

Enhancing Cultural Competence:

2nd Edition



Welcome

*Welcoming
Lesbian, Gay, Bisexual
Transgender, Queer People
in Mental Health Services*

*A joint project by:
Planned Parenthood Mid-Hudson Valley, Inc.,
Mental Health Association in Ulster County, Inc.,
University of Maryland Center for Mental Health Services Research,
and the New York Association for Gender Rights Advocacy (NYAGRA)
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Alicia Lucksted
University of Maryland Center for Mental Health Services Research
737 West Lombard Street, 5th floor, Baltimore MD 21201
aluckste@psych.umaryland.edu
410-706-3244

Jane Elven
Planned Parenthood Mid-Hudson Valley
Kingston Outreach Center
6 Van Buren Street, Kingston, NY 12401
jane.elven@ppmhv.org
845-339-4020

Ellen L. Pendegar, MS,RN,CS
Mental Health Association in Ulster County, Inc.
P.O. Box 2304
Kingston, NY 12402
ependegar@mhainulster.com
845-336-4747 ext. 136

Pauline Park, Ph.D.
New York Association for Gender Rights Advocacy (NYAGRA)
24 W. 25th St., 9th floor
New York, NY 10010
paulinepark@earthlink.net
(212) 675-3288, ext. 338



Cultural Competence: Maintaining an Asking Stance

What is cultural competence?

Cultural competence is the ongoing practice of gathering and utilizing knowledge, information, and data from and about individuals, families, communities, and groups. The information is integrated and serves to transform specific clinical practices, standards, techniques and service approaches, marketing strategies, and evidence-based initiatives to match the service population in effort to increase the quality and appropriateness of mental health care, (Davis, 1997). Competency refers to staffs' ability to acknowledge and understand the influences of oppressive histories, life experiences, language differences, beliefs, values, formal and informal help-seeking pathways, and traditional healing practices on an individual's recovery. In addition, competency is recognizing that recovery is individual and unique; to include the adaptation of approaches and interventions that are based on, and targeted to, the individuals being served. The task is not to memorize information about groups and make assumptions. The task is to partner with consumers, families and communities using a cultural lens to identify approaches, resources and networks to facilitate recovery. Cultural competence is maintaining an asking stance, remaining curious, staying open minded, asking individuals about who they are, understanding what they believe and then seek culturally and linguistically congruent treatment and service approaches that work best for them.

Cultural competence planning helps organizations to focus on cultural considerations in service design and delivery, establishment of community based networks, inclusion of natural supports, and methods to help ensure an effective cultural fit. Overall, the plan needs to include methods to ensure that cultural information is collected at intake, updated throughout the engagement process, and then utilized to develop and enhance services and their delivery.

Considerations for Planning

Culture can be defines as, "The shared values, traditions, arts, history, folklore, and institutions of a group of people that are *unified by* race, ethnicity, nationality, language, religious beliefs, spirituality, socioeconomic status, social class, sexual orientation, politics, gender, age, disability, or any other cohesive group variable." (Singh, 1998)

Often, in discussion about culture; race, ethnicity, and language come readily to mind. Acknowledging and understanding the impact of oppression based upon race, age and gender and the associated healthcare disparities, it is important for providers to recognize that many cultural considerations are involved for any one person and it is imperative to attend to these multiple memberships. In considering sexual orientation, there is not one "gay community." Rather, there are individuals who are exploring or

who already connect with a particular sexual identity, who may risk loss of other highly valued cultural, familial or community connections and these losses can impact mental health. For example, when addressing suicide; racial and ethnic minorities who belong to other high-risk populations, i.e. lesbian, gay, bisexual, or transgender youth, may be at increased risk. Examples of cultural considerations include but are not limited to race, ethnicity, sexual orientation, age, gender, physical disability or limitation, socio-economic status, primary language, English proficiency, education, literacy, employment, spirituality, religion, immigration status, geographic location, political context and criminal justice involvement.

Beginning to address cultural competence requires providers to consider:
What is your purpose? (service intent, job responsibility, tasks, and goals)
Who are the people in the community? (potential group to be served)
Who are the people you serve? What are their cultural norms and values?
Where are the gaps? Who needs but is not benefiting from the service?
What can you do differently to reach them based upon what you know from and about them and their community?

It is recognized that, “More often, culture bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have, and how much stigma they attach to mental illness...” (DHHS 1999) Successful outreach and service initiatives for the LGBTQ community will need to engage people through a cultural lens that recognizes existing layers of stigma; uniqueness in ethnic beliefs regarding sexual orientation, variations in help seeking pathways, beliefs about mental illness, and norms about privacy, secrecy and sexuality.

Culturally and Linguistically Appropriate Services (CLAS) Standards (2000)
The Federal Office of Minority Health released the CLAS Standards as a guide to providers. The themes include the following:

- Legal responsibility for provision of Language Assistance Services for consumers with limited English language proficiency at no cost to consumers. (interpreter services and document translation)
- Provision of culturally competent care
- Organizational supports for cultural competence
- Intent for Federal and State accrediting agencies to implement provider mandates

Improving cultural competence is a process which involves sustained effort over time. Providers need to seek meaningful inclusion of cultural considerations throughout service delivery. This requires examining the following areas of activity:

- Intake
- Informed Consent
- Identification of Supports
- Assessment of Consumers Health Literacy
- Diagnosis
- Wellness and Holistic Approaches
- Treatment and Service Delivery

- Consumer Partnering for Treatment Decisions

Planning can begin with a few specific improvements for immediate focus with other long-range strategies on the horizon. For assistance with planning, resources and implementation contact:

Cathy Cave, Director
The Office for Cultural Competence
518-408-2026
ccave@omh.state.ny.us



WELCOME

The Mental Health Association in Ulster County, Inc., and Planned Parenthood Mid-Hudson Valley, Inc., the University of Maryland Center for Mental Health Services Research, and New York Association for Gender Rights Advocacy (NYAGRA) 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 (LGBTQ) communities. You'll be able to assess where you are in the process of becoming an LGBTQ-welcoming mental health provider, and move forward to guarantee full citizenship for LGBTQ 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 Health 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 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 (LGBTQ) people. Thank you for joining us on this journey.



EXECUTIVE SUMMARY

Even though it is an integral aspect of most people's sense of self, sexuality is rarely well addressed in mental health services. Sexuality 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 of sexuality 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, bisexual and transgender (LGBTQ) people. The 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 four rationales that serve as a basis for this tool kit:

- ▼ **Legal** considerations include anti-discrimination statutes which vary from state to state, and locality to locality.
- ▼ **Ethical** guidelines for most mental health professional organizations include sexual orientation and gender identity.
- ▼ Treatment **outcomes** are enhanced when mental health settings maintain safe and welcoming environments for everyone.
- ▼ Mental health providers who develop **cultural competence** in *all* diversity dimensions (including LGBTQ) become more attuned to each multifaceted person's treatment needs.

The tool kit distinguishes between **sexual orientation, gender identity and gender expression**. Common false impressions about these issues are clarified; the effect of these misconceptions on mental health treatment for LGBTQ people is discussed; and

the **history/legacy** of pathologizing LGBTQ people in mental health settings is examined. The final section provides detailed, concrete **approaches to create and sustain LGBTQ affirming mental health services**. Specific **strategies** for the individual, direct service, agency, community, and public policy levels are discussed in depth, as are **problem solving**, the fundamentals of effective **staff training**, and the essential elements needed to **grow courage** to stimulate individual and institutional change.

Appendices include:

- ▼ Individual and Agency Assessment Tools
- ▼ Staff Training Curricula
- ▼ Glossary
- ▼ References
- ▼ Supplemental Texts
- ▼ Resources and Organizations
- ▼ Selected Bibliography on LGBTQ Issues
- ▼ Selected Bibliography on LGBTQ Affirming Psychotherapy
- ▼ Supplemental Texts
- ▼ Ethical Guideline Excerpts

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



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.

Four Rationales

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

Legal: In many states and smaller jurisdictions (counties, towns) it is illegal to discriminate against people based on 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 gender and sexual orientation in their ethical guidelines, and clearly state that discriminatory or insensitive treatment is unethical. 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 LGBTQ 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 A: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. Because our society considers heterosexuality to be normative, it is rarely thought of as a sexual orientation. Most heterosexuals experience their orientation as a "given," that requires 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 a range of other factors. While there have been

scores of theories and studies, we do not currently know why or how one person identifies as heterosexual, while another is bisexual, gay or lesbian.

- ▼ is discriminate. Just as heterosexuals are not attracted to *every* person of another gender, gay and lesbian people are not attracted to *every* person of the same gender, nor are bisexuals attracted to *every* person of both genders.
- ▼ can be experienced differently. Some people do not identify with terms like “straight,” “gay,” “lesbian,” “bisexual” or “queer,” and choose not to “label” themselves. Some use different language, some have different ideas about the meaning of their experience of their orientation, and people with the same orientation may experience it in dissimilar ways. For some people sexual orientation may remain consistent over their entire lives, while for others sexual orientation may evolve and change throughout their lives.
- ▼ is currently referred to as lesbian, gay, bisexual, or heterosexual in common parlance. Note that the term “homosexual” is not commonly used in LGBTQ-positive settings. Historically, the word came into common use as a psychiatric term that denoted pathology, and “homosexuality” was considered a mental illness. The painful, negative and judgmental connotations of the term have led to its disfavor in LGBTQ communities.

(Appendix A: 1, 3)

Gender Identity:

Note: the following text on gender identity and gender expression is by Pauline Park, PhD, Executive Director of the New York Association for Gender Rights Advocacy (NYAGRA)

- ▼ Refers to one’s inner sense of being female, male, both or neither, which may or may not correspond with the sex and/or gender assigned to that individual.
- ▼ *Transgender* is an umbrella term to encompass a range of gender identities, including transsexual, cross dresser, transvestite, “genderqueer,” etc.
- ▼ People who identify as “transgender” are as diverse as people whose biological or assigned sex coincides with their personal inner sense of gender identity. Most transgender people do not identify as transgender.
- ▼ Everyone has a gender identity (whether they realize it or not), just as everyone has a sexual orientation).

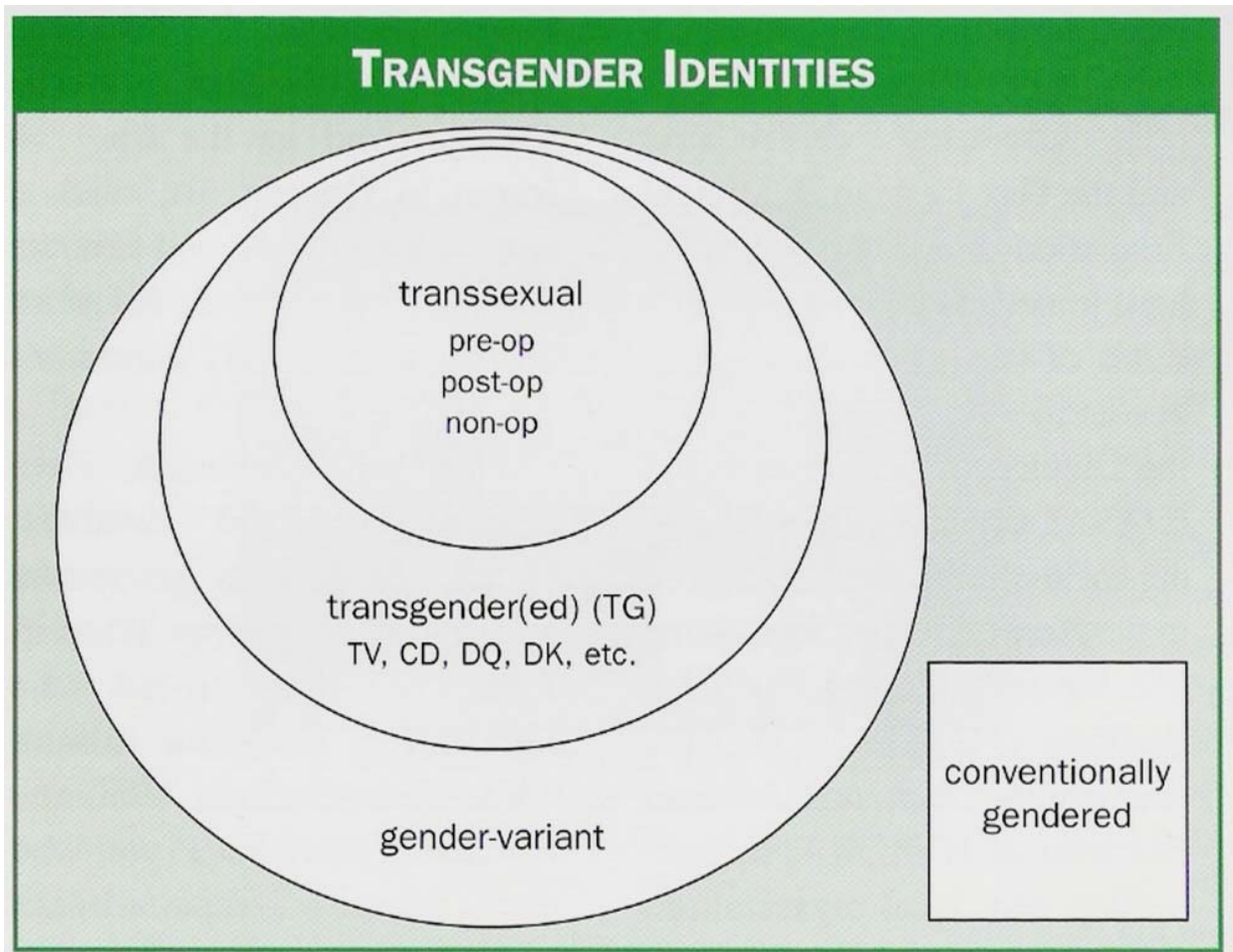
Gender Expression:

- ▼ Refers to how one expresses one’s inner sense of being a man or woman, boy or girl, both or neither, which may or may not correspond with the sex and/or gender assigned to that individual at birth.

Sex is distinct from gender, and one’s sex may not correspond to how one identifies one’s gender. Sex can be defined in terms that are legal, anatomical,

biological, genetic, and chromosomal, but at any one time, one could be male by one definition and female by another. Gender identity refers to one's inner sense of being a man or woman, boy or girl, both or neither, which may or may not correspond with the sex and/or gender assigned to that individual at birth.

Transgender is an umbrella term to encompass a range of gender identities, including transsexual, cross dresser, genderqueer, etc. There are as many different definitions of what it means to be transgender as there are transgender people. A simple way of explaining the transgender phenomenon is to view the transgender community as a set of three concentric circles:



The first circle includes those who identify as or are identified as **transsexual** – those who seek or have obtained sex reassignment surgery (SRS). While most transgender people do not want SRS, most of those who do (viz., those identified here as ‘transsexuals’) never obtain SRS, in most cases because they cannot afford it. The

usual distinction made is between those who are 'pre-operative' and those who are 'post-operative.' However, it is important to point out that what constitutes 'sex reassignment surgery, while well-established for male-to-female (MTF) transsexuals, is less clear for female-to-male (FTM) transsexuals.

For MTF transsexuals, SRS is sometimes referred to as 'convertive' surgery, in which the testicles are removed and the material from the penis and the scrotum are reconstructed as a vagina, clitoris, and labia. Because the surgical techniques for the procedure known as phalloplasty (the construction of a penis, usually from skin grafts from skin taken from the arms) have not been perfected, most FTMs do not seek phalloplasty. It should also be noted that phalloplasty is extraordinarily expensive and beyond the means of most transmen. Instead, many FTMs opt for a much less invasive procedure known as metoidioplasty, in which an incision is made in the folds of skin around the clitoris, causing the clitoris to elongate. For many transmen, 'top surgery' (reduction or removal of the breasts) is considered the most important medical intervention and the most important moment of medical transition. Some transgender women will seek hormones, while others will seek other forms of medical intervention such as orchiectomy (surgical removal of the testes). Some will seek breast augmentation, while others will seek facial reconstructive surgery to appear more feminine.

The second circle includes those who identify as or may be identified as '**transgender,**' and includes crossdressers, drag queens, and drag kings, among others. The term 'transvestite' (the Latinate form of the word 'crossdresser') is now considered overly clinical or even somewhat pejorative, and for the most part those who cross dress part-time use the term 'crossdresser' to describe themselves. The term 'drag queen' is often inappropriately applied and is even used by some to insult transgender women, regardless of whether or not they live full-time in the gender with which they identify. In its non-pejorative form, the term 'drag queen' is most appropriately used to describe someone male who is engaged in a performance on stage (whether professional or amateur) or in 'fun drag' such as at a pride parade, on Halloween or a similar occasion. Likewise, 'drag king' refers to someone born female whose performance is focused on the simulation of masculine behavior.

Those described as 'transgender' can be said to include all those who present themselves (at least part of the time) in a gender not conventionally associated with the gender assigned to them at birth or associated with the sex assigned to them at birth. It is important to note that there are literally hundreds of different terms transgender people use to describe themselves. In fact most transgender people do not identify as transgender; that is to say, they do not use the term 'transgender' to describe themselves. This is particularly true of transgender people of color and transgender immigrants. It is also important to understand that most transgender people do not undergo a linear medical transition from male to female or from female to male. There are as many different ways to transition as there are transgender people who transition.

A supportive clinician must not assume that someone's interest in gender transition necessarily means a linear progression to hormones and then to sex reassignment surgery. Hormones are right for some people but not for everyone, and the same is true for SRS. The best clinician is the one who helps each individual client figure out what is right for him or her.

The third circle includes those who may be termed '**gender-variant,**' and would include all those who 'transgress' gender boundaries to a greater or lesser extent. A non-transgender gender-variant person would include a male who is more feminine than the conventional 'norm' for boys or men but who nonetheless still identifies as a boy or a man, or a female who is more masculine in gender expression than most women but who nonetheless still identifies as a girl or a woman.

In contrast to the transsexual, transgender, and gender-variant, the majority in every society by definition is **conventionally gendered**, and such individuals more or less conform to the gender norms of their time and place.

It is crucial to understand that gender identity is not the same as sexual orientation. Many or even most lesbian, gay, and bisexual (LGB) people are not transgender, while many or even most transgender people are not lesbian, gay, or bisexual. There are many 'butch' gay men and 'lipstick lesbians,' and conversely, there are many transgender people who identify as heterosexual either before or after transitioning. It is important for the clinician not to assume sexual orientation even if s/he knows how the client identifies his/her gender identity. So, for example, while a

transgender woman (whether pre-op, post-op, or non-op) who is attracted to men may identify as heterosexual, for personal, cultural, or political reasons, she may identify as gay or 'queer.' The only way to know how a transgender person identifies his/her sexual orientation is to ask that person.

Just as the psychiatric profession once labeled homosexuality a mental illness, so the American Psychiatric Association (APA) continues to pathologize transgender identities through the inclusion of the diagnosis of gender identity disorder (GID) in the DSM -IV-TR (Appendix A:46, 47). Sometimes referred to as 'gender dysphoria,' the diagnosis of GID is the 'gateway' diagnosis required for access to hormone replacement therapy (HRT) and sex reassignment surgery (SRS) by the Standards of Care (SOC) published by the World Professional Association for Transgender Health (WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association).

It is important to point out that there is a movement to remove GID from the forthcoming issue of the DSM (DSM-V) and that an increasing number of psychiatrists, psychologists, and psychotherapists are coming to doubt the validity of the diagnosis (see Israel and Tarver, Appendix A:48, Appendix A: 49). There is in fact no empirical evidence whatsoever for the diagnosis of GID. In fact by pathologizing transgender identity *per se*, the GID diagnosis can often mask or obscure real forms of mental illness experienced by a transgender patient that may go undiagnosed because of the use of the false diagnosis of GID.

Some members of the transgender community continue to support the GID diagnosis for practical reasons, namely, the possibility of obtaining insurance payment for treatment. However, like most other Americans, most transgender people who have health insurance, are insured through a health maintenance organization. Virtually every HMO excludes coverage for any procedure related to gender transition, including HRT and SRS. And while Medicaid is a federal program for poor people, states administer the program, and many states prohibit Medicaid payment for HRT, SRS, and other procedures related to gender transition.

Some transgender people themselves believe that they have a gender identity disorder, but one could argue that the acceptance of such a diagnosis constitutes a form of internalized transgenderphobia, just as the acceptance by some gay men and

lesbians of the notion that homosexuality was a mental illness before its removal from the DSM in 1974 could be interpreted as a form of internalized homophobia.

While many health care and social service providers undoubtedly imagine that the GID diagnosis is primarily used with adult transsexuals affirmatively seeking the diagnosis in order to access hormones and surgeries that will help them complete a medical transition, anecdotal evidence suggests that most individuals diagnosed with GID are children and youth brought in by their parents to address gender-variant behavior. Such parents use the diagnosis in an adversarial manner in order to ‘cure’ or ‘prevent’ homosexuality or transsexuality in their children (conflating sexual orientation and gender identity). The diagnosis can be used to justify behavior modification therapy that includes electroshock therapy and can also be used to institutionalize a legal minor indefinitely, without the child’s consent. (See, for example, Scholinski, Daphne, *The Last Time I Wore a Dress: A Memoir*. New York: Riverhead Books, 1997.) Of course, neither homosexuality nor transgender can be ‘prevented’ or ‘cured,’ because neither is a disease (whether preventable or not), but rather natural variants in sexual orientation and gender identity. However, aversion therapies such as the ‘gay conversion therapy’ touted by ‘ex-gay’ ministries such as Exodus can be very effective in making one hate one’s sexual orientation or gender identity. For a full discussion of the GID diagnosis and its implications, see Pauline Park, [Transgender Health: Reconceptualizing Pathology as Wellness](http://www.paulinepark.com/writings.html) (Trans-Health Conference speech on GID, 4.7.07) <http://www.paulinepark.com/writings.html>

Just as GID in childhood and adolescence is frequently used in an adversarial fashion against gender-variant children and youth, so too it can also be used inappropriately by psychiatrists and other clinical professionals assisting parents who want to be supportive but who assume that any indication of gender variance means that the child is transsexual and that hormone therapy and sex reassignment surgery are therefore the prescribed ‘treatment’ for gender dysphoria. Many if not most of those diagnosed with GID in childhood or adolescence grow up to be non-transgender lesbian, gay, or bisexual adults. Assuming a linear medical transition for every child exhibiting gender-atypical behavior can lead to disastrous consequences for the child. Children naturally experiment, and the mere fact that Johnny is trying on his mother’s

dresses or that Janie is obsessed with sports does not necessarily mean that they are transsexual or that they should be put on a conveyor belt to sex reassignment surgery.

While some children have a strong sense of their gender identity as young as four years of age, others may not have a clear sense of what shape that identity will take until well into adulthood. Transgender people can begin transitioning as young as four or five and as old as 40, 50, 60 or even 70 years of age. Each of us is a unique human being, and some come to a mature understanding of who they are at a later age than others. The supportive clinician will avoid pushing a child or an adult into making a decision that may be premature.

It is also important to understand that transgender people are not *intersexed per se* (see below for a detailed definition of intersex). Intersexed people are those who are not born entirely male or female. What intersex advocacy organizations refer to as 'intersex genital mutilation' (IGM) deprives intersexed individuals of autonomy and self-determination in sex, sexuality, and gender identity and can even cause lifelong psychological and physiological harm. IGM is performed to 'normalize' what are in most cases natural variations in external sex organs. While performed under more hygienic conditions, IGM is no more justified than female genital mutilation (FGM), which is a practice common in a number of countries in Africa and the Middle East.

IGM is in a certain sense the obverse of SRS for transgender people: while many transsexuals seek SRS but cannot afford it or are denied it for other reasons (such as clinical obesity or HIV status), IGM is performed on intersexed infants and young children without their consent. Many intersexed people identify as transgender and/or transsexual and may 'transition' just as many transsexual and transgender people do. In fact, some intersexed people actually seek SRS to alter or reverse the IGM performed on them in infancy or youth.

To that extent, while intersexed people are not transgender *per se*, the two (somewhat overlapping and intersecting) communities share a common source of oppression in the sex/gender binary. The sex/gender binary divides the world into two sexes and two genders, and imposes sex and gender assignment on human beings from infancy through childhood and into adulthood, even through forced and non-consensual surgery.

Transgender and gender-variant people face pervasive discrimination, harassment, abuse, and violence in the United States as they do in most countries of the world. Discrimination in the provision of health care and social services as well as employment, housing, public accommodations, education, and the criminal justice system is particularly acute.

Because of the frequent experience of discrimination and even refusal of health care and other services, many transgender people will not go to doctors, hospitals, and other health care providers except in an emergency. And because many transgender people have either inadequate health insurance or no health coverage at all, they may have no recourse to health care except through the hospital emergency room. When they are finally seen, medical conditions that could have been easily treated may be life-threatening by the time a qualified medical professional has the opportunity to examine the patient. While access to services and procedures related to gender transition (including hormones, SRS, breast augmentation or reduction, etc.) is a serious issue for the community, the biggest problem facing transgender people is getting adequate health care for everything not directly related to gender identity. For more information on discrimination and other impediments to health care for transgender and gender-variant people, see: Brett Krutzsch, "Trans Health Fair Debuts at Center" (New York Blade, 1 June 2007) <http://www.nyblade.com/2007/6-1/news/localnews/healthfair.cfm>

Intersex

According to the Intersex International Organization (*Organisation Intersex International*):

An intersexed person is an individual whose internal and/or external sexual morphology has characteristics not specific to just one of the official sexes, but rather a combination of what is considered "normal" for "female" or "male."

Formerly used terms include 'hermaphrodite,' 'pseudo-hermaphrodite,' 'androgynous,' etc. There are many different intersex variations. Viewing these variations as a medical illness creates a special medical category which includes an extremely large group of 'disorders' which have nothing in common from a medical point of view except that the person is of intermediate sex as established by current norms. Intersex people need health care just as everyone else does but each intersex variation has its specific health

needs which will be overlooked when placed in a catch-all umbrella term such as DSD (Disorders of Sex Development) and will make 'gender' normalization the main issue because that is the only factor that all these 'disorders' have in common. This is why the term 'intersex' is preferable since it includes all the different variations without implying that they have any medical condition in common which they do not. What we have in common is that we are of "intermediate" sex as defined by current norms for male or female.

Intersex is not as rare as often believed and many people are intersexed, although it may not be visible at birth. Some intersexed persons are easily recognized as intersex at birth, with others only recognized later, especially during adolescence. Many people whose intersexuality is obvious are treated medically and are considered to have anomalies which need to be 'corrected' by surgery and hormone replacement therapy. OII opposes these procedures when performed without the informed consent of the individual." http://www.intersexualite.org/FAQ_English.html#anchor_9

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 complete sets of genitalia. The Intersex Society of North America (ISNA) is now advocating use of the term 'Disorders of Sexual Development,' which is the intersex equivalent of the diagnosis of gender identity disorder (GID) insofar as the 'DSD' diagnosis pathologizes intersex conditions as genetic defects or disorders. DSD also implicitly legitimizes intersex genital mutilation (IGM) by implying that intersexed people themselves are defective or disordered and that their genitalia require 'correction.' The term 'Disorders of Sexual Development' has no basis in genetic or biological science and has been rejected by the intersex community and by intersex community-based organizations such as the Intersex International Organization (OII).

Queer

In recent years, the term "queer" has become commonly used by some LGBTQ people as a positive and inclusive 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 LGBTQ 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 LGBTQ, 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 LGBTQ 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 LGBTQ community is often experienced as hostile (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 LGBTQ people. This does not mean that this language is appropriate for non-LGBTQ people to use casually. (Conversely, clinical sounding words like homosexual and sexual minority may be experienced as cold or marginalizing by LGBTQ individuals.) Ask about the language people feel comfortable hearing and would like you to use.

Even some heterosexuals use ‘queer’ as a self-descriptor, usually to indicate either their gender variance or their engagement in sexual practices that are unconventional (such as leather or BDSM, for example). In fact the ambiguity of ‘queer’ –whether its use is meant to indicate sexual unconventionality or gender variance—is what makes it difficult to employ. If a straight person can be ‘queer,’ the use of the term to denote ‘LGBTQ’ becomes less straightforward. In general, then, avoid use of the term with LGBTQ seniors (unless they specifically request its use in a given context) and when in doubt, leave it up to ‘queer’ people (those who use the word as a term of self-identification) to determine its use. (See the glossary for information about these and related terms.)



MENTAL HEALTH SERVICES AND LGBTQ IDENTITIES

Note: the text in this section was adapted from Lucksted, 2004 (Appendix A: 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 LGBTQ-sensitive mental health services, and that you are interested in helping your agency, individual practitioners, and/or yourself enhance skills in this area. The following overview of some of the roots of LGBTQ-insensitive practices among mental health providers is intended to identify and clarify the kinds of issues faced by many LGBTQ 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 LGBTQ 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 (LGBTQ) people who have mental health needs face abundant challenges in receiving quality mental health care. Along with the global problems of accessing affordable care, LGBTQ people often face anti-LGBTQ ignorance, disrespect, stereotypes, and hostility within mental health services. Prevailing public attitudes toward LGBTQ 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 A: 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;
- ▼ overlook that LGBTQ people come from all races, cultures, economic and social classes, abilities, religions etc, and that all of these diversity dimensions interact with sexual orientation and gender identity;
- ▼ conflate sexual orientation and gender identity;
- ▼ assume/believe that a consumer's LGBTQ identity is a symptom of mental illness, a mental illness *per se*, and/or indicates of substandard development;
- ▼ assume that sexual orientation/gender identity is a core problem for LGBTQ clients, but never presume so for heterosexual clients;
- ▼ believe that being gay, lesbian, or bisexual is "no big deal," and that clients who want to talk about sexual orientation are avoiding their "real" issues;
- ▼ constrain a client's exploration and self-discovery by imposing on the client the clinicians view of what the client's sexual orientation "really is" or "should be."
- ▼ employ invalidated interventions designed to change clients' LGBTQ identities (e.g. Conversion/ Reparative "therapies" discredited by most major mental health professional organizations);
- ▼ expect clients to conform to the clinician's beliefs of how one "should be" LGB (there are as many ways of being LGB as there are ways of being heterosexual);
- ▼ view heterosexual patterns as standards of both personal mental health and of relationships, functioning, so that LGB people and relationships are seen *de facto* as less healthy when compared to the heterosexual standard.
- ▼ make assumptions about a person's values or lifestyle based on cultural myths and stereotypes about LGBTQ people;
- ▼ romanticize or positively stereotype LGBTQ people which may distract therapists to from clients' problems;
- ▼ view clients' sexual lives and history as exotic or erotic, 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 exhibiting psychiatric symptoms (Appendix A: 9, 10, KI Cookie Gant, August 1998; KI Bert Coffman, May 1998). The tendency to misinterpret expressions of sexuality may be intensified for mental health providers who feel uncomfortable with sexuality in general, and with sexual orientation and gender identity in particular.

