The Center of Excellence on Racial and Ethnic Minority Young Men Who Have Sex with Men and Other Lesbian, Gay, Bisexual, and Transgender Populations is funded by Substance Abuse and Mental Health Services Administration (SAMHSA) as a supplement to the Pacific Southwest Addiction Technology Transfer Center, in partnership with the National American Indian & Alaska Native ATTC & the Northeast and Caribbean ATTC.

The content expressed herein is the work of the Center of Excellence on Racial and Ethnic Minority Young Men Who Have Sex with Men and Other Lesbian, Gay, Bisexual, and Transgender Populations and does not necessarily reflect the official opinions or positions of the Department of Health and Human Services (DHHS), Substance and Mental Health Services Administration (SAMHSA), or the Center for Substance Abuse Treatment (CSAT).
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“Openness may not completely disarm prejudice, but it’s a good place to start.”

- Jason Collins
Foreword

It is with great pleasure that the staff at the Center of Excellence on Racial and Ethnic Minority Young Men Who Have Sex with Men and Other Lesbian, Gay, Bisexual, and Transgender Populations (YMSM + LGBT CoE) presents the updated curriculum based on the 2001 SAMHSA publication, *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. This second edition of the training includes new statistics and knowledge gained about working with individuals in the LGBT community who have substance use disorders.

The YMSM + LGBT CoE was established through a grant from the Substance Abuse and Mental Health Administration (SAMHSA) as a supplement to the Pacific Southwest Addiction Technology Transfer Center, in partnership with the National American Indian and Alaska Native ATTC and Northeast and Caribbean ATTC. The Center aims to help providers develop the skills to deliver culturally-responsive and evidence-based prevention and treatment services for lesbian, gay, bisexual, and transgender populations dealing with co-occurring substance use disorders. The Center was tasked with revising and updating the training curriculum for *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals*.

The first edition of this curriculum was published in September 2007, and was based on the important content contributed by Dr. Barbara Warren and her colleagues. Staff at the Prairielands ATTC at the University of Iowa transformed this content into a training curriculum for providers working with members of the LGBT community. The curriculum was distributed widely across the country to providers, state administrators, and Single State Agencies (SSAs) for Substance Abuse Services.

Prairielands ATTC disseminated the curriculum over a five year period by developing training-of-trainer (TOT) opportunities and providing technical assistance to organizations and states to develop LGBT-affirming prevention and treatment programing. Through this process, 170 professionals became trainers, disseminating the first edition of the curriculum across the country. This would not have been possible without the support and collaboration of the ATTC Network.

Since *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals* was first published in 2001, there have been large shifts in the LGBT landscape including new research, constitutional rights, and wider cultural acceptance. This revised curriculum focuses on specific LGBT health issues, treatment approaches, and celebrates the victories won by the LGBT community.

The curriculum is meant to be a consensus document, developed by content experts from across the country. Their contributions have been invaluable throughout the entire process. Other versions of the curriculum will include a half-day training curriculum, tailored from this one-day training, and a Spanish translation of the one-day training.

We want to take this opportunity to thank everyone who contributed their time and energy to this project.
A Provider’s Introduction to Substance Abuse Treatment for Lesbians, Gay, Bisexual, and Transgender Individuals.

The purpose of this introductory training is to provide a detailed overview of substance abuse and health related issues among Lesbian, Gay, Bisexual, and Transgender (LGBT) individuals, which is intended to help improve the awareness and response of treatment providers (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) to the needs of LGBT clients.

The curriculum reviews important epidemiological data focused on LGBT substance use trends and HIV prevalence; reviews health related issues and provider considerations to support the move to improve treatment effectiveness; and concludes with evidence-based and promising clinical strategies.

The duration of the 7-module training is approximately 9 hours plus time for registration, breaks, and lunch. The duration of the entire training depends on whether the trainer chooses to present all of the slides, or a selection of slides. Other factors that determine the duration of the training include: duration and frequency of breaks, length of discussion, number of questions and duration of activities.

What Does This Trainer’s Manual Contain?

• Copy of the PowerPoint presentation with Trainer Notes to help the trainer(s) deliver the content effectively.

• The trainer notes contain background information, context, and/or resources that can be presented with each slide. This information in the trainer notes is designed to serve as a guidepost and can be adapted to meet the needs of the local training situation. Information can be added or deleted at the discretion of the trainer(s).

How is This Trainer’s Guide Organized?

On the top of each page are the PowerPoint slides for each module. On the bottom half are the trainer notes.

General Information about Conducting the Training

The training is designed to be conducted in medium-sized groups (20-30 people). It is possible to use these materials with larger groups, but the trainer may have to adapt the small group exercises to ensure that there is adequate time to cover all of the content.
Materials Needed to Conduct the Training

- Computer with PowerPoint software installed (2007 or higher version) and LCD projector to show the PowerPoint training slides.
- Flip chart paper and easel/white board, and markers/pens to write down relevant information.

Overall Trainer Notes

It is critical that, prior to conducting the actual training, the trainer practice using this guide while showing the slide presentation in Slide show Mode in order to be prepared to use the slides in the most effective manner.
Acknowledgments

The 2nd Edition of this curriculum, based on the publication, *A Provider’s Introduction to Treatment of Substance Abuse in Lesbian, Gay, Bisexual and Transgender Individuals*, is a labor of love over many years. I especially want to thank Government Project Officer, the late Suzan Swanton, MSW, who made this project possible, and Dr. Edwin Craft, the Cross-Cutting Lead for LGBT Issues at SAMHSA/CSAT, who provided guidance on the completion of this revision, and to Dr. Andrea Kopstein, who represented CSAT leadership. I also want to thank the staff in the Iowa City office of the Center of Excellence in Minority Y-MSM and other LGBT Populations, under the leadership of Matt Ignacio, MSSW; Lena Thompson, MPH; Adam Lewis, BA; ThankGod Ugwumba, BSc; Kate Thrams, BA; Jenny Gringer Richards, MSW, LMSW; Donna Dorothy, BA; and Jacki Bock. Without their energy and commitment, this project would not have been possible. Finally, a big thank you to all the content specialists that we worked closely with to revise this curriculum.

- Anne Helene Skinstad, PhD

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Module 1: Introduction
Welcome participants to training.
Introduce title and trainer(s) for this training.
Identify YMSM/LGBT CoE as the organization who developed curriculum.

If the entire, full-day training is delivered, the total hours of the curriculum is 9 hours. The suggested start and end times for the training are 8:30am to approximately 4:00pm. That includes 2 breaks and a 30 minute lunch break. There is a sample agenda included in this module.

The duration of the entire training depends on the level of participant questions, comments and discussion. Also, the duration of the training is impacted by slight modifications made to respond to group’s prior knowledge. Additional content can be added to localize and/or augment information. However, the expectation is that these slides will be presented as is, to ensure uniformity across the country.

If the trainer(s) are delivering a half-day training, It is recommended the trainer(s) begin with the Introduction module, ending with the Considerations for Clinical Work module. Select any 2 of the remaining 4 modules for the middle of the training. Selection of the 2 modules will depend on a variety of factors such as: the participants’ training needs, the target populations for the participants and the participants’ prior knowledge and expertise.

A half-day training can be scheduled in a 4 hour timeframe: 30 minutes for Introduction module, approximately 45 minutes for the Lesbian, Gay Men/MSM, Bisexual, and Transgender modules. Trainer(s) might consider including a short break between each module or after the second module.

The purpose of this slide is to provide more information about the YMSM/LGBT CoE.

The Mission of YMSM+LGBT CoE (hereafter, ‘CoE’) is to help providers develop skills to deliver culturally-responsive and evidence based prevention and treatment services for lesbian, gay, bisexual, and transgender populations dealing with co-occurring substance use and mental health disorders. Additionally, the CoE will provide a variety of innovative training and technical assistance resources, including training curricula, webinars, and a website clearinghouse to help providers working with LGBT populations and racial/ethnic minority young men who have sex with men (ages 18-26).

The CoE is funded by SAMHSA as a supplement to the Pacific Southwest Addiction Technology Transfer Center, in partnership with the National American Indian & Alaska Native ATTC & the Northeast and Caribbean ATTC. The views expressed in written materials or publications and by speakers and moderators do not necessarily reflect the official policies of the DHHS; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
This is a sample agenda with the recommended order of the modules.

This agenda will need to be modified to meet the requirements of the specific venue and logistics for the day (e.g., registration time, allowing for a longer lunch, etc). For a full day session, 6 hours of training time is needed.

If the trainer(s) are delivering a half-day training, the sample agenda will need to be edited before the day of the training to include 3-4 hours of training time.

If the trainer(s) are delivering a half-day training, it is recommended the trainer(s) begin with the Introduction module, ending with the Considerations for Clinical Work module. Select any 2 of the remaining 4 modules for the middle of the training. Selection of the 2 modules will depend on a variety of factors such as: the participants’ training needs, the target populations for the participants and the participants’ prior knowledge and expertise.

