male or female. Some sources define "sex" as the biological, and "gender" as the personal, social, or legal. Hence a person could have male (biological) sex but live full time as and think of herself as a woman.

Gender Identity: one's inner sense of being female or male or a mixture of both. This may or may not be consistent with biological, social or legal gender. (see further discussion on p. 12)

Gender Roles: female or male roles created by society and culture that often proscribe narrow sets of behavior for both men and women, and disregard transgender people.

Heterocentric or *heterosexist:* a presumption that everyone is heterosexual, or that heterosexuality is better or more normal than other orientations.

Heterosexism: institutional and social assumption of heterosexuality as better and "normal," compared to other sexual orientations, leading to its being privileged and non-heterosexual orientations being oppressed / disadvantaged.

Heterosexual ("straight"): a person who is attracted to people of the opposite gender.

Homophobia: the irrational fear or hatred of LGB people, often used as a justification for discrimination. *Internalized homophobia* refers to the experience of shame, aversion or self-hatred internalized by someone who is LGB in reaction to society's homophobia and discrimination.

Homosexual (gay or lesbian): a person who is attracted to people of the same gender. Note that in most cases, this word is considered outdated and negative due to its historical use as a clinical term when being gay or lesbian was considered de facto a mental illness. Gay and lesbian are preferred in most instances.

Intersex: people born with sex chromosomes, external genitalia, and/or internal reproductive systems that are not "standard" for either male or female, but instead are mixed, blended, or indeterminate. Intersex people may be of any sexual orientation and any gender identity. The historical term "hermaphrodite" is now considered offensive by many because of the inaccurate implication that the person was born with two sets of genitals. Intersex conditions are caused by any number of prenatal genetic or hormonal anomalies, including those listed below. Individual with these conditions are sometimes at higher risk for other medical conditions, for example, osteoporosis.

Adrenal Hyperplasia: the most prevalent cause of intersexuality amongst chromosomally XX people with a frequency of about 1 in 20,000 births, and is caused by an anomaly of adrenal function causing the synthesis and excretion an androgen precursor, initiating virilization (development of

male secondary sex characteristics) of a XX person in-utero. Because the virilization originates metabolically, masculinizing effects continue after birth.

Androgen Insensitivity Syndrome (AIS):a genetic condition occurring in approximately 1 in 20,000 individuals. In an individual with complete AIS, the body's cells are unable to respond to androgen. Some individuals have partial androgen insensitivity. Partial androgen insensitivity typically results in "ambiguous genitalia."

Progestin Induced Virilization: caused by prenatal exposure to outside androgens, most commonly Progestin, a drug that was administered to prevent miscarriage in the 50's and 60's. It is converted to an androgen (a virilizing hormone which causes the development of male secondary sex characteristics) by the prenatal XX person's metabolism.

Klinefelter Syndrome: Most men inherit a single X chromosome from their mother, and a single Y chromosome from their father. Men with Klinefelter syndrome inherit an extra X chromosome from either father or mother; their karyotype is 47 XXY. Klinefelter is quite common, occurring in 1/500 to 1/1,000 male births.

(all information from www.isna.org/faq),

LGBT: An abbreviation for Lesbian, Gay, Bisexual, and Transgender. Used as an inclusive shorthand to refer to all of the currently identified sexual minorities. It is common to also see it as GLBT, LesBiGay, LGBTQ, GLBTI, or LGBTA. The "Q" is added to include individuals who are *questioning* their sexual orientation/identity, the "I" is added to include *intersex* people, and the "A" is added to include *allies*.

Lesbian: a woman attracted to other women (as a noun), or denoting same-sex sexual orientation among women (as an adjective)

M to F: A "male to female" transgender or transsexual person. That is, someone who transitioned or is transitioning from living as a boy/man to living as a woman.

Men who have sex with men (in medical literature, MSM): Refers to sexual behaviors only, independent of the person's sexual orientation and/or identity.

Pink triangle: A symbol used by the LGBT community to designate pride and community. In the same way that the Nazi's identified the Jews with a yellow Star of David, they identified gay men with a pink triangle and lesbians, prostitutes, and "other undesirable women" with a black triangle prior to exterminating them. The lesbian and gay community reclaimed the use of the pink triangle to honor those who were killed and as a symbol of pride. Black triangles are used with similar meaning among some lesbian and bi women.

Queer: Increasingly used term by some people who identify outside of the sexual

majority and whom may or may not identify with other existing identity "labels." Historically this term was used as a hurtful, derogatory word. Those who use it today as a personal descriptor have "reclaimed" the word and use it with pride. (see further discussion on page 13)

Questioning: Refers to people who are questioning or exploring their sexual feelings, orientation and/or sexual identity (defined below).

Rainbow: A symbol used since the 1970's by the LGBT community to designate LGBT pride and community.

Sexual Behavior: refers to physical sexual activities one engages in. People's behavior can be different from their sexual orientation.

Sexual Minorities: An encompassing term, which includes lesbian, gay, bisexual, and transgender people, however they may identify themselves.

Sexual Orientation: The term used to describe the gender to whom a person is attracted. People who are attracted to members of the opposite gender are heterosexual, or straight. People who are attracted to people of the same gender are homosexual, or gay. Gay women are often called lesbians. People who are attracted to both genders are bisexuals. (See separate entries, and further discussion on pp. 11-12).

Transgender: An umbrella term used to describe people whose gender identity is not consistent with their biological gender or assigned gender roles. The term may include (and be used by) people of various specific identities such as transsexual, intersex, androgyne/androgenous, cross dresser or transvestite, and others. (See separate entries)

Transphobia: The irrational fear and hatred of people whose gender identity or gender presentation does not match, in a socially accepted way, the sex they were assigned at birth. Often used as a justification for discrimination.

Transsexual: A person whose gender identity is not consistent with their biological gender. Some may seek or want to make their body more gender congruence with their internal gender identity through surgery and/or hormonal treatment, although many do not. Transsexuals may be heterosexual, bisexual or homosexual in their orientation.

Women who have sex with women (in medical literature, WSW): Refers to sexual behaviors only, regardless of the individual's sexual orientation and/or identity.