(Appendix A: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 LGB clients? This is even a mistake for their heterosexual clients, and more so for LGB clients because of what they have to deal with regarding society and their sexual orientation. (Appendix A: 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 all 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 A: 1998)

Lingering Pathologization of LGBTQ 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 A:13)

People who do not fit into conventional heterosexual and gender roles have been pathologized for much of psychology and psychiatry's history (Appendix A:14-18). 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

(Appendix A: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 A:27-29). A psychiatrist at an LGBTQ-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 of misuse at the hands of the mental health system. In our LGBTQ 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 A: July, 1998.)

Many current mental health professionals were trained prior to 1973, or by people who were trained before that time (Appendix A:30). Some mental health professionals continue to pathologize LGB orientations. Thankfully, 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 A:31). From Evelyn Hooker (Appendix A:32) to the present (Appendix A:33-39) scientific research consistently disproves such theories. Regrettably, prejudices persist (Appendix A:40-42). LGBTQ people seeking mental health care continue to encounter mental health providers who consider their sexual orientation and/or gender identity a delusion or symptom that will vanish when their mental illnesses are resolved (Appendix A:43), and/or contend that gender relationships cause/exacerbate clients’ mental health problems (Appendix A:28). Pathologization of LGBTQ orientations/gender identities continues to be debated in prominent professional journals (Appendix A: 44, 45).

One effect of this lingering pathologization of LGBTQ identities is that LGBTQ

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 LGBTQ) 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 A: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 A: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 A: 49). Some professionals continue to view it as a psychosis or delusional system.

Biased Diagnoses

Although there has been little research in this area, there is evidence that mental health practitioners who are uncomfortable/unfamiliar with LGBTQ identities tend to inaccurately diagnose LGBTQ clients. One advocate (Appendix A: 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 LGBTQ-affirmative mental health providers support this point. Psychologist Steve Hartman (Appendix A: 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 gay male culture. Similarly, psychiatrist Orren Perlman (Appendix A: 4, KI June, 1998), has observed that some mental health professionals mistakenly consider people who identify as bisexual as having a Personality Disorder, mistakenly assuming 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 LGBTQ people and issues makes mental health professionals susceptible to believing harmful stereotypes—e.g. all gay men have HIV, all bisexual people are sexually promiscuous, people of color are never “really” LGBTQ but must have been coerced or co-opted by white LGBTQ people. Such misinformation can lead otherwise competent mental health providers to make serious mistakes. For example Avery, Hellman, and Sudderth’s 2001 survey (Appendix A:52) of clients of outpatient and inpatient mental health care, found that LGBTQ respondents were more than twice as likely to report substandard 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 you, 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 think 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 A: 4, KI, July 1998)

Denial

Many mental health programs ignore the existence of LGBTQ clients, and assume/assert that all clients (and staff) are heterosexual (Appendix A:54). This illusion allows mental health systems/agencies/providers to ignore LGBTQ clients and employees needs by simply denying that LGBTQ 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 A: 54), such denial leads to neglect and outright abuse. As a long-time mental health worker and peer advocate, Audrey Grifel (Appendix A: 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 LGBTQ, 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 A: 4, March 1998) concluded,

[LGBTQ consumers] are approached clinically from a heterosexual mode, mistreated by the public mental health system.... They get treatment for their mental illness, but not as a whole person. It's really very damaging...and creates a profound sense of isolation for LGBTQ people who are clients.

Discrimination & Harassment

Concrete manifestations of ignorance and bias are anecdotally common in many mental health settings, although exactly *how* common has not been well quantified. The more subtle expressions of ignorance, denial and disregard are evident the exclusionary policies, practices and procedures of countless mental health providers, and often leave LGBTQ clients and employees feeling excluded and un-welcome. For example most states forbid same-sex marriage, and most intake forms ask one to check “married,

single, widowed or divorced,” rendering LGBTQ clients’ relationships invisible and invalidated. Other LGBTQ clients have found that clinicians and administrators have refused to note same-sex significant others as family members, which denied LGBTQ clients the visitation, accompaniment and support that heterosexual clients enjoyed.

Similarly, some providers and programs discount that “coming out” (see glossary) is a deeply personal process. Several key informants described programs with policies and procedures that required LGBTQ clients to be “out” to all staff and clients without regard to whether or not being “out” places LGBTQ clients in physical and/or emotional jeopardy. Other programs demand that LGBTQ people stay closeted and fail to provide support when disclosure brings about harassment.

- ▼ 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)

When LGBTQ people feel unwelcome, refuse to disclose when required, or experience hostility after forced disclosure, they are not only denied safe and respectful services, they can be denied services entirely. Conversely, some key informants found that confidentiality was sometimes employed as a way to avoid talking about LGBTQ topics entirely:

- ▼ 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 A: August, 1998)

Egregious instances of hostile discrimination or harassment against LGBTQ people receiving mental health care are less common 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 LGBTQ clients and potential clients. First person accounts tell of mental health providers frankly homophobic remarks, and sometimes violent sentiments (e.g. “fags will all burn in hell”). Some tell of being isolated on an inpatient unit because staff loudly stated that LGBTQ clients sexually abuse their roommates (Appendix A: 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-LGBTQ verbal abuse (name-calling, provocation) from other clients continue indefinitely, and have sometimes even joined in the abuse.

Nancy Nystrom's 1997 (Appendix A:56) survey of gay men and lesbians found that 46% reported receiving mental health care that they experienced as homophobic. Similarly, a 1995/96 survey of 116 LGB consumers aged 18-75, across 36 states (snowball sample) reported the following experiences. (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 bisexual...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 A: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 A: 4, August 1998).

More studies are needed to learn the actual incidence of such mistreatment.

However, many LGBTQ consumers consider harassment and mistreatment likely and prepare for it when they attend a new mental health program (Appendix A: 55, 58-61). Ironically, the people and places LGBTQ people approach for help are experienced by these clients as potentially unsafe.

Peer Intolerance often goes unaddressed

In mental health settings where clients spend time and interact closely with each other (groups, day programs, residential, inpatient), LGBTQ people risk disrespect and harassment from other clients. Although research has yet to document the prevalence of this problem, it is common enough that many LGBTQ people in mental health care say they expect it. Staff routinely ignore incidents of the verbal abuse of LGBTQ clients

by their peers. Staff's failure to intercede when such abuse occurs is experienced as license to target and harass LGBTQ people by both the abusers and the abused. The problem of peer intolerance has also been found in mental health consumer self-help groups or consumer-run agencies.

- ▼ 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 A: 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 LGBTQ members. “Coming out” (see glossary) to family and close friends can be an intensely stressful process that is not a one time event for most LGBTQ people. Many LGBTQ 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 LGBTQ people have good reason to believe that family members will be unsupportive, rejecting, hostile or violent. While many LGBTQ people do come out to family in the first several years of their awareness of an LGBTQ 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 LGBTQ 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 [LGBTQ] consumers’ experience at the Alliance.” (Appendix A: 4, February 1998)

Effects

The issues described above cause many LGBTQ individuals to spend tremendous energy managing their identity, self presentation, fear, anxiety, and the negative reactions from the people from whom they 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 A: March, 1998). “For individuals diagnosed with serious mental illness who are LGBTQ, 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 A:62, pp. 1-2).



CREATING AND SUSTAINING LGBTQ AFFIRMING MENTAL HEALTH SERVICES

Many agencies, organizations, institutions, and social service providers are now adopting the more inclusive formulation of 'LGBTQ.' However, the mere adoption of inclusive nomenclature, without the revision and expansion of programming and policies, may result in the worst of both worlds: an organization that purports to be lesbian, gay, bisexual and transgender-inclusive but is not. Conversely, some agencies and organizations seek funding for LGBTQ-specific programming only to increase the size of their budgets, without any real commitment to making their work genuinely LGBTQ-inclusive. There are many ways to make an organization fully LGBTQ-inclusive, given commitment from the leadership of the organization, but that objective is rarely effectively attained without training by outside trainers following a comprehensive review of existing programming, policies, and procedures.

No single mental health professional or agency can eradicate homophobia and society's rigid gender dictates. At minimum each of us can effect positive change in our personal practices. And, wherever possible, we can become agents of change within our agencies and larger communities. Improvements at any "level of change" not only results in a more safe and welcoming environment for LGBTQ people, but also spills over to create a more safe and welcoming environment for heterosexual and conventionally gendered clients and staff as well.

- ▼ 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 A: 4, September 1998)

General guidelines for each level of change follow:

Individual Practitioner

- ▼ Recognize one's internalized trans/homophobia and examine how misinformation and stereotypic beliefs shape clinical assessments, attitudes and behaviors both one's professional and personal life.

- ▼ Reeducate oneself about LGBTQ identities, clarify what one wishes change (e.g. intake forms, language, agency policies, etc.), and begin the process of instituting those changes.

Direct Service Level

- ▼ Develop standards, procedures, client satisfaction instruments and other tools to help ensure the delivery of welcoming and respectful mental health services for everyone, including LGBTQ people.
- ▼ Add LGBTQ issues to diversity training. Include sensitivity and respect for all diversity dimensions in employee job descriptions, supervision and performance evaluations.

Agency Level

- ▼ Create agency-wide policies and practices that openly welcome LGBTQ individuals.
- ▼ Include lesbian, gay, bisexual and transgender people in agency non-discrimination policies, and provide the same benefits to domestic partners as are provided to heterosexual couples.
- ▼ Provide on-going training for all staff, volunteers and Board of Directors. Engage qualified LGBTQ people to serve on the agency's Board of Directors.

Community Level

- ▼ Promote equal treatment of LGBTQ people in the larger community.
- ▼ Speak out against discrimination and intolerance, and encourage traditional health and human service providers to incorporate sensitivity to LGBTQ concerns into their work.
- ▼ Build relationships with LGBTQ groups and service providers, and attend LGBTQ advocacy and fundraising events.
- ▼ Meet with LGBTQ groups and services providers to hear their concerns, discuss common interests, support their efforts, share resources, and develop coalitions.

Public Policy Level

- ▼ Support and advocate for LGBTQ-positive legislation and candidates on local, state, and national levels.
- ▼ Know the status of local, state and national non-discrimination statutes regarding in/exclusion of sexual orientation and gender identity.

- ▼ Support enforcement of inclusionary statutes when they exist, and advocate for inclusionary statutes when needed.

These levels are not mutually exclusive. Activities in one influence others, and levels blend into each other. Below, we focus on the Individual, Direct Service, and Agency levels in more detail:

Individual Practitioner:

To develop LGBTQ-affirming therapeutic relationships, mental health providers need to know:

- ▼ That becoming culturally competent is an ongoing process is never fully completed;
- ▼ about common misperceptions, false beliefs and biases that have shaped mental health providers' (and the larger society's) treatment of LGBTQ people;
- ▼ that human sexuality, sexual orientation and gender identity are significantly more complex than any of the ways we characterize them;
- ▼ that LGBTQ-identified or LGBTQ-affirmative mental health workers may not be the best matches for individual LGBTQ client's specific needs;
- ▼ LGBTQ providers and LGBTQ clients may have overlapping social cultural circles, and may be acquainted with more of each other's associates than is appropriate for a therapeutic relationship;
- ▼ some providers (and some consumers) view LGBTQ identities as beleaguered or tragic and ignore/discount the beneficial qualities of LGBTQ lives and relationships.

(Sources include Appendix A: 7, 69-71)

Mental health providers will find it useful to understand that many LGBTQ people bring with them to therapy a history of stressful interactions with health and human service providers, and with people in the larger culture, including:

- ▼ the effects of previous injurious interactions with health professionals;
- ▼ "hyper-vigilance," i.e. finely tuned self-protective abilities to read subtle signs of others' reactions sexual orientation and/or gender identity in order to avoid or prepare for humiliating/dangerous interactions;

- ▼ wariness until assured that clinician is both LGBTQ affirmative and able/willing to work with them in other areas (focal problems, culture, class, etc);
- ▼ reluctance to share their LGBTQ orientations/identities to shield themselves from rejection and intolerant reactions (even when clients are comfortable with their orientations/gender identities);
- ▼ distress that client's sexual orientation/gender identity has/will create conflict with family members who are not LGBTQ-affirmative (this is especially true for those who rely on family support, whose cultural/religious backgrounds stress family harmony, honor, filial loyalty, restricted concepts of sexual "morality," rigid sex role expectations, and/or clients who experience family conflict about 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 live far from a large metropolitan area;
- ▼ conflict/distress about sexual orientation/gender identity due to misinformation, intolerant cultural/religious values, and/or internalized hateful messages about LGBTQ people;
- ▼ a need to work deliberately to develop a positive identity (heterosexuals rarely consciously focus on this as heterosexuality is considered a given);
- ▼ concerns/stressors due to anti-LGBTQ discrimination (e.g. losing a job, housing, or custody of children, etc.);
- ▼ substance abuse that may (or may not) have arisen from discrimination, abuse, social isolation, stress, or personal conflict linked to being LGBTQ;
- ▼ pressures (and joys) unique to same-gender relationships in addition to those common to all relationships. (Pressures include lack of the social sanction, lack of relationship models, pathologization of relationships, discrimination, hostility, violence, etc. Joys include deep friendship, flexible/egalitarian roles, creative relationship models, profound emotional and sexual intimacy, etc.

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

Daily Direct Services: Policies and Practices

Physical Environment:

To present a welcoming "face" for LGBTQ people as soon as they walk in the door:

- ▼ Add LGBTQ resources, pamphlets, magazines existing informational tables/racks that provide resources for the larger community.

- ▼ Ensure that posters/artwork with images of people and families reflect the full range of those found in your community, including same gender people together, children with same gender parents, etc.
- ▼ Display “welcome triangles” or “safe space” cards in visible locations on doors, at the front desk, in consultation rooms, rest rooms, etc. (See <http://www.league-ncr.com/safe.cfm> or <http://www.northwestern.edu/LGBTQ/safespace.html> for examples.)
- ▼ Sound is also important: Do staff use LGBTQ 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 LGBTQ community?

Questions and Forms:

Intake and assessment questions, procedures, and forms typically exclude LGBTQ people. Four of the most common are:

Married, single, widowed, or divorced?

Because most states exclusively restrict marriage to heterosexuals, people in same sex relationships have no honest way to respond to the “married, single, widowed or divorced” question. Although this language might be necessary in some narrow circumstances when information about a person’s legal status is necessary, mental health providers ask about “marital status” to assess clients’ family structures and support networks. More inclusive language invites LGB people to respond honestly, and gathers more useful information at the same time, e.g.:

- ▼ Do you have a spouse,/partner/significant other?
- ▼ Are you in a romantic relationship?
- ▼ Who are your most important support people?
- ▼ Who do you consider your family?
- ▼ Do you live with someone?

Gender

Note: the following text on gender is by Pauline Park, Ph.D, Executive Director of the New York Association for Gender Rights Advocacy (NYAGRA)

Most intake interviews and clinical forms ask for sex and usually give only two choices (i.e., male or female). Such a form constitutes an invisible and usually

unintended impediment to the provision of services to transgender people. Most transgender people live most of their lives in a gender different from the legal sex designation on their identity documents. While some transgender people would appreciate a third choice, such as 'transgender,' many others would be reluctant to assign themselves to such a category, either out of fear of possible discrimination, or because they strongly identify with one gender or the other, or because they do not want to be singled out, or because they are living 'stealth' (i.e., presenting themselves as if they were born into the sex with which they identify).

There is no easy answer to the question of what question to put on intake forms. An alternative question to put on a form could be: How do you identify your gender? The question could include multiple possible responses, such as 'transgender man,' 'transgender woman,' 'genderqueer,' 'intersexed,' etc. The form could also include a blank line after 'other' so that the individual could self-identify. At the same time it is crucial that a question to identify sex/gender on an intake form not complicate insurance payment for the transgender client. An entirely separate form marked clearly as for internal agency use only to indicate gender identity and/or sexual orientation would avoid such a problem.

Sexuality and Sexual Orientation

Although sexuality is an integral aspect of a healthy sense of self, the subject is rarely addressed in mental health services. Sexuality involves significant emotions, behaviors, values, thoughts, norms, and interactions. Yet, too often in mental health settings only the "hazards" are discussed, i.e. avoiding sexually transmitted infections, exploitation, unwanted pregnancy, etc. Although these issues are serious, they exclude healthy desires for intimacy, companionship, and relationships. This marginalization of sexuality becomes further pronounced in cases of marginalized sexual orientations and gender identities.

Most mental health professionals want to help all of their clients develop full healthy lives, including personal identities, positive self esteem, 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, bisexual and transgender (LGBTQ) people. Part of creating LGBTQ-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 a justification for uncomfortable practitioners to avoid the topic. More comfortable practitioners may decide to ask a client his/her sexual orientation. "What is your sexual orientation?" is a fine question, if rather blunt. Some clients do not know the meaning of 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 LGBTQ 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." LGBTQ-affirming providers include same-sex partners as a matter of course, are knowledgeable about the legal and institutional policies regarding unmarried partners proxies/registrations etc., and include same sex parents in all "family" programs and events regarding their children's care. Many LGBTQ people consider former partners and other close friends to be "families of choice." Affirming providers engage LGBTQ clients' "families of choice" (in the same way that heterosexual clients' extended families are engaged) to create support networks for clients.

Agency Level Strategies

When agency practices incorporate a working knowledge of LGBTQ people and their concerns, and have policies and procedures in place before incidents occur, the process is built into agency systems that simplifies problem solving and leads to their constructive resolution.

- ▼ Apply policies equally to lesbian, gay, bisexual, and heterosexual clients (e.g. rules about relationships, visitors, displays of affection, etc. are the same for

everyone).

- ▼ Train all staff to use the same intervention tools to address “unfriendly” behavior towards LGBTQ clients as they do when those behaviors are directed toward other clients because of race, religion, gender, etc. (e.g. “We have a rule about being respectful to everyone in group. That comment was disrespectful toward gay people, so it’s not acceptable here.”)
- ▼ Respectful resolution of problems creates enormous good will. Most LGBTQ people know that bias can not be completely avoided. However, LGBTQ people look closely at how such incidents are handled.

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 your agency.

- ▼ Include LGBTQ mental health consumers in your agency’s program development efforts.
- ▼ Educate the Board of Directors, management, clinicians, support and direct care staff about the benefits of incorporating LGBTQ concerns into the agency’s policies, procedures and treatment protocols, e.g. new sources of client referrals, new supporters/donors, community recognition, employee retention, improved outcomes for LGBTQ clients and families.
- ▼ Engage agency management’s on-going leadership, vision, consistency, and support to create and maintain a truly safe and welcoming environment for LGBTQ clients and staff.
- ▼ Empower a management team or diversity committee to develop a feasible action plan that identifies specific objectives, time lines and responsible staff.
- ▼ Create an LGBTQ community advisory committee including LGBTQ people from a cross section of ages, races, genders, ethnicities and cultures to strengthen coalition efforts, connect with local resources, enhance sensitivity and ensure that LGBTQ voices are built into the agency’s change process.
- ▼ Build coalitions and working partnerships with your local LGBTQ community.
- ▼ Advertise directly to the LBBT community via ads in LGBTQ media, fliers in LGBTQ bookstores; add the “welcome” triangle to all marketing materials, etc.
- ▼ Publicly advocate for LGBTQ rights (this builds credibility, enhances trust and reinforces messages of respect).

- ▼ 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.

Staff Training

Carefully planned and on-going training for all staff and volunteers is central to realizing individual and systemic change. Training designed to address the specific tasks of clinicians, direct-care staff, board members, administrators, volunteers, receptionists, billing clerks, public affairs employees, housekeeping, etc. can create and maintain a safe and welcoming atmosphere for LGBTQ people.

Important training topics include:

- ▼ What is and is not LGBTQ friendly language (e.g. using LGBTQ instead of "homosexual" – see glossary), and asking when one is not sure (e.g. "what name do you prefer to use?").
- ▼ Information about LGBTQ 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).
- ▼ Updates on current issues important to the LGBTQ community that affect your clients, such as local gay-bashing incidents, political races, police harassment, same sex marriage debates, etc.
- ▼ Updates on clinical information about therapy issues with LGBTQ 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 effect on everyone, and how to identify, 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.
- ▼ Effective strategies on how to address the needs of and contain the behavior of staff and clients who use negative biases, beliefs and assumptions to inflict

physical, psychological, social and/or economic harm on themselves and/or others.

Incorporate diversity/LGBTQ awareness into *all* education and training programs (e.g. to avoid the assumption that all staff and clients are heterosexual, include LGBTQ people, people of color, religious minorities, etc. into examples of case studies).

See Appendix A for specific training curricula Appendix D for other resources.

Continuing Self Education (adapted from Appendix A: 4)

Creating and maintaining positive therapeutic relationships with LGBTQ clients requires awareness on multiple levels, from policies to décor. At the same time, individual practitioners in all roles and from all disciplines can take personal responsibility to build their own competencies. Several concrete suggestions are provided by lasenza in Appendix A:3:

- ▼ Educate yourself: read, attend events, follow issues, take action and become a visible ally.
- ▼ Explore sexual orientation and gender identity issues in your own therapy and peer groups.
- ▼ Consult with members of the groups you are trying to learn about, individually or through workshops and other training opportunities.
- ▼ Seek supervision to further develop your LGBTQ 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.
- ▼ Make the environmental and emotional atmosphere in your workplace safe and welcoming for LGBTQ staff and clients.
- ▼ Examine your language, attitudes and behavior for heterosexual assumptions.
- ▼ Reflect on your reactions and feelings as you attempt and do these things.

See Appendix for a review of the published literature about psychotherapy with LGBTQ clients.

Programming

- ▼ 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 A: 4 July 1998)
- ▼ Another absolutely crucial issue is increasing the opportunities for [support] groups and for social opportunities with other LGBTQ 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 A: 4 May 1998)

Full integration of LGBTQ issues into all services promotes safety and creates LGBTQ-affirming mental health care. Agencies and individual practitioners would do well to systematically assess:

- ▼ to what degree the therapeutic opportunities offered are LGBTQ inclusive;
- ▼ whether or not staff talk with clients about sexuality in all its dimensions;
- ▼ whether or not healthy sexuality is discussed as a gratifying part of adult relationships (along with considerations of potential exploitation, unintended pregnancies and sexually transmitted infections);
- ▼ whether or not "typical" sexual orientation/gender identity is assumed for all clients/staff;
- ▼ whether or not all sexual orientations/gender identities' presence is assumed;
- ▼ whether or not all sexual orientations/gender identities are considered "normal;" and
- ▼ whether or not LGBTQ-specific programs can be offered (e.g. peer support/discussion groups, social activities, resource books, etc.).

Problem Solving

LGBTQ bias occurs to some degree in all organizations. When agency practices incorporate a working knowledge of LGBTQ people and their concerns, and have policies and procedures in place before incidents occur, the process is built into agency systems that simplifies problem solving and leads to their constructive resolution.

- ▼ Apply policies equally to lesbian, gay, bisexual, and heterosexual clients (e.g. rules about relationships, visitors, displays of affection, etc. are the same for

everyone).

- ▼ Train all staff to use the same intervention tools to address “unfriendly” behavior towards LGBTQ clients as they do when those behaviors are directed toward other clients because of race, religion, gender, etc. (e.g. “We have a rule about being respectful to everyone in group. That comment was disrespectful toward gay people, so it’s not acceptable here.”)
- ▼ Respectful resolution of problems creates enormous good will. Most LGBTQ people know that bias can not be completely avoided. However, LGBTQ people look closely at how such incidents are handled.



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 LGBTQ 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. 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 LGB or T?...” 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. 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

- ▼ Become conscious of your personal power and privileges, and employ them to stimulate change.
- ▼ Clarify your own values, priorities and intentions, and then *live* them—your example is a powerful agent of change.
- ▼ *Be* the change you wish to create—e.g. being more compassionate in our personal and professional interactions is the first step toward creating a more compassionate mental health practice, agency, community and society.
- ▼ Accept the conditions that currently exist, identify what can and cannot be changed, identify and enlist allies, and develop an action plan that lead to achievable goals.
- ▼ Listen to your fears, factor reality based concerns into your strategic plans, and become willing to take small steps out of your comfort zone.
- ▼ Notice and use everyday opportunities to effect simple, small changes (e.g. substitute the word partner for wife/husband, etc.).
- ▼ Calmly, clearly and routinely respond to offensive/discriminatory/marginalizing attitudes, comments, “jokes,” behaviors, policies, regulations and laws as you encounter them.
- ▼ Negative/hostile responses from others are often fear based, and the same approaches that comfort fearful clients are likely to help when working with fearful colleagues as well.
- ▼ See “failure” as an expected part of the process, hold yourself in compassion, value the lessons “failure” brings, and incorporate those lessons into your on-going planning structure to create the change you wish to see.
- ▼ Practice patience—sustained change evolves by means of time and compassion.

Interpersonal

In addition to all of the above:

- ▼ Identify a core group of allies and invite them to work with you to create positive change.
- ▼ Work together to identify concerns, establish achievable goals, create strategic action plans and develop implementation timelines.
- ▼ Use the support, resources and expertise of local LGBTQ agencies/groups.

- ▼ Collect documentation, personal examples, data, research studies, etc. in support of your goals.
- ▼ Agree on responsibilities and meet regularly to report progress and to adjust strategies.
- ▼ Remember that slow, incremental changes are more likely to become integrated into systems than are rapid, massive changes.
- ▼ Celebrate each small step toward creating a truly safe and welcoming environment for everyone.

Organizational

In addition to all of the above:

- ▼ Link a safe and welcoming environment for all clients, volunteers and staff to your organization's mission statement.
- ▼ Engage your agency's management and Board of Directors to integrate LGBTQ awareness and concerns into agency non-discrimination policies, personnel benefits, hiring practices, staff training, program evaluation, and all aspects of client services procedures.
- ▼ Add sensitivity to all diversity dimensions (e.g. race, religion, gender/gender identity, sexual orientation, etc.) to all agency staff job descriptions and to all employee performance evaluation instruments.
- ▼ Review and adjust all client forms to be inclusive of all sexual orientations and gender identities.
- ▼ Develop safe, confidential mechanisms to elicit feedback from clients and staff.

Patience, persistence, humor and flexibility come in handy for change-agents, especially when one's carefully thought out new approaches run amok (as they tend to do). When this happens, back up, regroup, reassess, experiment with new strategies and try again. Systemic change is an on-going process, replete with unexpected outcomes, challenges, and surprising twists and turns. Creating change is often exciting, sometimes scary, and in the end, deeply gratifying. We hope you enjoy the process.

Appendices

Individual and Agency Assessment Tools

Staff Training Curricula

Glossary

Appendix A/References

Resources and Organizations

Selected Bibliography on LGBTQ Issues

Selected Bibliography on LGBTQ Affirming Psychotherapy

Supplemental Texts

Excerpts of Professional Organizations' Ethical Guidelines

Diversity Continuum



Planned Parenthood[®]
Federation of America, Inc.



434 West 33rd Street New York, NY 10001
212-261-4798 FAX: 212-261-4795

Diversity Continuum: Indicators of Success

INTRODUCTION



“We believe that respect and value for diversity in all aspects of our organization are essential to our well-being.” These words from the PPFA Mission Statement are being put into practice across the country as the Planned Parenthood movement meets the challenge to embrace a diverse work force (staff and volunteers) and to create partnerships with and provide services to diverse communities.

To measure our success in meeting this challenge, we have developed *The Indicators of Success* tool, a diversity continuum and checklist. In developing a measurement system, it has become clear that statistics assessing the diversity of staff and volunteers are essential, but numbers alone cannot reflect the degree of success we are seeking. Embracing diversity entails a long-term commitment that cannot be quantified over the short-term, yet the impact of these efforts that affect individuals and organizational culture can be periodically assessed. *The Indicators of Success* tool is a means of compiling hard data that can be tabulated over time to gauge our progress along the diversity continuum and to reveal the contours of the unique path each affiliate will follow.

The Indicators of Success measurement tool uses the terms **culturally unaware**, **culturally aware**, **culturally aware and active**, and **culturally competent** as milestones on the road toward

an inclusive organization. For our purposes, the continuum begins with being (1) **culturally unaware**, that is approaching management and service delivery through unexamined assumptions and norms. The next stage, (2) **culturally aware**, indicates acknowledgement of diversity and the need to become inclusive without an organizational commitment to address it. An organization that is (3) **culturally aware and active** commits resources to the development of diversity initiatives and cultural competence in all areas. The (4) **culturally competent** stage involves innovative approaches to management and service delivery based on the needs of diverse groups as an integral part of the organization. The continuum is divided into categories, which include client services, the workplace, policies and procedures, and vendors. The score key at the end of each category is used to help interpret the overall score. For example, a score of 11 in client services could mean that an affiliate is culturally aware and beginning to take action in that area.

You are welcome to change these terms if there are others you prefer. Semantics are important; discussing terminology is richly productive, yielding mutual understanding. It is upon sharing the meaning of language that connections are made and alliances are built. “**Culturally competent**,” the term selected for the end of

our proposed continuum, is not a fixed destination but a permanent ideal, for there are always new immigrants and new generations, new cultures and new subcultures. **Cultural competency** is not an ending point; it is a vital journey.

Just as we at Planned Parenthood continue to search for new clinical methods, additional sources of revenue, and improved business and marketing strategies, we will also apply our hallmark determination and creativity to find superior diversity initiatives and measurement tools. Our collective participation in this ongoing creative process is akin to our movement for women’s reproductive rights, and calls upon our core strengths:

- the courage to accept the complexity of diversity issues that cannot be quickly or easily resolved;
- the tenacity to persist on a course of action that will endure.

For more information or related materials, contact diversity@ppfa.org.