A half-day training can be scheduled in a 4 hour timeframe: 30 minutes for Introduction module, approximately 60 minutes for each module. Trainer(s) might consider including a short break between each module or after the second module.

The trainer(s) and training participants are dedicating valuable time to create a successful learning opportunity. It is important to establish some group agreements to create a positive, productive and safe learning environment.

The material in this training can be sensitive, personal and emotional. It is important that participants feel respected and safe during the training, and free to ask any questions they may have. A way we can “set the stage” is by collectively establishing group agreements.

This is a short list of common group agreements used in trainings. Trainer(s) might prepare the flip chart paper or dry erase board with the above list before the training so that all the participants are able to see and read them.

Then while trainer(s) are discussing this slide, ask participants to suggest other ideas to create a safe, fun, productive learning environment. You may also add to and refer back to the list as the training moves forward throughout the day.
Here is a sample list of housekeeping or overall training logistics participants may need to be aware of.

By discussing these items at the beginning of the training, participants will be less likely to interrupt the training in the event they need to answer a phone call, use the restroom and handle business outside of the training.

It is highly recommended you prepare a list of lunch options that are close-by the training facility so participants have time to purchase and consume lunch in a timely manner.

Suggestions of lunch options need to include a wide range of costs and cuisine.

ATTC NETWORK: Regional Centers and the Center of Excellence:

- YMSM/LGBT Center of Excellence
- Northwest ATTC
- Pacific Southwest ATTC
- Central Rockies ATTC
- Mid-America ATTC
- South Southwest ATTC
- Great Lakes ATTC
- Southeast ATTC
- Central East ATTC
- Northeast and Caribbean ATTC
- New England ATTC

There are 4 National Focus Area Centers:

- National Frontier and Rural ATTC, Reno, NV
- National American Indian and Alaska Native ATCC, Iowa City, IA
- National Screening and Brief Intervention and Referral to Treatment ATTC, Pittsburgh, PA
- National Hispanic and Latino ATTC, Bayamon, PR
In 2001 the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Substance Abuse Treatment (CSAT) published *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. The demand grew for copies of the publication as treatment providers sought to increase their awareness and respond to the needs of the LGBT clients in their programs.

This publication set the standard for providing effective and culturally relevant substance abuse treatment for LGBT clients and was the most widely used and requested SAMHSA publication for several years. It remains available for download at [store.samhsa.gov/A-Providers-Introduction-to-substance-abuse-treatment-for-lesbian-gay-bisexual-and-transgender-individuals/SmA12-4104](store.samhsa.gov/A-Providers-Introduction-to-substance-abuse-treatment-for-lesbian-gay-bisexual-and-transgender-individuals/SmA12-4104).

Encourage participants to visit the YMSM/LGBT CoE website for more resources including: webinar recordings, research material and upcoming events at: [www.ymsmlgbt.org](www.ymsmlgbt.org)

A recurring theme throughout this entire training is encouraging participants to become familiar with local resources, organizations, groups that address the needs of LGBT community members. In doing so, participants will enhance their own knowledge of LGBT issues in their community. This training provides a framework of emerging issues, health issues and provider considerations. It is then the participant’s responsibility to apply the knowledge and skills gained in this curriculum to the unique needs of their community.
Transgender is an umbrella term for diverse identities. It is important for providers to bear in mind that the evidence presented in this curriculum represents the best data and information available at this time.

This is not an exhaustive list. This training has been developed to reach a wide audience. It might also be helpful to inform participants there is a second curriculum focused specifically on reducing risk of HIV infection among racial/ethnic minority young men who have sex with men (YMSM) coming by October 2017.

Encourage participants to visit YMSM/LGBT CoE’s website for details: www.ymsmlgbt.org

The purpose of this section is to provide participants with terms and concepts that are mentioned throughout the entire training. Many people often have questions about these definitions. These definitions are meant to provide a basic understanding of who the target populations are. We will delve more deeply into the definitions as we discuss each population in the training.

Trainer(s) and participants may find challenges to use one definition to define entire populations. Trainer(s) needs to be mindful these definitions may not reflect different regions, cultures and communities. These are working definitions for this training. Participants may have their own definitions and it is important to validate those definitions and experiences.
Timeframe: 10 minutes
Trainers should make half page sheets with one term (choose from the categories or descriptors above) on each sheet. Trainers are to ask the participants to work in small groups (divided evenly among participants). The trainer will then hold up each half sheet and give the groups one minute to write their own definition of each term. Afterwards, ask each group to share and discuss their definitions. Trainer should allow trainees a few minutes and then generally discuss how to best define each category and descriptors.

In this part of the training session, trainers will dispel misconceptions about LGBT persons through establishing a common understanding of terms and definitions regarding sexual orientation and gender identity, differentiating between the two concepts, and enabling providers to help clients, and themselves, begin to assess sexual orientation and gender identity and treatment issues at intake.

Trainers can explain the need for a common language or a consensus of meaning on definitions and language to understand and more accurately describe who is discussed in this training series. It is still common for many people who are not familiar with LGBT identities, cultures, and lifestyles to be confused about the differences and similarities among these groups. Misunderstandings about language and terms of identity also may be the basis for inappropriate assessment or bias.

Trainer should remind trainees that clients often have questions regarding these definitions, and also emphasize that these definition are meant to provide a basic understanding of whom/what our clients identify as. On the following 7 slides are the definitions and can be reviewed in comparison.

---

Read the text on the slide and proceed to the next slide.
Sex assigned at birth involves classifying people as male or female.
Read the text on the slide and proceed to the next slide.
Additional Resource:

An alternative definition of sexual orientation is a consistent pattern of sexual desire for individuals of the same sex, other sex, or both sexes, regardless of whether this pattern is manifested in sexual behavior. Indicators of sexual orientation can include sexual and romantic desire, attraction, arousal and fantasy. (Diamond, 2008; Savin-Williams & Vrangalova, 2013)

Read the text on the slide and proceed to the next slide.
Key Terms and Concepts:

Coming Out:
- To disclose one’s sexual identity or gender identity.
  (Johns Hopkins, 2013)

Heterosexism:
- The assumption all people are or should be heterosexual. Assumption that heterosexuality is inherently normal and superior to LGBTQ people's lives and relationships.
  (Johns Hopkins, 2013)

Bisexual:
- An individual who is emotionally, romantically, sexually, affectionately, or relationally attracted to both men and women (or to people of any gender identity).
  (Johns Hopkins, 2013)

Klein Scale:
- The Klein Sexual Orientation Grid attempts to measure sexual orientation by exploring an individual’s sexual attraction, sexual behavior, sexual fantasies, emotional preferences, social preferences, lifestyle preferences and self-identification at a given time.
  (Klein, et al., 1988)

Kinsey Scale:
- The Kinsey scale attempts to describe a person’s sexual history or episodes of their sexual activity at a given time. The scale ranks sexual behavior from 0 to 6, with 0 being completely heterosexual and 6 completely homosexual.
  (Kinsey, et al., 1948)
It is important to highlight everyone (including non-trans clients) has a gender identity, gender expression, sex assigned at birth and a sexual orientation.

The trainer(s) can use themselves or a hypothetical client as an example. “Brian” was born with male sexual reproductive organs at birth, and was assigned “male” at birth. Since he was an adolescent, “Brian” has identified as “male” and expresses his gender as a “male” (e.g. plays sports, wears ‘male’ clothing, plays with other ‘males’) and since adolescence, “Brian” identifies as “heterosexual.” Therefore he has all four core concepts of identity, expression, sex assignment and sexual orientation.

Sex assigned at birth: A combination of biological markers (chromosomes and hormones) and anatomic characteristics (reproductive organs and genitalia). Impacted by legal, policy, cultural and social issues.

Gender expression: how one externally manifests their gender identity through behavior, mannerisms, speech patterns, dress, and hairstyles.

Gender identity: A person’s internal sense of their own gender. (Keatley, Deutsch, Sevelius & Gutierrez-Mock, 2015)

Sexual orientation: distinct from gender identity and expression. Describes a combination of attraction, behavior and identity for sexual and/or romantic partners. (Keatley, Deutsch, Sevelius & Gutierrez-Mock, 2015)
Before the training, trainer should move the Xs on the above chart so that they describe their own definitions on each of the 4 terms.

To understand the interrelationship of these terms, it is best to think of each of them as a continuum with female on one end and male on the other.

For Sex Assigned at Birth for instance, the child will generally be assigned “female” or “male” depending upon external sex characteristics observed at birth. Some children may be identified as intersex due to difference in development.

For Gender Identity, we ask a client where they fall on the continuum between male and female in terms of their internal identity. Clients may fall on one end or may identify as genderqueer or somewhere in the middle.

Gender Expression or Gender Role relates to how one externally manifests their gender identity through behavior, mannerisms, speech patterns, dress, and hairstyles.

And Sexual Orientation describes a combination of attraction, behavior and identity for sexual and/or romantic partners. It is based on the gender identity of the individual and the gender identity of those that they are romantically affectionately, and/or sexually attracted to. Someone may be exclusively attracted to males, females, or both, along the continuum.