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Appendix D: Resources & Organizations

Note: These resources are in addition to those listed in the References section and other appendices. All contact information was current as of May 2006

Topic Headings:

Bisexuality
Communities of Color Resources
Domestic Violence
Family and Parenting
Journals, Periodicals, Newspapers
Legal Assistance
LGBT Friendly Health Care Organizations (Mental and Physical Health)
Self-Help & Support Organizations for LGBT People with Mental Illnesses
Political & Advocacy Organizations
Referral Services
Religious and Spiritual Organizations
Transgender, Transsexual, Intersex Resources
Work & Human Resource
Youth

BISEXUALITY

Bisexual Resource Center
An organization that educates the general public about bisexuality, provides a public forum for the discussion of bisexuality, and provides a support network for individuals and interested organizations to discuss and obtain information about bisexuality.
(617) 424-9595 www.biresource.org

American Institute of Bisexuality
A not-for-profit organization dedicated to the support of the bisexual community and the education of the public at large about the bisexual community.
www.bisexual.org

COMMUNITIES OF COLOR RESOURCES

The Audre Lorde Project
Lesbian, Gay, Bisexual, Two Spirit and Transgender People of Color center for community organizing, focusing on the New York City area. Through mobilization, education and capacity-building, works for community wellness and progressive social and economic justice.
85 South Oxford Street, Brooklyn, NY 11217-1607
(718) 596-0342 www.alp.org

Lambda Publications
Publishes Blacklines (African American LGBT magazine) and En La Vida (Latino/a LGBT magazine.
1115 W. Belmont #2-D, Chicago, IL 60657
www.outlineschicago.com/blacklines.html
www.outlineschicago.com/enlavida.html

LLEGÓ, The National Latina/o Lesbian, Gay, Bisexual & Transgender Organization
National nonprofit organization devoted to organizing Latina/o Lesbian, Gay, Bisexual and Transgender (LGBT) communities on a local, regional, national and international level. Provides resources to Latina/o LGBT communities including Spanish Language LGBT health information (see "Nuestra Salud" videos in LGBT health section)
1420 K Street, NW Suite 200,Washington, DC 20005
(202) 408-5380 www.llego.org

Blackstripe
The Blackstripe exists to provide information for and about same-gender-loving, lesbian, gay, bisexual, and transgendered people of African descent. News, discussion groups, periodicals and resources.
www.blackstripe.com

Gay and Lesbian Arabic Society
Networking organization for Gays and Lesbians of Arab descent or those living in Arab countries. Advocates internationally for acceptance of L&G Arabs. Website provides news, resources, and information. You must be a member to access much of the website.
www.glas.org

Asian/Pacific-Islander Lesbian and Bisexual Network
A national organization founded in 1987 dedicated to bridging the Asian lesbian, bisexual, and transgender communities throughout the U.S. and abroad.
P.O. Box 210698
San Francisco, CA 94121
(650) 697-0375 www.expage.com/page/aplbn

Trikone
The world's oldest support group for queer people of South Asian heritage. Publishers of popular magazine.
(415) 789-7322 www.trikone.org

DOMESTIC VIOLENCE

Gay Men's Domestic Violence Project
24 hour emotion support for people in crisis; short term emergency shelter in MA & advocacy for gay, bisexual, and transgender male victims and survivors.
PMB 131
955 Mass Ave., Cambridge, MA 02139
Crisis Line: (800) 832-1901 Business: (617) 354-6056 www.gmdvp.org

Network for Battered Lesbians and Bisexual Women
Bilingual hotline, free on-going support group, emergency housing, legal and other referrals.
Hotline: (617) 423-7233 Office Line: (617) 695-0877
P.O. Box 6011, Boston, MA 02114

NYC Antiviolence Project
NYC services , LGBT specific short term counseling, advocacy with justice system, assistance with crime victims board, and support groups for survivors of sexual assault, domestic violence, HIV-related crimes, and bias crimes. Trainings for staff.
24 hotline: (212) 714-1141 Administrative: (212)714-1184 www.avp.org

Rainbow Domestic Violence Resources
Website with information and resources for LGBT people involved in an abusive relationship and links to domestic violence coalitions across the country.
www.rainbowdomesticviolence.itgo.com

FAMILY AND PARENTING

Children of Lesbians and Gays Everywhere (www.colage.org)
Offers peer support, news letters, and literature for children with LGBT parents.
(415) 861-5437

Parents, Families, and Friends of Lesbians and Gays (PFLAG)
Provides support, education, advocacy and excellent informational publications. Local chapters throughout the nation provide support for parents, siblings, friends, and for LGBT people themselves.
(202) 638-4200 www.pflag.org

Gay and Lesbian Parents Coalition International
P.O Box 50360
Washington, DC 20091
(202) 583-8029

Family Pride Coalition
Works to advance the well-being of lesbian, gay, bisexual and transgendered parents and their families. Provides support, access to local groups, technical assistance, and advocacy.
(619) 296-0199 www.familypride.org

Alternative Family Institute
San Francisco based non-profit, community-based agency serving LGBT couples, families, and their members
(510) 628-0965 www.altfamily.org

Family Net (Human Rights Campaign)
Website exploring all aspects of LGBT family life from procreation to parenting.
www.hrc.org/familynet

And Baby magazine
A magazine for Lesbian and Gay parents.
1-866-263-2229 www.andbabymag.com

See Also the LEGAL section for legal support around family and custody issues.