Date:

CLIENT SERVICES

	Culturally Unaware	Culturally Aware	Culturally Aware & Active	Culturally Competent	Assessment			
	1	2	3	4	1	2	3	4
Medical	All medical services are performed at the affiliate health centers.	All medical services continue to be performed at the affiliate health center but policies, procedures, and practices are reviewed for potential barriers to access for diverse groups.	Recognition that barriers exist. A plan is developed and implemented to increase accessibility for all clients by conducting outreach to diverse groups, such as women with disabilities, lesbians, immigrants, and other groups.	Medical services are delivered to a variety of sites (e.g., migrant camps, apartment complexes, organizations serving diverse communities, etc.) Woman with disabilities, lesbians, woman of color, youth, older persons, and others benefit from and help shape services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Educational	Education services are provided at the affiliate or delivered in more conventional settings such as schools and community agencies. Sexuality education assumes heterosexuality and that English is the spoken/written language.	Recognition that clients represent diverse backgrounds, but nothing is done to address the specific needs of subgroups. Clients are expected to speak, read, and/or write in English; although, in some instances a translator may be provided.	There are pilot programs using new methods such as comic book-style pamphlets in multiple languages to deliver medical and educational services in settings where clients from non-dominant cultures gather.	Client feedback is solicited regularly and integrated into service programs. Multicultural approaches are used in educational services to meet the needs of an increasingly diverse clientele.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Materials: forms, brochures, videos, etc.	Materials lack diversity content. Statements and questions assume heterosexuality. There is also an assumption of literacy. Writing and soundtracks are only in English.	Materials are in English; however, upon request they may be available in other languages. One or two persons of color are added to brochures, videos, or photographs.	A mechanism to review materials for multicultural competence and sensitivity is developed. Multicultural, multilingual materials acknowledge clients with disabilities, different sexual orientations, races, ethnicities, and other backgrounds in content and in images. Different educational backgrounds and literacy levels are addressed.	All materials are developed, accessed and reviewed by clients, staff, volunteers and community stakeholders of different cultures and different languages to continue to ensure continued cultural relevance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Date:

CLIENT SERVICES

	Culturally Unaware	Culturally Aware	Culturally Aware & Active	Culturally Competent	Assessment			
	1	2	3	4	1	2	3	4
Service Provision	All services are provided in English only, including visits, classes, counseling, materials and consent forms.	Most services continue to be delivered solely in English, but there is recognition that to serve clients from various cultural backgrounds, multilingual and multicultural staff and volunteers are needed.	Culturally-sensitive services are provided in a variety of languages with multilingual and multicultural staff and volunteers, materials and forms. Resources are directed towards meeting the needs of underserved populations in the geographical area.	Members from all diverse communities receive comprehensive services. Clients and community stakeholders of different cultures and different languages continually participate in shaping service provision.	○	○	○	○
	Practices in service delivery result in unconscious discrimination. Clients from diverse backgrounds do not seek services, or if so, they do not feel welcomed.	Clients are diverse; however, stereotypes remain present and unchallenged. Staff and volunteers are uncomfortable and/or inexperienced in addressing cross-cultural issues.	Teams are created to problem-solve service delivery concerns. Staff and volunteers learn cross-cultural communication skills. The office environment and culture are modified to reflect value for diversity.	The structure and delivery of services integrate a dynamic multicultural approach. Clients, staff and volunteers interact with ease and continue to build cross-cultural bridges. Opportunities to learn about different cultural groups are built into the regular course of business.	○	○	○	○
Score Key	1-5	6-10	11-15	16-20				

Results	Current Year 200_
	Previous Year 200_

NOTES:

Date:

WORKPLACE: Employees and Volunteers

	Culturally Unaware	Culturally Aware	Culturally Aware & Active	Culturally Competent	Assessment			
	1	2	3	4	1	2	3	4
Representation Employees	Employee pool lacks dimensions of diversity including economic, racial, gender, sexual orientation, age and abilities.	There is acknowledgement of the need for diversity. cursory efforts to recruit a diverse workforce are initiated. Diversity primarily exists at the lower levels of the organization. Statements such as "we can't find qualified candidates" are made.	Deliberate efforts are made to engage, attract, and retain diverse staff and management. The organization strives to reflect the diverse populations in which the organization is located.	Staff positions are occupied by people of many cultures and languages. The norms and values of the workforce are integrated into the organizational culture. Individual cultural competencies are solicited and valued by the organization. The organization seeks to surpass diversity levels in the general population.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Volunteers	Volunteer pool lacks dimensions of diversity including economic, racial, gender, sexual orientation, age and abilities.	Minimal representation by chance. Limited representation in governance. Discomfort with change is evident.	Deliberate efforts are made to engage, attract, and retain a diverse group of volunteers in particular those working with clients. Diverse representation in key committees such as the nominating committee is seen as critical.	Clinic, public affairs, and governance volunteers surpass the diversity of the community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Board	The board is not diverse.	Board members begin discussions on diversification, but are concerned that increasing diversity will diminish board's ability to raise funds. Fear of change prevents action.	Nominating committees actively recruit diverse candidates for the board. The board begins to address board culture for barriers to retention of diverse members. The board is diverse.	The board's leadership and membership are diverse. Multicultural methods and values have been completely integrated into the normal course of business. Board meetings are held in diverse locations and communities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Date:

WORKPLACE: Employees and Volunteers

	Culturally Unaware	Culturally Aware	Culturally Aware & Active	Culturally Competent	Assessment			
	1	2	3	4	1	2	3	4
Communication	All communication occurs in the language of the mainstream culture. Staff who are bilingual are not valued for their language skills and are discouraged from speaking languages other than English on the work site with each other.	Bilingual staff and volunteers are hired to address the needs of clients. Their cultural background and language skills are valued and appreciated.	It is recognized that the organization benefits from the diverse cultures, languages, and communication styles of its employees . Benefit brochures, employee handbooks are available in English and other languages.	Multilingualism and multiculturalism are viewed as absolute assets and flexible communication styles are the norm. Various language classes are available during the workday. The whole person is valued.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coalition Building	Staff and volunteer efforts focused solely on the organization itself. Issues have a narrow, exclusive focus. There are no connections to organizations serving culturally diverse communities.	Recognition that relationships with other organizations are needed. Token gestures made to invite others to participate in "our" meetings." One or two people are responsible for community outreach.	Relationships based on mutual respect are sought and established with organizations and groups representing diverse communities. Agendas are set together and are collaborative efforts.	The value and practice of coalition building is institutionalized. The organization is an integral part of multicultural networks that promote a partnership model. All members of the organization see the value in coalition building. Coalition building is widespread in the organization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Score Key	1-5	6-10	11-15	16-20				

Results	Current Year 200_
	Previous Year 200_

NOTES:

Date:

POLICIES AND PROCEDURES

	Culturally Unaware	Culturally Aware	Culturally Aware & Active	Culturally Competent	Assessment			
	1	2	3	4	1	2	3	4
Representation	There is compliance with local, state and federal non-discrimination laws, but there are no policies addressing diversity.	Minimal attempts are made to address diversity issues. Policies are reviewed for overt barriers to hiring, retaining, and promoting staff of culturally diverse backgrounds.	Policies are created affirming the inclusion, respect, and value of people from culturally diverse backgrounds at all levels of the organization. Guidelines are developed to ensure accountability for increasing diversity and promoting cross-cultural understanding.	A high level of diversity is achieved and maintained through policies and practices that are dynamic and informed by multicultural staff, volunteers, clients and communities. All policies rest on a foundation that values diversity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Benefits	Benefits are provided in the manner mandated by law.	Demands for equity in benefits voiced by staff have not been addressed.	Policies are developed to address needs of different groups. Complete benefits are allotted to all, including same-sex partners, single parents, etc.	The organization is at the forefront in developing benefits, policies, and practices that innovatively address the shifting needs of a diverse workforce and account for family/work life balance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff and Volunteer Development	Programs to increase awareness of cultural differences do not exist. Outside diversity training opportunities are ignored or unknown or seen as unimportant.	The organization is reactive to the training needs expressed by employees and volunteers of different cultures. When training is available, few staff and volunteers attend diversity training due to lack of priority.	Diversity training is embraced and seen as essential. Diversity orientations and programs are attended by staff and volunteers. Diversity skills are shared with coalition partners and the community.	Multicultural programs such as diversity training are systemic and ongoing. The organizational structure and delivery of services are multicultural. Trainings are a source of greater understanding, skill-building, and team-building.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

NOTES:

Date:

POLICIES AND PROCEDURES

	Culturally Unaware	Culturally Aware	Culturally Aware & Active	Culturally Competent	Assessment			
	1	2	3	4	1	2	3	4
Board	Mission statement, bylaws, and other guiding statements do not address diversity.	Bylaws and other documents require a specific number of representatives from diverse communities to avoid criticism. Practice however, may not reflect this diversity.	Bylaws and other documents explicitly state that becoming an organization inclusive of all cultural groups is a goal. Board members are expected to address and ensure diversity.	Policies and practices are aligned and reflect a high degree of commitment to members of different cultures and different models of governance. All board members are willing to embrace diversity.	○	○	○	○
Institutional Commitment	Management shows no interest or commitment to diversity.	Management minimizes the validity of criticisms pointing to a lack of diversity. Discussions addressing diversity are rare.	Management indicates a desire to learn about diversity and to increase the diversity of staff and volunteers by developing programs and allocating resources for these efforts.	Management is diverse and its commitment to diversity is systemic. Management leads the efforts to promote multicultural methods and values within the organization and in the community at large.	○	○	○	○
External Relations	There are no policies that address the organization's involvement in community issues. The focus is solely internal.	Minor involvement exists with community groups through individuals. The organization remains insular.	Policies are created to guide involvement with diverse organizations and communities. Recognition that the organization has a role to play in issues that affect many communities.	Policies and practices reveal an ongoing commitment to social justice. The organization is routinely involved with issues affecting the communities of clients, staff and volunteers.	○	○	○	○
Score Key	1-6	7-12	13-18	19-24				

Results	Current Year 200_
	Previous Year 200_

NOTES:

Date:

VENDORS

	Culturally Unaware	Culturally Aware	Culturally Aware & Active	Culturally Competent	Assessment			
	1	2	3	4	1	2	3	4
Representation	Vendors are drawn from mainstream businesses.	There is an awareness of the need to create partnerships with People of Color and women-owned businesses, but no action is taken.	A plan is developed to increase business partnerships with culturally diverse vendors. A system of measurement is designed.	It is the norm to establish partnerships with culturally diverse businesses.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diversification	Mainstream networks are the only source for new vendor partnerships. Little, if any, thought is given to diversifying the vendor pool.	There is an absence of a policy stating that the organization values a diverse vendor pool. There is no effort made to increase the diversity, that may exist, in the vendor pool unless required by law.	Following an official policy, resources are allocated to diversifying vendors, to include groups in addition to women and people of color. Ongoing monitoring is implemented.	The vendor database is updated and modified to reflect changing demographics and diversity needs. New business partnerships with vendors from different cultures are formed continually.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Institutional Commitment	There is no management or board support for diversification.	Business partnerships with vendors of different cultures occurs by chance. No resources are provided to diversify vendors.	Incentives are used to create a diverse vendor pool. Management is held accountable via performance objectives and evaluations for maintaining a diverse vendor database.	Use of vendors of different cultures becomes a part of the organizational culture. It is institutionalized. The organization is recognized widely for maintaining vendors of different cultures.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Score Key	1-3	4-6	7-9	10-12				

Results	Current Year 200_	<input type="text"/>
	Previous Year 200_	<input type="text"/>

Total Score Key	1-19	20-38	39-57	58-76
------------------------	-------------	--------------	--------------	--------------

Total Results <small>(from four categories)</small>	Current Year 200_	<input type="text"/>
	Previous Year 200_	<input type="text"/>

I am a member of the following group (check one): Administrator Clinical Staff Administrative Staff Board Member Other Volunteer



Diversity Department

Promoting Diversity and Cultural Competence

Self-Assessment Checklist for Personnel Providing Culturally and Linguistically Competent Services

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of diversity and cultural and linguistic competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment.

Directions: Choose A, B, or C for each item listed below.

A = Things I do **frequently** **B** = Things I do **occasionally** **C** = Things I do **rarely** or not at all

COMMUNICATION STYLES

A **B** **C**

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. For clients/staff/volunteers who speak languages other than English, I attempt to learn and use key words in those languages so that I am better able to communicate with them. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. I use visual aids, gestures, and physical prompts in my interactions with clients who have limited English proficiency. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. I use bilingual staff or trained volunteers to serve as interpreters during assessments, meetings, or other events for clients/staff/volunteers who would require this level of assistance. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. When interacting with those who have limited English proficiency, I always keep in mind that |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | limitations in English proficiency is in no way a reflection of their level of intellectual functioning. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | a client's limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | clients may or may not be literate in their language of origin or English. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. When possible, I insure that all notices and correspondence to clients/staff/volunteers are written in their language of origin. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. I understand that it may be necessary to use alternatives to written communications for some people, as verbal dialogue may be a preferred method of receiving information. |

VALUES & ATTITUDES

A = Things I do frequently **B** = Things I do occasionally **C** = Things I do rarely or not at all

- | A | B | C | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. I discourage others from using racial and ethnic slurs by helping them understand that certain words can hurt others. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with clients served by my program or agency. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. I intervene in an appropriate manner when I observe other staff within my program or agency engaging in behaviors that show cultural insensitivity or prejudice. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. I understand and accept that family is defined differently by different cultures (e.g., extended family members, godparents, family of choice). |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g., who makes major decisions for the family, play and social interactions expected of male and female children). |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. I understand that age and life cycle factors must also be considered in interactions with individuals and families (e.g., respect for the decisions of elders). |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 15. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 16. I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 17. I recognize and accept that folk and religious beliefs or practices may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 18. Before visiting or providing services in community settings, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to specific cultures and ethnic groups served by my program or agency. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 19. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence. |

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

A = Things I do frequently **B** = Things I do occasionally **C** = Things I do rarely or not at all

- | A | B | C | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of those served by my program or agency. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of people served by my program or agency. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 22. When using videos, films, or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of people served by my program or agency. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 23. When using food during a workshop/training, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of those served by my program or agency. |

CLINICAL SERVICES

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. I utilize a client-centered approach by treating each client as a unique individual. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. I am knowledgeable about the traditional beliefs of clients concerning health and wellness. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Traditional or folk remedies are respected and discussed with clients in the context of their overall care. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. I provide satisfaction surveys in the languages spoken in the community and a secure box in which to deposit the surveys anonymously. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. I provide clients with the choice of female or male clinicians and/or educators, whenever possible. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. I understand the importance of employing staff and volunteers that represent the communities served. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. I make sure extra time is scheduled for those clients who have limited English proficiency, as their appointments may take longer than others. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. I have referral services available to accommodate the varied social/cultural needs of our clients. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. In discussions with clients about sexual practices, I focus on behaviors, not sexual orientation. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. When asking about relationships, I use gender-neutral pronouns (such as partner). |

A = Things I do frequently **B** = Things I do occasionally **C** = Things I do rarely or not at all

- | A | B | C | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. When asking clients about behaviors, I ask whether their partners are men, women, or both. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. I am aware of the stigma present in many cultures about sexual orientation and recognize that this may affect a client's willingness to discuss certain sexual behaviors. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. If a client reveals that she/he identifies as LGBT, they are assured that Planned Parenthood is a safe and welcoming place for them. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. I treat transgender clients with the same respect as any other client, and acknowledge and use the pronouns with which they identify. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I ensure co-workers are respectful, as well. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 15. I discuss cultural beliefs with clients when addressing safer sex issues. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 16. I am aware that racism, prejudice, and homophobia are still present within the health care system and understand that these negative attitudes affect clients in their perception of care providers, willingness to disclose information, and willingness to follow proscribed courses of treatment. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 17. I am aware that certain cultural groups may be at higher risk than others for certain conditions or illnesses, such as depression, alcohol/substance abuse, and HIV/STI infection. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 18. I make eye contact with a client, unless it is considered culturally inappropriate. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 19. I ask for clarity when I am unsure of the meanings of terms that a client may use. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20. I provide an open and caring environment in which the client is encouraged to ask questions and provide feedback. |

There is no answer key with correct responses. However, if you frequently responded "**C**", you may not necessarily demonstrate values and engage in practices that promote a diverse and culturally and linguistically competent service delivery system.

Adapted from:

Goode, Tawara D. Georgetown University Center for Child and Human Development—University Center for Excellence in Developmental Disabilities Education, Research & Service (Adapted from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings*—June 1989. Revised 1993, 1996, 1999, and 2000) [Online].
<http://gucchd.georgetown.edu/nccc/nccc7.html>

Cultural Competence Self-Assessment



The following self-assessment will assist you to explore your cultural competence in the areas of self-exploration and knowledge of the dimensions of diversity, linguistic competence, and organizational competence. It is a short, easy to use tool that can be incorporated into your diversity work with staff, boards, or other volunteers. It is one of many tools available to you in your ongoing journey toward cultural competence. Please feel free to use it as needed, and enjoy the process!

Individual self-assessment: How familiar am I with . . .		Very Familiar	Somewhat Familiar	Not Familiar
1.	the aspects of my own cultural identity I feel strongest about and why?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	white, male, heterosexual, and/or Christian privilege and how they impact my interaction with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	the reasons many people of color are distrustful of health care institutions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	what culturally competent services are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.*	why the phrase “sexual orientation” is more accurate than “sexual preference”?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	why it is important to know the immigration and migration patterns in my area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.**	why the phrase handicapped is offensive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	what internalized oppression is and what it looks like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.***	why “color-blindness” in relation to race recognition is a myth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	why the phrase “reverse discrimination” is inaccurate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Linguistic competence: How often do I . . .		Frequently	Occasionally	Seldom
1.	learn and use key phrases to better communicate with clients, staff, and volunteers who speak other languages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	collaborate with bilingual staff or trained volunteers to serve as interpreters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	create notices and correspondence to clients, staff, and volunteers for whom English is a second language in their language of origin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizational competence: How often do I . . .		Frequently	Occasionally	Seldom
4.	avoid imposing values that may conflict or be inconsistent with other cultures or ethnic groups?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	learn the courtesies, customs, and expectations that are culturally-specific to the communities in which my agency provides services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	advocate for program and agency goals, policies, and procedures that promote cultural diversity and cultural competence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	listen actively and reflect on my relationship with clients, staff, and volunteers who are both similar to and different from me?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	discourage others from using offensive comments about diverse groups by helping them understand that regardless of their intent the impact can be hurtful to others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	screen books, videos, and other material for negative stereotypes before using them in my agency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	reference sources for culturally competent healthcare offered in my affiliate, the national office, or other organizations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This tool is meant to encourage self-discovery. If you choose to hold a discussion after using it, you may find the following principles useful as you explore the cultural competence self-assessment questions.

Embracing diversity is a life-long journey.

- **One size does not fit all.** The nature of a diversity initiative in the northeast corner of Vermont may be very different from one in southern Texas.
- **We are one another's teachers and students.** We are all on this journey together and will support, teach, and learn from one another's experiences and insights. In addition, we recognize that we may need to engage outside experts to work with us.
- **Creating safe conditions for embracing diversity is essential.** Some variables that guide the creation of safe conditions include
 - mutual agreements for behavior
 - ongoing individual-to-individual contact and discussion
 - affirmation and appreciation of cultural differences and similarities
 - development of allies across identity groups
 - creativity and fun with the work
 - leadership development
 - an atmosphere of learning
- **Healing is vital for those who have lost faith in the process.** We need to regain confidence in our ability to make significant progress together toward creating a truly diverse organization. Creating systemic change requires a critical mass of diversity activists supporting one another.

Source: The Diversity Strategic Plan for Planned Parenthood Federation of America, 2002-2006

Things to consider . . .

- 5.* "Sexual orientation" reflects the complexity of factors that determine to whom we are sexually attracted and with whom we fall in love. It is different from sexual behavior; since one's sexual behavior may not match one's innate sexual orientation.
- 7.** The term "handicapped" is outdated, and connotes that people with disabilities need charity. Disabilities don't handicap: attitudes and architecture handicap. Some people prefer the term "differently-abled".
- 9.*** Saying that one is "color blind" in reference to race recognition denies the existence of racism, and ignores the existence of white privilege. As such, it protects these privileges from being fully acknowledged and addressed.

Related Diversity Resources

The PPFA Diversity Department Publications

- *Cultivating Diversity: Organizing Within and Without (brochure)*
- *Enhancing Cultural Competence: Welcoming the Lesbian, Gay, Bisexual, and Transgender Community (tool kit)*
- *Diversity Strategic Plan for Planned Parenthood Federation of America, 2002-2006 (booklet)*

Websites

- Advocates for Youth at www.advocatesforyouth.org
- The Human Rights Campaign Foundation at www.hrc.org/worknet
- National Center for Cultural Competence at www.georgetown.edu/research/gucdc/nccc/index.html
- Office of Minority Health Resource Center at www.omhrc.gov/omhrc

For more information or related materials, contact diversity@ppfa.org.

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Assessing your LGBTQ Friendliness

To enhance your LGBTQ work, it's helpful to annually identify the steps you've taken to create a safer and more welcoming environment for LGBTQ people and to notice the steps that need more attention. Make copies for future use and put a check mark in the small triangle to indicate your completion of each step. Date completed: _____

CEO supports us.	Management team supports us.	LGBTQ advisory committee's
Board has LGBTQ members.	Board trained & informed yearly.	All volunteers & staff trained yearly.
Client forms sensitive & gender neutral	We advertise directly to LGBTQ	Offices visibly welcome LGBTQ
Ed. & training programs LGBTQ	Coalitions built with LGBTQ community.	We publicly advocate for LGBTQ rights.

RECRUITMENT AND RETENTION RESOURCE GUIDE

Establishing and Maintaining
Diverse Staff, Boards,
and Other Volunteers





Establishing and Maintaining Diverse Staff, Boards, and Other Volunteers: Recruitment and Retention Strategies

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Establishing and Maintaining Diverse Staff, Boards, and Other Volunteers: Recruitment and Retention Strategies

The PPFA Diversity Department and its Mission

Planned Parenthood Federation of America (PPFA) is committed to its evolution as a “model for embracing diversity and expanding the decision-making powerbase of its stakeholders.” (PPFA Vision in Action, 2002) Our mission as an organization is based on providing quality reproductive health services and information to clients, and to attracting and retaining diverse staff and volunteers that reflect the communities we serve. In order to attract and retain culturally and linguistically diverse individuals, PPFA has developed the *Diversity Strategic Plan for Planned Parenthood Federation of America 2002-2006* that articulates the underlying values and principles guiding our work. Strategic Objective II is to create diverse representation, participation, retention, power sharing, and leadership within and among our staff, board, and other volunteers.

In January 2005 the PPFA board passed a resolution to reaffirm PPFA’s commitment to the priorities listed in the *Diversity Strategic Plan for Planned Parenthood Federation of America 2002-2006*. In addition, the board recently approved the piloting of changes to several of the affiliate accreditation indicators designed to strengthen services to diverse clients. The PPFA Diversity Department has undertaken many initiatives to assist both the national organization and its affiliates in their journey toward becoming culturally and linguistically competent. One such initiative is to support the efforts of the national organization and affiliates to institutionalize their efforts to recruit and retain cadres of diverse staff and volunteers. Embracing diversity in this manner advances PPFA’s Vision Goal 10 to “be acknowledged as one of the 10 best places to work and volunteer.”

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I. Introduction

Developing Affiliate and National Organization Resources

This packet is designed to assist affiliates recruit and retain diverse staff, board members, and other volunteers so that it becomes a standard procedure in both affiliate and national business practice.

Based on information provided by the U.S. Department of Labor, it is increasingly evident that the changing demographics in the U.S. are shaping the way in which health services and support are accessed and utilized. It therefore becomes both an ethical and a business imperative for health service organizations and providers to seek out and engage individuals from diverse backgrounds.

Diversity — refers to differences in culture, age, race, gender, ethnic heritage, language, national origin, spiritual belief or tradition, sexual orientation, physical, mental or emotional nature, and economic circumstances. Each of these differences brings a varied perspective, reflection, and insight to every life experience. Attention to diversity within the PPFA context should include:

- **Diverse representation** — the presence and inclusion of people of various social, cultural, and racial groups, and people with disabilities at all levels of Planned Parenthood — volunteer, front line staff, support staff, middle and upper management, CEO/COO, etc.
- **Diverse business/vendor** — owned by people of color, women, people with disabilities, gays, lesbians, etc.
- **Diverse organizations** — organizations that reflect and/or serve specific diverse groups within society and that share PPFA's diversity and social justice goals.
- **Economically diverse** — the presence and inclusion of people from a wide range of income levels.

PPFA's Dimensions of Diversity

Core Dimensions

age
color
disability
gender
national origin
physical characteristics
race/ethnicity
sexual orientation
socioeconomic status

Additional Dimensions (include, but not limited to)

educational background
religion
family configuration
geographic background (e.g. rural/urban, North/South, etc.)
language
level/function
lifestyles
marital status
military experience
organizational culture
political beliefs
skills
work background

Health Care Disparities

As noted in the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), the provision of culturally and linguistically competent services by diverse staff and volunteers is one critical venue through which the country can

- address disparities in health status for underserved populations
- assure access to care and quality of services

Organizations that aspire to provide services that are culturally and linguistically competent first need to address how they themselves become competent. One element in becoming competent is to value diversity by creating an organization that is culturally diverse, and representative of the communities they serve.

Benefits to Affiliates and National Organization

The Business Case for Diversity

In making the commitment to becoming culturally diverse, both the national organization and affiliates can anticipate multiple benefits:

- Staff, boards, and other volunteers will experience **increased satisfaction** in providing culturally appropriate and relevant care that meets the needs of the clients.
- **There will be decreased staff turnover.**
- Affiliates will be in **compliance with mandates of the Office of Civil Rights**. A diverse work environment **supports access and utilization of services by diverse clients** in an effective manner thereby maintaining compliance with federal mandates and reducing potential for lawsuits
- Clients who are well-served are **more likely to use and return for services** when needed, thereby improving their health outcomes
- A diverse workforce has **links to diverse communities**, increasing the pool of potential funders, volunteers, staff and supporters.
- Opportunities for **increased revenue** from expanded health care services and increased patient recruitment will emerge.
- Securing a diverse workforce will enhance the **exchange of differing values, beliefs, and practices** that will increase the organization's capacity to relate to the populations served.
- Establishing inroads to **new alliances** with other social justice organizations can result in **added support** in advancing our principles and legislative initiatives.
- Affiliates will be better positioned to **meet and even exceed** recruitment and retention **requirements delineated in the revised accreditation indicators**.

As organizations position themselves to serve the diverse communities they are targeting, it is critical that they recruit and retain diverse representatives from these communities as staff, boards, and volunteers.

Reference

PPFA (2002) *Vision in Action: The Strategic Plan for National Organization of Planned Parenthood Federation of America, Inc.*

PPFA (2003) *The Diversity Strategic Plan for Planned Parenthood Federation of America 2002-2006*

National Standards for Culturally and Linguistically Appropriate Services in Health Care; U.S. Department of Health and Human Services, Office of Minority Health, Washington DC, 2001

Policy Guidance – title VI Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency; & Fact Sheet: Language Assistance to Persons with Limited English Proficiency
Office for Civil Rights (OCR) U.S. Department of Health and Human Services; Washington, DC



II. Recruiting and Retaining

Diverse Staff

By 2050, the U.S. population is expected to increase by 50 percent and minority groups will make up nearly half the population. Immigration will account for almost two-thirds of the nation's population growth. The population of older Americans is expected to more than double. One-quarter of all Americans will be of Hispanic origin. Almost one in ten Americans will be of Asian or Pacific Islander descent. And more women and people with disabilities will be on the job.

— Futurework: Trends and Challenges for Work in the 21st Century
the U.S. Department of Labor, 1999

Staff

An organization's greatest asset is its workforce. In today's increasingly diverse society, effective organizations are seeking to create diverse workforces that not only reflect the society at large, but also are capable of responding to its myriad needs. Planned Parenthood believes and is vested in creating this diversity in its workforce. Respect and value for diversity are essential for attracting and retaining a diverse staff that will help accomplish the mission. Talented individuals from diverse communities are attracted to an organization that

- demonstrates its diversity values
- actively works toward creating an environment that is supportive and inclusive
- has a reputation for being a Great Place to Work and volunteer

Building a Diverse Workforce

The key to successfully building a diverse, high-quality workforce including volunteers, begins with

- having a **strong leadership** committed to this process
- **assessing** the current levels of **diversity and cultural competence** of the organization

Organizational Positioning

According to the United States Office of Personnel Management (USOPM), creating a successful diversity program **depends on how the organization positions itself** for becoming diverse. Positioning has several aspects including

- a strong commitment to the diversity initiative
- support from top-level management
- the commitment of resources (both fiscal and personnel)

Second, it is critical to have a **realistic picture of the readiness of the organization** to move forward, based on both

- the current demographics of the organization
- organizational cultural, atmosphere, and any administrative or other challenges that may exist

Finally, an articulated and widely disseminated diversity strategy should be

- integrated into the existing workforce development plan
- used to target opportunities for recruitment, hiring, and retention of both staff and volunteers

Commitment

Commitment, **the foundation for a successful diversity initiative**, should be clearly articulated and communicated from the top leadership to all employees and volunteers at all levels. Commitment can be demonstrated by

- creating an environment of inclusion that values difference
- assigning adequate resources to support diversity initiatives
- ensuring managers are directly involved in planning and implementing diversity initiatives
- ensuring that employees and volunteers are an integral part of the agency's efforts to plan and conduct diversity activities
- training managers and supervisors about EEO (Equal Employment Opportunity) requirements
- offering EAP (Employee Assistance Program) or other programs as a means of providing staff support, especially to those who may need assistance related to issues that are reflected in our Dimensions of Diversity (*i.e.*, age, disability, family configuration, socioeconomic status, etc.)
- encouraging managers to conduct targeted recruitment in support of diversity goals (USOPM, 2000)

Affiliate Assessment

Assessing the current situation requires the organization to

- develop a workforce profile, *i.e.*, a **complete picture of their workforce** and how it reflects diversity at all levels, in all key occupations, and in all components of the organization

- develop an assets/needs profile by conducting an **organizational assessment** to determine **strengths and areas needing improvement** within the organization as they relate to diversity issues
- create a **workforce development plan** based on the organizational assessment — through this type of planning, opportunities for targeted recruitment may surface, and targeted approaches will be clarified to developing a volunteer program that reflects the diversity of the communities being served

Building a Diverse Workforce

Building a diverse workforce requires multiple approaches and steps.

Step 1. Finding the Candidates

- prepare an accurate job description
- describe the skill set and work experience of the ideal candidate
- describe the work environment
- specify that you are looking for someone with experience working with diverse populations

Specifying the Organization’s Commitment to Diversity

Statements that emphasize the organization’s commitment to diversity are important in positioning the organization for successful recruitment of diverse candidates both for employment and volunteer opportunities. The following statements indicate the commitment of the organization toward diversity:

- *Planned Parenthood has implemented a diversity initiative to foster a more inclusive, productive, and creative work environment.*
- *Planned Parenthood is committed to achieving greater diversity nationwide.*
- *People of diverse backgrounds are encouraged to apply.*
- *Skills and experience in working with diverse populations are a plus.*
- *An ability to work well with people of diverse backgrounds is required.*
- *Knowledge of diversity issues and multicultural groups is required.*

Inclusion of a brief statement regarding the type of skills and experiences related to diversity that are required will attract the attention of candidates that are interested in such opportunities. The following are some statements that can be used on job advertisements:

- Experience working within diverse communities sought.
- Ability to work with diverse and underserved populations required.
- Candidates from diverse backgrounds are strongly encouraged to apply.

Job descriptions should also be reviewed to assess where including diversity and cultural and linguistic competence requirements would enhance a candidate's performance. For example, requirements might include:

- experience working with diverse communities, or a specific community, if appropriate
- association with or connections to diverse community or national organizations
- fluency in a second language

Where to Advertise and Recruit

Effective placement of job descriptions in media sources that are utilized by diverse communities will ensure access to a large and diverse pool of prospective employees. Job advertisements can be sent to a variety of venues, for example, the Internet, faxes to community-based organizations and print media, newsletters, etc. that serve diverse communities, local and national college placement centers, Historically Black College and Universities (HBCUs), sororities and fraternities, student of color associations, radio and TV programs that target diverse audiences, church and religious groups, libraries, and local businesses and civic associations that cater to diverse populations.