After defining each of the continua, advancing the slides will animate in each X, one at a time. Advancing one final time, will cause the Xs to disappear and then the Trainer can describe their identity and then give a couple of examples of other identities (e.g., a person with a different gender identity, a person with a different sexual orientation).

The problem with these continua is that they are still based on binary understanding of gender and sexual orientation. Some people do not use these concepts to define themselves. The may define themselves as “Queer,” “Non conforming,” or “not defined.” Therefore a client may describe their sexual orientation as “queer” or “not defined.” They may describe their gender as “gender queer” or “gender nonconforming” or may use a variety of other terms to state the they see themselves as outside of the Male Female binaries. These continua and definitions are provided to help the provider understand the vast diversity of presentations. Providers should use the terms used by the clients.
Acknowledgements
Our team of 17 content experts have provided guidance, content and feedback in the development of this revision.

Content experts include national representation and offer expertise in a variety of areas.

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Module 2: Addressing Issues of Cultural Diversity
Welcome participants to module.
Introduce title and trainer(s) for this module.
Identify YMSM/LGBT CoE as the organization who developed curriculum.

It might be helpful to mention the duration of the module, which is approximately 60 minutes in length. The duration of this module depends on the group’s level of participation with any activities, questions, comments and discussion. Also, the duration of the module is impacted by the number of slides presented. Trainer(s) might opt to omit slides/sections due to time constraints, prioritization of content or redundancy of information based on group’s prior knowledge.

If necessary, remind participants of housekeeping details such as, the location of restrooms and silencing cell phones, etc...

These SMART (specific, measureable, attainable, realistic and time-bound) learning objectives provide the participant with key ideas or themes that will be covered in this module.

Cultural humility is the lifelong process of learning, self-examination & refinement of one’s own awareness, knowledge, behavior and attitudes on the interplay of power, privilege and social contexts. Cultural humility is a more accurate representation of the process of constant reflection and change that takes place when learning about ever-changing cultures. Cultural competency suggests that there is a finite body of knowledge that one can gain.

Concepts that contribute to self-awareness include cultural knowledge, cultural skills, and an open attitude.

Examples of two strategies providers can use to enhance culturally sensitive interactions include 1) supporting & encouraging positive images of persons of color, YMSMs, LGBT, gender variant/non conforming, elderly, other abled individuals (perhaps posters that show people of color or people who are from the LGBT community) and; 2) acknowledging clients’ significant others and encourage their participation/support.
This section provides working definitions for culture and why it is important to address culture when working with racial and ethnic minority YMSM and LGBT populations.

The purpose of this slide is to give a working definition for “culture.”

The trainer will facilitate a large group discussion and start by asking the participants to share their definition of culture. Then the trainer will show this slide and ask for reactions, comments. The trainer will make the following key points:

Culture is a structure and it is broad. It could be as broad as “Western civilization” and it can also be as specific as what your parents taught you in your house, such as “always look good when you go out”.

Cultures decide who has and does not have power. Some behaviors are rewarded with power and others are not. In some cultures, men engaging in sexual behaviors only with the opposite sex is rewarded, affirmed and publically sanctioned. Same sex behavior is discouraged and may result in public shaming and/or threats of violence.

Each individual’s experience of culture is unique.

Read some of the terms on the slide and ask for examples.

Culture is dynamic and has a lot of moving parts and influences. It includes but is not limited knowledge and beliefs, values, morals and customs, language, behaviors and practices.
Timeframe: 10 minutes
Trainer divide participants into small groups and ask them to list challenges that their organizations face when engaging diverse communities. As you continue through this module, go back to some of these examples and discuss as a large group how to address these challenges.
Examples of challenges that some organizations may face include: inability to recruit people from diverse communities, language barriers, finding providers who can relate to diverse populations.

Dynamics of culture describes what guides and shapes human behavior. They exist in different forms and could involve the following:

- Customary patterns of everyday life that specify what is socially correct and proper
- Customary patterns; repetitive or typical habits and patterns expected behavior followed within a group of community
- Unconsciously set in operation; like instinctive ways of thinking

Although cultural patterns can be used to understand groups of people, a pattern is not an individual. Our work is to seek to understand the individual and their culture(s).
One key element of culture is language. Still, people who speak the same language, English for example, does not mean that they have the same culture. English is spoken differently in India, Australia, Nigeria, and Belize. People who have the same ethnicity do not always speak the same language. Families who immigrated to the United States generations earlier may identify with the culture of their country of origin, but may not speak the language.

There are other aspects of communication, both verbal and non-verbal, that are unique to different cultural groups. There are varying levels of eye contact, physical distance, and physical contact that is acceptable in different cultures. It is not fair to assume that a client from another culture is aggressive just because that person sits/stands close to you and it is not fair to assume that a client is not engaged if that client does not make eye contact while talking. Remember that in many ways, we are products of the cultures in which we live.

(SAMHSA, 2014)

The following examples are broad descriptions of some expectations people from other cultures may have:

- Individuals from White/European culture may be uncomfortable with long silences. They may feel like nothing is being accomplished.
- Latinos often value personalismo, which is a warm and genuine form of communication.
- Some cultures are more comfortable with confrontation. Latino and Native American culture values cooperation and agreeableness.

(Comas-Diaz, 2012)

http://store.samhsa.gov/shin/content//SMA14-4849/SMA14-4849.pdf

Comas-Diaz, 2012

Each culture has unique qualities and expectations. The trainer can read through this list and consider with the group how this might apply to particular cultures. Use LGBT culture, if possible, as an example.

For example, members of the LGBT community may be more likely to have chosen family instead of blood-related family due to lack of acceptance (Dolliver, 2010). There is a long history of abuse and trauma for members of the LGBT population, but changes have been made throughout the years moving towards acceptance. Some people from the LGBT community may feel that certain religions have not been accepting of them.
The purpose of this section is to discuss the terms “cultural competency” and “cultural humility”. Participants will also learn the terms “cultural sensitivity” and “cultural proficiency.”

The purpose of this slide is to give a working definition of the term “cultural humility”. Trainer should emphasize that cultural humility is a lifelong process that requires self-examination, critique, and refinement. A person who is culturally humble recognizes that they will always be changing and so will culture.

Cultural Humility developed out of the nursing profession, as a way to eliminate the power dynamics between patient and provider.

When we use cultural humility as an approach to effectively engage individuals, we recognize that we have an opportunity to provide services and that we need the client to teach us about their lives, culture, and community.

Tenants of Cultural Humility:

- A lifelong commitment to self-evaluation and critique.
- Understanding life is a learning process.
- Redress (make right) the power imbalances in the provider-client dynamic.
- Develop mutually beneficial, non-paternalistic partnerships with communities on behalf of individuals and defined populations.
- Providers remain open to learning.
- Understanding and accept we can never be truly “competent” in another’s culture.
- Challenge yourself in identifying your own values as not the “norm.”

(Tervalon & Murray-Garcia, 1998)
A term that might be commonly used is “cultural competency”. The word “competent” indicates mastery of a concept or that there is a finite body of knowledge that one can learn. You can’t complete one training, or 50 trainings, and receive a “culturally competent” stamp of approval. This term is considered by many to be outdated.

“Cultural competence” has been historically used to describe the process of learning about different cultures and showing sensitivity towards them. In 1989, it was described as “a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum” (Cross et al., 1989)

Practicing cultural humility is critical to the engagement and retention of LGBT individuals. By addressing individual and societal history (experiences of murder, violence, rejection, degradation, and discrimination), we can help clients resolve traumatic and violating past experiences.

You may also hear the term “cultural proficiency.” From a cultural humility perspective we will never be “culturally competent”; what we strive for is “cultural proficiency”. This is a practice stance and set of behaviors that we choose to use that make it possible for us to engage and work with people that are different than us in obvious and unseen ways.

Another term sometimes used is “cultural sensitivity,” which is an awareness of different cultures and values that exist

Read the text on the slide and proceed to the next slide.
Although they may be called “cultural competency” trainings, many trainings focus on the skills and processes of “cultural humility”.

Cultural humility comes from stepping away from the comfort zone/role of expert and acknowledging when we might not know what else to do. Becoming a student of the patient means learning about who patients are, including their beliefs, expectations, and values, and what “quality of life” would look like to them. By asking questions and listening carefully, we may tap into the patient’s potential to be a capable and full partner in the therapeutic alliance.

Cultural humility is also an important step in helping to “redress the imbalance of power inherent in physician-patient relationships”. Approaching each encounter with the knowledge that one’s own perspective is full of assumptions and prejudices can help one to keep an open mind and remain respectful of the person seeking care.

These are skills that we use to form trusting relationships.
The trainer will use this slide to reinforce the concept that actions don’t always match values & beliefs because of conditioning and blind spots and that self-awareness and subsequent actions are required to move toward congruent cultural proficiency.
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These skills will help the client feel more comfortable and could help clients who have experienced trauma due to phobias or lack of acceptance in the healing process.