JOURNALS, PERIODICALS, NEWSPAPERS

National Gay Newspaper Guild
Marketing group with links to many regional gay newspapers.
www.rivendellmarketing.com

National Gay and Lesbian Hotline
See NGLH's listing of regional LGBT press.
www.glnh.org

Lambda Publications
Publishes Blacklines (African American LGBT magazine) and En La Vida (Latino/a LGBT magazine.
1115 W. Belmont #2-D, Chicago, IL 60657
www.outlineschicago.com/blacklines.html
www.outlineschicago.com/enlavida.html

The Advocate
Nationally circulated Gay & Lesbian news magazine available in many book stores.
www.advocate.com

Curve
National magazine with a focus on Lesbian issues.
www.curvemag.com

Out
Magazine with lots of photos and primarily gay-male oriented content.
www.out.com

Journal of the Gay and Lesbian Medical Association
The world's first peer-reviewed, multi-disciplinary journal dedicated to lesbian, gay, bisexual, and transgender health. Published quarterly, JGLMA specializes in original clinical research; JGLMA also publishes review articles, brief reports, topical essays, and commentaries. Full text of current issue available on line.
www.glma.org

Transgender Tapestry
A publication by, for, and about all things trans, including crossdressing, transsexualism, intersexuality, FTM, MTF, butch, femme, drag kings and drag queens, androgyny, female and male impersonation, and more. Includes full listing of Trans Support Groups. See www.ifge.org/tgmag/tgmagtop.htm

International Journal of Transgenderism
This electronic journal will be an important vehicle for the transmission of scholarly work in the area of transgenderism.
www.symposion.com/ijt/

LEGAL ASSISTANCE

Lambda Legal Defense and Education Fund
A national legal organization working on lesbian, gay, bisexual, transgender and HIV/AIDS civil rights issues. Assistance with workplace, family, school, and various other legal issues available.
212-809-8585 www.lambdalegal.org

American Civil Liberties Union (ACLU)
Lesbian and Gay Rights and AIDS Project
Legal advice, referral to LGBT supportive legal representation.
125 Broad Street, 18th Floor
New York, NY 10004-2400
(212) 549-2627 Fax: (212) 549-2650
Email: lgbthiv@aclu.org

National Center for Lesbian Rights
NCLR is a progressive, feminist, multicultural legal center devoted to advancing the rights and safety of lesbians and their families. Assistance with legal issues including immigration, adoption, and child custody.
415-392-6257
www.nclrights.org

Servicemembers Legal Defense Network
Services for members of the US military needing legal assistance regarding the "Don't Ask, Don't Tell" policy.
(202) 328-3244 www.sldn.org

Gay and Lesbian Advocates & Defenders (GLAD)
A nonprofit, public interest legal organization whose mission is to achieve full equality and justice for New England's lesbian, gay, bisexual, and HIV or AIDS affected individuals. Referrals and advice for New England residents.
Boston-Area Bilingual Hotline: (617) 426-1350 New England: 1-800-455-GLAD.
TTY number, (617) 426-6156. www.glad.org

Lesbian and Gay Immigration Rights Task Force
Coalition of immigrants, attorneys, and activists that addresses the widespread discriminatory impact of immigration laws on the lives of lesbians, gay men, and people with HIB through education, outreach and advocacy and by providing legal services, information, referrals and support.
350 West 31st Street, Suite 505, New York, NY 10001
(212) 714-2904 www.lgirtf.org

LGBT FRIENDLY HEALTH CARE ORGANIZATIONS (MENTAL AND PHYSICAL HEALTH)

Lesbian Health Foundation
National Foundation working to increase awareness and understanding of the special health needs of lesbian, bisexual, and transgendered women among policy makers, health care professionals, researchers, and the public. Provides training for health care providers, national speakers bureau, and web-based information.
510-883-0778 www.lesbianhealthfoundation.org

GayHealth
A health and wellness site dedicated to lesbian, gay, bisexual, and transgender men and women. Includes information and referral database to LGBT friendly clinics and physicians. www.gayhealth.com

The Lesbian Health Resource Center www.trianglelrc.org
A North Carolina based grassroots, all-volunteer organization that helps lesbians and women who partner with women gain access to quality health information and services. We work with lesbians and our allies to promote our health and well-being by providing health education, information, and resources.
(919) 956-9900

Nuestra Salud: Lesbianas Latinas Rompiendo Barreras (VIDEO)
(Our Health: Latina Lesbians Breaking Barriers) is a compassionate, peer-based, assertive, educational series of Spanish-language videos aimed at promoting preventive care and wellness to Latina Lesbians.
http://www.llego.org or 202-468-5380

Gay, Lesbian, Bisexual, Transgender Health Web Pages
Web pages addressing the health concerns of GLBT people, sponsored by the Seattle-King County Health Department
http://www.metrokc.gov/health/glbt

Transgender Care Conference
Information, including full transcripts of 2000 conference of healthcare providers discussing the provision of care to transgender people.
http://hivinsite.ucsf.edu/InSite?doc=2098.473a

Mautner Project for Lesbians with Cancer
A national organization based in DC dedicated to lesbians with cancer, their partners, and caregivers.
(202) 332-5536 www.mautnerproject.org

Gay Men's Health Crisis
Organization whose mission is to provide compassionate care to New Yorkers with AIDS; educate to keep people healthy; advocate for fair and effective public policies.
1-800-AIDS-NYC www.gmhc.org

The Association of Gay and Lesbian Psychiatrists
Can provide the names of Psychiatrists (M.D.s) in 20 states, Puerto Rico, and Canada who are LGBT friendly and affirmative.
(215) 222-2800 www.aglp.org

Fenway Community Health
A community health center whose cultural competence in the provision of care to the LGBT community has gained it national recognition. (See also "The Evolution of the Fenway Community Health Model" American Journal of Public Health, June 2001; 892, as cited in the articles section)
(617)267-0900 In Massachusetts: (888)242-0900 TTY 617.859.1256
www.fenwayhealth.org

Michael Callen-Audre Lorde Community Health Center
New York medical facility dedicated to meeting the health care needs of the lesbian, gay, bisexual and transgender (lgbt) community and people living with HIV/AIDS regardless of any patient's ability to pay.
356 West 18th Street, New York, NY 10011
(212) 271-7200 www.callen-lorde.org

Howard Brown Health Center
The Midwest's largest lesbian, gay , bisexual health organization. Excellent website.
4025 N. Sheridan Road
Chicago, Illinois 60613
(773)388-1600

Whitman-Walker Clinic
Non-profit, community based clinic established by and for the gay and lesbian community. Sites throughout DC metro area including MD & VA.
1407 S Street, NW
Washington, DC 20009
(202)365-5225 (24-Hour Line); (202)328-0697 (En Espanol)
www.wwc.org