Search Firms

Another good avenue for locating suitable candidates is by using **search firms that specialize in recruiting diverse candidates**. It is critical to use search firms that have a reputation for recruiting from within diverse communities. In contracts with firms, make sure you clearly state the skills and experiences you are seeking and your desire to attain a diverse applicant pool.

Networking

Through effective networking, you can reach prospective employees and volunteers within diverse communities. Some useful strategies are

- Begin viewing all volunteers as potential new employees.
- Talk to friends and acquaintances about the mission of Planned Parenthood and potential work opportunities (word of mouth).
- Become involved in organizations and groups that serve diverse communities. Sit on their boards. Attend their community events. Talk with their members and leaders.
- Become involved in local college organizations and clubs.
- Conduct outreach at sports events, recreation centers, youth events, etc.
- Involve staff family members and friends in Planned Parenthood events, volunteering, etc.

Step 2: Hiring Diverse Candidates

After finding the candidates the organization must now ensure a well-developed process for interviewing and recruiting eligible candidates.

A. Diverse Interview Panels

Using a diverse interview panel shows both a **commitment to and value of diverse perspectives in the work environment**. It may also help the prospective employee feel less anxious during the interviewing process. Multiple perspectives from diverse staff, volunteers, and community members who serve on interview panels are critical. Age, race/ethnicity, job level and function, sexual orientation, and gender are other aspects of diversity to consider when forming interview panels.

B. Asking the Right Questions

Including questions about the candidate's experience and ability to work with diverse populations when interviewing for staff positions is essential. Some examples are

- What previous experience do you have working with diverse communities?
- How will you help ensure Planned Parenthood is an organization that respects diversity?
- How effective are you at working with diverse and underserved populations? Give some examples of such experiences.
- As a volunteer, what are some specific skills you bring with respect to diversity?

Managers should work closely with Human Resources staff to ensure adherence to legal mandates/restrictions regarding the types of questions that can be asked.

Designing and implementing a diversity program requires inclusion of those specific requirements that will serve to build a diverse, high-quality workforce. Current workforce profile, agency environment, and future workforce needs are all factored into the diversity recruitment plan.

Maintaining a Diverse Workforce

Building a diverse workforce is only the **first step** in achieving a diverse, high-quality workforce. Ensuring that these newly hired staff and volunteers stay is the much larger challenge that most organizations face.

Retention

By fostering a culturally competent work environment, you can help ensure that you are retaining and promoting a diverse staff and volunteer base. Here are some ways to better facilitate a culturally competent work environment:

- Promote policies that focus on diversity.
- Ensure quality management and supervision within the organization.
- Establish safe and open lines of communication.
- Recognize staff for a job well done and offer other incentives.
- Develop clear avenues for promotions.
- Assist staff with work/life balance issues.
- Offer flexible hours, telecommuting, and job sharing options.

Creating a flexible and supportive work environment that values diversity sustains employee involvement and commitment. When reviewing and developing policies it is helpful to first **define diversity and cultural/linguistic competence goals. Language in those policies should reflect the organization's commitment to diversity.** The following are some actions that send a message regarding the organization's commitment to valuing and sustaining diversity:

- Establish **policies** that proactively embrace diversity and cultural/linguistic competence in addition to those that focus on non-discrimination.
- Create a **welcoming** environment that includes images, symbols, and reflections of diverse communities throughout the affiliate's physical space.
- Strive to have teams of employees that reflect the communities they serve rather than hire a few individuals — **avoid tokenism.**
- **Avoid unrealistic and unfair expectations** of diverse staff to represent entire cultural or racial groups.
- **Recognize "diversity within diversity"** by honoring individual self-identity, for example, one which may be based not only on race, but on nationality or another dimension of diversity.
- Assess personnel and site **policies** concerning employees making sure they are **equitable and free from bias.** Include
 - hiring and promotion
 - holidays and benefits
 - safety and physical accessibility policies
- Provide **professional development opportunities** that increase skills and knowledge and that lead to career growth within the organization.

Orientation and professional development are critical elements in maintaining a high-quality diverse workforce. The following are some ways in which the organization can ensure effective training:

- Provide **training** on culturally and linguistically competent services, including general diversity training and more focused population-specific trainings that do not over-generalize or stereotype.
- Ensure all other professional development workshops incorporate **cultural and linguistic competence**.
- Provide **ongoing awareness-building activities/training** to dispel myths and stereotypes, and to help staff address comments and/or behaviors that can be seen or experienced as offensive/discriminatory.
- Set up formal or informal **mentor programs** connecting staff or managers of color with senior managers.
- Provide **"Lunch-n-Learn"** or other opportunities for sharing information related to diversity and cultural competence.

A supportive environment is also one that provides employees with the **direction and tools they need to perform** the work of the organization to the very best of their ability. Performance appraisals are an important tool with which to gauge staff cultural competence. Evaluation of the following functions is a way in which performance can be measured:

- ability to communicate and serve diverse clients in culturally sensitive and appropriate ways
- willingness to recruit and mentor diverse employees
- ability to manage/supervise diverse staff in a respectful and professional manner
- ability to work collaboratively with co-worker with different dimensions of diversity

Provide Incentives

Providing the proper **incentives** for cultural and linguistic competence can be another effective tool in changing attitudes and behavior of your staff. You can provide incentives, such as

- merit increases to reward good performance
- recognition awards for specific activities/actions that exemplify culturally and linguistically competent services
- promotions based on commendable performance evaluations
- pay differentials for fluency in a second or third language

Integration and Sustainability Are Key

A truly successful diversity program is one that becomes **integral** to the culture and business processes of the organization and is **sustained** over time. Organizations will need to develop measures to continually **monitor** the

effectiveness of their diversity initiatives and make adjustments as needed. The results should be shared with the entire organization.

Accountability

Accountability is another hallmark of a successful diversity program. All executives, managers, and supervisors should be held accountable for their effectiveness in implementing diversity initiatives. As noted above, this should be reflected in performance evaluations, and should also be a topic of discussion during supervisory meetings.

Celebrate!

Finally, organizations should remember to **recognize and celebrate** successful diversity programs.

References

United States Office of Personnel Management (2000) Building and Maintaining a Diverse, High-Quality Workforce: a Guide for Federal Agencies Washington, DC

U.S. Department of Labor (1999) Futurework: Trends and challenges for Work in the 21st century. Washington, DC

Greenwood, A. (2005). Creating a Culture for Success: Finding and Keeping the Right Employees, RT Image.

Diversity Inc. (2006). Why Diversity? The Top 50 have the Answers from a Special Issue on Relationships: The Nature of Diversity Management.

Great Places to Work[®] Institute, Inc.

Recruitment Action Steps

- ❑ **Job Descriptions:** Define, in specific terms, the type of candidate you are seeking. Clearly request candidates who have experience working with diverse communities.
- ❑ **Job Advertisement:** Place advertisements in media sources accessed by diverse communities. Consider alternative newspapers, magazines, radio programs, and local cable networks. Include online sources, college and university contacts, civic groups, and professional organizations.
- ❑ **Job Fairs:** Participate in job fairs and other local events that focus on exposing organizations to job seekers from diverse communities.
- ❑ **Search Firms:** Use search firms that recruit within diverse and underserved communities. Describe in clear terms the characteristics you are seeking in a potential employee.
- ❑ **Networking:** Build ongoing relationships with groups serving diverse communities. This will enable you to reach out to a broader pool of prospective employees who are familiar with, and committed to, the mission of Planned Parenthood.
- ❑ **Diverse Interview Panels:** Select an interview panel that is diverse and who will address the issues most relevant to serving diverse communities. This will ensure that the selection of the candidate is based on the needs of the community.
- ❑ **Developing Interview Questions:** Model some of your questions around the candidate's ability to work for diverse and underserved populations. Make sure you also ask questions about the prospective employees past experience working with diverse communities and their ability to work in an organization which respects and values diversity.
- ❑ **Employment Contracts and Work Plans:** Define in your new-hire contracts that employees are presumed to work well within an environment that fosters diversity and are expected to participate in the implementation of the Planned Parenthood diversity initiative.

Retention Action Steps

- ❑ **Personnel Policies:** Review the language in personnel policies to reflect Planned Parenthood's commitment toward diversity. It is important to create policies that proactively foster diversity (through assessments, trainings, performance reviews, etc.).
- ❑ **Creating Effective Orientations:** Orient new employees to the organization's diversity initiative, emphasizing that all Planned Parenthood employees and clients will be treated with dignity and respect.
- ❑ **Create a Great Place to Work Initiative:** Build trust and ensure managers mentor and support staff by fostering a nurturing environment where staff feel valued, take pride in what they do, and enjoy the people they work with.
- ❑ **Professional Development:** Provide ongoing diversity trainings and other professional development opportunities to help ensure that your staff is committed to culturally and linguistically competence. It is important to make sure that these activities focus on treating staff, as well as clients, with respect and dignity.
- ❑ **Performance Evaluation:** Use evaluations to gauge staff and organizational cultural competence, and the need for further development activities. Skills to consider when assessing an individual's performance are; serve diverse clients, recruit and mentor diverse employees, and manage in a culturally competent manner.
- ❑ **Succession Management:** Include a process that ensures the development of future managers and leaders who represent various dimensions of diversity.
- ❑ **Incentives and Promotions:** Provide proper incentives to your staff for service that exemplifies cultural competence. Employee recognition events, opportunities to attend meetings usually available only to senior management, tickets to events, etc. can be as valuable as monetary compensation.



II. Establishing a Culturally Diverse Board

Recruitment Action Steps

- ❑ **Vision and Mission:** Ensure that the board has conducted a values clarification process and has identified a clear vision and mission as it relates to incorporating diversity as an integral element to organizational activities. Articulating a clear vision and mission will enhance the board's capacity to draw committed individuals from diverse communities.
- ❑ **Community Perceptions:** Clarify the board's understanding of what defines community and who composes the community to be served. Additionally, clearly illustrate how the organization is perceived by the community to be served. This will enable the board to rectify misperceptions and design effective board recruitment strategies.
- ❑ **Board Assessment:** Conduct a board assessment to 1) determine current strengths, including knowledge and skills of board members and 2) determine knowledge and skills that require enhancement, including knowledge of diverse communities, cultural and linguistic competence. The assessment will also provide feedback on where to target recruitment efforts for skilled and knowledgeable board members.
- ❑ **Board Member Requirements:** Identify the key characteristics required of new board members, using the information from the strategic plan, board assessment and community perceptions data.
- ❑ **Board Composition Analysis:** Compare the composition of the board to PPFA's Core Dimensions of Diversity and seek adequate representation. Determine whether the board is more heavily weighted in one dimension. This analysis, or board profile, coupled with the board assessment, will guide the board's nominating committee.
- ❑ **Board Rotation:** Adhere to an established board rotation policy that ensures term limits are used to create seats for potential new members.
- ❑ **Finding New Members:** Engage in networking and collaborative efforts in the community, as a way of identifying potential board members. Top leadership and executive management need to play a critical role in this search process since they determine the needs of the organization.
- ❑ **The Nominating Committee:** Ensure that the nominating committee is diverse, and has a clear understanding of the organizational philosophy as it relates to diversity, cultural and linguistic competence.

- ❑ **Extending the Invitation:** Strategically determine who will invite the potential board member to the interview. This is a critical step since many people from culturally diverse communities make decisions based on existing relationships, in addition to their belief in and dedication to the organization's mission.
- ❑ **The Interview Process:** Ensure that the interview process is inclusive and is conducted in a manner that elicits the strengths and resources the candidate brings to the board.
- ❑ **Orientation:** Provide an in-depth orientation to the new board member, including a written code of behavior. When a board functions within a behavior code that is unstated, new board members may feel uncertain, excluded and/or diminished.
- ❑ **Development:** Provide ongoing group development initiatives such as team building and coalition building in-service trainings to enhance the capacity of the entire board and to create a respectful and trusting environment for work.

Retention Action Steps

- ❑ **Inclusive Process:** Develop guidelines to ensure an inclusive process for discussing issues and providing input. (See Board Paper 14 for details)
- ❑ **Mentoring:** Assign each new board member with a mentor from the current board
- ❑ **Decision making:** Plan proactively for handling decisions that might not be accomplished through group consensus. Voting on issues, though a frequently used practice, marginalizes the minority point of view, and can maintain the *status quo*.
- ❑ **Communication Plan:** Create a communication plan to ensure inclusiveness. For example, develop protocols on how to: 1) communicate to everyone regarding an emergency meeting; 2) ensure that minutes are provided to absent members so that they are informed of current issues prior to attending the next meeting, and therefore participate effectively.
- ❑ **Communication Needs:** Assess the communication needs of all board members, for example: 1) do materials need to be developed in alternate formats for board members who have disabilities; 2) is there a need for translation of materials into another language? 3) do members prefer hard copies or e-mail?
- ❑ **Expectations:** Have a candid discussion regarding the expectations for group participation and the competencies that are invaluable to functioning as effective Board members.
- ❑ **Individual Responsibilities:** Provide guidelines for individual responsibility — members need to be responsible for what they communicate and what information or feedback they need to receive.
- ❑ **Committee Work:** Encourage board members to actively participate in committees that match their interests, skills, and availability. Encourage members to rotate among committees throughout their board term.
- ❑ **Ongoing Training:** Provide ongoing training and dialogue on issues related to diversity, and cultural and linguistic competence. Retreats are an excellent way to include experiential training on these topics.

- ❑ **Alliance Building:** Encourage board members to continue working with other diverse groups and to build alliances. Their experiences will enrich and strengthen their capacity as board members.
- ❑ **Research:** Collect and evaluate data on the tenure of board members.
- ❑ **Survey:** Conduct periodical satisfactions surveys among board members to enhance board culture and effectiveness.



III. Establishing a Culturally Diverse Volunteer Program

Recruitment Action Steps

A culturally diverse volunteer program can provide many benefits to both affiliates and the national organization. Outreach to new clients, attraction of new funders, and support for shared social justice issues are a few benefits that can be gained by incorporating diversity and cultural/linguistically competence components into volunteer programs.

- Position Description:** Be specific about the type of volunteer you are looking for, remember to stress the importance of volunteers being able to work effectively with diverse communities. Make sure you are also clear about the type of commitment you expect of volunteers.
- Outreach:** Reach out through community leaders, organizations, and student groups who work with diverse communities. Also, use your network of friends, family, colleagues, clients, and donors to reach out to prospective volunteers.
- Coalition Building:** Work with socially conscious organizations serving diverse communities, in part to further educate active community members about Planned Parenthood, and to foster a relationship that could lead to their future involvement.
- Volunteer Programs:** Join programs that help nonprofit organizations find dedicated, socially conscious volunteers, such as *Freedomcorps* (www.usafreedomcorps.gov).
- Diverse Interview Panels:** Ensure your interview panel is diverse. This may be helpful in reducing the anxiety of the volunteer who may feel they are entering an unfamiliar domain. The presence of diverse individuals on your interview panel also conveys your commitment towards diversity and cultural competence more effectively than mere words.
- Volunteer Work Plans:** Convey the importance of cultural competence by integrating it into goals and expectations in volunteer work plans.

Retention Action Steps

- ❑ **Workplace Culture that Values Diversity:** Create an organization that is committed to cultural competence in order to retain diverse volunteers. You can help achieve this by
 - providing volunteers with diversity trainings
 - recognizing volunteers for a job well done
 - establishing safe and open lines of communication
 - ensuring volunteers that they are an important part of the organization
 - providing volunteers with a mentor to give them guidance
 - provide meaningful opportunities for volunteers to utilize their skills and experience, etc.

- ❑ **Volunteer Policies:** Make sure internal policies regarding volunteers reflect Planned Parenthood's commitment toward diversity.

- ❑ **Creating Effective Orientations:** Provide an overview on diversity and non-discrimination policies in volunteer orientations. Offer training on cultural and linguistic competence.

- ❑ **Professional Development:** Make cultural and linguistic competence trainings available to volunteers on a periodic basis.

- ❑ **Performance Guidance and Feedback:** Include accountability for diversity in giving guidance and feedback to volunteers. Discuss such things as
 - ability to communicate and serve diverse clients
 - ability to help advance the organization's diversity initiative

- ❑ **Recognition:** Provide recognition and rewards for volunteers who contribute to the established diversity goals and objectives.

- ❑ **Meetings and Other Events:** Ensure that meetings scheduling does not exclude some members. Social activities, such as benefits and annual meetings may also exclude people by requiring large entrance/registration fees. Create opportunities for people to make non-monetary contributions to "pay" for their attendance.

- **Eliminate Financial Obstacles:** Explore other socioeconomic barriers that may surface on your board, and build bridges across all differences.

“It can be very insensitive to ask a working person to attend a breakfast meeting or a meeting at inconvenient times during the workday, especially if job flexibility is lacking. At the same time some of these meetings can create financial hardships both in terms of work time lost and actual expenses.”

— Excerpted from the Western Region Cultural Diversity Task Force Focus Group Report



V. Resources

PPFA Diversity Department Publications Available on the Extranet

- Cultivating Diversity: Organizing Within and Without, 2002
- Guidance for Achieving and Maintaining Diversity: Board Paper 13, 2002
- Guidance for Achieving and Maintaining Diversity: Board Paper 14, 2002
- Diversity Continuum: Indicators of Success, April 2002
- Developing Cultural and Linguistic Competence: Muslim and Arab-American Communities, October 2001
- Strategic Plan for Increasing Diversity at PPFA, 2002 - 2006
- Enhancing Cultural Competence: Welcoming the Lesbian, Gay, Bisexual, and Transgender Community, 2003
- Vision in Action: The Strategic Plan for the National Organization of Planned Parenthood Federation of America, Inc., 2003 - 2006
- Enhancing Cultural Competence: Welcoming Young Latino Men, 2005
- Guide to Historically Black Colleges & Universities and Greek Letter Organizations, 2004

Other Publications

- Cohen, E. & Goode, T. (1999), Revised by Goode, T. & Dunne, C. (2003) *Rationale for Cultural Competence in Primary Care*. Washington, DC: National Center For Cultural Competence, Georgetown University Center for Child and Human Development.

- Cross T., Bazron, B. Dennis, K., & Isaacs, M. (1989) *Towards a Culturally Competent System of Care, volume I*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
- Health Resources and Services Administration. (2002) *Indicators of Cultural Competence in Health Care Delivery Organizations: an Organizational Cultural Competence Assessment Profile*. Accessed 2003, December
<http://www.hrsa.gov/culturalcompetence/indicators/>
- McIntosh, P. (1998) *White Privilege: Unpacking the Invisible Knapsack. Working Paper 189: White Privilege and Male Privilege: "A personal Account of Coming to See Correspondences through Work in Women's Studies."* Wellesley, MA: Wellesley College Center for Research on Women.
www.wcwoonline.org/seed/unpacking.html
- Thomas, D. and Ely, R.J. (1996) *Making Differences Matter: A New Paradigm for Managing Diversity*. Harvard Business Review, Sept-Oct.

Web Resources

Diversity

Diversity Inc.com

<http://www.diversityinc.com>

Diversity RX

<http://www.diversityrx.org>

Diversity Web

<http://www.diversityweb.org>

Cultural Competence

National Center for Cultural Competence

<http://gucchd.georgetown.edu/nccc>

Center for Effective Collaboration

<http://cecp.air.org>

CEO Services

<http://www.culturalcompetence2.com/index.html>

Organizations

National Center for Cultural Competence
**Georgetown University Center for
 Childhood & Human Development**
P.O. Box 571485
Washington, DC 20057-1485
Tel: 800/788-2066 or 202/687-5387
www.gucdc.georgetown.edu/nccc

National Council of LaRaza
1126 16th Street, NW
Washington, DC 20036
Tel: 202-785-1670
www.nclr.org/

National Multicultural Institute
3000 Connecticut Ave NW, Ste. 438
Washington, DC 20008-2556
202-483-0700
www.nmci.org

Human Rights Campaign
1640 Rhode Island Ave, NW
Washington, D.C. 20036-3278
202-628-4160
www.hrc.org

American Institute for Managing Diversity
1155 Peachtree Street, Suite 6B
Atlanta, GA 30303
404-575-2131
www.aimd.org

National Asian Women's Health
Organization
1 Embarcadero Center, Suite 500
San Francisco, CA 94111
415-773-2838
www.nawho.org

Cook Ross, Inc
1515 Noyes Drive
Silver Springs, MD 20910
301-565-4035
www.cookross.com

Black Women's Health Imperative
1420 K Street, NW
Suite 1000 (10th Floor)
Washington, DC 20005
202-548-4000
www.BlackWomensHealth.org

Alliance for Change
146 Shea Avenue
Belchertown, MA 01007
413-283-2502
www.allianceforchange.com

Books

Cross, T., Elsie, Y. *Managing Diversity: The Courage to Lead*. Available at Elsie Y. Cross Associates, Inc at: 215-248-8100, Fax: 215-242-3328, or e-mail: lcortez@eyca.com

Cross, T., Elsie, Y. and Margaret Blackburn White, eds. *The Diversity Factor: Capturing the Competitive Advantage of a Changing Workforce*. Available at Elsie Y. Cross Associates, Inc at 215-248-8100, Fax: 215-242-3328, or e-mail: lcortez@eyca.com

Thomas, R. Roosevelt, Jr. *Beyond Race and Gender: Unleashing the Power of Your Total Work Force by Managing Diversity*. Available from American Institute for managing Diversity at 404-302-9226. Fax: 404-302-9252, <http://www.aimd.org/research/books/beyond.html>

Kennedy, Debbe. (1999) *Action Books: Diversity Breakthrough! Strategic Action series-Set of Six Books*. San Francisco: Berrett Koehler Communications.

PPFA Diversity Department Contact Information

For more information on cultural and linguistic competence in service delivery, please contact the staff listed below:

Laurel Huggins, Manager
Melissa Orlando, Program Manager
Diversity Department
Planned Parenthood Federation of America
434 West 33rd Street
New York, NY 10001
212-261-4798
diversity@ppfa.org

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Trash that Myth Exercise

Purpose: The purpose of “Trash that Myth” is to help participants differentiate misconceptions from accurate information about LGBTQ 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, & “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 & women,
and 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 get sex
change
operations.**

10)

**Transgender
people are all
mentally ill.**

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 & 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 LGBTQ
Students drop out
of school because
of assault, verbal
abuse & isolation.**

18)

**LGBTQ 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 LGBTQ people than among heterosexual people.**

20)

**Intimate partner
violence does not
occur between
same sex
partners.**

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

22)

Many mental health providers are not informed about issues and concerns of LGBTQ clients, and don't know about resources that could benefit them.

23) **Parents, families
and friends of
LGBTQ 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 LGBTQ 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 LGBTQ people who experienced decades of "treatment" for "homosexuality," and the history of psychiatric abuse of which younger LGBTQ 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 LGBTQ people still

sometimes encounter these beliefs when they seek mental health services. Some LGBTQ 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 get sex change operations. Myth. ‘Transgender’ is an ‘umbrella’ term that refers to a broad community of individuals with diverse gender identities and modes of gender expression, including transsexuals, crossdressers, drag queens and drag kings, ‘genderqueers,’ and others who do not necessarily consistently conform to conventional gender norms. (*International Foundation for Gender Education, 2002, www.ifge.org*)

10. Transgender people are all mentally ill. Myth. There is no empirical evidence that transgender identity per se is mentally disordered. However, the psychiatric profession continues to insist on pathologizing natural variance in gender identity and expression. The DSM-IV-R defines Gender Identity Disorder (GID) 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.” The American Psychiatric Association (APA) is currently considering revision or removal of the GID diagnosis from the forthcoming edition of the DSM. While a diagnosis of GID is still considered a prerequisite to gender transition procedures (including hormone therapy and sex reassignment surgery) under the guidelines known as the Standards of Care published by the World Professional Association for Transgender Health (WPATH, formerly known

as the Harry Benjamin International Gender Dysphoria Association), many transgender activists and advocacy organizations support reform of GID from the DSM and the replacement of that pathologizing diagnosis with a non-pathologizing medical diagnosis; others support removal of GID from the DSM altogether.

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 LGBTQ youth from abuse in the halls, with disastrous results LGBTQ teens have successfully sued school districts for failing to protect them. As

word of this gets out, more schools are taking actions to protect LGBTQ youth and thereby prevent lawsuits (77).

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

Fact. Even though LGBTQ 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, LGBTQ 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. LGBTQ 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 LGBTQ 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

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 it felt to be asked these questions in front

- of group members and list responses on newsprint.
- Ask about the degree of safety the client felt in the group, and feelings about 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?

Training Options for Pauline Park's Questionnaire for the Non-Transgender

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

Before beginning any version of this exercise, explain to the group that there may be transgender people in the room. Ask that everyone please pretend to be non-transgender for the purposes of this exercise.

The Questionnaire for the Non-Transgender turns on its head basic assumptions and misconceptions about what it means to be transgender by reversing some of the questions most commonly asked of transgender people. The tool can be used in a variety of ways to provide non-transgender people with a personal sense of how transgender 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 gender identity), ask participants to work in "interview" pairs, and request that one partner interview the other with questions one through eight, then switch so that the interviewed partner becomes the interviewer for questions nine through sixteen. 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 non-transgender 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 gender identity (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 gender identity 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 non-transgender felt about witnessing others asked to justify their non-transgender identity.
- 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 gender identity (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:

- Ask the client who was questioned how it felt to be asked these questions in front

of group members and list responses on newsprint.

- Ask about the degree of safety the client felt in the group, and feelings about 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 being non-transgender.
- 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 gender identity (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).

Pauline Park's
Questionnaire for the Non-Transgender

1. Do you have a penis?
2. (If the answer to question #1 is yes:) Have you always had a penis or is this a recent development?
3. Have you ever had sex reassignment surgery?
4. (If the answer to question #3 is no:) If not, why not?
5. Do you think your gender identity is the result of a hormone imbalance in utero?
6. What is your real sex?
7. When did you become a man?
8. Are you sure you're a man?
9. When did you become a woman?
10. Are you sure you're a woman?
11. Why did you choose to be a man?
12. Why did you choose to be a woman?
13. When did you choose to be conventionally gendered?
14. Do you prefer to be addressed as 'sir' or 'ma'am'?
15. Which pronoun do you prefer, 'he' or 'she'?
16. Which restroom do you use, the men's room or the ladies' room?

Moving Survey Exercise

Training developed by Alicia Lucksted, Ph.D.

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 LGBTQ 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.

Potential Scenarios to Choose From

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 LGBTQ 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 LGBTQ 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 things 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

Training developed by Alicia Lucksted, Ph.D.

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 LGBTQ 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 LGBTQ 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 LGBTQ?
 - 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

Training developed by Jane Elven, Ellen Pendegar, R.N. and Alicia Lucksted, Ph.D.

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 LGBTQ mental health issues, enhance staff comfort level, increase sensitivity to diversity dimensions and improve cultural competence in working with LGBTQ 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 LGBTQ clients
 - ▼ LGBTQ 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 and/or Questionnaire for the Non-Transgender 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/gender identity and makes assumptions about you. Give each participant the "Heterosexual Questionnaire" and/or the "Questionnaire for the Non-Transgender" 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/gender identity 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 or non-transgender 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 LGBTQ client a question, first substitute the words "heterosexual" and/or "non-transgender" in your mind before you ask the question. How does the question sound? Positive? Respectful? Insulting? Ridiculous? That is probably how it will sound to your 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 create 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 LGBTQ Issues in Mental Health Services**

Training developed by Alicia Lucksted, Ph.D.

Preparation:

- ▼ Informal discussions beforehand with staff to assess training 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 LGBTQ 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 LGBTQ 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 LGBTQ is condoned, not addressed
 - D. Programs have little information/resources about LGBTQ affirmative resources in community or for own programs
 - E. Personal religious beliefs vs. professional conduct and community welfare
 - F. We don't have any LGBTQ clients
 - G. Transgender people / issues
5. Remaining Questions and Conclusions (10 minutes)

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

- ▼ How LGBTQ-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 LGBTQ 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 LGBTQ people, hostile to them, try to avoid, don't treat people well
- Stereotypes crop up in policies and practices, assumptions that continue unquestioned – often this topic is not even on the radar.
- Knowledge and training re LGBTQ 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 judgmentalism, don't know about LGBTQ resources in their region that could help clients.

3. Consumer – consumer intolerance is condoned, not addressed

- LGBTQ 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 LGBTQ affirmative resources in community or for own programs

- Do staff know about local LGBTQ 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 LGBTQ 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 LGBTQ 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 LGBTQ 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 LGBTQ clients, so why do we need to know this stuff?

1. If a practice/program never has any LGBTQ clients, they might inquire into their reputation in the LGBTQ community – are people staying away? Afraid to be known as LGBTQ when clients? LGBTQ people live in every community, so it would be unusual to never have any LGBTQ clients.
2. Might there be LGBTQ clients who are not comfortable being known as such? LGBTQ people are often very skilled at remaining “closeted” when it feels necessary.
3. Often even people who are NOT LGBTQ 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 issues in sex-segregated facilities

The following section was written by Pauline Park, Ph.D.

Gender identity seems to be an even more challenging issue than sexual orientation for many providers – even well-educated, sophisticated individuals often have difficulty seeing their own prejudices and moving beyond them. Why? Most likely because we don't realize the extent to which we have internalized the sex/gender binary (male/female).

Most health care (including mental health) settings have sex-segregated facilities – bathrooms, changing rooms, residential wings, support groups – which create serious impediments to transgender clients equitably and effectively.

Where there are no specific legal requirements for sex segregation of facilities, agencies and providers can revise organizational policies to make them transgender-friendly and inclusive. Most people assume that public restrooms are sex-segregated by law; in fact, in most jurisdictions, there is no statute law governing sex-segregated facilities such as public restrooms, and sex segregation has only the status of 'customary law' (i.e., social custom). Even where there may be statute laws and regulations that require a degree of sex segregation in facilities, there are ways to accommodate transgender people in a manner that is affirming.

One of the biggest impediments in providing services for transgender people is the inappropriate use of names and pronouns, often by staff who insist that an individual has a 'real' sex corresponding to the legal sex designation on that individual's identity documents, or that staff have a legal requirement to call a person by the name on a form or a government-issued ID or address an individual by the pronoun conventionally associated with that legal sex.

Since most transgender people spend most of their lives presenting in a gender not conventionally associated with the legal sex designation on their ID documents, the insistence on addressing them by the name on ID and/or with the pronoun associated with their legal sex is tantamount to discrimination and can create a hostile environment for transgender people.