The trainer shares this key concept and reinforces the life long “journey” that does not have a destination other than understanding and continued learning.
The purpose of this section is to highlight the importance of clarifying one’s own values before working with individuals with other values and cultures. Participants are given an opportunity to consider their own values.

Timeframe: 10 minutes

Group Exercise: Labeling Exercise
Trainer should break up participants into small groups and ask them to discuss the following questions.

Examples of negative labels can include:
- Indecisive
- Confused
- It’s a Phase
- Never happy in a monogamous relationship
- Promiscuous
- Bisexual is non-existent
- Greedy
- Transition
- Unnatural
- Unfaithful
- Attention Seekers
- Deviants
- Experimenting

Examples of impact on health:
- This can cause feeling of marginalization and stigmatization which leads to higher substance use, depression, suicide and risky sexual behavior
- Reduced social support
- Increased stress
- Mistrust of providers and the healthcare system thus limiting ones ability to access high quality care
- Develop an intense fear of coming out and being true to themselves
- Develop practice of self-stigmatization
- Delay seeking necessary health care

Segue from this discussion into the process of coming out as being able to accept and then share an identity, in this case being LGBT, as a positive and empowering experience, not as a label.
The purpose of this slide is to give a working definition of “values clarification” and what may happen when we clarify our values.

Your values are your ideas about what is most important in your life. It is important to consider your values and how they affect your actions and decisions as a provider. Everyone has a unique set of values determined internally and by their large culture and the smaller social groups through which they move.

After spending time clarifying our own values, we can use them to serve a wide range of people and communities.

It might seem overwhelming to understand an individual who has a different set of values or a different culture from our own. We need to be aware that each person has a different set of values that come from that person’s unique experience.

It is ok to ask questions and seek explanations.

One key aspect of creating change with a client is keeping that client engaged in the process. Offering statements of affirmation and using attention probes to show that you are following the client through the process help keep the client engaged (Rubin, 2012).

Read the text on the slide and proceed to the next slide.
When we explore our values, we need to consider the external factors, personal experiences, and our obligations as providers to clients who have different values from ours.

Examples: Your first sexual encounter, current sexual health status, any sexual abuse and assault, and our attitudes about what’s acceptable and not (condom dispensaries in high school bathrooms).

It is ok to refer out if you encounter something that you are not comfortable with. Taking time to clarify our values will give us the opportunity to recognize if/when this may happen.

**Timeframe: 10 minutes**

Examples of values providers may rely on include: willingness to learn new skills, ability to create non-judgmental environment, ability to offer co-worker support, respect of co-worker privacy.
Here are some examples of values that a provider may have.

The trainer can then open up a discussion about how these values affect a provider’s ability to work with a client.

The purpose of this section is to introduce participants to the conceptual framework of using self awareness to build knowledge, skills, and attitude. This section also offers recommendations for providers who work with racial and ethnic minority LGBT individuals.

This conceptual framework module can help us understand how awareness, knowledge, and skills create an attitude that is willing and able to work with a wide and varied population.

Earlier in the module, we discussed “values clarification.” Identifying and clarifying one’s values leads to improved self awareness, which in turn leads to awareness of others. Once we are aware of our own values and the values of those around us, we are better able to learn about other cultures. The application of cultural knowledge is cultural skills. As we move through this process, we are creating an open attitude. Because cultural humility is an on-going process, an open attitude may lead to re-clarification of values. With each repeat of this cycle, you are improving your ability to work with those from other cultures.

http://store.samhsa.gov/shin/content//SMA14-4849/SMA14-4849.pdf)
Other models may only show the relationship between knowledge, skills, and attitude. Self awareness and awareness of others gives the provider access to this cycle by preparing the provider to seek knowledge in a way that can be translated into skills.

For example, a provider who has little experience with bisexual people or bisexuality may feel that a client who is bisexual is ambivalent or “on the fence” about how to identify. In fact, the client may know exactly how they identify and come to the provider’s office with negative experiences of biphobia (hatred towards bisexuals) or bi-invisibility (the lack of acknowledgement that bisexuals exist). A provider who practices cultural humility can show self-awareness by addressing that bias internally. That provider can then show an awareness of others by recognizing that the client may have experienced biphobia or bi-invisibility in the past.

The trainer will use this slide to reinforce the concept that actions don’t always match values & beliefs because of conditioning and blind spots and that self-awareness and subsequent actions are required to move toward congruent cultural proficiency.

It does not make us bad human beings when we make assumptions. It is imperative that we address those assumptions, where they came from, and how we can work through them to provide the best care.
Timeframe: 5 minutes

The trainer can review the following suggested activities that focus on “conditioning” in a fun not threatening way. The what color is this paper should be done and done last before moving to the next slide.

The key message to communicate is, our conditioning can cause us to respond in ways that are reactive and reflexive and may not be culturally competent.

Trainer: What do you put in a toaster? (Group will likely say toast. Correct answer is bread)

Trainer: Spell "hop." Group: H-O-P
Trainer: Spell "mop." Group: M-O-P
Trainer: Spell "top." Group: T-O-P
Trainer: What do you do at a green light? Group: (Accustomed to the "op" sound will say “Stop.” Correct answer is “Go.”)

Trainer: (Hold up a sheet of white paper)
Trainer: “What color is this paper?” Group: White.
Trainer: “What color is this paper?” Group: White.
Trainer: “What color is this paper?” Group: White.

Read the text on the slide and proceed to the next slide.
This slide gives participants an opportunity to reflect on their ability to be self-aware. Trainer can facilitate a conversation around a difficult population that one of the participants identifies or use the example provided in the trainer notes for slide 37.

Gathering knowledge about another’s culture may mean asking questions of the client, asking a mentor, or doing some research of your own. Knowledge can also be gained by listening to subtle verbal and non-verbal cues. If we return to the example from slide 37, a provider may gain knowledge about bisexuals and bisexuality through speaking with a client who identifies as bisexual. The provider can go from the original belief that the client is ambivalent about their sexual orientation to understanding that bisexuality is a sexual orientation.

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This slide provides participants with LGBT-specific recommendations for using knowledge.

When you put your knowledge and awareness into action, you are using skills. Returning to the example in the slide 37 trainer notes, a provider who uses skills based on the awareness and knowledge gained through working with a client who is bisexual will be able to process with another client who may be coming out as bisexual. The provider can assure the client that bisexuality is a common and true sexual orientation.

Develop effective communication skills:
- Be cautious about identifying LGBT client to others (including other LGBT) without permission
- Respect an LGBT client’s decision to “come out” or not
- Listen without judgment
- Interrupt anti-LGBT comments, jokes, or stereotypic pronouncements by peers, colleagues, clients, residents
- Ask open-ended questions
- Use gender-neutral language when appropriate
Creating a safe and welcoming environment:

- Explicitly welcome LGBT clients to your place of service
- Use appropriate terms (gay, lesbian, bi)
- Ask transgender people what term and pronoun they prefer, and use these in all situations.
- Refrain from speculating about a person’s sexual orientation or gender identity.

Components of a inclusive infrastructure:

- Assume that in any group, LGBT clients are present
- If your sexual orientation is heterosexual, understand your privilege and the ways it is rewarded in this culture.
- Learn about the LGBT cultures that exist around you.
- Find ways to make LGBT culture visible in your organization
- Be able to make appropriate referrals for services, resources, products, and organizations.

Trainers are welcome to use another example. In the example from slide 37, the provider was able to use self-awareness, knowledge, and skills to create an attitude of acceptance, affirmation, and support for clients who are or may be bisexual.

The cyclical nature of this model suggests that a change in attitude could lead to re-evaluation of one’s values and increased self-awareness.
The trainer shares this quote and invites the group to share their reactions and comments.

“Be open to someone’s individuality. Just because you’ve worked with one ____, doesn’t mean the next ____ will be just like them.”

[Source: Potilla, Cultural Impact, Program Manager, NIMH/TA, NIMH-USAD]

The following slides offer recommendations for providers. Trainers can read through the slides, stop if needed, and process with the group.

Recommendations:
- Avoid labeling your clients.
- Meet clients where they are in the coming out process and respect their need to feel safe.
- Be guided by your LGBT clients; listen to what they say is comfortable for them.

Trainers can read through the slides, stop if needed, and process with the group. “What might this look like in your organization?”

Recommendations:
- Receive training to help you increase your knowledge and understanding of LGBT-related culture and beliefs.
- Create an atmosphere that is supportive.
- Acknowledge clients’ significant others and encourage their support and participation in prevention and treatment programs.
Trainers can read through the slides, stop if needed, and process with the group. “What might this look like in your organization?”

**Recommendations:**
- Advocate and create safety for LGBT clients.
- Support and encourage positive images of persons of color, YMSMs, LGBT, gender variant, non conforming, elderly, other abled individuals.
- Read and learn about LGBT community and culture.

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**Questions and Comments?**

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Resources:


References:


Module 3: Addressing the Needs of Lesbian Individuals
Welcome participants to module.

Introduce title and trainer(s) for this module.