The Gay, Lesbian, Bisexual, and Transgender Health Access Project
130 Boylston Street
Boston, MA 02116
(617)988-2605
Email: access@jri.org
www.glbthealth.org/index.html

The National Gay and Lesbian Medical Association: www.glma.org

SELF HELP AND SUPPORT ORGANIZATIONS FOR LGBT PEOPLE WITH MENTAL HEALTH CONCERNS OR MENTAL ILLNESSES

Identity House
includes peer counseling, rap groups, events, referrals, conferences, speakers bureau Contact: Mailing address: Identity House, P.O. Box 572, Old Chelsea Station, New York, NY 10011
Meeting address: 39 West 14th Street, Suite 205, Manhattan NYC
212 / 243-8181

Light House Community Support Program, Sexual Minorities Support Group.
Contact: Light House CSP, 1825 Chicago Ave., Minneapolis MN, 55404 or 612 / 879-5474; Theresa Flynn (612/879-5491) or Randy Nelson (612/871-1449)

Zappalorti Society: Support Group, social outings and advocacy
Contact: Bert Coffman 917 / 286-0616 or bertcoffmanzsmh@hotmail.com
14 E 28th Street, #1014, New York, NY 10016-7464

Pink & Black Triangle Society
Contact:c/o Project Return: The Next Step
1336 Wilshire Blvd. 2nd Floor,
Los Angeles CA, 90017-1705
213 / 413-1130 ext 121 or Prtns@aol.com

Hearts & Ears, Inc.: Support Groups, Social events, Advocacy
1900 E. Northern Parkway, Suite 310, Baltimore, MD 21239
Contact: Paula Lafferty 410/ 323-0444 or heartsandears@toast.net

Pink & Blues: LGBT Mental Health and Recovery Support Group
Contact: Mark A. Davis, Philadelphia, PA
Mark.davis@phila.gov
215/546-0300 x 3301 or 215 / 627-0424

MC Video Productions, Inc. carries several videos and audiotapes (for rent or purchase) about LGBT Mental Health Consumer issues. Write or call for a list and prices: PO Box 3012, Madison, WI 53704-0012. Phone: 608/244-2793 E-mail: MCvideoPro@aol.com

Websites & On-line Resources Groups

LesbiansWDepression: www.onelist.com/subscribe/LesbiansWDepression
From the list description: "Created as a forum for Lesbians who are suffering from, or recovering from depression. Topics can include, but are not limited to: medications, therapies, social support and alternative treatment methods. Lesbians only please. All information regarding subscribers will be kept confidential. "
Contact: LesbiansWDepression-owner@onelist.com

QWORLD (LGBT people with Mood Disorders): www.onelist.com/subscribe/QWORLD
From the site description: "Support E list for Queers, Gay men, Fags, Lesbians, Dykes, Lesbigays, Womyn, Bisexuals, Drag Queens, F/F, F/M, M/M, people affected with HIV/AIDS – and the politics of it all – who are living with Mental and Mood Disorders such as Bipolar Illness, Clinical Depression, Borderline Personality , Schizoaffective Disorder, etc. QWORLD is a members-only list."
Contact: Co-Moderators: Jace (jacevela@mcia.com) and Jen (jpadron@toto.csustan.edu)

POLITICAL & ADVOCACY ORGANIZATIONS NOT OTHER WISE LISTED

National Gay and Lesbian Task Force
NGLTF is the national progressive organization working for the civil rights of gay, lesbian, bisexual and transgendered people, with the vision and commitment to building a powerful political movement.

Human Rights Campaign
A national GLBT political organization working to establish equal rights for lesbians and gay men through lobbying Congress on issues of concern, educating the public, participating in election campaigns, and providing training and technical assistance to the community
www.hrc.org

Parents, Families, and Friends of Lesbians and Gays (PFLAG)
Provides support, education, advocacy and excellent informational publications. Local chapters throughout the nation provide support for parents, siblings, friends, and for LGBT people themselves.
(212) 463-0629 www.pflag.org

Al-Fatiha
DC-based gay Muslim advocacy group.
Gaymuslims@yahoo.com

REFERRAL SERVICES

Gay and Lesbian National Help Line
Trained peer counselors providing information and support to LGBT and questioning people. Also provides national referral services for local resources including support groups, attorneys, doctors, counselors, or other professionals.
(888) THE-GLNH (843-4564) toll free; M-F 4pm-Midnight; SAT Noon-5pm (Eastern)
Administrative (212) 633-7492
www.glnh.org or email, glnh@glnh.org

The Association of Gay and Lesbian Psychiatrists
Can provide the names of Psychiatrists (M.D.s) in 20 states, Puerto Rico, and Canada who are LGBT friendly and affirmative.
(215) 222-2800 www.aglp.org

Gay and Lesbian Medical Association (GLMA)
A nonprofit organization working to end homophobia in health care. Information and online referral service to LGBT affirmative providers.
(415) 255-4547 www.glma.org

International Foundation for Gender Education
Advocacy group, referral and information service on gender and Transgender issues. Full bookstore available by phone, in person, or on the web.
P.O. Box 540229, Waltham, MA 02454-0229
781-894-8340 or 781-899-2212 www.ifge.org

F-t-M International
Worldwide network of support and information services for F-t-M (female to male) trans people. "People to talk to," referrals, and extensive resources.
(877) 267-1440 www.ftmil.org

LGBT AFFIRMING RELIGIOUS AND SPIRITUAL ORGANIZATIONS

We are indebted to Alvin Fritz for his excellent LGBT resources listings at http://faculty.washington.edu/alvin/gayorg.htm#RELIGN

Affirmation: Gay and Lesbian Mormons http://www.affirmation.org

Affirmation: United Methodists for Gay, Lesbian, Bisexual and Transgendered Concerns
see also (below): Reconciling Congregation Program United Methodist Church
http://www.umaffirm.org

Al-Fatiha Foundation http://www.al-fatiha.org
note: "An international organization for lgbt Muslims...The Al-Fatiha aims to support LGBTQ Muslims in reconciling their sexual orientation or gender identity with Islam..."