When in doubt, staff should ask individuals what name or pronouns they prefer to be addressed by, regardless of what is on an intake form or personal ID. Staff should also be aware that some transgender people will present in more than one gender presentation over time and should not insist on consistent gender presentation. Nearly 50 percent of the population of the United States now resides in a state, county, or city with a transgender rights ordinance that prohibits discrimination in employment, housing, and public accommodations as well as the provision of social services. Staff should also note that religious beliefs do not constitute valid legal grounds for refusing to abide by such statute laws. Even in states and localities without such non-discrimination statutes, staff members have an ethical obligation to treat transgender

and gender-variant people with respect, and failure to do so may seriously compromise their ability to deliver effective care; in such jurisdictions, providers are still bound by professional codes of ethics that require them to deliver services and care in a respectful manner.

In short, there is no issue related to gender identity and expression that cannot be resolved successfully and effectively without sufficient commitment on the part of all the parties concerned; where there's a will, there's a way.

(end of 90-minute Staff Workshop outline)

45-60 minute Discussion Outline

Training developed by Alicia Lucksted, Ph.D.

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 LGBTQ 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 LGBTQ 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)

Meeting the needs
of lesbian, gay, bisexual and
transgender people
with mental illness

Meeting the needs of LGBT people with mental illness

Christian Huygen, Ph.D.
Michael Chew, M.S.W.
Rainbow Heights Club
Brooklyn, New York

We generally agree that...

- Cultural differences are important...
- and can have a lot of impact on patients' understanding and experience of mental illness
- We should be knowledgeable about these differences,
- and examine our own assumptions as necessary, even if it makes us uncomfortable,
- because we have an ethical mandate to provide culturally competent care.

Racial, ethnic and cultural differences

- Sometimes they're visible...
- and sometimes they're not.

Goals for today

- Discuss the particular needs of LGBT people with mental illness...
- and the fact that these needs are often neither recognized nor met
- Particular developmental challenges faced by LGBT people with mental illness
- How we can skillfully address their needs
- Rainbow Heights Club

Why even talk about sexuality and gender identity?

- Because all stigmatized groups face unique problems and challenges
- Because these problems and challenges can have a lot to do with their mental health and mental illness
- Because if we understand these problems and challenges we can help our clients understand and address them
- Because they're key to real understandings of problems and solutions
- Because not doing so means clients remain at risk for relapse for both psychiatric symptoms and substance abuse

LGBT

- Lesbian
- Gay
- Bisexual
- Transgender

According to the APA, sexual orientation...

- is not a choice
- is determined by many factors, usually at a very early age
- is not an illness or emotional problem
- is different from sexual behavior
- cannot be changed by therapy

Providing effective care to LGBT people with mental illness

... and the obstacles and barriers that
sometimes get in the way

LGBT people with mental illness...

- Are a doubly stigmatized population
- They often don't "fit" in mainstream mental health clinics or hospitals
- They often don't "fit" in the LGBT community either
- They need a place where they don't have to hide

Why hide?

- 1973
- Reparative therapies
- Pervasive homophobia
- Fear of being rejected by care givers
- Sensitivity to subtle signals we may not realize we're sending

“But why do I need to hear about anybody’s sexuality?”

- Competent treatment
- Competent discharge planning
- Competent care produces improved outcomes
- Relationships are often at the core of what’s best and worst in all of us

Developmental obstacles

- Development of a healthy, resilient identity as an LGBT person requires social interaction, exploration and support
- LGBT people with mental illness often can't maintain positive social interactions
- People in the prodromal phase of schizophrenia often disrupt many of their social relationships - and this happens just as issues of sexuality are making themselves felt
- Lack of social support; lack of an opportunity to explore the LGBT community; lack of positive role models and positive interactions; lack of opportunities to acquire social skills...

- Which leads to social isolation
- And exacerbation of psychiatric symptoms
- As well as the absence of the buffering that a healthy resilient LGBT identity can provide
- Thus leaving individuals at greater risk for decompensation.

Effective care with LGBT patients

- Use inclusive language
- Be welcoming when patients discuss relationships, sexuality and gender
- Avoid overpathologizing
- Avoid underpathologizing
- Provide a safe and affirming environment
- Empathize with your patients

This is a very challenging issue
for most people.

- Continuum of mental health and mental illness
- Continuum of sexualities
- Continuum of gender identities
- Stepping out of your comfort zone
- Possible conflicts with cultural background or religious beliefs

Rainbow Heights Club

- Providing safety, social support and advocacy for LGBT people with mental illness
- Open since September 2002
- Our history
- How to refer patients to us

Benefits of referring patients to Rainbow Heights Club

- More social support and more affirmative environment means fewer symptoms
- A safe environment in which to experiment with the interventions you have made in treatment with them
- A place to practice telling their stories to a supportive audience
- Fewer instances of hospitalization (only 7 out of 250 people)

One final word

Questions and discussion

Thank you

Christian Huygen, Ph.D.

Michael Chew, MSW

Rainbow Heights Club

718-852-2584

www.rainbowheights.org



Expanding Culturally Competent Care: Gender Identity and Gender Expression



*Christian Huygen, Ph.D.
Michael Chew, LMSW
Parker, MSW*

*Rainbow Heights Club
718-852-2584
www.rainbowheights.org*

Photos mostly by Shannon Taggart





After this presentation you...

- Will have a working knowledge of Trans-inclusive terminology
- Become aware of some of the barriers that gender non-conforming individuals face when accessing affirming health care.
- Learn ways to apply knowledge in a social service setting.





Terms

- Sexual Orientation=emotional, physical, spiritual attraction to other people.

VS.

- Gender Identity=An individual's sense of being male, female, or something else. Not always visible to others

Why is it important to know the difference?





Transgender vs. Transexual vs. Transvestite

- Transgender is an umbrella term
- Transexuals=FtMs(transmen),
MtFs (transwomen)

Reductive and Offensive Comments:

- There is no such thing as “the surgery”
- “Real” men and “Real” women: nontransperson, or biological
- **Transvestites**=Usually heterosexual men who dress in “women’s” clothing for sexual or otherwise pleasurable purposes-often grossly depicted by media





Gender Neutral Pronouns

- Hir (pronounced:here) A non-gender specific pronoun used instead of “her” and “him”
- Sie or Zee (pronounced:see or zee) A non-gender specific pronoun used instead of “she” and “he.”





Individual Practitioner Interventions

- Expanding our definition of “culture”
- Comfort with discomfort
 - Examine your beliefs, attitudes, and behaviors
 - Examine your current language use
- General clinical guidelines
 - Use affirming and inclusive language
 - Maintain an asking stance
 - Sexuality is a healthy part of everyone
 - Avoid overpathologizing/underpathologizing gender expression and identity





Individual Practitioner Interventions (continued...)

□ Clinical Issues with TG Clients

- Prevalence of stressors resulting from anti-TG prejudice, e.g. losing one's job
 - Low-income and sub-poverty living
 - Sex work
 - Substance abuse
- Harassment and physical assaults – PTSD
- Hyper-vigilance to environment
- Distress about the discord their identity creates with their biological families





Individual Practitioner Interventions (continued...)

☐ Clinical Issues with TG Clients

- Legal, religious, and social pressures to maintain heterosexism and dyadic gender expression
- Historical distrust of the mental health system – Gender Identity Disorder
- Previous experiences of discrimination and maltreatment with mental health providers





Direct Service Level Interventions

☐ Physical Environment - what one sees and hears in a facility makes a strong impression

- Community resource pamphlets
- Representative posters and artwork
- Waiting Room reading materials
- Visible “welcome triangle” or “safe space” card
- Sound is also important – staff is using culturally competent language
- Gender-neutral / single bathrooms





Rainbow Heights Member Information Form

This information is confidential and will not be shared with anyone without your written permission.

Name: _____ D.O.B.: ____ / ____ / ____
(Last) (First) (M.I.)
(interviewer, circle one: under 35 / 35-64 / 65 or over)

Address: _____
(Street) (Apt.#) (City) (State) (Zip)

is it OK if we send you mailings occasionally? yes no

Telephone: (____) _____ - _____ Social Security Number: _____ - _____ - _____
is it OK if we call you on the phone if we haven't heard from you in a while? yes no

Do you have an email address? Yes No _____ @ _____

Currently Employed? Yes No _____

How did you hear about our program?

1. How would you like to be identified in the program?

Lesbian Gay Bisexual Transgender Other _____

2. I am: Female Male Other _____ 3. I consider myself to be Out? Yes No

4. My race or ethnicity is:

Native American/Alaskan Asian/Pacific Islander Black (non-Latino)
 Latino/Latina White (non-Latino) Other race/ethnicity

5. Are you primarily English speaking? If not, what other language do you prefer?

6. Marital Status

Single, Never Married Widowed Divorced Separated
 Married Permanent Partner How long? _____

7. Education Level

Less than High School Some High School High School Diploma GED
 Trade School Some College Junior College Bachelor's Degree
 Some Graduate Work Master's Degree Advanced Graduate Degree

8. What would you most like to accomplish as a member of the club?

9. What are some skills you have that might be helpful to the club? _____

10. Who are the most important people in your support system? Could we get in touch with them if we needed to?

Emergency Contact: _____ Telephone: (____) _____ - _____
(Name) (Relationship)





Direct Service Level Interventions

(continued...)

- Questions and Forms – do the intake and assessment questions, procedures, or forms you use send unintended messages?
 - Married, single, widowed, or divorced?
 - Gender
 - Asking about sexuality and sexual orientation on a regular basis
 - Who is family?





Agency Level Interventions

Policies and Procedures

- What is your policy for admitting transgender or gender-nonconforming patients?
- How does your agency handle incidents of transgender bias and/or harassment?
- Guarding against anti-LGBT comments or behaviors in both staff and clients





Agency Level Interventions

(continued...)

- Make diversity a stated goal of your board and management
- Add sexual orientation and gender identity to your organization's anti-discrimination or equal opportunity statement





Community Level Interventions

- Forge relationships with LGBT groups and community resources
- Share resources with other organizations working specifically with the transgender community





The Intersection of Mental Health and Gender Nonconformity





- Let me start with a story.
- Maria M.
- “Mira esa puta”





In general, LGBT people with mental illness...

- Are a doubly stigmatized population
- They often don't "fit" in mainstream mental health clinics or hospitals
- They often don't "fit" in the LGBT community either
- They need a place where they don't have to hide





Why hide?

- 1973
- Reparative therapies
- Pervasive homophobia
- Fear of being rejected by care givers
- Sensitivity to subtle signals we may not realize we're sending





In particular...

- Gender nonconforming people have to accept a diagnosis of Gender Identity Disorder if they want treatment, whereas gay, lesbian and bisexual people don't have to agree to have their sexual orientation pathologized in this way
- Most people find gay, lesbian and bisexual people's experience easier to identify with since the feelings are the same even if the object choice is different, whereas trans experience, or the experience of gender nonconformity, is hard for many people to imagine





Accepting the client's goals for treatment

- Most of us want to protect our clients from harm... but in the case of nonconforming gender expression, we may harm the treatment alliance if we insist on imposing our view on the client
- Story: Tiffany
- We can still express our concerns about clients' safety
- We need to assess clients' insight and judgment carefully in such cases





Is it clinically desirable to affirm a nonconforming gender identity?

- Be pragmatic. Look at the results.
- Addressing the client by their preferred name and gender is a simple step, the clinical impact of which can be profound and is available for you to examine and evaluate.
- If someone's affective lability is reduced, their ego strength improves, and they open up to you, affirming their gender identity was probably a good thing to do.
- Can nonconforming gender identity be a delusion? *Clinical anecdote*
- Can it be a phase? *Clinical anecdote*
- Within the Rainbow Heights Club community, we've seen repeatedly that affirming egosyntonic nonconforming gender identity is easy and natural for people to do, even when they're living with serious mental illness. Conversely, when the individual has internal conflicts about their gender identity, the assertion of their manifest gender identity can cause confusion and conflict in the community.





Effective care with LGBT patients

- Use inclusive language
- Be welcoming when patients discuss relationships, sexuality and gender
- Avoid overpathologizing
- Avoid underpathologizing
- Provide a safe and affirming environment
- Empathize with your patients





This is a very challenging issue for most people.

- Continuum of mental health and mental illness
- Continuum of sexualities
- Continuum of gender identities
- Stepping out of your comfort zone
- Possible conflicts with cultural background or religious beliefs





One final word





Resources

- **On the web:**

Trans-Health: www.trans-health.com

National Center for Transgender Equality: www.nctequality.org

International Foundation for Gender Education: www.ifge.org

TransGenderCare: www.transgendercare.com

Transgender Law and Policy Institute: www.transgenderlaw.org

- **Some of what's available here in NY:**

LGBT Center's Gender Identity Project: for support groups individual counseling, etc.

www.gaycenter.org

Callen-Lorde: LGBT Community Health Center www.callenlorde.org

Sylvia Rivera Law Project (SRLP): Works specifically with transgender people...they maintain an amazing resource and referral guide. www.srlp.org

Rainbow Heights Club: Holds a weekly support group for gender non-conforming people living with persistent mental illness and many other trans specific events.

www.rainbowheights.org





Questions and discussion





Thank you

- *Christian Huygen, Ph.D.*
- *Michael Chew, LMSW*
- *Parker, MSW*
- *Rainbow Heights Club*
- *718-852-2584*
- *www.rainbowheights.org*



Cultural Competence:
a Sampling of Conversation Points and Considerations to Assist Staff
to Understand Individual and Family Views and Life Experiences

*Created by Cathy Cave, Director, Office for Cultural Competence, New York State
Office of Mental Health, 518-408-2026, ccave@omh.state.ny.us*

1. Country of origin
2. Reason for immigration or migration
3. Length of time in this country, number of generations in this country
4. Economic change as result of movement
5. Current employment status relevant to acquired education, training, and skills
6. Current financial resources
7. Languages and dialects spoken
8. Communication style and norms of communication
9. English proficiency of self and family members
10. Significant life events
11. Family and kinship networks, past and current roles
12. Past and present living space-rooms, numbers, and relationships of occupants
13. Children and whether or not they live in the home
14. Gender roles and expectations
15. Sexual orientation and cultural perspective
16. Value placed on family and/or community cohesiveness verses independence
17. Rules of decorum and discipline
18. Educational attainment
19. Community description; safety, ethnic diversity, rural, suburban, urban
20. Orientation to community, social activities
21. Perceptions of time and space
22. Perceptions of work and play
23. Perceptions of natural phenomenon (disaster)
24. Experiences with traumatic events and loss (war, personal violence)
25. Views about household pets
26. Experience with rejection/discrimination; racism, sexism, homophobia

27. Experience with culturally based conflicts
28. History and expectations dealing with authority figures
29. Pride versus shame regarding one's background
30. Spiritual beliefs, practices and affiliation
31. Holidays and traditions
32. Artistic values and tastes
33. Literacy
34. Preferred diet and exercise
35. Health and hygiene
36. Substance use
37. Beliefs about causes of mental illness, stigma
38. Words used to describe distress and illness symptoms
39. Definitions for "recovery"
40. Attitudes and ideas about where and how to seek help and healing
41. Acceptability of medication
42. Beliefs about social difference
43. Criminal Justice system involvement
44. Political context

Glossary

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)

Crossdresser (transvestite): A person of any sex or sexual orientation who wears clothing that is not usually associated with the sex and gender assigned to that individual at birth. Note that the term ‘transvestite’ is now considered pejorative by most who identify as crossdressers.

FTM: Someone who transitions from female to male. Few transmen actually seek phalloplasty, the most extensive form of sex reassignment surgery available to FTM transsexuals.

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: A key part of the sex/gender binary, the system by which society organizes its members into men and women, boys and girls, assigning them to rigidly delineated categories regardless of their internal sense of gender identity.

Gender Identity: One's internal sense of being a man or woman, boy or girl, both or neither, which may or may not correspond with the sex and/or gender assigned to that individual at birth.

Genderqueer: An individual (often but not necessarily young) who does not identify unambiguously either with the socially constructed identity of 'man' or that of 'woman' and may not have a clearly gendered or consistent gender presentation.

Gender Roles: roles prescribed by society based on an arbitrary and artificial division of human beings into two rigidly defined groups of 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: an individual whose internal and/or external sexual morphology has characteristics not specific to just one of the official sexes, but rather a combination of what is considered "normal" for "female" or "male." (Formerly used terms include "hermaphrodite," "pseudo-hermaphrodite," "androgynous," etc.)

LGBTQ: 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, , GLBTI, or LGBTQA. 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: Someone who transitions from female to male.

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 LGBTQ 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 LGBTQ community to designate LGBTQ pride and community.

Sex: Distinct from gender, sex can be defined in terms that are legal, anatomical, biological, genetic, and chromosomal, but at any one time, one could be male by one definition and female by another. An individual's sex may not correspond to how one identifies one's gender.

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 encompass a range of gender identities, including transsexual, crossdresser, genderqueer, etc. (See separate entries for each of these terms.) Transgender people may be lesbian, gay, bisexual, or heterosexual.

Transgenderphobia: The irrational fear and hatred of people whose gender identity or gender expression does not conform to societal expectations.

Transsexual: An individual who seeks or has obtained sex reassignment surgery (SRS). Transsexuals may be lesbian, gay, bisexual, or heterosexual.

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.

References

1. PPFA-DD, Planned Parenthood Federation of America, Diversity Department. 2002. Enhancing Cultural Competence: Welcoming the Lesbian, Gay, Bisexual, and Transgender Community. New York, NY: PPFA.
2. Muehlenhard, C.L. Conceptualizing Sexual Orientation, Conceptualizations, VIII(8), 1998. Available at the following web site:
<http://www.rtis.com/reg/bcs/pol/touchstone/september98/muehlenhard.html>
3. Lucksted, A., Goldberg, R., Gustus, A. et al. (2000) The LGBTQ Training Collaborative. Unpublished training materials developed for mental health staff and client workshops in Maryland, available through the first author at aluckste@psych.umaryland.edu or 410-706-3244.
4. Lucksted, A. Raising Issues: Lesbian, Gay, Bisexual, and Transgender People Receiving Services in the Public Mental Health System. Unpublished report, available from the author or at <http://www.rainbowheights.org/resources.html> A summary of this report was also published in the Journal of Gay and Lesbian Psychotherapy, vol8(3/4), 2004, and as a chapter in the Handbook of LGBTQ Issues in Community Mental Health, Binghamton, NY: Haworth Medical Press, 2004.
5. Greene, B. Ethnic and cultural diversity among lesbians and gay men: Vol. 3 Psychological perspectives on lesbian and gay issues. London: SAGE Publications, 1997.
6. Hartman, S. (1997, Summer). Affirming gay and lesbian experiences in psychotherapy. Carrier Foundation Medical Education Letter, 198, 1-4.
7. Markowitz, L. M. (1991). Homosexuality: Are we still in the dark? Networker, 15(1), 27-35.
8. Sherebrin, H. (1996). Gender dysphoria: The therapist's dilemma--The client's choice. Art Therapy, 13(1), 47-53.
9. Cook, J.A. (2000). Sexuality and people with psychiatric disabilities, Sexuality and Disability, 18(3), 195-206.
10. Mossman, D., Perlin, M. L., & Dorfman, D. A. (1997). Sex on the wards: Conundra for clinicians. Journal of the American Academy of Psychiatry and the Law, 25(4), 441-460.
11. Akhtar, S., Crocker, E., Kickey, N., Helfrich, J., & Rheuban, W. (1977). Overt sexual behavior among psychiatric inpatients. Diseases of the Nervous System, 38(5), 359-361.

12. Trudel, G., & Desjardins, G. (1992). Staff reactions toward the sexual behaviors of people living in institutional settings. Sexuality and Disability, 10(3), 173-188.
13. Hughes, N. (1985). Still happening. In P. Blackbridge & S. Bilhooly, Still Sane. Vancouver, BC: Press Gang Publishers.
14. Esterberg, K. G. (1990). From illness to action: Conceptions of homosexuality in The Ladder, 1956-1965. The Journal of Sex Research, 27(1), 65-80.
15. Fassinger, R. E. (1991). The hidden minority: Issues and challenges in working with lesbian women and gay men. The Counseling Psychologist, 19(2), 151-176.
16. Friedman, R. M. (1986). The psychoanalytic model of male homosexuality: A historical and theoretical critique. Psychoanalytic Review, 73(4), 79-115.
17. Ogborn, A. (1993, August). One of us is sick: It's not me. The Lavender Network, 90, 20-21.
18. Scasta, D. (1997, October). Historical perspectives on homosexuality. Paper presented at the meeting for the Treatment of Lesbians and Gay Men in Psychiatric Practice, Washington, DC.
19. Friedman, R. C., Green, R., & Spitzer, R. L. (1976). Reassessment of homosexuality and transsexualism. Annual Review of Medicine, 27, 57-62.
20. Lief, H. I., & Kaplan, H. S. (1986). Ego-dystonic homosexuality. Journal of Sex & Marital Therapy, 12(4), 108-114.
21. Stoller, R. J., Marmor, J., Bieber, I., Gold, R., Socarides, C. W., Green, R., & Spitzer, R. L. (1973). A symposium: Should homosexuality be in the APA nomenclature? American Journal of Psychiatry, 130(11), 1207-1216.
22. Smith, J. (1980). Ego-dystonic homosexuality. Comparative Psychiatry, 21(2), 119-127.
23. Stone, A. A. (1980). Presidential address: Conceptual ambiguity and morality in modern psychiatry. American Journal of Psychiatry, 137(8), 887-91.
24. Berkman, C. S., & Zinberg, G. (1997). Homophobia and heterosexism in social workers. Social Work, 42(4), 319-332.
25. Chaimowitz, G. A. (1991). Homophobia among psychiatric residents, family practice residents, and psychiatric faculty. Canadian Journal of Psychiatry, 36, 206-209.
26. O'Hare, T., Williams, C.L., & Ezoviski, A. (1996). Fear of AIDS and homophobia: Implications for direct practice and advocacy. Social Work, 41(1), 51-58.

27. Duberman, M. B. (1992). Cures: A gay man's odyssey. New York: Plume.
28. Green, G., Peraza, L., McFadden, R., & Compton, B. (1998). Fruits & Nuts: Where are we now? Audiotape of conference discussion at the Alternatives, 1998 conference, Long Beach, CA. (Available from: National Empowerment Center www.power2you.org).
29. Nardi, P. M., Sanders, D., & Marmor, J. (1994). Growing up before Stonewall: Life stories of some gay men. London & New York: Routledge.
30. Deacon, M., Rea, I., & Largey, M. (Panel Discussion). (1991). Psychiatric survivors: Surviving bigotry [Film]. (Available from MC Video Productions, PO Box 3012, Madison, WI 53704-0012).
31. Falk, P. J. (1989). Lesbian mothers: Psychosocial assumptions in family law. American Psychologist, 44(6), 941-947.
32. Hooker, E. (1957). The adjustment of the male overt homosexual. Journal of Projective Techniques, 21, 18-31.
33. Friedman, R. C. , & Downey, J. I. (1994). Homosexuality. The New England Journal of Medicine, 331(14), 923-929.
34. Gonsiorek, J. C. (1982). An introduction to mental health issues and homosexuality. American Behavioral Scientist, 25(4), 367-384.
35. Gonsiorek, J. C. (1991). The empirical basis for the demise of the illness model of homosexuality. In J. C. Gonsiorek & J. D. Weinrich (Eds.), Homosexuality: Research implications for public policy, (pp. 115-137). Newbury Park, CA: Sage Publication.
36. Herdt, G., & Boxer, A. (1993). Children of horizons: How gay and lesbian teens are leading a new way out of the closet. Boston: Beacon Press.
37. Nurius, P. S. (1983). Mental health implications of sexual orientation. The Journal of Sex Research, 19(2), 119-136.
38. Riess, B. F., Safer, J., & Yotive, W. (1974). Psychological test data on female homosexuality: A review of the literature. Journal of Homosexuality, 1(1), 71-85.
39. Remafedi, G., Farrow, J. A., & Deisher, R. W. (1991). Risk factors for attempted suicide in gay and bisexual youth. Pediatrics, 87(6), 869-75.
40. Brody, J. E. (1982, January 26). Psychiatrists on homosexuality: Vigorous discord voiced at meeting. The New York Times, pp. C1-C3.

41. Freedman, M. (1975, March). Far from illness: homosexuals may be healthier than straights. Psychology Today, 28-32.
42. Turner, W. J. (1981). Alcoholism, homosexuality, and bipolar affective disorder (Letter to the Editor). American Journal of Psychiatry, 138(2).
43. Lucksted, A. (1996, March). Lesbian and Bisexual Women who are Mental Health Care Consumers: Experiences in the Mental Health System. Paper presented at the meeting of the Association of Women in Psychology Conference, Portland, OR.
44. Igbokwe, U.O. (2004). Treating homosexuality as a sickness: Enlightenment is worrying. [Letter] British Medical Journal, 328, 955.
45. Boynton, P. (2004). More on treating homosexuality as a sickness: Publication of bigoted letter is worrying. British Medical Journal, 328, 1261.
46. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised. Washington DC, American Psychiatric Association, 2000.
47. Bradley, S. J., Blanchard, R., Coates, S., & Green, R. (1991). Interim report of the DSM-IV subcommittee on gender identity disorders. Archives of Sexual Behavior, 20(4), 333-343.
48. Israel, G.E., Tarver, D.E. (1998). Transgender care: Recommended guidelines, practical information, and personal accounts. Philadelphia, PA: Temple University Press.
49. Jones, B. E., & Hill, M. J. (2002). Transgender mental health: the intersection of race, sexual orientation, and gender identity. In BE Jones & J. Hill (Eds.) Mental Health Issues in Lesbian, Gay, Bisexual and Transgender Communities. Review of Psychiatry 21(4). Washington DC: American Psychiatric Publishing.
50. Iasenza, S. (1989). Some challenges of integrating sexual orientation into counselor training and research. Journal of Counseling and Development, 68, 73-76.
51. Buhrke, R.A. (1989). Incorporating lesbian and gay issues into counselor training: A resource guide. Journal of Counseling and Development, 68, 77-80.
52. Avery, A. M., Hellman, R. E. Sudderth, L. K. (2001) Satisfaction with mental health services among sexual minorities with major mental illness [research letter], American Journal of Public Health. 91(6), 990-991.

53. Johnson, D. (1994). Gays, lesbians: Often sexual orientation is ignored by providers. Office of Mental Health Quarterly, New York State Office of Mental Health, 10.
54. Roberts, L. (1996, April). Recognizing all of a person's life. The Gay & Lesbian "Consumer" Newsletter, 1(2), 3.
55. Duff, L. (1993, August). Incarcerated for being queer. The Lavender Network, 90, 13-14.
56. Nystrom, N. (1997). Oppression by mental health providers: A report by gay men and lesbians about their treatment. Unpublished Doctoral Dissertation, University of Washington, Seattle.
57. Lafferty, P. (1999, June). Success story: An interview. Hearts and Ears Newsletter 1(1), 3. (Available from A. Lucksted).
58. Coffman, B., & LittleMoon, M. (1997). LGBTQ Sexual Minorities [Audiotape of conference discussion held at the 1997 Alternatives conference]. (Available from National Empowerment Center, 20 Ballard Road, Lawrence, MA, 01843-1018, 1-800-769-3728).
59. Hellman, R. (1996). Issues in the treatment of lesbian women and gay men with chronic mental illnesses. Psychiatric Services, 47(10), 1093-1098.
60. McClure, R. (1994). Lesbians in the psychiatric system. In R. McClure & A. Vespry (Eds.), The lesbian health guide (pp. 231-235). Toronto: Queer Press.
61. Smith, G. B. (1993). Homophobia and attitudes toward gay men and lesbians by psychiatric nurses. Archives of Psychiatric Nursing, 7(6), 377-384.
62. Chassman, J. (1996, April). Deviance or diversity. The Gay & Lesbian "Consumer" Newsletter, 1(2), 1-2.
63. Iasenza, S. (1989). Some challenges of integrating sexual orientation into counselor training and research. Journal of Counseling and Development, 68, 73-76.
64. Brown, L. S. (1989). New voices, new visions: Toward a lesbian/gay paradigm for psychology. Psychology of Women Quarterly, 13(4), Special issue: Theory and method in feminist psychology, 445-458.
65. Browning, C., Reynolds, A., & Dworkin, S. (1991). Affirmative psychotherapy for lesbian women. The Counseling Psychologist, 19(2), 177-196.
66. Firestein, B. A. (1996). Bisexuality: The psychology and politics of an invisible minority. Thousand Oaks, CA: SAGE Publications.

67. Gottfried, L. (1990, Winter). Choosing a bi-sensitive therapist. BiFocus,
68. Markowitz, L. M. (1991). Homosexuality: Are we still in the dark? Networker, 15(1), 27-35.
69. American Psychological Association, Committee on Lesbian and Gay Concerns. (1990). Bias in psychotherapy with lesbians and gay men. Washington, DC: American Psychological Association.
70. Amico, J. M., & Neisen, J. (1997, May/June). Sharing the secret: The need for gay-specific treatment. The Counselor, 12-15.
71. American Psychological Association (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients, American Psychologist, 55 (12), 1440-1451.
72. Kinsey, Alfred C. et al. (1948/1998). *Sexual Behavior in the Human Male*. Philadelphia: W.B. Saunders; Bloomington, IN: Indiana U. Press.
73. Marckwardt, Albert H. et al. (1968). Standard College Dictionary. New York: Funk & Wagnall's.)
74. Cantwell, M.A. (1996) Homosexuality: The secret a child dare not tell., San Rafael, CA, US: Rafael Press.
75. Peplau, L.A. and Cochran, S.D. (1990). A relationship perspective on homosexuality. In Homosexuality/heterosexuality: Concepts of sexual orientation. DP McWhirter, S.A. Sanders; J.M. Reinisch, (Eds); pp. 321-349. New York, NY, US: Oxford University Press.
76. Russel 1996
77. Hatred in the Hallways, Human Rights Watch report, 2001
<http://www.hrw.org/reports/2001/usLGBTQ/toc.htm>
78. Davidson, L., and Linnoila, M., eds. *Report of the Secretary's Task Force on Youth Suicide, 2: Risk Factors for Youth Suicide*. Washington, DC: HHS, PHS, 1989
79. Vega, R. R., Cortés, D. E., Diverse Drug Abusing Populations, In Addiction counseling review: Preparing for comprehensive, certification and licensing examinations. RH Coombs, (Ed); pp. 129-147. Mahwah, NJ, US: Lawrence Erlbaum Associates, Publishers, 2005.

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

LGBTQ Friendly Health Care Organizations (Mental and Physical Health)

Self-Help & Support Organizations for LGBTQ 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 LGBTQ magazine) and En La Vida (Latino/a LGBTQ magazine).