Identify YMSM/LGBT CoE as the organization who developed curriculum.

It might be helpful to mention the duration of the module, which is approximately 60 minutes in length. The duration of this module depends on the group’s level of participation with any activities, questions, comments and discussion.

If necessary, remind participants of housekeeping details such as, the location of restrooms and silencing cell phones, etc...

These SMART (specific, measureable, attainable, relevant and time-bound) learning objectives provide the participant with key ideas and themes that will be covered in this module.

Examples of two challenges describing who contemporary lesbians are in research: 1) defining who lesbians are by using a single term and 2) getting a diverse representation of lesbians in research with regard to age and race/ethnicity.

Examples of two factors that might contribute to substance use among lesbian clients are: 1) social circles/networks where alcohol and drugs are used and 2) homophobia.

Examples of two barriers for health screenings for lesbian clients are: 1) fear of receiving biased care and 2) fear of lack of confidentiality.

The purpose of this section is to provide an overview of who contemporary lesbians are with regard to research and the challenges to defining who lesbians are in society.
This slide provides a general description of who is being referred to when using the term, “lesbian” in this module.

There are challenges with using this narrow of a description of “lesbian” as it is not all encompassing of different regions, cultures and communities. Again, this is a working description provided for this module.

Participants may have their own descriptions of “lesbian,” and it is important to validate those definitions and experiences.

For research purposes, describing, defining and understanding the needs of lesbian individuals and communities can be challenging.

Lesbians can be under-represented in research information. Information can be outdated or minimal at best.

Of the lesbians who are represented in research, they are often the most visible (i.e. college-age and identify as ‘lesbian’ in community).

A possible explanation as to why there are systematic challenges to defining who lesbians are in both research and society might be attributed to historic approaches to understanding women’s’ health.

In general, historic understandings of health were based on populations that were affluent, educated and not racially/ethnically diverse.

If providers are not educated on the health disparities that exist for lesbians from different races, communities and populations, they might assume that there are none.
A lesbian-specific healthcare risk is the increased use of drugs and alcohol, and the harm drug and alcohol use can cause to one’s health over time. If providers are not aware of this, providers may not adequately screen and assess lesbian individuals. As a result, symptoms and overall health get worse. Lesbian individuals may also assume providers are not concerned about their privacy or confidentiality. This is a critical consideration for organizations in communities where homophobia is a problem.

The next section will cover related health issues specific to lesbian individuals and communities. It is important for providers to view the client as a whole being, aiming to increase wellness not just in some areas, but in all areas of the client’s life. When providers work from this approach – the client may experience greater overall health outcomes.

Because lesbian women may access services in later stages of disease progression, albeit from fear, prior discrimination and/or lack of confidentiality, it is important to create a welcoming environment and establish trust from the first appointment. Some questions that a provider can ask may include “what kind of partner do you have?”
When having a comprehensive, open discussion about sexual identity, inclusive of sexual and behavioral risks, make no assumptions about current or prior (or even described future) behaviors that may put individual at risk. Having an honest discussion with no judgment is all part of authentic provider/client relationship building. In addition, providers should know that women who have sex with women and men might be at a variable risk compared to women who have sex with women only.

In making no assumptions, the provider is also creating a welcoming, engaging environment for the individual.

As a result, a more comprehensive assessment will be captured, which will help inform a patient-centered treatment plan.

Providers are recommended to make an effort to understand their clients’ healthcare needs, particularly trans men who may need cervical cancer screening but may not be offered such services.

Examples of social circles are bars, nightclubs and restaurants that cater to the lesbian community or other social events where lesbians socialize with alcohol and/or other substance.

Opportunities to socialize where alcohol and substances are consumed may be the only opportunity for lesbians to socialize and build community with each other.

If the client states they want to find other support systems where substance and alcohol are not used, the provider and client can identify other ways to find support and build community. One might be able to find community support by reaching to LGBT-oriented community resources such as LGBT Sports teams, LGBT papers, LGBT Community Centers, LGBT Mental Health Centers etc.
The purpose of this slide is to highlight heavy drinking and binge drinking are more common among lesbians.

**Optional Activity:**

It might be helpful to explore with participants the following question, “Given that heavy and binge drinking is more common among lesbians, what specific efforts are being made in your community to address this?”

Depending on the participants, trainer(s) may or may not get very many responses. This is an opportunity for participants to begin thinking about how to address this issue.

Facilitator is encouraged to write responses down on easel chart or dry erase board so all participants can read and review responses.

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The reliance on bars as a focal point for developing social networks and entrée into LGBT communities has also been explored as a contributing factor to heavier drinking and alcohol-related problems.
**Timeframe: 10 minutes**

Trainers and trainee should discuss the following case example and ask trainees for some suggestions on how a counselor would treat his/her lesbian client.

Suggestions for treatment:

Participants may point out Andrea will probably need to go back and come out again in some form, now that she’s clean and sober, and that she will need to learn the tasks of adolescence that she missed learning. Although the responsibilities involved in counseling substance-abusing lesbians may seem daunting, there is no denying the importance and influence of the caring counselor. Counselors who don’t know a lot about lesbians can still offer much of value to their clients if they start with what they know about women and take the time and make the effort to understand the special problems of lesbians.

Empower the client—this should be the primary goal, no matter how it is reached.

Honor diversity.

Use nonjudgmental language.

Avoid labeling.

Do not confront, but support and explore.

Respect the client’s position, whatever that may be (“I’m not a lesbian”; “I’m confused”; “I’m a lesbian and proud of it!”).

Respect some lesbians’ unwillingness to attend AA or Narcotics Anonymous because they consider these programs male institutions with no room for them as women, and especially as lesbians, or because of the emphasis on powerlessness, which they feel emphasizes their status as victims. There are AA and NA groups for multi-demographics now. If there isn’t one, it is possible to start one. Lesbians may also feel hesitant to attend faith-based institutions if they have been rejected by faith-based communities in the past. This may apply to all people in the LGBT community.

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Read the text on the slide and proceed to the next slide.
Lesbians may have increased risks for ovarian cancer because they are less likely to have used birth control pills. Birth control pills decrease a woman's risk of developing ovarian cancer.

Also, lesbians are less likely than heterosexual women to have biological children. Pregnancy and breastfeeding, especially before age 30, have been shown to reduce the risk for ovarian cancer.

Additional Resource:
http://www.cancer-network.org/cancer_information/lesbians_and_cancer/lesbians_and_ovarian_cancer.php

Individuals may not be aware of screening guidelines, particularly if they have not accessed regular, ongoing health care. It is important to provide education on gynecological cancers, screening guidelines and the importance of routine STI tests for those who are sexually active.

Furthermore, individuals may not be aware of treatment options, or think treatment options do not exist, especially if they have not been in regular, ongoing care.

For example, the advances of HIV prevention, such as PrEP and PEP, as well as advanced HIV treatment options may be new information for individuals not in routine care.

Additional Resource:
http://www.whatisprep.org/
According to the National LGBT Cancer Network, information on breast cancer in lesbians is limited. Lesbians may have an increased risk of developing breast cancer based on a “cluster of risk factors” theory. The cluster of risk factors is a result of living with stress and stigma as a result of discrimination and homophobia.

Breast cancer is associated with:

1. Pregnancy - lesbians are less likely to have biological children before age 30. Having children before the age of 30 offers some protection against cancer.

2. Alcohol use – As reported earlier, they are possible higher rates of heavy drinking among lesbians.

3. Obesity - Lesbians are more likely to have a Body Mass Index (BMI) over 25, which is categorized as overweight. BMI Categories: underweight = <18.5, normal weight = 18.5–24.9, overweight = 25–29.9, obesity = BMI of 30 or greater.

Additional Resources:
http://www.cancer-network.org/cancer_information/lesbians_and_cancer/lesbians_and_breast_cancer.php
http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

Tobacco use among lesbians might be attributed to coping with stress and discrimination brought about by misogyny and/or homophobia.

Even further, tobacco use among lesbians might be attributed to tobacco companies specifically targeting and sponsoring LGBT events such as annual gay pride events and/or LGBT events and concerts at nightclubs.
Behavioral healthcare and other service providers can play a role in helping clients achieve their desired goals. If a client’s stated goal is to quit/reduce tobacco use, increase physical activity or loose weight, providers can offer specific information on how to achieve those goals.

If providers are not able to give information on how to achieve those or any other goal, it is the provider’s responsibility to offer resources and referrals so clients may receive the information they need.

It might be helpful to have a list of lesbian or LGBT-specific referrals and resources readily available for distribution.

Providers can educate on the impact of obesity on one’s overall health.

If client’s do not identify their obesity as a problem, focusing on their weight is not helpful.

The client may have other goals and it is helpful to address the client’s stated goals, as opposed to addressing what we think is best for the client. In doing so, you are building an authentic, trusting relationship with the client. This may help create a safe environment for a later opportunity to address weight and body image when the client is ready.
The most understood causes of minority stress are prejudice and discrimination. Specifically, having a biased attitude and biased behavior toward another.