American Friends [Quakers] Service Committee. Programs Addressing Lesbians, Gay Men, Bisexuals and Transgender Persons
http://www.afsc.org/pindx/lgbt.htm

Apostolic Catholic Church in America
note: an inclusive, sacramental, and liturgical Christain denomination...welcome all persons...regardless of sexual orientation."
http://www.apostoliccatholicchurchinamerica.org

Association of Welcoming & Affirming Baptists http://users.aol.com/wabaptists

AXIOS. Eastern & Orthodox Christian Gay Men & Women
http://www.qrd.org/qrd/www/orgs/axios

Brethren/Mennonite Council for Lesbian and Gay Concerns
http://www.webcom.com/bmc

Cathedral of Hope (Dallas, Texas)
note: "world's largest gay and lesbian church"
http://www.cathedralofhope.com

The Center for Lesbian and Gay Studies in Religion and Ministry (New York City)
note: provides scholarly and religious resources on marriage in the US...promoting views of marriage that are more open, just, and inclusive of all citizens regardless of sex, gender identity, or sexual orientation
http://www.clgs.org/marriage/index.html

CLOUT. Christian Lesbians OUT
http://www.andrew.cmu.edu/~riley/CLOUT.html

The Coalition. The United Church of Christ Coalition for Lesbian, Gay, Bisexual, and Transgender Concerns
http://www.coalition.simplenet.com

Dignity Canada Dignite Roman Catholic
http://www.odyssee.net/~prince.dcd.html

Dignity USA. Lesbian, Gay, Bisexual & Transgendered Catholics
http://www.dignityusa.org/

Emergence International, Christian Scientists Supporting Lesbians, Gay Men, and Bisexuals
note: with link to Lesbian, Gay, Bisexual and Transgendered Christian Scientists
http://www.cslesbigay.org/emergence

The Evangelical Network (T-E-N)
http://www.theevangelicalnetwork.org

Evangelicals Concerned with Reconciliation. ECWR
http://www.ecwr.org

Friends [Quakers] for Lesbian & Gay Concerns
http://www.geocities.com/WestHollywood/2473/flgc.html

Gay and Lesbian Atheists and Humanists. GALAH. (U.S.)
note: to educate about atheism & humanism; to support equal rights for glbt persons; to support separation of church and state; to provide environment for freethinkers
http://www.galah.org

Gay and Lesbian Humanist Association (United Kingdom)
note: "...a voice the many non-religious in the lesbian & gay community...promotes a rational...approach...to human rights..."
http://www.galha.org

Gay Spirit Visions
note: to create a spiritual/healing community for gay men
http://www.mindspring.com/~gayspirit

Gay WitchCraft
note: with numerous links to glbt pagan and other pagan sites
http://www.witchvox.com/xgay.html

GLAD Alliance, Inc. The Gay, Lesbian and Affirming Disciples Alliance, Inc.
Disciples of Christ
http://pilot.msu.edu/user/laceyj/

glbt UAAR (Italy)
note: GLBT network within the Italian Union of Rationalist Atheists and Agnostics; site available in Italian and English
http://www.gay.it/gayuaar

Grupo GLS de Judeus Brasileiros. (GLBT Jews/Brazil)
http://sites.uol.com.br/jgbr

Honesty (Southern Baptist)
note: support, education, and advocacy for gay, lesbian, bisexuals, and transgendered Baptists http://www.geocities.com/WestHollywood/2032/honesty.html

Integrity. A National Association of Lesbian and Gay Episcopalians and Their Friends (U.S.) http://www.integrityusa.org

Interweave. Unitarian Universalists for Lesbian, Gay, Bisexual and Transgender Concerns http://www.qrd.org/qrd/www.orgs/uua/uu-interweave.html

The Lesbian, Gay, Bisexual and Transgender Religious Archives Network.
note: "A resource center and information clearinghouse for the history of LGBT religious movements." A project of the Chicago Theological Seminary.
http://lgbtran.org

Lutherans Concerned North America http://www.lcna.org/

Mel White's Justice Net
note: Mel White is Minister of Justice for the Universal Fellowship of Metropolitan Community Churches; numerous full text reports, news articles, information
http://www.melwhite.org

More Light Presbyterians
note: movement with the Presbyterian Church U. S. A.
http://www.mlp.org

National Gay Pentacostal Alliance. NGPA (United States & Russia)
http://www.ameritech.net/users/lighthse84/ngpa.html

New Ways Ministry
note: gay-positive ministry of advocacy and justice for lesbian and gay Catholics
http://mysite.verizon.net/~vze43yrc/

Office of Bisexual, Gay, Lesbian, and Transgender Concerns
Unitarian Universalist
http://www.uua.org/obgltc

Ontario Consultants on Religious Tolerance
note: many full text sources related to religion and homosexuality and bisexuality
http://www.religioustolerance.org/homosexu.htm

Presbyterian Parents of Gays and Lesbians
note: support group for glbt persons and their families and friends
http://www.presbyterianparents.org

Q-LIGHT http://world.std.com/~rice/q-light
note: LGBT Quakers issues & communications

Quest. An Organisation of Lesbian and Gay Catholics in the UK
http://www.users.dircon.co.uk/~quest/

Reconciling Congregation Program United Methodist Church
note: also sponsors a student group: MoSAIC. Methodist Students for an All-Inclusive Church. see also (above): Affirmation: United Methodists for Gay, Lesbian, Bisexual and Transgendered Concerns
http://www.rcp.org

SDA Kinship International, inc. Gay & Lesbian Support Group Seventh-day Adventists
http://www.sdakinship.org/

Soulforce http://www.soulforce.org
note: "network of friends learning nonviolence from Gandhi and King seeking justice for God's lesbian, gay, bisexual and transgendered children"

Stonecatchers http://www.radix.net/~execware/stonecatchers
note: Presbyterian group seeking an inclusive church