1115 W. Belmont #2-D, Chicago, IL 60657

www.outlineschicago.com/blacklines.html

www.outlineschicago.com/enlavid.html

LLEGÓ, The National Latina/o Lesbian, Gay, Bisexual & Transgender Organization
National nonprofit organization devoted to organizing Latina/o Lesbian, Gay, Bisexual and Transgender (LGBTQ) communities on a local, regional, national and international level. Provides resources to Latina/o LGBTQ communities including Spanish Language LGBTQ health information (see “Nuestra Salud” videos in LGBTQ 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 , LGBTQ 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 LGBTQ 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 LGBTQ 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 LGBTQ 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 LGBTQ couples, families, and their members

(510) 628-0965 www.altfamily.org

Family Net (Human Rights Campaign)

Website exploring all aspects of LGBTQ 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 for 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 LGBTQ press.

www.glnh.org

Lambda Publications

Publishes Blacklines (African American LGBTQ magazine) and En La Vida (Latino/a LGBTQ magazine).

1115 W. Belmont #2-D, Chicago, IL 60657

www.outlineschicago.com/blacklines.html

www.outlineschicago.com/enlavid.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 LGBTQ supportive legal representation.

125 Broad Street, 18th Floor

New York, NY 10004-2400

(212) 549-2627 Fax: (212) 549-2650

Email: LGBTQhiv@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

LGBTQ 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

Gay Health

A health and wellness site dedicated to lesbian, gay, bisexual, and transgender men and women. Includes information and referral database to LGBTQ 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 LGBTQ 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 LGBTQ 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 (LGBTQ) 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

Rainbow Heights Club

Located in Downtown Brooklyn, Rainbow Heights Club is a psychosocial advocacy and support program serving lesbian, gay, bisexual and transgender individuals living with a mental illness in the New York City Metropolitan area. We provide socialization, affirming support groups, peer advocacy, and a safe place to take the next step on the road to emotional recovery and wellness. Our program is open to our 300 members on weekday afternoons, 12:30 PM – 5:30 PM. Services are free to all members.
25 Flatbush Avenue, 3rd Floor
Brooklyn, NY 11217
Phone: (718) 852-2584 Fax: (718) 875-5496 Email: info@rainbowheights.org
www.rainbowheights.org

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 LGBTQ 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: LGBTQ 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 LGBTQ 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 (LGBTQ people with Mood Disorders):

www.onelist.com/subscribe/QWORLD

From the site description: "Support E list for Queers, Gay men, Fags, Lesbians, Dykes, Lesbigans, 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 LGBTQ 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 LGBTQ 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 LGBTQ 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 LGBTQ 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

LGBTQ AFFIRMING RELIGIOUS AND SPIRITUAL ORGANIZATIONS

*We are indebted to Alvin Fritz for his excellent LGBTQ 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 LGBTQ Muslims...The Al-Fatiha aims to support 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/LGBTQ.htm>

Apostolic Catholic Church in America
note: an inclusive, sacramental, and liturgical Christian 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 LGBTQ religious movements." A project of the Chicago Theological Seminary.

<http://LGBTQran.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: LGBTQ 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 Metropolitanaines

<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 AND INTERSEX RESOURCES

FTM International
740A-14th St. #216
San Francisco, CA 94114
(877) 267-1420
<http://www.ftmi.org>

International Foundation for Gender Education
P.O. Box 540229
Waltham, MA 02454-0229
781-894-8340 or 781-899-2212
<http://www.ifge.org>

Intersex International Organization (Organisation Intersex International)
<http://www.intersexualite.org>

National Center for Transgender Equality □
1325 Massachusetts Ave., Suite 700 □
Washington, DC 20005 □
(202) 903-0112
<http://www.nctequality.org>

New York Association for Gender Rights Advocacy (NYAGRA)
24 W. 25th St., 9th floor
New York, NY 10010
(212) 675-3288, ext. 338
<http://www.nyagra.com>

Planned Parenthood of Tompkins County
Ithaca, NY
(607) 273-1526 x134
<http://www.sextalk.org>

Transgender Legal Defense & Education Fund, Inc.
216 Avenue A
New York, NY 10009
(347) 284-6710
<http://www.transgenderlegal.org/>

WORK & HUMAN RESOURCES

Gay Work.com

Workplace issues, discussion boards, LGBTQ 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 LGBTQ 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 LGBTQ parents.

(415) 861-5437 www.colage.org

National Youth Advocacy Coalition

Lobbies for legislative protection for sexual minority youth. Publishes news magazine on LGBTQ youth issues.

(202) 319-7596 www.nyacyouth.org

!Out Proud! National Coalition for Gay, Lesbian, Bisexual and Transgender Youth
Resources, advocacy and support for LGBTQ 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

SELECTED BIBLIOGRAPHY FOR LGBTQ ISSUES:

Topics:

Bisexuality

Coming out to Family

Communities of Color Resources

Domestic Violence

Family and Parenting

History

LGBTQ 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.

LGBTQ HEALTH AND HEALTH CARE

American Journal of Public Health, special issues on lesbian, gay, bisexual, and transgender health: June 2001 Vol. 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 LGBTQ Health

The Healthy People 2010 Companion Document for LGBTQ Health is a comprehensive look at multicultural LGBTQ 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 and 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

Valerio, Max Wolf, A Man: the Transsexual Journey of an Agent Provocateur. New York: William Morrow, 1998.

Transforming Families: real stories about transgendered loved ones.
By Mary Boenke (Editor); Walter Troom 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 Francisco, CA 94102-6033. Phone: 415 / 252-2500

Recommendations from New York Association for Gender Rights Advocacy (NYAGRA):

Books:

Barbin, Herculine. Herculine Barbin: Being The Recently Discovered Memoirs Of A Nineteenth-Century French Hermaphrodite. Translated by Richard McDougall. Translation of Herculine Barbin, dite Alexina B. Brighton, England: Harvester Press, 1980.

Beyer, Georgina and Cathy Casey. A Change for the Better: The Story of Georgina Beyer. Auckland and London : Random House New Zealand, 1999.

Bornstein, Kate, My Gender Workbook. New York: Routledge, 1998.

Helen Boyd, My Husband Betty: Love, Sex and Life with a Crossdresser. New York: Thunder's Mouth Press, 2003.

Boylan, Jennifer Finney. She's Not There: A Life in Two Genders. New York: Broadway Books, 2003.

Cromwell, Jason, Transmen & FTMs: Identities, Bodies, Genders & Sexualities. Urbana and Chicago: University of Illinois Press, 1999.

Green, Jamison. Becoming a Visible Man. Nashville: Vanderbilt University Press, 2004.

Israel, Gianna and Tarver, Donald E. Transgender Care: Recommended Guidelines, Practical Information, & Personal Accounts. Philadelphia: Temple University Press, 1998.

Jones, B. E., & Hill, M. J. (2002). Transgender mental health: the intersection of race, sexual orientation, and gender identity. In B.E. Jones & J. Hill (Eds.) Mental Health Issues in Lesbian, Gay, Bisexual and Transgender Communities. Review of Psychiatry 21(4). Washington DC: American Psychiatric Publishing.

Lang, Sabine, Men as Women, Women as Men: Changing Gender in Native American Cultures (translated from the German by John L. Vantine). Austin: University of Texas Press, 1998.

Mallon, Gerald (editor), Social Services with Transgendered Youth. Binghamton NY: Harrinton Park Press, 1999.

McCloskey, Deirdre N. Crossing: A Memoir. Chicago: University of Chicago Press, 1999.

Park, Pauline, "GenderPAC, the Transgender Rights Movement and the Perils of a Post-Identity Politics Paradigm" in Georgetown Journal of Gender and the Law (symposium issue, Vol. IV, No. 2, spring 2003, pp. 747-765,).

Park, Pauline, "Sympathy, But Finding Pathology: A new study on transsexualism challenges community's views, creating stir" (Gay City News, 5.30.2003).

Park, Pauline, "Transgender Health: Reconceptualizing Pathology as Wellness" (Trans-Health Conference speech on GID, 4.7.07).
<http://www.paulinepark.com/writings.html>

Roscoe, Will, Changing Ones: Third and Fourth Genders in Native North America. New York: St. Martin's Press, 1998.

Scholinski, Daphne, The Last Time I Wore a Dress: A Memoir. New York: Riverhead Books, 1997.

Films:

Berliner, Alain. "Ma vie en rose" ("My life in pink") (feature film, 1997). Sony Pictures Classics release. The story of Ludovic, a transgendered Belgian child born male who identifies as a girl.

Brooks, Philip & Laurent Bocahut. 1998. "Woubi Chéri" (documentary, 1998). San Francisco, CA: California Newsreel. Homosexuality and transgender in the West African country of Cote d'Ivoire (Ivory Coast).

Davis, Kate. "Southern Comfort" (documentary, 2001). New York: Q-Ball Productions. A 90-minute documentary about Robert Eads, a 52-year-old female to male transsexual who lives in the back hills of Georgia and who dies of ovarian cancer after being turned away by more than two dozen doctors who feared that taking on a transgendered patient might harm their practice. Winner Grand Jury Prize, Documentary Competition, Sundance Film Festival 2001.

Peirce, Kimberly. "Boys Don't Cry" (feature film, 2000). Fox Searchlight Pictures and the Independent Film Channel Productions. The fictionalized account of the life and death of Brandon Teena, a transman raped and murdered in Nebraska.

Thongkongtoon, Yongyoot. "The Iron Ladies" ("Satee-lex") (feature film, 2002). The true story of a Thai male volleyball team that competes in the national championships in 1996 with a team consisting mostly of gay and transgendered members.

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 Ryan and 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.

SELECTED BIBLIOGRAPHY ON LGBTQ AFFIRMING PSYCHOTHERAPY

GENERAL / MIXED GROUP

Alexander, C. J. (1996). Gay and lesbian mental health: A sourcebook for practitioners. New York: Harrington Park Press/Haworth Press.

American Psychological Association, Committee on Lesbian and Gay Concerns. (1990). Bias in Psychotherapy with Lesbians and Gay Men. Washington, DC: American Psychological Association, 750 First St., N.E., Washington, DC 20002-4242.
Phone: (202) 336-5500

Amico, J. M., & Neisen, J. (1997, May/June). Sharing the secret: The need for gay-specific treatment. The Counselor, 12-15.

Ball, S. (1994). A group model for gay and lesbian clients with chronic mental illness. Social Work, 39(1), 109-115.

Bepko, C. & Johnson, T. (2000). Gay and lesbian couples in therapy: Perspectives for the contemporary family therapist. *Journal of Marital & Family Therapy*, 26(4), 409-419.

Bernstein, A.C. (2000). Straight therapists working with lesbians and gays in family therapy. *Journal of Marital & Family Therapy*, 26,443-454.

Bieschke, K.J., McClanahan, M., Tozer, E., Grzegorek, J.L., & Park, J. (2000). Programmatic research on the treatment of lesbian, gay, and bisexual clients: The past, the present, and the course for the future. In R.M. Perez, K.A. DeBord, & K.J. Bieschke (Eds.), *Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual Clients* (pp. 309-335). Washington, D.C.: American Psychological Association.

Brown, L.S. (1996). Preventing heterosexism and bias in psychotherapy and counseling. In E.D. Rothblum & L.A. Bond, *Preventing heterosexism and homophobia*, (pp. 36-58). Thousand Oaks: Sage.

Cabaj, R. P., & Stein, T. S. (1996). Textbook of Homosexuality and Mental Health. Washington, DC : American Psychiatric Press.

Campbell, H. D., Hinkle, D. O., Sandlin, P., & Moffic, H. S. (1983). A sexual minority: Homosexuality and mental health care. The American Journal of Social Psychiatry, 3(2), 26-35.

- Campos, P.E. & Goldfried, M.R. (2001). Introduction: Perspectives on therapy with gay, lesbian, and bisexual clients. *In Session: Psychotherapy in Practice*, 57, 609-613.
- D'Augelli, A. R., & Patterson, C. J. (Eds.). (1995). Lesbian, gay, and bisexual identities over the lifespan: Psychological perspectives. New York: Oxford University Press.
- Davies, D., & Neal, C. (Eds.). (1996). Pink therapy: A guide for counselors and therapists working with lesbian, gay and bisexual clients. Buckingham, England: Open University Press.
- Dillon, F. & Worthington, R.L. (2003). The lesbian, gay and bisexual affirmative counseling self-efficacy inventory (LGB-CSI). *Journal of Counseling Psychology*, 50, 235-251.
- Drescher, J., e'Ercole, A., Schoenberg, E (Eds.) (2003). Psychotherapy with gay men and lesbians; Contemporary dynamic approaches. Binghamton NY: the Harrington Park Press / The Haworth Press.
- Fassinger, R. E. (1991). The hidden minority: Issues and challenges in working with lesbian women and gay men. *The Counseling Psychologist*, 19(2), 151-176.
- Garnets, L., Hancock, K.A., Cochran, S.D., Goodchilds, J. & Peplau, L.A. (1991). Issues in Psychotherapy with lesbians and gay men. *American Psychologist*, 46(9), 964-972.
- Gluth, D. R., & Kiselica, M. S. (1994). Coming out quickly: A brief counseling approach to dealing with gay and lesbian adjustment issues. *Journal of Mental Health Counseling*, 16(2), 163-173.
- Gonsorick, J.C. (1985) *A guide to psychotherapy with gay and lesbian clients*. New York: Harrington Press.
- Greene, B. (1997). Ethnic and cultural diversity among lesbians and gay men: Vol. 3 Psychological perspectives on lesbian and gay issues. London: SAGE Publications.
- Greene, B., & Herek, G. (1994). Lesbian and gay psychology: Theory, research, and clinical applications. Thousand Oaks, CA: SAGE Publications.
- Hartman, S. (1997, Summer). Affirming gay and lesbian experiences in psychotherapy. *Carrier Foundation Medical Education Letter*, 198, 1-4.
- Helfand, K. (1993). Therapeutic considerations in structuring a support group for the mentally ill gay/lesbian population. *Journal of Gay & Lesbian Psychotherapy*, 2(1), 65-75.

- Hellman, R. (1996). Issues in treatment of lesbian women and gay men with chronic mental illness. Psychiatric Services, 47(10), 1093-1098.
- Jones, M.A., Botsko, M., & Gorman, B.S. (2003). Predictors of psychotherapeutic benefit of lesbian, gay, and bisexual clients: The effects of sexual orientation matching and other factors. *Psychotherapy: Theory, Research, Practice, Training*, 40, 289-301.
- Jordan, K. M., & Deluty, R. H. (1995). Clinical interventions by psychologists with lesbians and gay men. Journal of Clinical Psychology, 51(3), 448-456.
- Mallon, G. P. (Ed.). (1998). Foundations of social work practice with lesbian and gay persons. New York: Harrington Park Press/The Haworth Press.
- Mattison, A. M., & McWhirter, D. P. (1995). Lesbians, gay men, and their families: Some therapeutic issues. Psychiatric Clinics of North America, 18(1), 123-137.
- McDonald, H. B., & Steinhorn, A. I. (1990). Homosexuality: A practical guide to counseling lesbians, gay men, and their families. New York: Continuum Publishing Company.
- McDougall, G. J. (1993). Therapeutic issues with gay and lesbian elders. Clinical Gerontologist, 14(1), 45-57.
- Milton, M. Coyle, A. & Legg, C. (2002). Lesbian and gay affirmative psychotherapy: Defining the domain. In A. Coyle & C. Kitzinger (Eds.), *Lesbian and gay psychology: New Perspectives*, (pp. 175-197). Malden, MA: Blackwell Publishers.
- Milton, M. & Coyle, A. (1998). Psychotherapy with lesbian and gay clients. *The Psychologist*, February, 73-76.
- Morrow, S.L. (1999). First do no harm: Therapist issues in psychotherapy with lesbian, gay and bisexual clients. In R.M. Perez, K.A. DeBord, & K.J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients*, (pp. 137-156). Washington, DC: American Psychological Association.
- O'Hare, T., Williams, C. L., & Ezoviski, A. (1996). Fear of AIDS and homophobia: Implications for direct practice and advocacy. Social Work, 41(1), 51-58.
- Purcell, D.W., Campos, P.E., & Perilla, J.L. (1999). Therapy with lesbians and gay men: A cognitive behavioral perspective. *Cognitive & Behavioral Practice*, 3, 391-415.
- Rekers, G. A., & Pepper, M. A. (1998). Assisting gays and lesbians through the stages of "coming out." In L. VandeCreek & S. Knapp (Eds.), Innovations in clinical

practice: A sourcebook (pp.163-178). Sarasota, FL: Professional Resource Press/Professional Resource Exchange.

Ritter, K.Y. & Terndrup, A.I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York: Guilford Press.

Steigerwald, F. & Janson, G.R. (2003). Conversion therapy: Ethical considerations in family counseling. *Family Journal: Counseling & Therapy for Couples & Families*, 11(1), 55-59.

Vacc, N. A., & DeVaney, S. B. (1995). Experiencing and counseling multicultural and diverse populations. Muncie, IN: Accelerated Development Inc.

Specific to Gay Men

Amico, J. M., & Neisen, J. (1997, May/June). Sharing the secret: The need for gay-specific treatment. The Counselor, 12-15.

Beane, J. (1981). I'd rather be dead than gay: Counseling gay men who are coming out. The Personnel and Guidance Journal, 60(4), 222-226.

Butler, M., & Clarke, J. (1991). Couple therapy with homosexual men. In D. Hooper & D. Windy (Eds.), Couple therapy: A handbook. Milton Keynes, England: Open University Press.

Hall, A.S. & Fradkin, H.R. (1993). Affirming gay men's mental health: Counseling with a new attitude. *Journal of Mental Health Counseling*, 14, 362-374.

Harrison, N. (2000). Gay affirmative therapy: A critical analysis of the literature. *British Journal of Guidance & Counseling*, 28(1), 37-53. York: Routledge.

Mair, D. & Izzard, S. (2001). Grasping the nettle: Gay men's experiences in therapy. *Psychodynamic counseling*, 7, 474-490.

Pollack, W. S., & Levant, R. F. (Eds.). (1998). New psychotherapy for men. New York: John Wiley & Sons, Inc.

Stein, T.S. & Cabaj, R.P. (1996). Psychotherapy with gay men. In R.P. Cabaj & T.S. Stein (Eds.), *Textbook of homosexuality and mental health*. Washington, D.C.: American Psychiatric Press, Inc.

Specific to Lesbians

Bradford, J., Ryan, C., & Rothblum, E. (1997). National lesbian health care survey: Implications for mental health care. *Journal of Consulting & Clinical Psychology* 62(2), 228-242.

- Browning, C., Reynolds, A., & Dworkin, S. (1991). Affirmative psychotherapy for lesbian women. The Counseling Psychologist, 19(2), 177-196.
- Davis, N. D., Cole, E., & Rothblum, E. D. (Eds.). (1996). Lesbian therapists and their therapy: From both sides of the couch. New York, NY: Harrington Park Press/Haworth Press.
- Falco, K. L. (1996). Psychotherapy with women who love women. In R. P. Cabaj & T. S. Stein (Eds.), Textbook of homosexuality and mental health. Washington, DC: American Psychiatric Press.
- Igartua, K. J. (1998). Therapy with lesbian couples: The issues and the interventions. Canadian Journal of Psychiatry, 43(4), 391-396.
- Kleinberg, S., & Zorn, P. (1995). Rekindling the flame: A therapeutic approach to strengthening lesbian relationships. In J. M. Glassgold & S. Iasenza (Eds.), Lesbians and psychoanalysis: Revolutions in theory and practice. New York: Free Press.
- Saari, C. (2001). Counteracting the effects of invisibility in work with lesbian patients. Journal of Clinical Psychology, 57, 645-654.
- Sorenson, L., & Roberts, S. J. (1997). Lesbian uses of and satisfaction with mental health services: Results from Boston lesbian health project. Journal of Homosexuality, 33(1), 35-48.

Specific to Bisexual People

- Deacon, S. A., Reinke, L., & Viers, D. (1996). Cognitive-behavioral therapy for bisexual couples: Expanding the realms of therapy. American Journal of Family Therapy, 24(3), 242-258.
- Gottfried, L. (1990, Winter). Choosing a bi-sensitive therapist. BiFocus, 6.
- Matteson, D. R. (1996). Counseling and psychotherapy with bisexual and exploring clients. In B. A. Firestein (Ed.), Bisexuality: The psychology and politics of an invisible minority (pp. 185-213). Thousand Oaks, CA: SAGE Publications.
- Reynolds, A.L. (2003). Counseling issues for lesbian and bisexual women. In M. Kopola & M.A. Keitel (Eds.), *Handbook of counseling women*, (pp. 53-73). Thousand Oaks: Sage.
- Smiley, E. B. (1997). Counseling bisexual clients. Journal of Mental Health Counseling, 19(4), 373-382.

Weasel, L. H. (1996). Seeing between the lines: Bisexual women and therapy. Women and Therapy, 19(2), 5-16.

Specific to Transgender / Transsexual People

Borenstein, K. (1995). Gender outlaw: On men, women, and the rest of us. New York: Random House, 1995.

Braunthal, H. (1981). Working with transsexuals. International Journal of Social Psychiatry, 27(1), 3-11.

Brown, M. L., & Rounsley, C. A. (1996). True selves: Understanding transsexualism - for families, friends, coworkers, and helping professionals. San Francisco, CA: Jossey-Bass Publishers.

Clare, D. & Tully, B. (1989). Transhomosexuality, or the dissociation of sexual orientation and sex object choice. Archives of Sexual Behavior, 18(6), 531-536.

Denny, D. (1996, February). Transgendered youth at risk for exploitation, HIV, hate crime. In Inter-Q-Zone [On-line]. (Available: <http://www.aidsinfonyc.org/Q-zone/youth.html>).

Denny, D. (1998). Working with transgendered and transsexual college and university students. In R. L. Sanlo (Ed.), Working with lesbian, gay, bisexual, and transgender college students: A handbook for faculty and administrators. Westport, CT: Greenwood Press.

Denny, D. (1998a). Current concepts in transgender identity. New York: Garland.

Feinberg, L. (1993). Stone butch blues. Ithaca, NY: Firebrand Books

Feinberg, L. (1997). Transgender warriors: Making history from Joan of Arc to Dennis Rodman. Boston: Beacon Press.

Jones, B. E., & Hill, M. J. (2002). Transgender mental health: the intersection of race, sexual orientation, and gender identity. In BE Jones & J. Hill (Eds.) Mental Health Issues in Lesbian, Gay, Bisexual and Transgender Communities. Review of Psychiatry 21(4). Washington DC: American Psychiatric Publishing.

Wilson, D. (1998). Counseling the transsexual: Developmental perspectives on a transsexual's transition [On-line]. (Available: <http://www.lava.net/~dewilson/gender/resources.html> or www.GenderWeb.org/medical/psych/devel.html).

Specific to Youth

- DeCrescenzo, T. (Ed.). (1994). Helping gay and lesbian youth: New policies, new programs, new practice. New York: Harrington Park Press/Haworth Press.
- Farrow, J. A. (1995). Service delivery strategies for treating high-risk youth: Delinquents, homeless, runaways, and sexual minorities. National Institute on Drug Abuse Research Report Series, 156, (1, Publication No. 95-3908).
- Fontaine, J. H., & Hammond, N. L. (1996). Counseling issues with gay and lesbian adolescents. Adolescents, 31(124), 817-830.
- Mallon, G. P. (1992). Serving the needs of gay and lesbian youth in residential treatment centers. Residential Treatment for Children and Youth, 10(2), 47-59.
- Mallon, G. P. (1998). We don't exactly get the welcome wagon: The experiences of gay and lesbian adolescents in child welfare systems. New York: Columbia University Press.
- Radkowsky, M., & Siegel, L. J. (1997). The gay adolescent: Stressors, adaptations, and psychosocial interventions. Clinical Psychological Review, 17(2), 191-216.
- Ryan, C., & Futterman, D. (1993). Lesbian and gay youth: Care and counseling. New York, NY: Columbia University Press.
- Safren, S.A., Hollander, G., Hart, T.A., & Heimburg, R.G. (2002). Cognitive-behavioral therapy with lesbian, gay, and bisexual youth. *Cognitive & Behavioral Practice, 8*, 215-223.
- Sanlo, R. L. (1998). Working with lesbian, gay, bisexual, and transgender college students: A handbook for faculty and administrators. Westport, CT: Greenwood Press.

EXCERPTS OF PROFESSIONAL ORGANIZATIONS’ ETHICAL GUIDELINES

Examples of Anti-discrimination Statements from the Ethics and Practice
Standard Codes of Several Mental Health Professions
(*italics added to verbatim text*)

American Psychological 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 Psychiatric 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."



Providing Transgender-Inclusive Healthcare Services



Providing Transgender-Inclusive Healthcare Services

© 2006 Planned Parenthood of The Southern Finger Lakes
Sexuality Education & Training Center
314 West State Street, Ithaca, NY 14850
Phone 607.216.0021 • Fax 607.216.0023
www.ppsfl.org
www.sextalk.org

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Providing Transgender- Inclusive Healthcare Services

All people, regardless of gender or sexual orientation, have rights that need to be respected and responsibilities that need to be exercised.

-Planned Parenthood Federation of America, Values Statement

Understanding, teaching about and promoting healthy sexuality is at the core of our work, passion and commitment as members of the Planned Parenthood community. We believe that sexuality is a lifelong aspect of being human to be celebrated with respect, openness and mutuality.

We have learned so much over the years as medical providers, educators and activists about diversity, cultural competence, and serving underserved people and communities. It is no surprise that our commitment grows and our understanding deepens about human sexuality as we continue to improve our services.

One of the most exciting aspects of being a Planned Parenthood and operating as a learning organization is that we are continually improving, changing, assessing and evaluating our services to assure that we are meeting the needs of the people in the communities we serve. This is one of our greatest challenges and greatest assets. It's a challenge because simply put, it's hard. It's hard to grapple with new language, emerging community needs, staff training, and providing respectful, competent and informed care. It's an asset because we provide services, education and activism that sees whole people and honors all of the layers of identity that they bring forth as rich and diverse human beings.

In rural upstate New York, some emerging community needs are sexuality education, medical services, and advocacy for transgender people. For many of our staff, understanding new language, the use of pronouns, unique medical needs and discrimination faced by transgender people posed a steep learning curve that required training, information and resources. This packet of information comes from our own process of learning and wanting to serve an emerging underserved population with care and respect.

This document is a work in progress, and will continually be updated as we learn more about improving our services for and outreach to transgender people. Your ideas, questions, suggestions, and stories of your successes and challenges are invited! Email SexEd@sextalk.org.

...we provide services, education and activism that sees whole people and honors all of the layers of identity that they bring forth as rich and diverse human beings.

Barriers Transgender Clients Face When Seeking Healthcare

And while each of us may not know trans people who are directly impacted by all of these public health concerns, transgender communities are very broad and varied, and collectively we are impacted greatly by each of these.

-National Center for Transgender Equality

In addition to the barriers that many people face when seeking healthcare, transgender clients have some unique barriers that arise. From filling out forms, to the language used in a medical office, to insurance coverage, transgender clients may find any number of obstacles that make obtaining healthcare more difficult, or even impossible.

Everyone's gender identity is a personal and unique construct, and because of that, you can't know if someone is transgender unless they tell you themselves. Gender presentation (how someone looks, dresses, acts in relation to gender roles and expectations) is also not necessarily indicative of any specific gender identity. The point of being a transgender-inclusive health center is not to figure out who is transgender and who isn't. The point is to provide healthcare services that are inclusive to all people of all gender identities, even if you don't know their gender identity. Keeping that in mind, here is a list of some concrete barriers that transgender clients in particular may face while in a health center:

- **Forms** – Some health centers have separate male & female health history and intake forms, which can cause confusion for both staff and transgender clients. Staff may not know (and should not assume) the gender of a client, and may be uncomfortable asking their gender to figure out what form they need. Clients may have health concerns that are not included on the form they are given. Combining male & female forms for health history into one form will allow a transgender client to fill out all portions that are appropriate for them, and ease the pressure on staff to guess gender identity.
- **Preferred Name vs. Legal Name** – For insurance and billing purposes health centers may need a client's legal name, even though clients may not use their legal name. Being called by their legal name, rather than their preferred name, can be distressing to any client, particularly if the client associates their legal name with a gender they don't identify with.

The point of being a transgender-inclusive health center is not to figure out who is transgender and who isn't. The point is to provide health care services that are inclusive to all people of all gender identities, even if you don't know their gender identity.

Providers should have a space for ‘preferred name’ on all forms, and use this name when talking to or about any client.

- **Bathroom** – In any setting where bathrooms are separated by sex, transgender people may feel uncomfortable and/or unwelcome in both bathrooms. Unisex bathrooms are much easier to navigate.
- **Medical/Anatomical Language** – For a transgender individual, it may be difficult to acknowledge or come to terms with biological body parts that are in conflict with their gender. Some transgender clients may be uncomfortable using ‘anatomically correct’ terms to describe their body parts, and may be uncomfortable hearing medical providers talk about their body parts. For instance, someone who identifies as a man may not want to acknowledge or talk about having a vagina. Healthcare providers should be sensitive to this possibility, and if necessary ask the client how they would prefer to talk about medical issues (through different language, slang, pictures, anatomical models or other methods).
- **Pronouns** – It may be unclear to staff which pronouns (he/she, him/her) to use when speaking to or about a transgender client. The only way for staff to know which pronouns to use is to politely ask the client what their ‘preferred pronoun’ is, and to have a space for preferred pronoun on forms.
- **Having to educate their providers** – Transgender clients may feel pressured to educate their health care providers about an array of transgender issues and health concerns. The pressure to explain oneself, or the frustration of encountering medical professionals who don’t know about transgender issues may keep transgender people from visiting the doctor when they need care. It can be very tiring to constantly have to explain one’s identity, especially if it is not directly related to the medical issue at hand. It is not fair to expect that clients educate staff, nor is it fair to expect any one transgender client to speak for all transgender people.
- **Discriminatory providers** – Sadly, there are providers who are outrightly hostile or discriminatory towards transgender clients. Refusing to provide medical services based on someone’s gender identity is inappropriate, and should not be tolerated in any health agency or office. Discriminatory or disparaging remarks are also inappropriate, as is providing inferior or delayed care to someone based on their gender. Discrimination in any form should not be tolerated by any health agency or practice.
- **Drug interactions** – Some transgender clients may be on hormones. Many providers (and transgender clients themselves) don’t know how hormones will interact with other drugs or medical procedures. Providers should have a general understanding of how drugs and medical procedures may

interact with hormones, or be willing to research this information. Providers should also be aware of potential side-effects associated with taking hormones so they can properly assess medical conditions.

There are also many societal factors larger than the logistics of your health center that play into transgender people's lack of access to quality healthcare. Although you will not be able to solve the bigger societal problems with the information in this document, it is important to be aware of them, as they play very important roles in the lives and healthcare of transgender people.