Minority stress can take the form of a micro-aggression. Micro-aggressions can be brief and commonplace and can include daily verbal, behavioral, or environmental indignities. These indignities can be intentional or unintentional, and are insulting to racial, ethnic and sexual minorities. An example of a micro-agression is when a client states they are married, and the provider assumes the client is married to someone of the opposite gender.

Additional Resource: www.microaggressions.com

Again, discrimination can come from many sources. For this example, tribal membership is often a critical component of cultural identity. If an American Indian/Alaska Native lesbian is facing discrimination from her tribe because of her sexual orientation, that may create identity conflicts with her racial and cultural identity.

The purpose of this section is to describe some considerations and key concepts when working with lesbian clients. These considerations and key concepts may serve as a roadmap for future exploration or future education as they apply to the clients you are working with.
Being mindful of our own biases is a way for providers to become a more open, trusting and nonjudgmental provider.

If clients are experiencing violence in their relationship(s), we want to help find appropriate care where the client would feel most safe.

In some instances, that might mean finding services that serve and affirm lesbian clients.

Therefore, it is important for providers to become knowledgeable of local resources and referrals for lesbian clients.

It is also helpful for providers to identify supportive services that meet the unique needs of racially/ethnically diverse lesbian populations.

Example: Clients from racially/ethnically diverse communities might hold suspicion or weariness towards Western medical providers. Therefore, it might be helpful to be open to and aware of Non-Western/medical ways of healing such as: herbal medicine, Curanderas, traditional consultants, energy work and acupuncture.

Selected evidence-based mental health interventions included on following slides that are women-focused interventions. Criteria used in search include: mental health promotion, mental health treatment, substance abuse prevention, substance abuse treatment, co-occurring disorders, female only.

These interventions might serve as a starting point for working with lesbian clients.

Additional Resource: www.nrepp.samhsa.gov
Couples who received BCT and individual therapy for the identified client with alcohol use disorder also had less alcohol consumption and higher levels of adjustments. Important to note, these were the same results as with heterosexual couples.

References:
Read all or selected interventions on the slide and proceed to the next slide.

Couples who received BCT and individual therapy for the identified client with alcohol use disorder also had less alcohol consumption and higher levels of adjustments. Important to note, these were the same results as with heterosexual couples.

References:

According to the Institute of Medicine (2015), Person-centered planning (approach) is, “A highly individualized comprehensive approach to assessment and services that is founded on an understanding of the person’s history, strengths, needs, and vision of his or her own recovery and includes attention to issues of culture, spirituality, trauma, and other factors.”

An aspect of working from a person-centered approach is moving away from the provider as being the “expert” in the room, with all their knowledge, skills and training as a behavioral health provider.

Rather, the client is the expert in the room. The client holds the experience, knowledge and goals for their own health and wellness.

Additional Resource:
https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/Chapter1.pdf
Provider Considerations:

- Lastly, it is recommended providers and organizations adopt an “inviting, person-centered approach” toward lesbians seeking healthcare, ensuring delivery systems are inclusive of all aspects of lesbian health.

- When adapting a “person-centered approach,” examining cultural contexts such as heterosexism, homophobia and racism might be helpful in identifying underlying factors compromising health and wellness for lesbian clients.

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Resources:

- Women/health pro lesbian and transsexual feminist women:

- SAWAS/DA Treatment approaches for women:
  http://aids.gov/aidsinfo/good-practices/Treatment:Resources/Metabib/150026

- Area Resource and Referral Organization for Women: Evidence-Based Lesbian Health:
  http://americanpractitioner.org/guidanceources/2015/03/27/evidence-based-lesbian-health簡化

- American Psychological Association: New data on lesbian, gay and bisexual mental health:

- American Academy of Pediatrics: Gay and Lesbian Parents:

- Gays and Lesbians in Alcoholics Anonymous:
  http://ga-lt.org/

- COLGAE: People with LGBT Parents:
  http://www.colgae.org
Resources

- SAMHSA: Treatment approaches for women: http://www.samhsa.gov/treatment/types-of-treatment/ women
- Gay and Lesbian in Alcoholics Anonymous: http://lgaa.org/

COGUL: People with LGBT Parents: http://www.cogul.org/

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Module 4: Addressing the Needs of Gay Men and Men Who Have Sex with Men (MSM)
Welcome participants to module.
Introduce title and trainer(s) for this module.
Identify YMSM/LGBT CoE as the organization who developed curriculum.
It might be helpful to mention the duration of the module, which is approximately 60 minutes in length. The duration of this module depends on the group’s level of participation with any activities, questions, comments and discussion. Also, the duration of the module is impacted by the number of slides presented. Trainer(s) might opt to omit slides/sections due to time constraints, prioritization of content or redundancy of information based on group’s prior knowledge.
If necessary, remind participants of housekeeping details such as, the location of restrooms and silencing cell phones, etc...

These SMART (specific, measureable, attainable, relevant and time-bound) learning objectives provide the participant with key ideas and themes that will be covered in this module.

Example of one challenge to locating gay male research subjects: research has historically focused on recruiting participants at gay venues such as bars and nightclubs as it is much harder to reach “out” gay men in other venues.

Examples of two health issues for which gay men have a higher risk: 1) gay men who have unprotected anal intercourse are at high risk for HIV and 2) gay men use substances more than their heterosexual counterparts, which may lead them to engage in unsafe sexual behavior, such as unprotected anal intercourse.

Examples of two differences between gay men and MSMs: 1) men who identify as “gay,” creates a linkage to the larger LGBT community, whereas MSM, is only describing a behavior. 2) Gay men are more likely to find networks and social connection among others in the larger LGBT community whereas MSMs might identify as heterosexual or bisexual, and not identify find connection with other MSMs.

Example of one way providers can work effectively with MSMs is to assess risk behavior from a nonjudgmental approach.
The purpose of this section is to provide an overview of who contemporary gay men are with regard to research and the challenges to defining who gay men are in society.

When reviewing research on gay men, there are three major differences in how gay men are described.

Attraction – can describe the gender one is most attracted to, but does not necessarily mean someone would disclose if they are attracted to the same gender. A client can be attracted to both males and females, but may identify as straight or bisexual or queer. Therefore, as a provider it is important to know that a someone can still identify as straight regardless of their attraction.

Behavior – can describe attraction, but does not necessarily mean someone would disclose if they are attracted to the same gender. A client can engage in same-sex behaviors, and still not identify as gay.

Identify – can describe attraction, but not necessarily behavior. A client may identify as gay, but have yet to engage in any sexual behavior.

There are other challenges to understanding who contemporary gay men are.

Providers might be quick to judge who is and who is not a gay male among their clients, regardless of how their clients identify.

It is not helpful for providers to determine their client’s sexual orientation. It is the client who makes this determination, not the provider.

Making judgments about client’s sexual orientation only hinders building a trusting, supportive, nonjudgmental connection. When we work from a place of judgment, clients can assess this, and are less likely to return for services – which can exacerbate problems in their lives.
The purpose of this slide is to encourage researchers focusing on gay male populations to recruit participants in venues outside of where gay men typically socialize such as community events or concerts that are not LGBT-specific.

Another suggestion might be to consider using online, confidential and/or anonymous surveys (example: Survey Monkey) as a way to engage gay men outside of LGBT venues.

Recruiting gay male research subjects is not as hard as it once was. One might be able to find gay males who are willing to participate in research on organized gay sports teams, at LGBT Community Centers, LGBT Mental Health Centers, LGBT teams, papers, community centers, local LGBT newspapers and magazines.

Research focusing on gay men might take place at a college or university setting. Out of convenience, research subjects are often recruited at the same college or university.

With research studies focusing on gay men, it is important to consider the research procedures made to obtain a diverse, representative sample of participants. Segments or “pockets” of community members might not be represented on college and university campuses.

Culturally appropriate behavioral health treatment and prevention clinics are a good source of recruitment for LGBT research subjects. These locations may hold promise for researchers who are looking to locate a new demographic of gay men.
Because state nondiscrimination laws can vary state to state with regard to sexual orientation and gender identity, it might be helpful for you to research beforehand the nondiscrimination policies that exist in the state, city and/or community you are delivering the training in.

Officials in American Samoa are discussing whether the ruling applies to the territory. Currently, same sex marriages are neither licensed or recognized in American Samoa. American Samoa does not have anti-discrimination laws in place.

Additional Resources:
https://www.aclu.org/map/non-discrimination-laws-state-state-information-map
http://www.hrc.org/resources/entry/cities-and-counties-with-non-discrimination-ordinances-that-include-gender

Gay men can lead “double lives,” especially if the client is not out to the people close to them. It might be a lifelong process of selecting and choosing who to be “out” to, and who to not disclose their sexual orientation to.

Selecting who and who not to be “out” to can be a matter of life or death. Leading a life where one cannot be authentic with everyone can cause a lot of stress, and considering how much time the average adult spends in the working environment, this can add up to a lot of stress. These and other reasons pose challenges to getting a clear understanding of the health needs of gay men

Optional Activity:

It might be helpful to explore with participants the following question, “Would we expect heterosexual co-workers to hide or not discuss aspects of their spouses or significant others? Why is this the same or different for homosexual co-workers?”