United Church of Christ Coalition for Lesbian, Gay, Bisexual and Transgender Concerns
note: includes a youth and young adult program
http://www.coalition.simplenet.com/

Unity Fellowship Church Movement (U.S.) http://members.aol.com/UFCCNYC

Universal Fellowship of Metropolitan Community Churches http://www.ufmcc.com/

Universal Fellowship of Metropolitan Churches Canada La Confrerie Universelle des Eglises Communautaires Metropolitaines
http://www.ualberta.ca/~cbidwell/UFMCC/uf-home.htm

Welcoming Congregations
note: provides lists by state of welcoming, gay-affirming Christian congregations
http://www.christianlesbians.com/congregations

World Congress of Gay, Lesbian, Bisexual, and Transgender Jews: Keshet Ga'avah.
http://gbltjews.org

TRANSGENDER, TRANSSEXUAL, AND INTERSEX RESOURCES

Planned Parenthood of Tompkins County (Ithaca, New York)
PPTC has a great deal of experience in making PP affiliates into active service providers and educators for and about the Transgender community. Contact Maureen Kelley and check out their website for info and links on Trans issues.
(607) 273-1526 x134 www.sextalk.org

International Foundation for Gender Education
Advocacy group, referral and information service on gender and Transgender issues. Full bookstore available by phone, in person, or on the web. Also publishes the magazine “Transgender Tapestry.”
P.O. Box 540229, Waltham, MA 02454-0229
781-894-8340 or 781-899-2212 www.ifge.org

F-t-M International
Worldwide network of support and information services for F-t-M (female to male) trans people. “People to talk to,” referrals, and extensive resources.
www.ftmi.org (877) 267-1420

American Boyz
East Coast’s largest Female-to-Male Transgender organization. Hosts conferences, newsletter, provides resources.
(413) 585-9059

Gender PAC
National advocacy organization based in Washington which lobbies the government around gender/trans issues. Provides educational materials and makes great use of internet activism.
www.gpac.org (202) 462-6610

Intersex Society of North America
Public awareness, education, and advocacy organization which works to create a world free of shame, secrecy, and unwanted surgery for intersex people (individuals born with anatomy or physiology which differs from cultural ideals of male and female).
PO Box 301, Petaluma, CA 94953
(707) 283-0036 www.isna.org

The Transgender Forum
A paid online forum for crossdressers, transvestites, transsexuals, transgenderists, their families, and friends. Subscribers have access to referral and support group databases.
www.tgfmall.com/info/search.html

It's Time America!
A public advocacy organization seeking legal protections for people with gender-variant expression in the US. www.tgender.net/taw

WORK & HUMAN RESOURCES

Gay Work.com
Workplace issues, discussion boards, LGBT friendly job postings for seekers and employers. www.gaywork.com

WorkNet
The Human Rights Campaign's workplace resource center that includes sample policies, advice to workers and employers, and legal information.
http://www.hrc.org/worknet/index.asp
"Including sexual orientation in diversity programs and policies" Ed Mickens Employment Relations Today 21: 3, Autumn 1994 p. 263-275.

YOUTH

The Trevor Project National Suicide Hotline for LGBT Youth
Round-the-clock national toll-free suicide hotline for gay and questioning youth. Teens who call, can talk to trained counselors, find local resources and take important steps on their way to becoming healthy adults. All calls are free and confidential.
(800) 850-8078

Gay, Lesbian & Straight Education Network (GLSEN)
National organization working to end anti-gay bias in schools. Provides materials, training, support to students and educators.
(212) 727-0135 www.glsen.org

Advocates for Youth
Promotes programs and policies, which help young people make informed and responsible decisions about their sexual reproductive health. Provides information, training, and advocacy.
(212) 419-1448 www.advocatesforyouth.org

Children of Lesbians and Gays Everywhere
Offers peer support, news letters, and literature for children with LGBT parents.
(415) 861-5437 www.colage.org
National Youth Advocacy Coalition
Lobbies for legislative protection for sexual minority youth. Publishes news magazine on LGBT youth issues.
(202) 319-7596 www.nyacyouth.org

!Out Proud! National Coalition for Gay, Lesbian, Bisexual and Transgender Youth
Resources, advocacy and support for LGBT Youth. Excellent and informative website.
(415) 499-0993 www.outproud.org

Peer Listening Line
Toll free hotline staffed by trained youth volunteers backed up by mental health professionals from the Family Community Health Center in Boston, MA
(800) 399-PEER (M-F 7pm to 1am Pacific Time)

Project 10
Begun in 1984 in the LA School District as the first on-campus gay-affirmative counseling program for gay youth, has become the model program for other districts. Program handbook, resource directory, curriculum for teachers are all available in English and Spanish.
(213) 241-7682 or (818) 441-3382 www.project10.org

Appendix E: Selected Bibliography for LGBT Issues:

See Appendix G for additional readings specifically on LGBT-affirming psychotherapy

Topics:

Bisexuality
Coming out to Family
Communities of Color Resources
Domestic Violence
Family and Parenting
History
LGBT Health and Health Care
Legal Issues
Transgender, Transsexual, Intersex Resources
Employment & Human Resource
Youth

BISEXUALITY

Bisexuality: The Psychology and Politics of an Invisible Minority, Beth A. Firestein.
Bisexual Resource Guide 2000, The Bisexual Resource Center, 2000.
www.biresource.org

Dual Attraction : Understanding Bisexuality 1995
by Martin S. Weinberg, Colin J. Williams, Douglas W. Pryor

Bisexuality in the Lives of Men: Facts and Fictions 2001
by Brett Beemyn and Erich W. Steinman (Editors)
Harrington Park Press, Binghamton NY

Bisexuality in the United States 2000
by Paula C. Rodriguez Rust
Columbia University Press, Chichester NY

COMING OUT TO FAMILY

Beyond Acceptance: Parents of Lesbians and Gays Talk About Their Experiences,
C Griffin, M Wirth, and A Wirth
Martins Press, 1986.

The Family Heart, Rob Forman Dew
Fawcett Books,1995.