The National Coalition for LGBT Health has reported on several health priorities for transgender people in the United States. The report identified the following public health and health care concerns as the most pressing health issues for the transgender community at present:

1. **Violence and Murder Prevention** – Several studies show an epidemic of violence against transgender individuals in the U.S., as well as significant underreporting of violent crimes against transgender individuals.
2. **HIV/AIDS and Other STD Prevention & Treatment** – Transgender women, in particular sex workers in cities, have shockingly high HIV-infection rates, and other transgender individuals may also be at elevated risk of HIV-infection.
3. **Substance Abuse Prevention and Treatment** – Studies have found significant substance abuse among transgender populations, and also found that accessing treatment is particularly difficult because many treatment programs are separated by sex, or simply unwelcoming and discriminatory.
4. **Depression, Suicide Ideation, and Suicide Prevention** – In major U.S. cities, anywhere from 16-37% of transgender people have made suicide attempts. Mental health care for this group is lacking because of discrimination, not having insurance, or not having enough mental health professionals familiar with transgender clients' needs.
5. **Lack of Health Insurance and Underinsurance** – High rates of joblessness and poverty among transgender populations often results in no insurance coverage.
6. **Lack of Health Insurance Coverage for Trans Health Services** – Hormone therapy and sex reassignment surgery are excluded by nearly all U.S. health insurers.
7. **'Gender Identity Disorder' and access to Trans Health Services** – Admitting to having 'Gender Identity Disorder' – a stigmatizing mental

disorder – is often a pre-requisite to obtaining Trans Health Services (such as hormone therapy or sex reassignment surgery).

8. **No FDA Approval for Transgender Hormone Therapy** – The FDA has never approved Transgender Hormone Therapy and considers the use of testosterone and estrogen for this purpose as ‘off-label’.
9. **Widespread Injection Silicone Use** – Injecting silicone can often give transgender women ‘curves’ and allow them to ‘pass’ without hormone therapy. However, silicone is often injected under unsanitary conditions and can lead to HIV and Hepatitis infections.
10. **Classifying Sex Reassignment Surgery as “Experimental”** – Because it is classified as “experimental”, sex reassignment surgery is not covered by health insurers. However this surgery is done on a daily basis in the U.S. and does not need to be classified as experimental any longer.
11. **Lack of Training in Medical Schools on Trans Health Service Delivery** Traditionally viewed as a mental health issue, transgenderism is not typically covered in medical schools, and as a result physicians are unprepared to serve transgender clients.
12. **Health Care Provider Insensitivity and Hostility Towards Transgender People** – Many transgender individuals perceive intense insensitivity and/or hostility from health care providers, and therefore are unwilling to disclose their gender identity, which in itself is a significant barrier to care.
13. **Tobacco Use** – No studies have been done to assess tobacco use in the transgender community. However, smoking may pose a greater risk to transgender individuals who are taking hormones or who are HIV-positive. Transgender people have also reported difficulty accessing smoking-cessation treatment programs, including programs run by lesbian and gay organizations.

To view the entire report from The National Coalition for LGBT Health visit: <http://www.nctequality.org/HealthPriorities.pdf>

With such severe public health problems facing the transgender community, it is crucial that health care agencies do all they can to make accessing health care a respectful and helpful process for transgender individuals. There are many practical steps that Planned Parenthood affiliates and related health care agencies can take to be more welcoming and inclusive of their transgender clients. For any client, when they feel respected, listened to, and receive appropriate treatment, they will have a more positive experience and be more likely to access health care in the future. The following checklist will allow your agency to assess how transgender-friendly your services are.

Checklist: Is Your Health Center Transgender-Inclusive?

The acronym LGBT is often used to describe the lesbian, gay, bisexual, and transgender communities. These four groups share some similar challenges and barriers, such as coming out, self-esteem, harassment and accessing non-judgmental health care. However, these identities are each very different and have their own specific concerns. It is crucial to recognize that building and maintaining an agency that is specifically inclusive of transgender clients is in many ways different than maintaining one that is inclusive of lesbian, gay, and bisexual clients – and both are vital!

What does ‘inclusive’ mean in regards to transgender or gender non-conforming individuals?

- Not making assumptions about clients’ gender,
- Being willing to accept gender fluidity and non-traditional gender presentation, and
- Treating all clients with compassion, understanding, and respect.

To get an idea of where your agency falls in the spectrum of being transgender-inclusive, fill out this checklist. You will be able to identify what your agency is already doing well and what areas your agency can work on to be more transgender-inclusive.

More Resources

Even if you rate your agency as ‘excellent’, you are probably still interested in finding all of the resources you can to continue to provide excellent, inclusive services to all of your clients. After completing the checklist, check out the resource list of books, manuals and websites that have already done a lot of the work for you on page 25.

Checklist: How Transgender-Inclusive is Our Agency?

Excellent
OK
Needs Work

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There is an agency wide commitment to providing transgender friendly services.

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This commitment is reflected in mission statements and work plans.

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There is an understanding of the connections between discrimination based on gender identity and other social injustices.

--	--	--

Written personnel policies, including non-discrimination, diversity and non-harassment policies explicitly include gender identity and expression.

--	--	--

These policies are clearly posted in all of the agency's facilities.

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Process for electing or appointing members of the Board of Directors and other institutional bodies includes outreach to and inclusion of transgender candidates.

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Written policies explicitly state that the agency does not discriminate on the basis of gender identity or expression in provision of services.

Education Department

--	--	--

Education materials are inclusive to people of all genders, including transgender people.

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During programming, educators use language that is inclusive and examples that could also apply to transgender individuals.

--	--	--

Education materials include resources for transgender individuals.

--	--	--

Transgender issues and discussions of gender are distinguished from discussions about sexual orientation. Educators can clearly define the difference between gender identity and sexual orientation.

--	--	--

Educators maintain relationships with other agencies and providers with expertise in transgender health concerns.

Patient Services

--	--	--

Waiting rooms, intake areas, check out areas, and other physical spaces in the clinic are welcoming to all gender identities.

Excellent	OK	Needs Work
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROVIDING TRANSGENDER-FRIENDLY
HEALTH SERVICES

All agency staff are trained about basic transgender issues and how to use culturally appropriate language.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Intake and health history forms have space for optional self-identification in the following categories: gender identity, sexual orientation, marital partnership, family status; and provide space for written explanation.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Reception, intake and medical staff recognize the importance of using clients preferred name and pronoun in all situations, including the waiting room, and include space for preferred name to be noted on all forms and charts.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Staff are familiar with providers within the agency who have expertise in and sensitivity to transgender issues, and refer clients to them when appropriate.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Staff are trained to provide medically and culturally appropriate referrals to organizations and professionals serving transgender clients and their families.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Agency maintains a resource list and relationships with appropriate referrals, agencies and other healthcare providers for transgender clients.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Staff are trained in finding creative ways to discuss anatomy, sexual health and medical issues using language (or pictures, or anatomy models) that are comfortable for the client.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Written confidentiality policies explicitly include gender identity and indicate that such information is to be considered highly sensitive and treated accordingly.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

There is a system in place to address discordance of gender, legal name, and preferred name on insurance documents (i.e. insurance card doesn't match client's preferred name).

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Clinicians have knowledge of common medical issues affecting people going through physical transition and how that may affect their sexual and reproductive health.

If you checked mostly **Excellent**, you are an amazing resource for the transgender community and other health centers. Make yourself known as a resource, put yourself out there, give yourself a pat on the back and keep up the good work!

If you checked mostly **OK**, you are on the right track. Refer to some of the references listed. Choose a few areas you know your agency can work on, and focus on them.

If you checked mostly **Needs Work**, knowing what needs to be done is the first step to improving services. Choose several areas that you feel confident your agency can change. Check out the following resources, build these areas into your work plan, brainstorm steps your agency can take over the next couple of years. You've already completed the first step towards becoming a transgender-inclusive health center!

Action Plan: Providing Transgender-Inclusive Services

Notes on Names & Pronoun Uses

We encourage you to use a transgender person's chosen name. Often transgender people cannot afford a legal name change or are not yet old enough to change their name legally. They should be afforded the same respect for their chosen name as anyone else who lives by a name other than their legal name.

We also encourage you to ask transgender people what pronoun they would like you to use. A person who identifies as a certain gender, whether or not they have taken hormones or had surgery, should be referred to using the pronouns appropriate for that gender.

If it is not possible to ask the person which pronoun he or she prefers, use the pronoun that is consistent with the person's appearance and gender expression. For example, if the person wears a dress and uses the name "Susan", feminine pronouns are appropriate.

NOTE: It is never appropriate to put quotation marks around a transgender person's chosen name or the pronoun used to reflect their gender identity.

*Excerpted from GLAAD's
Transgender Glossary of Terms,
www.glaad.org*

Most agencies will not score 'excellent' for all items on the Transgender Inclusive Checklist. The transgender population is only recently becoming more visible in our society and emerging as a recognized group with its own unique needs. By assessing where your agency is, you can more clearly see where your agency needs to go. Use this checklist as a guide when creating your long term work plan.

Here are some concrete suggestions that any healthcare agency can use to make their services more transgender-inclusive:

- **Get to know the community.** Plan a meeting between your agency and a local LGBT organization. Share resources, information, and ideas. Agree to meet periodically, and commit to continuing this relationship.
- **Update your forms.** Create a small committee to update intake forms and other paperwork so that they are transgender-inclusive. Make sure to include a space for 'preferred name' and 'preferred pronoun'. Having one health history form (instead of separate male and female forms) makes checking-in more comfortable for transgender clients and for intake staff. Staff does not need to guess a person's gender to give them the correct form at check-in, and transgender clients can fill out all sections that apply to them.
- **Schedule an in-service training for staff.** Start with what you think would be most useful to your co-workers. Do they need an LGBT overview? Are they ready to focus providing excellent service to LGBT clients? Do they have enough 'LGB' background to concentrate solely on providing transgender-inclusive services? If you're comfortable you can provide the training yourself, or bring in an educator. Many transgender organizations have educators that specifically provide training to medical staff.
- **Make pictures and anatomical models available to clinicians.** Coming to terms with having body parts that are divergent from one's gender identity may be difficult for some transgender clients. Clinicians can use models and/or pictures (rather than 'anatomically correct' language) to describe medical procedures or issues, which may allow some transgender clients to more comfortably address their sexual & reproductive health concerns. Providers should also make themselves comfortable hearing and using slang, if that is how the client initiates discussing their body.

- **Make agency bathrooms unisex.** If at all possible, make public and staff bathrooms unisex, allowing transgender clients and staff to comfortably access the bathroom.
- **Provide written materials for staff.** There are pamphlets available about both sexual orientation and gender identity. Gather some pamphlets you think would be useful to your co-workers. For a pamphlet that provides some general information and resources about transgender issues check out Planned Parenthood of the Southern Finger Lakes' pamphlet *Transgender, What's Up With That?* (see end of this document for a copy).
- **Add gender identity to your agency non-discrimination policy.** Why not start at the top? Including gender identity in your non-discrimination policy sends a message that your agency is serious about providing services that are accessible and friendly to the transgender community.
- **Create a resource sheet.** Included in this packet is an example of a local resource and referral list and tips for how to create one for your community. Make sure that staff are aware of the list and know when and how to use it.
- **Educate yourself.** Become an in-house resource and an advocate for transgender clients. Providing transgender-inclusive services can't happen with just one person, but you only need one person to get things started.
- **Make realistic plans.** Looking at a list of things that need to be done can be overwhelming. It's important to remember that creating real change does not happen quickly and to give yourself a realistic timeline for your plans.
- **Build on what you are already do** to ensure that your services are accessible, comprehensive and useful to your clients. Planning ways to provide more transgender-friendly services will be a part of what you already do every day as your agency works to serve all populations in need of your services.
- **Recognize that working to provide transgender-friendly care will improve the quality of care for all of your clients,** because you will actively be creating a welcoming and inclusive atmosphere in you health centers and agency as a whole.

Creating a Local Resource List for Transgender Clients

Planned Parenthood is a vital community resource for accurate, non-judgmental, and accessible sexuality and sexual health information and services. Our visibility as a welcoming and safe space means that people can turn to us when they have nowhere else to go. We are in an ideal position to provide resources and information for transgender clients, a population that is often overlooked.

Below are some tips for how to go about creating your own transgender resource list. Highlighting local resources provides information for clients who don't have internet access and provides an opportunity for community dialogue. Creating a resource list also gives your agency a chance to connect with other transgender-inclusive organizations and let them know that your agency is a safe place for their clients and members to go for services.

Ask

The best way to find resources that are transgender-inclusive is to ask people in the community who identify as transgender. Talk to several different transgender groups or communities. They may already have a similar list available that you could build on. When you speak with local representatives of the transgender community you can also find out what information people want to know more about.

Acknowledge that you're not going to meet everyone's needs and that this is just a starting point. No one transgender person's experience is the same. Be clear that you're not asking anyone to speak for all transgender people and not assuming that the resources listed are going to be useful to all transgender people. Putting together a resource sheet is simply a way to provide clients with more choices.

Research

Talk with providers you trust as well as clients. Who do they know in town that is transgender-inclusive? You may want to include clinics, physicians, therapists, and other medical providers, as well as community and support groups focusing on transgender issues. Look online to see what information you can find. For instance, some counties list all registered therapists and their specialties. Contact your local mental health association and other professional organizations to find practitioners in your area. **NOTE:** Including therapists in the list is not meant to suggest that all transgender people need therapy, but to aid those who are looking for services. Make sure this is clear when including therapists in the resource list.

Verify

A note about the Harry Benjamin Standards:

The Harry Benjamin Standards (Appendix) were originally written in 1979 to provide doctors and patients guidelines for the process of physically transitioning from one sex to another.

Today there is some controversy over the Harry Benjamin Standards. While they serve a very important role, they strongly adhere to a binary gender system. Some transgender people don't want to switch from "one gender to the other", but instead see transitioning and gender itself as more fluid.

The Health Law Standards for Transsexualism (Appendix) were created as an alternative to the Harry Benjamin Standards.

The resources that you list are a reflection of your agency. Make sure that they're competent and meet a certain standard of experience, knowledge, and friendliness. Call each of the potential referrals to talk about their experience and ask their permission to be included on your resource list.

Here are some suggested questions to ask when talking with a potential provider:

- Please tell me a little bit about your practice.
- Have you worked with transgender clients before?
- What are your thoughts about the Harry Benjamin Standards?
- Would you be interested in being on a resource list for transgender clients?

Providers' answers to these questions are of course important, but *how* they answer them is also important. Do they seem confident and comfortable discussing transgender issues? Are they knowledgeable? Do they sound friendly and interested in the project?

Some offices choose not to participate because they don't want to be known as only a "transgender provider". Be prepared to explore other options such as keeping a separate list of providers that you can refer people to, but not publishing them on the public list.

Feedback

Your resource list can only grow and improve through feedback. Include contact information and encourage clients to share their experiences with you, both positive and negative. Consider creating a transgender advisory group who can provide feedback on a continuing basis. Maintain a flexible approach. The resource list isn't a definitive hard standing document, rather it's an ever changing and fluid resource base that has potential to grow and fit the wants and needs of individuals and communities.

The following is a sample two-page resource list for transgender clients.



Transgender Resources in the Southern Finger Lakes

Organizations and Resource Centers:

Expressing Our Nature

eonsyr@yahoo.com
<http://www.nytga.org/eon/>

EON is a non-profit community service organization for the transgendered community in upstate New York offering advocacy, support, friendship and personal growth for FTMs, MTFs, crossdressers, transsexuals, their friends and families

Iota Nu Tau, Tri-Ess International

PO Box 791
Trumansburg, NY 14821
victoriacctvny@hotmail.com
<http://www.geocities.com/WestHollywood/Village/2295/triess/>

Tri-Ess was established in 1973 for the purpose of support for heterosexual crossdressers and their families.

Cornell Lesbian, Gay, Bisexual and Transgender Resource Center

282 Caldwell Hall
Cornell University
Ithaca, NY 14853
(607)254-4987
lgbtrc@cornell.edu
lgbtrc.cornell.edu

The resource center provides information, advising and counseling, referrals, social events, and educational programs to Cornell students, faculty, and staff; and community members.

Ithaca College Center for LGBT Education, Outreach, & Services

150 J. David Hammond Center
Ithaca, NY 14850
(607)274-7394
lmaurer@ithaca.edu
www.ithaca.edu/lgbt

The Center for LGBT Education, Outreach, & Services actively fosters the academic success and personal growth of LGBT students and offers college wide services to enhance the campus community's awareness, understanding and appreciation of LGBT students, staff and faculty.

Parents and Friends of Lesbians and Gays (PFLAG) Transgender Network

www.youth-guard.org/pflag-tnet

PFLAG Elmira/Corning
(607)535-4053

PFLAG Ithaca
(607)2734796

Southern Tier Gals

Janis, Outreach
PO Box 4114
Ithaca, NY 14852
6072750563
southerntiergals@aol.com

Meetings 2nd Wed of the month, contact Janis for screening and location. This is a closed meeting, with confidentiality and privacy protocols for closeted people's safety. Other public events are open, frequent and fun.

Books available at the PPSFL Resource Center:

As Nature Made Him, John Colapinto
Body Alchemy, Loren Cameron
Gender Outlaw, Kate Bornstein
My Gender Workbook, Kate Bornstein
Physician's Guide to Transgendered Medicine,
Sheila Kirk
Pomosexuals, Queen and Schimmel eds
Read My Lips, Riki Wilchins

S/HE, Mini Bruce Pratt
She's Not There: A Life in Two Genders, Jennifer
Finney Boylan
Stone Butch Blues, Leslie Feinberg
Transforming Families, Mary Boenke
Transgender Warrior, Leslie Feinberg
TransLiberation, Leslie Feinberg
Transmen & FTMs, Jason Cromwell

Counseling:

Kate Halliday, CSW

122 W. Court St.
Ithaca, NY 14850
(607)279-5439
Specializing in EMDR.

David Mordovanec, MSW, CSW

427 N. Tioga Street
Ithaca, NY 14850
(607)273-3520

Linda Roessler, MS, MA, RN, CS

Elmira, NY
(607)734-7225
LRR407@aol.com

Karen Suskin, CSW

309 N. Aurora Street
Ithaca, NY 14850
(607)275-0652

Moonhawk River Stone, M.S.

Connections Psychotherapy Associates
50 Colvin Avenue
Albany, NY 12206
(518)446-1261
HawkRStone@aol.com
Specializing in transgender/gender variant related psychotherapy; consultation, education of transgender issues; provides consultation and supervision for people working with gender variant clients.

Websites:

Bodies Like Ours
www.bodieslikeours.org

FTM Informational Network
www.ftminfo.net

Gender Education and Advocacy Website
www.gender.org

International Foundation for Gender Education (IFGE)
ife@world.std.com
www.ifge.org

Intersex Society of North America
www.isna.org

National Coalition for Transgender Equality (NCTE)
www.nctequality.org

The Network/La Red: Ending Abuse in Lesbian, Bisexual Women's, and Transgender Communities
info@thenetworklared.org
www.thenetworklared.org

Trans*topia
www.youthresource.org

The Transitional Male
www.thetransitionalmale.com

Transsexual Women's Resources
www.annelawrence.com

Transgender is an umbrella term that includes people with many diverse experiences, cultures, identities, and sexual orientations. There is not one right way to be transgender and there are a myriad of terms people may use to describe their gender identity. Not all people want to transition. However, for many transgender people the fear of coming out can be a barrier to health care, including mental health care. The therapists listed here are transgender friendly and are not meant to suggest that all transgender people need therapy, but to aid folks that are looking for these services.

This list of resources was researched and many suggestions came from local transgender community members and allies. However, this does not guarantee a positive experience. Suggestions and feedback are welcomed. For more information please contact the PPSFL Sexuality Education and Training Department Ithaca Office, (607)216-0021.

**Planned Parenthood of the Southern Finger Lakes
Sexuality Education and Training Department
www.sextalk.org sexed@sextalk.org**

Horseheads Office Ithaca Office
301 South Main Street 314 West State Street
Horseheads, NY 14845 Ithaca, NY 14850
(607)796-0220 (607)216-0021

Staff In-Service – Training for Staff in Your Agency

Conducting an in-service staff training is a great way to get your entire agency on the same page regarding your agency’s commitment to providing transgender-inclusive services. When talking about being transgender-inclusive at a healthcare agency, here are a few key points to be sure to cover:

- **Your agency’s official non-discrimination statements & policies**, if they include gender identity and expression,
- **Definitions** – See the following section for definitions of many words that come up when discussing gender identity,
- **Difference between gender identity & sexual orientation**,
- **Barriers to accessing health care that are specific to transgender clients**,
- **Discussion of potential barriers staff in your agency may face** in providing transgender-inclusive services, and what can be done to remove these barriers,
- **Practical tips for staff in providing inclusive services** – such as asking for a client’s preferred pronoun/name, not assuming gender identity, using pictures/models when explaining medical issues, and so on, and
- **Discussion of follow up work** – Who among staff would like to be involved in a work group to promote transgender-inclusive services in the agency? Would staff like another training on this subject or a related subject? Who on staff is willing and able to serve as a resource person on transgender issues?

You may be providing an in-service training yourself, or you may be bringing in another educator. Whoever is providing the training needs to have a thorough understanding of transgender issues, as well as an ability to facilitate thoughtful discussion and learning among staff. If you would like more specific ideas and suggestions for what to include in a staff training on being transgender-inclusive, please email or call us at SexEd@sextalk.org or 607.216.0021 ext. 134.

Definitions: Gender & Sexuality

As we stated earlier, transgender is an umbrella term that encompasses many possible gender identities. There is not one single way to define transgender, nor many other words that we use frequently in discussing gender, sex and sexuality. As our understanding of gender and sexuality continues to deepen, the definitions of words we use to talk about gender also change. We have provided a list of definitions from the Gay & Lesbian Alliance Against Defamation (GLAAD), as well as a few additional words that commonly come up when discussing gender. Please be aware that the definitions GLAAD and others use may change at anytime. Check GLAAD's website (www.glaad.org) and other online sources regularly to find updated definitions and new uses of words.

Aren't sex and gender the same thing???

Many people use the terms sex and gender interchangeably, but for our purposes we need to understand the difference between them. For an interesting discussion of 'sex' and how it relates to 'gender', visit Wikipedia, a free online encyclopedia at en.wikipedia.org. Type 'sex' into the search field, and read more about this fascinating subject!

General Terminology

Sex

The classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics including: hormones, internal reproductive organs, and genitals.

Gender Identity

One's internal, personal sense of being a man or a woman (or a boy or girl). For transgender people, their birth-assigned sex and their own internal sense of gender identity do not match exactly.

Gender Expression

External manifestation of one's gender identity, usually expressed through "masculine" or "feminine" behavior, clothing, haircut, voice or body characteristics. Typically, transgender people seek to make their gender expression match their gender identity, rather than their birth-assigned sex.

Sexual Orientation

Describes a person's physical, emotional and/or spiritual attraction to another person. Gender identity and sexual orientation are **not** the same. Transgender people may be heterosexual, lesbian, gay, or bisexual. For example a male who becomes a woman – and is attracted to men – would be identified as a heterosexual woman.

Transgender-Specific Terminology

Transgender

An umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. Transgender may include but is not limited to: transsexuals, intersex people, cross-dressers, genderqueer and other gender-variant people. Use the descriptive term (transgender, transsexual, cross-dresser, FTM, MTF, genderqueer, etc) preferred by the transgender person. Transgender people may or may not choose to alter their bodies hormonally and/or surgically.

Transsexual

An older term which originated in the medical and psychological communities. Just as many gay people prefer “gay” to the medical term “homosexual”, many transgender people prefer “transgender” to “transsexual”. However, some transsexual people still prefer to use the medical term to describe themselves. It is best to ask someone which term they prefer.

Transvestite

DEROGATORY – See Cross-Dressing

Transition

Altering one’s birth sex is not a one-step procedure – it is a complex process that takes place over a long period of time. Transition includes some or all of the following cultural, legal and medical adjustments: telling one’s family, friends, and/or co-workers; changing one’s name and/or sex on legal documents; hormone therapy; and/or possibly (though not always) some form of chest and/or genital alteration. Preferred over the term “sex change operation”.

Sex Reassignment Surgery (SRS)

Refers to genital alteration, and is only one small part of transition (see transition above). Not all transgender people choose or can afford to have SRS. Preferred to the term “sex change operation”.

Cross-Dressing

To occasionally wear clothes traditionally associated with people of the other sex. Cross-dressers are usually comfortable with the sex they were assigned at birth and do not wish to change it. (“Cross-dresser” should **not** be used to describe someone who has transitioned to life full-time as the other sex, or who intends to do so in the future.) Cross-dressing is a form of gender expression. It is not necessarily tied to sexual orientation or erotic activity. Most cross-dressers are heterosexual men. Very few women identify as cross-dressers.

Gender Identity-Disorder

A controversial medical/psychiatric diagnosis given to transgender and other

gender-variant people. Because it labels people as “disordered”, Gender Identity Disorder is often considered offensive. The diagnosis is frequently given to children who don’t conform to expected gender norms in terms of dress, play or behavior. Such children are often subjected to intense psychotherapy, behavior modification and/or institutionalization. Replaces the outdated term “gender dysphoria”.

FTM (Female-to-Male)

Someone who has transitioned from female to male and lives full-time as a man.

MTF (Male-to-Female)

Someone who has transitioned from male to female and lives full-time as a woman.

Intersex

Describing a person whose biological sex is ambiguous. There are many genetic, hormonal or anatomical variations which make a person’s sex ambiguous (e.g. Klinefelter Syndrome, Adrenal Hyperplasia). Parents and medical professionals usually assign intersex infants a sex and perform surgical operations to conform the infant’s body to that assignment. This practice has become increasingly controversial as intersex adults are speaking out against the practice, accusing doctors of genital mutilation. Replaces the outdated term “hermaphrodite”.

Yellow Flag Language (some people choose to use this language, while some people regard it as offensive)

Queer

Blurs both gender and sexual orientation and is regarded by some as more inclusive than the terms gay or lesbian, because it encompasses both sexual orientation and gender identity. Some people also regard the word queer as offensive and derogatory because of its history of being used as a slur.

Genderqueer

A term often used by people whose gender identity is fluid and does not neatly fit into ‘man’ or ‘woman’, or by people who reject our society’s binary gender system. People who identify as genderqueer typically do not identify as a man or a woman, because neither gender accurately describes them.

Tranny; Trannie

Slang; some transgender people choose to refer to themselves as a tranny or trannie. Some transgender people find these terms offensive and dehumanizing. Your best bet is to refer to people as they refer to themselves, or use the widely accepted term transgender, unless someone asks you to use another term.

Transgender Terminology to Avoid

Problematic: “transgendered”

Preferred: “transgender”

The word transgender never needs the extraneous ‘ed’ at the end of the word.

Problematic: “sex change”, “pre-operative”, “post-operative”

Preferred: “transition”

Referring to a sex change operation, or using terms such as pre- or post-operative inaccurately suggests that one must have surgery in order to truly change one’s sex. The term “transition” is more universal and encompasses many other steps that transgender people may take to change their sex.

Problematic: “hermaphrodite”

Preferred: “intersex person”

The word “hermaphrodite” is a stigmatizing and misleading word, usually used to sensationalize intersex people. “Intersex” is a more accurate and less incendiary term.

Defamatory: “deceptive”, “fooling”, “pretending”, “posing” or “masquerading”

Gender identity is an integral part of a person’s identity. Please do not characterize transgender people in this way, such descriptions are extremely insulting.

Defamatory: “she-male”, “he-she”

These words only serve to dehumanize transgender people and should not be used.

Putting It All Together

Making your agency's services more transgender inclusive is part of a larger effort your agency makes to improve services to all marginalized and underserved groups. Compared to the severity of public health concerns that face the greater transgender community, actions such as making bathrooms unisex or asking for 'preferred name' on forms could start to seem somewhat trivial. They are not.

Successfully promoting public health at community and national levels is deeply linked to and dependant on providing inclusive services at the individual level. Making your agency a supportive and inclusive environment is invaluable for each of your clients, including your transgender clients. Your health center may be one of the few public spaces transgender individuals visit where their gender identity is acknowledged, respected and even understood.

Educating staff about transgender issues will certainly help your agency provide more inclusive services to transgender clients. More globally, it will help to broaden the pool of health care professionals in your community and in our field who are sensitive to transgender issues. These small, tractable steps are parts of a larger movement, and they are essential.

As health care providers, educators and advocates, we want to serve all people in our communities with care and respect. We can do this by allowing people to be who they are, and providing them with a supportive, inclusive and non-judgemental array of services. Part of valuing sexuality as a lifelong aspect of being human is acknowledging and respecting the diversity of individual sexualities, including individual gender identities. As our society becomes increasingly aware of the challenges transgender individuals face in seeking healthcare and education, we will be working to serve their emerging needs.

Appendix:

The Harry Benjamin Standards of Care for Gender Identity Disorders and the Health Law Standards of Care for Transsexualism

The major purpose of the **Harry Benjamin Standards of Care (SOC)** is to articulate this international organization's professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders. Professionals may use this document to understand the parameters within which they may offer assistance to those with these conditions. Persons with gender identity disorders, their families, and social institutions may use the SOC to understand the current thinking of professionals. All readers should be aware of the limitations of knowledge in this area and of the hope that some of the clinical uncertainties will be resolved in the future through scientific investigation.

Read the Harry Benjamin Standards of Care in full at <http://www.hbigda.org/soc.htm>.

The **Health Law Standards of Care** were developed in the wake of widespread dissatisfaction by many in the transgender community with the Harry Benjamin Standards of Care. Also relevant is the pending de-listing of transsexualism per se as a mental disorder from the DSM-IV. Many, if not most, of the patients doctors see for transgender medical services (hormones or sex reassignment surgery) do not require any psychological services.

Read the Health Law Standards of Care in full at http://www.transgencare.com/guidance/resources/ictlep_soc.htm.

PROVIDING TRANSGENDER-INCLUSIVE
HEALTH SERVICES

Some words defined...

Transgender is becoming more understood & talked about. As that happens, definitions change & become more clear. The following are intended as a guide, knowing that they will change over time.

Crossdresser

Someone who sometimes wears clothing not traditionally associated with their gender. A crossdresser can be male or female.



Intersexed

Someone who is born with primary or secondary sex characteristics that do not fit neatly into society's definition of male and female.

Transgender

Someone whose gender identity is different from the one society associates with them. This can include people with fluid gender identities, people who do not wish to change their genital sex but feel it offers an incomplete definition of their gender identity, transsexual people and crossdressers.

Transsexual

Someone who wishes to change their sex, sometimes through sex reassignment surgery or hormones.

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For more information on gender and sexuality issues, to order copies of this pamphlet, or to find out about other resources available from Planned Parenthood of the Southern Finger Lakes write, call or e-mail:

PSSFL Education & Training
314 W. State Street
Ithaca, NY 14850
607.216.0021 ext. 135
SexEd@sextalk.org

What's Up With That: Talking About Transgender was written by Lis Maurer, MS, CFLE for Planned Parenthood of the Southern Finger Lakes.

Want to know more?