Facilitator is encouraged to write responses down on easel chart or dry erase board so all participants can read and review responses.
The next section will cover related health issues specific to gay male individuals and communities. It is important for providers to view the client as a whole being, aiming to increase wellness not just in some areas, but in all areas of the client’s life. When providers work from this approach – the client may experience better health outcomes.

Recent studies have improved our understanding of substance use in the gay community. Higher substance abuse rates have been found among gay men in many places, not just in larger communities such as New York, San Francisco, and Los Angeles.

Tobacco use among gay men might be attributed to coping with stress and discrimination brought about by heterosexism and/or homophobia. Even further, tobacco use among gay men might be attributed to tobacco companies specifically targeting and sponsoring LGBT events such as annual gay pride events and/or LGBT events and concerts at nightclubs.
There are many potential consequences associated with meth use. HIV and other infectious diseases can be transmitted between users by sharing needles to inject the drug intravenously and, due to disinhibition and increased libido caused by the drug, users can repeatedly engage in unprotected sex.

Other consequences of meth use include severe tooth decay, resulting in the syndrome known as meth mouth, temporary or potentially permanent brain damage, and erratic, sometimes violent behavior.

Additional Resource:

http://www.drugabuse.gov/publications/research-reports/methamphetamine/are-methamphetamine-abusers-risk-contracting-hivaids-hepatitis-

Culturally sensitive mental health services that specifically target gay men have been shown to be more effective in the prevention, early detection, and treatment of mental health conditions.

It is important for providers to research and become familiar with local behavioral health providers who have competency working with gay men. It might also be helpful to encourage providers to develop and/or routinely update a resource list of local providers who work with gay men readily available for clients.
Data from a large nationally representative sample (N=2,917) of men between the ages of 25 and 75.

Participants may wonder why gay and bisexual men are lumped together into one category. This is not uncommon. For example, national, state and local health department data on HIV often lumps these two categories together, which can provide an unclear picture when we are focusing solely on gay men.

More information on the harms of lumping bisexual people with either gay men or lesbian populations is included in the bisexual module.

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Across all populations of the general public, the most significant risk factors for suicide are: 1) prior suicide attempt(s), 2) alcohol and drug abuse, 3) mood and anxiety disorders, and 4) access to a lethal means (example: gun and ammunition).

Additional Resource:

Multiple studies have shown that depression and anxiety affect gay men at a higher rate than the general population, and are often more severe for men who remain “in the closet.”

Providers should aim to create a safe, trustworthy, and nonjudgmental environment for all their clients, especially those struggling with their sexual orientation.

Providers should also seek immediate supervision regarding clients who have suicidal ideation or thoughts. Providers can also provide crisis hotlines, locations of local emergency rooms and discuss emergency planning with clients.
Providers should routinely assess their male clients for a history of domestic violence and/or victimization.

If gay male clients are experiencing violence in their relationship(s), providers should aim to find appropriate care where the client would feel most safe.

In some instances, that might mean finding services that affirm gay male clients.

Therefore, it is important for providers to become knowledgeable of local resources and referrals for gay male clients.

Clearly, more prevention efforts are needed, particularly targeting young gay and bisexual men.

HIV prevention efforts can include: accurate HIV information, access to HIV testing, access to condoms and lubricant, access to sterile syringes for those who inject drugs, access to PreP, access to drug treatment, access to HIV treatment, and appropriate supportive services for both HIV-negative and positive gay and bisexual men.
Read the text on the slide and proceed to the next slide.

For more information on this, please see the CoE website for more resources: [www.ymsmlgbt.org](http://www.ymsmlgbt.org)

Additional Resource:
[http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/prevalence.htm](http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/prevalence.htm)

Anal cancer is caused by the same strains of HPV that cause cervical cancer in women.

While there are over 100 different types of HPV, only certain strains are believed to increase the risk of cancer.

HPV is often downplayed as an unsightly inconvenience. However, these infections may play a role in increased rates of anal cancers in gay men. Safer sex reduces the risk of STIs; as well as screening and the treatment of STIs helps prevent the spread of STI infection.

Additional Resource:
A growing number of gay physicians and health activists now believe that routine screening, using an anal pap smear, can reduce the incidence of anal cancer. An anal pap smear screening can be used to test the anus for cancer and pre-cancerous cell changes.

Most health insurance policies do not cover anal pap smears.

Recommendations for anal pap smear include: all MSMs, especially those who are HIV+, be tested every 1-3 years depending on their immunological well-being and CD4 count.

HIV negative individuals be tested every 3 years.

Additional Resource:
http://www.cancer-network.org/cancer_information/gay_men_and_cancer/anal_cancer_hiv_and_gay_men.php

Providers should be able to recognize the signs and symptoms of eating disorders and supply their male clients with the necessary referrals for eating disorder supportive services.

Anorexia, bulimia, and binge eating disorders can involve obsessive and extreme emotions, attitudes, and behaviors surrounding food and weight.

The DSM-5 (2015) estimates that the female-to-male ratios of eating disorders are: 10:1 for anorexia nervosa; 10:1 for bulimia nervosa; and 2:1 for binge eating disorder. Male ratios may be significantly smaller because male eating disorders are often underreported, misdiagnosed and/or overlooked.

There is a broad consensus that eating disorders in males are clinically similar to eating disorders in females (National Eating Disorders Association website below)

Additional Resource:
http://www.nationaleatingdisorders.org/research-males-and-eating-disorders
Often, gay cultural attitudes regarding ideal male body shape, masculinity, and sexuality are shaped by stereotypes in the media.

It is important to note, eating disorders do not discriminate on the basis of gender.

It is recommended providers learn about and create a resource list of local treatment centers and self-help groups that are available to gay men.

The purpose of this section is to describe some considerations and key concepts when working with gay men.

These considerations and key concepts may serve as a roadmap for future exploration or future education as they apply to the clients you are working with.
Prior to 1973, goals for those seeking treatment for homosexuality were to decrease the intensity and frequency of homosexual thoughts, feelings, and behaviors while simultaneously increasing heterosexual thoughts, feelings, and behaviors. There were aversive therapies such as conversion therapy which served as a form of treatment that aimed to change sexual orientation from homosexual to heterosexual. Other examples of aversion therapy include the use of electric shocks or the ingestion of nausea-inducing drug.

Gay men, lesbians, and those with attraction to both genders volunteered for psychosurgeries and hormonal treatments that would theoretically masculinize gay men or feminize lesbians. Families with members attracted to same-sex had them involuntarily committed to psychiatric hospitals, often for years.

Celibacy was ultimately a common suggestion after other treatments inevitably failed.

Over 40 years later, there are still efforts to eliminate conversion or reparative therapies which are aimed to change sexual orientation from homosexual to heterosexual. The American Psychiatric Association has now discredited conversion therapy and the practice has been banned in multiple states including California, New Jersey, Illinois, Oregon and District of Columbia.
Also, it is important to remind participants when a client identifies as “gay,” we honor that description and use the same terminology clients use to describe themselves.

If a client identifies as a “homosexual,” we honor and use that term with that client.

Providers who do not identify as a “gay male” can support gay male co-workers and clients in a variety of ways such as advocating for gay male specific services, using data and research that focuses solely on gay men and learning more about the issues facing gay men in our society. For more information please see the Human Rights Campaign’s publication, An Allys Guide to Issues Facing the LGBT Community.

Additional Resource:

It is the provider’s role to help address and resolve the client’s presenting problem(s). This may or may not involve including spouses or significant others. This is achieved via mutually agreed upon goals set between the provider and client. Goals may or may not involve issues related to “coming out.” Reparative or conversion therapy has historically been used across LGBT populations in an attempt to change their sexual orientation based on the notion that homosexuality is a defect or disorder. The American Psychiatric Association, American Academy of Pediatrics, and the Pan American Health Organization all have made statements that oppose these practices. Conversion therapy is dangerous and can be fatal. In 2009, the APA reported risks associated with these practices including depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidality, substance abuse, stress, disappointment, self-blame, decreased self-esteem, increased self-hatred, problems in sexual and emotional intimacy, sexual dysfunction, high-risk sexual behaviors, a feeling of being dehumanized and untrue to self, a loss of faith, and a sense of having wasted time and resources. The risks are even greater for youth who reported higher levels of family rejection, attempted suicide, high levels of depression, increased use of drugs, and increased rates of unprotected sexual intercourse.

The 2015 SAMHSA publication, “Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth” provides information and recommendations of consensus statements developed by experts in the field.

Read all or selected interventions on the slide and proceed to the next slide.

References:

Read all or selected interventions on the slide and proceed to the next slide.

Couples who received BCT and individual therapy for the identified client with alcohol use disorder also had less alcohol consumption and higher levels of adjustments. Important to note, these were the same results as with heterosexual couples.