Now That You Know: A Parents' Guide to Understanding Their Gay and Lesbian Children, Updated Edition, by Betty Fairchild, Nancy Hayward
Harcort Brace & Company, San Diego CA, 1998

Alyson Books, one of the first GLBT publishing houses; www.alyson.com

COMMUNITIES OF COLOR

Critical Essays: Gay and Lesbian Writers of Color
by Emmanuel S. Nelson (Editor), Harrington Press, 1994.

Sister Outsider: Essays and Speeches by Audre Lorde, Crossing Press, 1984.

Asian American Sexualities : Dimensions of the gay and lesbian experience.
By Russell Leong (Editor), New York : Routledge, 1995.

This Bridge Called My Back: Writings by Radical Women of Color
By Cherrie Moraga and Gloria Anzaldua, Eds.
Watertown, MA: Persephone, 1981.

Does Your Mama Know? : An Anthology of Black Lesbian Coming Out Stories
by Lisa C. Moore (Editor), Redbone, 1998.

Latino Gay Men and HIV : Culture, Sexuality, and Risk Behavior
by Rafael M. Diaz, Routledge, 1997.

DOMESTIC VIOLENCE

Violence in Gay and Lesbian Domestic Partnerships (1996)
Edited by Claire M. Renzetti, PhD and Charles Harvey Miley, PhD
New York: The Haworth Press

A Professional's Guide to Understanding Gay and Lesbian Domestic Violence: Understanding Practice Interventions (Symposium Series, Edwin Mellen Press,V. 56.) ()
by Joan C. McClennen and John Joseph Gunther (Editors)

FAMILY AND PARENTING

Mom, Dad, I'm Gay.: How Families Negotiate Coming Out
by Ritch C. Savin-Williams, American Psychological Assn., 2001.

The Queer Parent's Primer : A Lesbian and Gay Families' Guide to Navigating Through a Straight World
by Stephanie A. Brill, New Harbinger Press, 2001.

For Lesbian Parents by Suzanne M. Johnson and Elizabeth O'Connor
Guilford Publications, 2001.

The Ultimate Guide to Pregnancy for Lesbians : Tips and Techniques from Conception to Birth : How to Stay Sane and Care for Yourself
by Rachel Pepper, Cleis Press, 1999.

Mothering Without a Compass : White Mother's Love, Black Son's Courage
by Becky Thompson, University of Minnesota Press, 2000.

Lesbians Raising Sons : An Anthology by Jess Wells (Editor), Alyson, 1997.

The Lesbian and Gay Parenting Handbook: Creating and raising our families.
By A. Martin, HarperCollins, 1993.

HISTORY

Out of the Past: The Struggle for Gay and Lesbian Rights in America
This excellent film reviews the stories of civil rights activists (including Henry Gerber, Bayard Rustin, and more) through the eyes of Kelli Peterson, a 17 year old high school student in Salt Lake City. (70 min.).

Modern American Queer History (Critical Perspectives on the Past)
by Allida M. Black (Editor), Temple Press, 2001.

LGBT HEALTH AND HEALTH CARE

American Journal of Public Health, special issues on lesbian, gay, bisexual, and transgender health: June 2001Vol. 91, No. 6 .

Gateways to Improving Lesbian Health and Health Care: Opening Doors,
By Christy M. Ponticelli, Haworth, 1998.

Healthy People 2010 Companion Document for LGBT Health
The Healthy People 2010 Companion Document for LGBT Health is a comprehensive look at multicultural LGBT community. It is written by and for health care consumers, providers, researchers, educators, government agencies, schools, clinics, advocates, and health professionals in all settings. Call the Gay ad Lesbian Medical Association to obtain copies. (415) 255-4547

A Provider's Handbook on Culturally Competent Health Care: Lesbian, gay, bisexual, and transgendered population. Published by Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department, 2000
Call 510-271-6485 to obtain copies

Lesbian Health: Current Assessment and Directions for the Future Committee on Lesbian Health Research Priorities, Institute of Medicine, 1999.

Lesbian Health Guide, Regan McClure, Anne Vespry, eds., Queer Press, 2001.

Report from a Meeting on Services for Lesbians, Gay Men, Bisexuals, and Transgendered Persons with Psychiatric Disabilities. (October, 1998). Copies may be obtained from Janet Chassman, New York State Office of Mental Health, Training Bureau, 44 Holland Ave, Albany NY, 12229 .
Phone: 518/474-2578 or 800-597-8481

Removing Barriers to Health Care for Lesbian, Gay, Bisexual and Transgendered Clients: A Model Provider Education Program, (March, 1997). Trainer Handbook and Participant Resource Guide, as well as other materials developed by the National Lesbian & Gay Health Association and the Mautner Project for Lesbians with Cancer.
Contact: NLGHA, 1407 S Street NW, Washington DC, 20009 Phone: 202-939-7880; Fax: 202-234-1467

Giving the Best Care Possible: Unlearning Homophobia in the Health and Social Service Setting, (1996). Office of Gay and Lesbian Health Concerns, New York City Department of Health and Community Health. 125 Worth Street, New York, NY 10013.
Phone: 212-788-4310.

Cultural Diversity Series: Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons, (August, 1999). Prepared by Susan r. McCarn, MA, for the National Technical Assistance Center of State Mental Health Planning, 66 Canal Center Plaze, Suite 302, Alexandria VA 22314
Contact: 703 / 739-9333, or ntac@nasmhpd.org, or go to: www.masmhpd.ntac

Health Concerns of the Gay, Lesbian, Bisexual, and Transgender Community, 2nd Ed. (June, 1997). Produced by the Medical Foundation for the Massachusetts Dept. of Public Health, 250 Washington Street, Boston MA 02108-4619 or 617/624-6000

Health Care for Lesbians and Gay Men: Confronting Homophobia and Heterosexism
By K. Jean Peterson, DSW, Editor; 1996, Harrington Park Press

Human Services for Gay People: Clinical and Community Practice
By Michael Shernoff, CSW, ACSW, Editor; 1996, Harrington Park Press

Gateways to Improving Lesbian Health and Health Care : Opening Doors,
By Christy M. Ponticelli; Haworth Press, 1998.