Books

- ① *Genderqueer: Voices from Beyond the Sexual Binary*, J. Nestle, R. Wilchins & C. Howell, Alyson Publications, 2002.
- ① *Lessons from the Intersexed*, S. Kessler, Rutgers University Press, 1998.
- ① *My Gender Workbook: How to Become a Real Man, a Real Woman, the Real You, or Something Else Entirely*, K. Bornstein, Routledge, 1998.
- ① *TransForming Families: Real Stories About Transgender Loved Ones*, M. Boenke, Trook Publishing, 1999.
- ① *Transgender Warriors: Making History from Joan of Arc to RuPaul*, L. Feinberg, Beacon Press, 1996.
- ① *Two-Spirit People: Native American Gender Identity, Sexuality, and Spirituality*, S. Jacobs, editor, University of Illinois Press, 1997.
- ① *Vested Interests: Crossdressing and Cultural Anxiety*, M. Garber, Routledge, 1991.

Web Sites, Organizations & Groups

Intersex Society of North America
PO Box 301, Petaluma CA 94953
<http://www.isna.org>

The American Boyz
<http://www.amboyz.org>

International Foundation for Gender Education
P.O.Box 540229, Waltham, MA 02454-0229
(781) 899-2212
<http://www.ifge.org>



 **Planned Parenthood**
of the Southern Finger Lakes, Inc.

**What's Up
With That?
Talking About
Transgender**

What is transgender?

Transgender describes a person whose internal sense of gender doesn't match the gender identity that society expects of them based on their genitals.

Transgender is also used as a general term to describe the many different gender identities that exist, like: transsexuals, & people who feel conflict or fluidity between internal gender identity and physical sex. Other words like: drag king, drag queen, crossdresser, genderqueer, shapeshifter, bigendered, & androgyne are also used by some people to define themselves.

Isn't transgender just like being gay?

No. Transgender describes a person's internal sense of their own gender identity & sexual orientation describes a person's attraction to other people.

Transgender people have many issues in common with lesbian, gay & bisexual communities like: coming out, access to non-judgmental health care, self-esteem, & violence, to name a few.

But, gender identity is not the same as sexual orientation.

Where can I find out more about transgender?

You can learn more about transgender by checking out the resources listed on the back of this pamphlet. Some lesbian, gay & bisexual centers or groups may also have useful information for people dealing with transgender issues.

How will I know when I meet a transgender person?

You won't know until someone decides to tell you! There isn't a formula or test to determine gender identity. A person's sexual experiences don't define their gender identity. Neither does a child's personality, just because a boy likes to play with dolls or a girl likes to climb trees doesn't make them transgender.

Remember, transgender is about a person's inside feelings about their gender identity, not what they wear or what they liked to play with when they were kids.

What can I do if someone comes out to me?

When someone shares personal information with you, it helps to listen first, to hear the person out & see what they may want or need from you before you offer advice or help. If someone does come out to you as transgender & is looking for information you may want to suggest checking out the resources listed on the back of this pamphlet.

It's also important for you to educate yourself! Take advantage of the listed resources to build your understanding of gender diversity & look for opportunities to be an advocate or an ally to transpeople.

“I just never felt like I fit...when I came out as transgender, 9 years after coming out as gay, I finally felt like I made sense”
-Erin, 26

What's transphobia?

Transphobia is the fear of and discrimination against transgender people (and people thought to be transgender, regardless of their actual gender identity). Transphobia can lead to violence and bias that can make coming out as transgender even harder.

Current studies say that more than 80% of transgender people have been physically assaulted based on their actual or perceived gender identity. Some transgender people report losing their job, being ignored by their families & losing friends when they share their gender identity. Transphobia hurts everyone, the transpeople who do not feel like they can share an important part of themselves & anyone who feels restricted by traditional sex role stereotypes.



Transpeople are people too...

Transpeople are people with hopes, dreams, careers, goals, partners, families & children. As society builds an awareness & acceptance of the diversity of gender identities, transgender will become far less confusing & feared. Many societies throughout history have recognized and celebrated gender diversity. With increased understanding & education, this society can be a more inviting & comfortable place to express all the parts of an individual's sense of self.

More Information & Resources

This packet is produced by:

Planned Parenthood of the Southern Finger Lakes

Sexuality Education & Training Center

607.216.0021 ext. 134

SexEd@sextalk.org

www.sextalk.org

www.ppsfl.org

Books and Reports:

Community Standards of Practice for Provision of Quality Healthcare Services for Gay, Lesbian, Bisexual and Transgender Clients, **GLBT Health Access Project**

Enhancing Cultural Competence: Welcoming the Lesbian, Gay, Bisexual and Transgender Community, **Planned Parenthood Federation of America**

Healthcare Without Shame, **Charles Mosher**

Overview of U.S. Trans Health Priorities: A Report by the Limiting Disparities Working Group, **National Coalition for LGBT Health**

Physician's Guide to Transgender Medicine, **Sheila Kirk**

Transgender Care, **Gianna Isreal and Donald Tarver**

Websites and Organizations:

Gay, Lesbian, Bisexual & Transgender Health Access Project

www.glbthealth.org

Gay & Lesbian Alliance Against Defamation (GLAAD)

www.glaad.org/media/guide/index.php

Gender Education and Advocacy (GEA)

www.gender.org

Gender Public Advocacy Coalition (GPAC)

www.gpac.org

Harry Benjamin International Gender Dysphoria Association

www.hbigda.org

International Foundation for Gender Education

www.ifge.org

The American Boyz

www.amboyz.org

The National Coalition for LGBT Health

www.lgbthealth.net

Trans-Health.com

www.trans-health.com

TransGenderCare (medical practice website)

www.transgendercare.com

PROVIDING TRANSGENDER-INCLUSIVE
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Sexuality Education & Training Center
314 West State Street, Ithaca, NY 14850
Phone 607.216.0021 • Fax 607.216.0023

www.ppsfl.org
www.sextalk.org
SexEd@sextalk.org

EXECUTIVE SUMMARY

I Do, But I Can't: The Impact of Marriage Denial on the Mental Health and Sexual Citizenship of Lesbians and Gay Men in the United States

Gilbert Herdt, Ph.D.
San Francisco State University

Robert Kertzner, M.D.
Columbia University

This document summarizes “I Do, But I Can’t: The Impact of Marriage Denial on the Mental Health and Sexual Citizenship of Lesbians and Gay Men in the United States,” a pivotal study that will be published in March in *Sexuality Research and Social Policy: Journal of NSRC*.

Marriage is a fundamental institution in American culture that rewards participants with social advantages in multiple forms. Unlike mixed-sex couples in the United States, same-sex couples are denied the tangible and intangible benefits of marriage, a deprivation that restricts their citizenship and hinders their mental health and well-being.

A momentous debate now surrounds the extension of marriage rights to lesbians and gay men. Should that debate be framed solely in human rights terms, or should scientific evidence from psychological and mental health studies also support such advocacy? Conclusive scientific evidence compels us to highlight the psychological and social harm done to gay men and lesbians by denying them access to marriage.

Courts have previously used data regarding mental health and well-being as a long-term test of the impact of discrimination. For example, negative mental health effects were vital to arguments made against education segregation laws.

Policymakers should be concerned about the impact the denial of marriage has upon the mental health and well-being of gay men and lesbians. We argue that this harm calls for immediate rectification of laws and policies to allow same-sex marriage.

Key Findings

This systematic review of research literature analyzes the historical and cultural factors serving to maintain discrimination in marriage. These issues are explored from the dual perspectives of the social sciences and psychiatry/psychology.

Well-being, mental health, and marriage

The correlation between marriage and well-being is robust. Marriage provides a critical context for the realization of individual potential via the social opportunities afforded to adults to fully develop capacities for love, care, and self-transcendence. Typically, marriage leads a couple toward greater social engagement in the community and, concomitantly, to greater rights and duties. In this way, modern marriage, particularly in the United States, grants couples the full privileges of citizenship. Many lesbians and gay men have expressed an interest in being legally married, and the realization of this deep interest is likely to translate into an enhanced sense of well-being. As is true for heterosexuals, however, marriage for same-sex couples will have variable meanings and mental health significance for specific individuals.

According to studies:

- On average, married individuals have better mental health, more emotional support, less psychological distress, and lower rates of psychiatric disorder than the unmarried (see Ross, Mirowsky, & Goldstein, 1990; Umberson & Williams, 1999; and Waite & Gallagher, 2000, for reviews).
- Marriage in Canada and the United States is uniquely associated with benefits that are linked to psychological health, e.g. income tax benefits; inheritance, insurance, and survivorship rights; power to make medical decisions on behalf of a spouse (Rutter & Schwartz, 1996).
- Married individuals report more emotional support and are more likely to have a close confidant than the unmarried (Gerstel, Riessman, & Rosenfield, 1985; Ross & Mirowsky, 1989; Turner & Marino, 1994; Umberson, Chen, House, Hopkins, & Slaten, 1996). The effects of emotional support seem to provide protection against the negative health consequences of stress (Thoits, 1995).

Marriage, heterosexuality, and sexual citizenship

Historically, Americans seemed to regard marriage as a “God-given but also a civilized practice, a natural right that stemmed from a subterranean basis in natural law” (Cott, 2002, p. 9). Because marriage was widely perceived to be natural, it was difficult to amend. Public preservation of marriage became associated with private life and more broadly with the requirement of heterosexuality for citizenship. In its denial of marriage for same-sex couples, “Civil society can be conceptualized as a heterosexual construction that serves to make entry into the public realm ... very difficult for those whose sexual lives are judged ‘immoral’” (Hubbard, p. 55). Immorality in this rhetoric is a proxy for an older idea that homosexuality is mentally abnormal, a disease or a sin. In this view, gay men and lesbians are rendered “partial citizens” (Richardson, 1998).

According to studies:

- Heterosexual networks are subtle but critical mechanisms that support marriage. A case study of a town in rural Oregon (Stein, 2001) revealed how heterosexuals routinely relied on churches, schools, and neighborhood visibility to secure or enhance jobs, access social support such as child care, and form local political alliances. A same-sex couple residing in the same town was shut out of this structure of opportunities.
- Meyer (1996) refers to opportunity structures that permit or prevent individuals from realizing culturally prescribed goals and define legitimate means of achieving these goals. In an earlier formulation of opportunity structure (Merton, 1957), minority group members were seen as disadvantaged in attaining monetary success because of exclusion from common social structures. For lesbians and gay men, marriage denial leads to a similar minority group disjunction between goals and opportunities.

- Mays and Cochran (2001) found that the experience of discrimination among lesbians and gay men had harmful effects on quality of life and increased the chance of having psychological distress.
- Mental health studies were included in the amicus briefs for *Lawrence v. Texas* (2003), which decriminalized private, intimate same-sex sexual relationships between consenting adults.

The psychosocial fitness of lesbians and gay men for marriage

Marriage denial to same-sex couples in the United States has been based in part on assumptions about the immorality and sexual promiscuity of gay men and lesbians. Such cultural stereotyped attitudes have undermined the full sexual citizenship of millions of individuals and have reinforced the claim that the instability of same-sex couples makes lesbians and gay men unfit for marriage. However numerous studies have shown that a significant number of lesbians and gay men form committed long-term relationships and, of these, many raise children. In a recent position statement supporting civil marriage for same-sex couples, the American Psychiatric Association (APA) noted that long-term spousal and family support, which marriage rights would strengthen, enhance physical and mental health at all stages of childhood development. We also note that the fitness for marriage and parenthood of mixed-sex couples is almost never sufficient justification to prevent them from marrying.

According to studies:

- Kurdek (2003) found that there were far more similarities than differences in the psychological attributes and advantages associated with being coupled in same-sex and opposite-sex relationships.
- Peplau (1991) reported that lesbians and gay men in general were no more likely to experience dissatisfaction in their relationships than heterosexuals.
- A study on children raised in same-sex families (Wainright, Russell, & Patterson, 2004) showed that American adolescents with same-sex parents had the same personal and school adjustments as adolescents living with opposite-sex parents.
- In the United Kingdom, (Golombok et al., 2003) a sample of children with lesbian mothers was as well adjusted and had the same gender role behaviors as children of heterosexual parents.

The impact of marriage denial on the mental health of gay and lesbian couples

Studies have noted that the lack of legally recognized marriage contributes to common problems for gay and lesbian couples. Some couples may not value their own relationships as legitimate expressions of commitment and intimate sexual citizenship. For others, lack of recognition of their relationships deprives them of social and family support that could help counteract a sense of social isolation. Such invisibility can perpetuate stigma and shame and undermine a sense of life meaning, morale, and well-being.

“Greenan and Tunnell’s (2003) clinical studies demonstrated how relationship ambiguity can affect same-sex couples. They described a gay couple who had lived together for 25 years in mutual commitment but experienced difficulties in recognizing the legitimacy of their relationship. They had no plans to recognize the twenty-fifth anniversary of their relationship and had not come out to their families, employers, or neighbors, either as gay individuals or as a male couple. In their 25 years together neither partner’s family members had referred to them as a couple. On the

verge of ending their relationship, they sought couples therapy. The therapists believed that their social invisibility as a couple had resulted from lifelong experiences of stigmatization and fear of discrimination and violence and that it underlay this couple's distress."

According to studies:

- Green and Mitchell (2002) observed that some lesbian and gay couples had a sense of *ambiguous commitment* consisting of uncertainty about when relationships started; the extent of mutual obligations; and the recognition of the partnership by family, friends, co-workers.
- Green and Mitchell noted that discrimination and fear of discovery can undermine relationships if the partners do not have internal ways of countering the social stigma of homosexuality.

Marriage denial and human rights

Canada recently passed a marriage equality law and the United Kingdom has adopted legislation recognizing domestic partnerships. How could these two countries, sharing such a long history of economic, legal and political ties with the United States, now diverge so radically from the U.S. position?

History may be part of the explanation. The concept of *sexual rights* remains poorly understood in American values and public discourse (Herdt, 2005). More recently, the current U.S. administration has disregarded scientific research on sexuality and been insensitive to the relevance of human rights to such policies—not only at home but also abroad (Girard, 2004).

While Canada has yet to develop neoconservative economic and social agendas, over the past quarter century, neoconservative and sexual conservative platforms surrounding sexuality and social rights in the United States have become hegemonic (Irvine, 2002). Consequently, strong and organized opposition to human rights arguments policing many arenas exists in the United States today, which is a barrier to the appeal to rights in the arena of marriage equality. This policy lag requires an additional level of analysis of the U.S. moral panic surrounding gay and lesbian marriage (Frank, 2004) before a more rational human rights policy can be built. Sexual conservatives have challenged the fitness of gay men and lesbians to marry, to be parents, and to adopt children. These ideas are based in large measure on an older but persistent discourse that views homosexuality as a sin, disease, or decadent lifestyle.

For more information about this study, contact the National Sexuality Resource Center at 415-437-5121. For press inquiries, contact Geoffrey Knox and Associates at 212-229-0540.

REFERENCES

- Cott, N. F. (2002). *Public vows: A history of marriage and the nation*. Cambridge: Harvard University Press.
- Frank, T. (2004). *What's the matter with Kansas?* New York: Metropolitan Books.
- Gerstel, N., Riessman, C. K., & Rosenfield, S. (1985). Explaining the symptomatology of separated and divorced women and men: The role of material conditions and social support. *Social Forces*, 64, 84-101.
- Girard, F. (2004). Global implications of US domestic and international policy on Sexuality. *IWGSSP Working Paper No. 1*. New York: Columbia University.
- Golombok, S., Perry, B., Burston, A., Murray, C., Mooney-Somers, J., Stevens, M., et al. (2003). Children with lesbian parents: A community study. *Developmental Psychology*, 39, 20-33.

- Green, R. J., & Mitchell, V. (2002). Gay and lesbian couples in therapy: Homophobia, relational ambiguity, and social support. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd Ed.) (pp. 546-568). New York: Guilford Press.
- Greenan, D. E., & Tunnell, G. (2003). *Couple therapy with gay men*. New York: Guilford Press
- Herdt, G. (2005). *What is sexual literacy? And why is it so needed now?* Retrieved December 10, 2005, from http://nsrc.sfsu.edu/HTMLArticle.cfm?Article=396&PageID=142&SID=56B46F56B2F48602520109700620A46D&DSN=nsrc_rev2
- Hubbard, P. (2001). Sex zones: Intimacy, citizenship, and public space. *Sexualities*, 4, 51-71.
- Irvine, J. (2002). *Talk about sex: The battles over sex education in the United States*. Berkeley: University of California Press.
- Kurdek, L. A. (2003). Differences between gay and lesbian cohabiting couples. *Journal of Social and Personal Relationships*, 20(4), 41-436
- Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*, 91, 1869.
- Merton, R. K. (1957). *Social theory and social structure*. New York, Free Press.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 36, 38-56.
- Peplau, A. L. (1991). Lesbian and gay relationships. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 177-196). Newbury Park, CA: Sage Publications.
- Richardson, D. (1998). Sexuality and citizenship. *Sociology*, 32(1), 83-100.
- Ross, C. E., & Mirowsky, J. (1989). Explaining the social patterns of depression: control and problem solving or support and talking. *Journal of Health and Social Behavior*, 30, 206-219.
- Ross, C. E., Mirowsky, J., & Goldstein, K. (1990). The impact of family on health: the decade in review. *Journal of Marriage and the Family*, 52, 1059-1078.
- Rutter, V., & Schwartz, P. (1996). Same-sex couples: courtship, commitment, context. In A. E. Auhagen & M. von Salisch (Eds.), *The diversity of human relationships* (pp. 197-226). New York: Cambridge University Press.
- Stein, A. (2001). *The stranger next door: The story of a small community's battles over sex, faith, and civil rights*. Boston: Beacon.
- Thoits, P. A. (1995). Stress, coping, and social support processes: Where are we? What next? *Journal of Health and Social Behavior* [Extra issue], 53-79.
- Turner, R. J., & Marino, F. (1994). Social support and social structure: A descriptive epidemiology. *Journal of Health and Social Behavior*, 35, 193-212.
- Umberson, D., & Williams, K. (1999). Family status and mental health. In C. Aneshensel & J. Phelan (Eds.), *Handbook of the sociology of mental health* (pp. 225-253). New York: Kluwer Academic/Plenum.
- Umberson, D., Chen, M. D., House, J. S., Hopkins, K., & Slaten, E. (1996). The effect of social relationships on psychological well-being: Are men and women really so different? *American Sociological Review*, 61, 837-857.
- Wainright, J., Russell, S., & Patterson, C. (2004). Psychosocial adjustment, school outcomes and romantic relationships of adolescents with same-sex parents. *Child Development*, 75, 1886-1898.
- Waite, L. J., & Gallagher, M. (2000). *The case for marriage: Why married people are happier, healthier, and better off financially*. New York: Doubleday.

Public Schools and Sexual Orientation

A First Amendment framework for finding common ground

The process for dialogue recommended in this guide has been endorsed by:

**American Association of School Administrators
Association for Supervision and Curriculum Development (ASCD)
BridgeBuilders
Christian Educators Association International
First Amendment Center
Gay, Lesbian and Straight Education Network (GLSEN)**

The drafting of this publication was facilitated by the First Amendment Center (www.firstamendmentcenter.org) and BridgeBuilders (www.bridge-builders.org), which provide mediation services to help schools and communities find common ground on the issues addressed in this guide.

Public Schools and Sexual Orientation

A First Amendment framework for finding common ground

In recent years, many public schools have increasingly become a front line in the escalating debates over homosexuality in American society. Conflicts over issues involving sexual orientation in the curriculum, student clubs, speech codes and other areas of school life increasingly divide communities, spark bitter lawsuits, and undermine the educational mission of schools.

These fights are unfortunate, but hardly surprising. Since the earliest days of the common school movement, Americans have viewed the schoolhouse as a microcosm of the public square, an arena where we debate and define who we are as a people. But when these disputes degenerate into personal attacks, ridicule, false characterizations of opposing positions, and similar tactics, they tear communities apart and alienate large numbers of citizens from their local schools. If we cannot find ways to negotiate our differences in public schools with more civility and respect, then schools – and the nation – face a difficult future.

The advice in this guide is built on the conviction that we urgently need to reaffirm our shared commitment, as American citizens, to guiding principles of the First Amendment to the U.S. Constitution. The rights and responsibilities of the First Amendment provide the civic framework within which we are able to debate our differences, to understand one another, and to forge public policies that serve the common good in public education.

What divides us

Few issues expose our national divide more starkly than the conflict over how to deal with sexual orientation in public schools. Advocacy groups on both sides are working hard to promote their perspective in the schools – or at least to prevent the other side from promoting theirs.

On one side, many argue that public schools should not deal with homosexuality at all, believing that such discussions should be left entirely to parents. Citing moral and religious convictions, they believe that any state effort to normalize society's perception of same-sex relationships is harmful to family life and a violation of the deeply held beliefs of many Americans. In their view, public schools should uphold a view of family that affirms sexual abstinence until marriage between one man and one woman.

On the other side, many argue that such convictions about homosexuality are primarily a private and religious matter that should not be used as a basis for public school policy. In their view, families with same-sex parents must be included in the school's definition of family. They point out that harassment based on actual or perceived sexual orientation is a pervasive

problem in public schools that adversely affects the academic performance of students who experience it – and sometimes leads to violence and even suicide. They contend that the issue for schools is sexual orientation and identity, not sexual behavior. And they advocate school policies and practices that require school officials to deal with discrimination against gay and lesbian students.

These differences are deep – and difficult to negotiate. Current efforts to legalize or ban same-sex unions in the courts, in legislatures and on ballot initiatives have only exacerbated the debate in schools and raised the stakes for public school officials. Every act by one side is seen as a hostile move by the other. A “Day of Silence” to promote awareness of discrimination against gays and lesbians is now followed by a “Day of Truth” to promote conservative religious views of homosexuality. A T-shirt proclaiming “Straight Pride” is worn to counter one professing “Gay Pride.”

Even finding the right terminology to discuss these differences that neither side will see as problematic can prove extremely difficult. One student's call for toleration is perceived by another student as a challenge to deeply held convictions. And one student's religious convictions are perceived by another student as hostility toward gays and lesbians. One parent is concerned that the school's definition of family might exclude his family, while another parent worries that a definition inclusive of same-sex parents will undermine what her children are taught at home and at church.

Even the most well-intentioned efforts by school officials to address these differences can easily trigger angry protests from one side or the other.

The role of public schools

In light of these passionate differences, it is important to reaffirm that public schools belong to all Americans. The role of school officials, therefore, is to be fair, honest brokers of a dialogue that involves all stakeholders and seeks the common good. Policy decisions about issues concerning sexual orientation should be made only after appropriate involvement of those affected by the decision and with due consideration for the rights of those holding dissenting views. Under the First Amendment, all sides have the right to express their points of view.

School officials struggle to reconcile deeply conflicting community views and legal imperatives on these issues. Sometimes difficult choices must be made, and sometimes there is no option that will satisfy all parties. In some cases, however, school officials mistakenly assume that they must choose sides in

the debate over homosexuality – and that schools will promote the side they choose. Some are convinced that the only way to address this issue is to insist that one view be imposed on all students and parents. But too often this approach only provokes more conflict and solves nothing.

If schools are going to win the peace, it will not be by choosing a side and coercing others to accept it. When matters of conscience are at stake, this strategy is both unjust and counterproductive. It is possible, however, to find areas of agreement if school officials create a climate of mutual respect and honest dialogue.

It would serve us all to remember that the core mission of public schools is to prepare young people for citizenship in a democratic society. This means, first and foremost, maintaining a school environment that respects the rights of students to free speech and free exercise of religion while simultaneously ensuring that student speech does not degenerate into name-calling, bullying, or attempts to silence other views.

Under the First Amendment, a school is both safe and free when students, parents, educators and all members of the school community commit to addressing their religious and political differences with civility and respect. A safe school is free of bullying and harassment. And a free school is safe for student speech even about issues that divide us.

When Americans disagree deeply about religious or political questions, public schools should try hard to avoid taking sides. School officials should address the controversy fairly and openly by including all of the stakeholders in the effort to develop policies that promote fairness for all and practices that can be widely supported.

First Amendment ground rules

No ideological or religious consensus is possible – or perhaps even desirable – in our diverse society. But a civic agreement across differences is not only possible but absolutely essential for civil dialogue. The place to begin is to agree on the guiding principles of rights, responsibilities and respect that flow from the First Amendment. These “three Rs” provide a shared framework within which Americans are able to negotiate conflicts over public policy in schools:

- **Rights.** Religious liberty and freedom of expression are inalienable rights for all guaranteed by the First Amendment to the U.S. Constitution. The very purpose of the First Amendment is to safeguard individual rights from actions of majorities and governments. Every effort should be made in public schools to protect these rights for all students and parents.
- **Responsibilities.** As American citizens, we have a civic responsibility to respect these rights for others, including those with whom we deeply disagree. Rights are best guarded

and responsibilities best exercised when each person and group guards for all others those rights they wish guarded for themselves.

- **Respect.** Conflict and debate are vital to democracy. Yet if controversies about sexual orientation and schools are to advance the best interests of the disputants and the nation, then how we debate, and not only what we debate, is critical. All parties involved in public schools should agree to debate one another with civility and respect, and should strive to be accurate and fair.*

A principled compact that spells out the rights, responsibilities and respect required by our commitment to the First Amendment creates a common ground that serves the interests of our religious and political diversity. Within these ground rules, all sides come to the table prepared to seek a greater common good.

Finding common ground

In a growing number of school districts, these First Amendment principles provide a civic framework for constructive dialogue and a basis for cooperation across deep differences. Parents and educators on all sides are reaching across the cultural divide and finding ways to work with people who see the world very differently from themselves. How is this possible? Although individual districts use a variety of strategies, successful school and community leaders adopt the following principles and practices:

1. **Create a “common ground task force,” appointed by the school board and consisting of representatives with a wide range of community views.** Such a task force can help to advise the district on a range of issues involving sexual orientation such as how to create safe schools, develop balanced curricula, and protect appropriate student expression. By building relationships among people with opposing views, the task force builds trust and mutual respect that can translate into shared agreements on school policy and practice.
2. **Agree on the civic ground rules and understand current law.** A good first step is to make the First Amendment principles of rights, responsibilities and respect the ground rules for the discussion. Then, come to a shared understanding of what current laws and regulations in your state and district may say about the issue of sexual orientation in general and in public schools specifically. The laws of each state (which vary widely and change frequently) are both the starting point and framework for addressing sexual orientation in local schools.

* This definition of the First Amendment principles of rights, responsibilities and respect is drawn from the Williamsburg Charter, a reaffirmation of religious liberty drafted by representatives of America’s leading faiths and signed by nearly 200 leaders from every sector of American life in 1988.)

Public schools are required to represent and carry out the laws of the land. Within this civic and legal framework, all sides come to the table understanding the parameters of the discussion and prepared to engage the issues with civility and respect.

3. **Include all stakeholders.** In public schools, there must be room for people who see the issue from a variety of perspectives in an environment that calls for everyone to respect the right of others to hold their views. Democratic citizenship does not require a compromise of our deepest convictions. But at times it will require us to work with others who may hold views we find offensive. It is the civic responsibility of people on all sides to state their views in as respectful a manner as possible. Through constructive dialogue we can often find creative solutions that will treat others the way we want to be treated.
4. **Think outside the box of “us vs. them” politics.** As deeply as we may feel about this issue, we must refrain from using the public schools to impose our views on others. Advocacy groups play an important role in a democracy. But public schools have a very different role. Schools serve the entire community and, in so doing, cultivate a common good that includes us all.
5. **Listen to all sides.** Given the opportunity, the vast majority of parents, students, administrators and school board members will commit to a principled dialogue and will work for

solutions that bring the community together. While it may be true that a small number of people on both sides resist any attempt to find common ground, most people will support a process of deliberation that is open and fair.

6. **Work for agreements on civic principles and safe schools.** It is important to start deliberations where agreement is most likely to be achieved. All parents, for example, want schools to be safe learning environments where no student is harassed or bullied for any reason. And most people will support policies that prohibit the mistreatment of any individual or group and provide appropriate avenues for redress of grievances.
7. **Provide educational opportunities for administrators, teachers, parents and students in the First Amendment principles of rights, responsibilities and respect.** When people understand their constitutional rights and civic duties, they are better prepared to engage in civil dialogue – and work together for a learning environment that is safe and free for all students.

This guide is not an attempt to ignore or minimize differences that are important and abiding, but rather a reaffirmation of what we share as Americans across our differences. First Amendment principles can and do work to advance the best interests of education and the nation, but only when they are understood and applied by citizens committed to advancing a common vision of the common good.

Tips for school officials

1. **Take seriously complaints of name-calling, harassment and discrimination regardless of the reason.** Do not dismiss it as playground teasing or tell the student or staff to “toughen up.” Investigate the complaint and intervene directly when it has merit, making clear that such behavior is unacceptable on the public school campus. The public school environment cannot be a hostile place to study or work.
2. **Assure parents and students that the school district will listen carefully, be fair to all parties, and try hard to avoid choosing sides in the broader national conflict.**
3. **Don't be afraid to talk openly about these issues.** Some districts may seek to avoid controversy by trying to fly under the radar when dealing with this complicated issue. Whether it is students asking to form a gay-straight alliance, a new textbook introduced into the curriculum, or a new video adopted for family-life education, parents don't like surprises. When it finally becomes known, as it always does, parents will lose trust with a district that will not be straightforward with them and will respect the one that is.
4. **To the extent practical, strive to keep your community discussion a local one.** This doesn't mean that outside groups and individuals can't be helpful facilitators or resources, and some perspectives that are important to the discussion may not be well represented in your community. But neighbor-to-neighbor dialogue works best when a local disagreement doesn't become a national controversy.
5. **While your district will have to respond fairly and equitably to the variety of home environments of your students, it does not have to define family in the broader culture to do so.** Family is a term often defined in state law and schools can acknowledge that various groups use it differently.
6. **Be careful that you do not discriminate against student clubs or expression simply because the political or religious message is unpopular or potentially offensive to some.** Educators can and should require that all viewpoints be expressed in a respectful manner, but they may not exclude some views merely because they don't agree with them. To do so constitutes viewpoint discrimination in violation of the First Amendment.

Tips for parents and students

1. **Don't jump to conclusions about your school district based on news reports about the national conflict over these issues.** Local control and varying state laws make it unlikely that any one approach will be implemented universally across the country without regard to the different perspectives in your community. Start by finding out what is happening in your district. Ask questions and seek information rather than making accusations.
2. **If you have concerns about what is happening in your school, start by sharing them with those closest to the problem.** If the issue is with your own school, start with teachers or school administrators. If the concern is districtwide, bring it to the attention of district administrators and your local school board. Civil local discussions that lead to solutions are less costly, less divisive, and more effective than lawsuits or shouting matches in the media.
3. **Realize your district not only has a responsibility to address the needs and wishes of your family, but it must also provide a fair and safe environment for people who view this issue differently than you do.** We all have a vested interest in ensuring that public schools are a safe learning environment for every student and staff member.
4. **Remember the civic duty to respect the First Amendment rights of others, including the rights of those with whom you deeply disagree.**