Health Care Without Shame: A Handbook for the Sexually Diverse and Their Caregivers. Charles Moser, Ph.D., M.D.; Greenery Press, 1999.

LEGAL ISSUES

The Rights of Lesbians and Gay Men : The Basic ACLU Guide to a Gay Person's Rights (American Civil Liberties Union Handbook) by Nan D. Hunter, Sherryl E. Michaelson (Contributor), Thomas B. Stoddard (Contributor).

A Legal Guide for Lesbian and Gay Couples (10th Ed)by Hayden Curry (Editor), Denis Clifford, Robin Leonard, Frederick Hertz; Nolo Press, 2001.

TRANSGENDER ISSUES

Transforming Families: real stories about transgendered loved ones.
By Mary Boenke (Editor); Walter Trook Publishing, 1999.

Transgender and HIV: Risks, Prevention & Care.
By Bockting, W & Kirk, S. (Editors.) Binghamton NY : Haworth Press, 2001
.
True Selves: Understanding Transsexualism for Families, Friends, Coworkers, and Helping Professionals.
By Brown, M., and Rounsley, C. San Francisco: Jossey-Bass, 1996

Transgender Care: Recommended Guidelines, Practical Information, & Personal Accounts. Israel, G. & Tarver, D. Philadelphia: Temple University Press, 1998.

Medical, Legal, & Workplace Issues for the Transsexual.
by Kirk, S., & M. Rothblatt. Blawnox, PA: Together Lifeworks, 1995.

Social Services with Transgendered Youth.
By Mallon, G (Editor.); Binghamton NY: Harrinton Park Press, 1999

Investigation into Discrimination Against Transgendered People, (Sept., 1994). A Report to the Human Rights Commission or the city and county of San Francisco, by Jamison Green & Larry Brinkin. Contact: San Francisco HRC, 25 Van Ness Ave., Suite 800 San Fancisco, CA 94102-6033. Phone: 415 / 252-2500

EMPLOYMENT & HUMAN RESOURCES

Straight Talk About Gays in the Workplace
by Liz Winfeld and Susan Spielman; Harrington Park Press, 2001.

Gay Issues in the Workplace by Brian McNaught, St. Martins, 1995.

Sexual Orientation in the Workplace : Gay Men, Lesbians, Bisexuals, and Heterosexuals Working Together
by Amy J. Zuckerman, George F. Simons, Sage Publications., 1995.

Transsexual Workers: An Employers Guide
by Janis Walworth, 2003, Center for Gender Sanity, director@gendersanity.com

Working with a Transexual: A Guide for CoWorkers
By Janis Walworth,; 2999 Center for Gender Sanity.

YOUTH

It's Elementary: Talking About Gay Issues In School, prod. by Helen S. Cohen and Debra Chasnoff, dir. by Debra Chasnoff, Women's Educational Media, 1997, (Videocassette, 78 min.; Educational Training Version - 37 min.)
415-641-4616 www.womedia.org, email: wemfilms@womedia.org

That's a Family, prod. by Debra Chasnoff, Ariella J. Ben-Dov, and Fawn Yacker. Women's Educational Media, 2000. A documentary that "helps children to see and understand many of the different shapes that families take today." Explains concepts such as, "birth mom, mixed race, guardian, gay and lesbian, and stepdad." (Videocassette, 35 minutes.) See contact information above.

Teaching Respect for All
This video, featuring Kevin Jennings, Executive Director of GLSEN, tells why parents, administrators and teachers as well as schools need to care about issues of sexual orientation. (52 min.)

Lesbian, Gay, and Bisexual Identities and Youth : Psychological Perspectives
by Charlotte J. Patterson and Anthony R. D'Augelli (Editors); Oxford U Press, 2001.

Lesbian and Gay Youth by Caitlin Ryanand Donna Futterman; Columbia Press, 1998.

Two Teenagers in Twenty : Writings by Gay & Lesbian Youth
by Ann Heron (Editor); Alyson Books, 1995.

Free Your Mind : The Book for Gay, Lesbian, and Bisexual Youth--And Their Allies by Ellen Bass, Kate Kaufman (Contributor), Harper Collins, 1996.

A Boy's Own Story, by Edmund White, Vintage, 2000.

Am I Blue? : Coming Out from the Silence: Gay & Lesbian Fiction for Young People, by Marion Dane Bauer (Editor), Harper Trophy, 1995.

Appendix F: Ethical Guideline Excerpts

Examples of Anti-discrimination Statements from the Ethics and Practice Standard Codes of Several Mental Health Professions

(italics added to verbatim text)

American Psycological Association, 2002
http://www.apa.org/ethics/

Ethical Standards, Section 3.
Human Relations, 3.01 Unfair Discrimination: "In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, *gender identity*, race, ethnicity, culture, national origin, religion, *sexual orientation*, disability, socioeconomic status, or any basis proscribed by law."

American Psyciatric Association, 2001
http://www.psych.org/psych_pract/ethics/medicalethics2001_42001.cfm

The Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry, Section 1 : A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

> **[Sub-section] 2.** A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or *sexual orientation*.

National Association of Social Workers, 1999
http://www.socialworkers.org/pubs/code/code.asp

Excerpt from the Preamble: Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

> **Section 4**. Social Workers' Ethical Responsibilities as Professionals:
>
> > **4.02 Discrimination:** Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, *sexual orientation*, age, marital status, political belief, religion, or mental or physical disability.

International Association of Psychosocial Rehabilitation Programs
http://www.iapsrs.org/pdf/multicultPrinciples.pdf

Principles of Multicultural Rehabilitation Services (1996)
Principle Nine: Professionals recognize that discrimination and oppression exists within our society; these take many forms, including race, ethnicity, gender, *sexual orientation*, class, disability, age, and religion discrimination/oppression. PSR professionals have a role and responsibility in mitigating the effects of these "isms," advocating not only for access to the opportunity and resource structure, but for the elimination of all "isms."

Appendix G: Selected Bibliography on LGBT-affirming Psychotherapy

(Also see appendix E for general LGBT readings)

GENERAL / MIXED GROUP

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