References:
This next section will focus on Men who have Sex with Men (MSM).

A recurring theme in this module is allowing clients to identify however they choose. If a client identifies as “gay,” we honor that description and use the same terminology to describe the client. If a client describes in detail his attraction to, sexual behaviors with and how he strongly relates to gay men, and also identifies as “heterosexual” or “straight,” then we honor that description and reflect his terminology when interacting with him.

Additional Resource:
http://web.jhu.edu/LGBTQ/glossary.html
**Timeframe: 10 minutes**

Trainers should go through the following myths and ask participants how believing each myth might negatively influence or impact how a counselor would treat a Gay/MSM male client.

Examples of myth and bias:

- Sexually promiscuous
- Uncontrollable sexual desires
- They are not relationship-oriented
- Male homosexuality is caused by parenting or trauma in childhood
- Sexually and emotionally indecisive
- Untrustworthy

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“At the beginning of the 1980s various reports began to emerge in California and New York of a small number of men who had been diagnosed with rare forms of cancer and/or pneumonia. The pneumonia, Pneumocystis Pneumonia Carinii (PCP), is generally only found in individuals with seriously compromised immune systems. However, the men were young and had previously been in relatively good health. The only other characteristic that connected them was that they were all gay” (Avert, 2015).

It might be helpful to point out to participants, we know now it wasn’t just gay men who were becoming infected, but injection drug users, bisexual men, men who have sex with men and many others who were infected too. However, one’s sexual orientation was singled out and identified first as a risk factor, not their sexual behaviors.

Additional Resource:

www.avert.org/history-hiv-aids-usa.htm#sthash.Tc7axY3p.dpuf
Outreach was also directed towards Injection drug users, because they too were becoming infected and dying quickly.

Stigma and discrimination towards gay men and injection drug users was held by national and local elected officials, as well as some medical experts and researchers.

(Note: Slide contains animation. The quote below will appear on the right side of the slide when you advance the slide after reviewing the information on the left)

“For a while the American government completely ignored the emerging AIDS epidemic. In a press briefing at the White House in 1982, a journalist asked a spokesperson for President Reagan “...does the President have any reaction to the announcement – the Center for Disease Control in Atlanta, that AIDS is now an epidemic and have over 600 cases?” The spokesperson responded - “What’s AIDS?” (Avert, 2015).

Additional Resource: www.avert.org/history-hiv-aids-usa.htm#sthash.Tc7axY3p.dpuf

“A number of non-governmental organizations were founded in the most affected areas of the USA such as The Kaposi’s Sarcoma Research and Education Foundation in San Francisco (later renamed the San Francisco AIDS Foundation) and, in New York, Gay Men’s Health Crisis (GMHC)” (Avert, 2015).

Additional Resource: http://www.avert.org/history-hiv-aids-usa.htm#sthash.Tc7axY3p.dpuf
Again, providers respect and honor the client’s chosen identify. If a client identifies as “straight,” we honor that description and use the same terminology when interacting and describing the client.

If the client identifies as “gay,” we honor and use the term. If the client declines to identify or label themselves, we honor that decision as well.

The purpose of this slide is to restate the importance for providers to focus on risk behaviors, rather than sexual orientation.

MSM risk factors for HIV may include: unprotected anal sex, unprotected vaginal sex, and sharing used syringes via injection drug use.

Even if client’s do not state they are engaging in same-gender sexual behavior, it is still helpful to educate them on all the risks. Especially because same-gender sexual behavior may differ depending on sexual expression and the sex assigned at birth of their partners.

The purpose of this slide is to highlight how same-gender sexual behaviors can occur only in certain environments.

For some clients, these behaviors may have happened in the past, and may never occur again.

For other clients, it may be important to discuss prevention strategies if the client is planning on returning to a specific environment (example: prison) where he has historically engaged in same-gender sexual behaviors.
If a client disclose they are engaging in sexual behaviors at venues such as bookstores, gym and sex clubs, it is important to strategize safer-sex practices. Motivating clients to identify strategies that are realistic and achievable, the providing support and encouragement are steps the provider can take to reduce risks and promote wellness.

This next section will cover related health issues specific to MSMs. It is important for providers to view the client as a whole being, aiming to increase wellness not just in some areas, but in all areas of the client’s life. When we do this – the client is likely to achieve better health outcomes.

A challenge to not having a universally agreed upon definition for the term MSM is: some researchers might classify men who have sex with men as “bisexual” and other researchers might classify them as “gay.” This makes the definition of MSM subjective to the researchers.

Another challenge to data collection might be that MSMs may be less likely to disclose their sexual behaviors, even if the survey is anonymous or confidential.
The HIV risks associated with meth use include: injecting meth intravenously and engaging in unprotected anal intercourse while intoxicated. When meth is injected by an HIV-positive individual, HIV can be spread to others via the re-use or sharing of contaminated syringes.

Furthermore, meth use is associated with risky sexual behavior, which may be attributed to the fact meth and other stimulants can increase libido.

However meth is ingested (snorted, smoked, swallowed and/or injected), its intoxicating effects can alter judgment and lead people to engage in risky behavior.


The purpose of this slide is to illustrate how HIV is disproportionately affecting MSMs in the U.S., inclusive of racial/ethnic age groups.

Optional Activity:

It might be helpful to explore with participants the following question, “If research suggests gay and MSM populations are disproportionately affected by HIV, what is being done in your organization or community to prevent the spread among these populations?”

This question might prompt some ideas as to how participants might take steps to reduce the spread of HIV within their community.

Facilitator is encouraged to write responses down on easel chart or dry erase board so all participants can read and review responses.
Nearly half of the estimated people living with HIV in the United States are African-American.

Additional Resources:
http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/prevalence.htm

The purpose of this slide speaks to the importance of prevention messaging that targets specific populations at risk.

Social marketing campaigns, prevention messages and outreach materials can all be developed targeting specific populations. Some strategies to develop a targeted message can include:

1. Getting input from the target community to help design prevention material that reflects their community needs.
2. Hold focus groups soliciting feedback on effectiveness of prevention messages from target audience.
3. Have representatives from target audience distribute and promote completed prevention messages.
At this point of the module, it should be clear to participants that homophobia, judgment, shame and stigma can impact both mental health and physical health.

This may be complicated further if the client is HIV-positive.

A strategy for providers not currently targeting MSMs might be to develop HIV prevention programming for MSMs, rather than lump them together in programming that targets gay and bisexual men.

Clearly MSMs have specific needs that may not be addressed in gay and bisexual specific prevention programming.

Four stages of syphilis are: primary, secondary, latent, and tertiary.

1. Primary stage: the appearance of a single chancre marks the primary (first) stage of syphilis symptoms.

2. Secondary stage: skin rashes and/or mucous membrane lesions (sores in the mouth, vagina, or anus) mark the second stage of symptoms.

3. Latent and late stage: the latent (hidden) stage of syphilis begins when primary and secondary symptoms disappear. Without treatment, the infected person will continue to have syphilis infection in their body even though there are no signs or symptoms.

4. The late stages of syphilis can develop in about 15% of people who have not been treated for syphilis, and can appear 10–20 years after infection was first acquired. In the late stages of syphilis, the disease may damage the internal organs, including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints.

Additional Resource:

http://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm
The health problems caused by syphilis can be serious. Additionally, it is now known that contracting syphilis also makes one more likely to transmit or acquire HIV infection sexually.

Clients should see a doctor as soon as possible if they are experiencing any unusual discharge, sore or rash, particularly if it occurs in the groin area.

Additional Resource:
http://www.plannedparenthood.org/learn/stds-hiv-safer-sex/syphilis

The purpose of this section is to describe some considerations and key concepts when working with MSMs.

These considerations and key concepts may serve as a roadmap for future exploration or future education as they apply to the clients you are working with.

Developing prevention messages that focus on risky sexual behaviors minimizes the shame and stigma associated with sexual orientation and reaches the widest possible audience.

Targeted messaging is recommended to reach specific communities. Use the assistance of the target audience help develop messaging that reflects the community’s needs. This is of particular importance for communities that have historically been underrepresented in HIV prevention social marketing campaigns (e.g. American Indian/Alaska Native peoples).
One way providers can build trust and create a safe environment for clients is to provide services from a nonjudgmental stance. Another way to build trust is to refrain from gossiping or discussing client’s sexuality with co-workers who are not on a need-to-know basis.

Providers Considerations:
- For some men there is concern for stigma, ridicule and even violence and homicide if they are suspected to be anything other than heterosexual.
- We meet clients anywhere along the continuum of sexual behaviors, orientations and identities – our goal is to be effective helpers.

Read the text on the slide and proceed to the next slide.

Providers Considerations:
- Annual screening for HIV (in uninfected patients) and for bacterial STDs, such as syphilis, gonorrhea, and chlamydia, is recommended for all sexually active MSMs.
- More frequent screening is indicated for MSMs who have multiple or anonymous partners, those who have sex in conjunction with drug use (such as meth), and those who have drug-using partners.

It might be easy to skip or hurry though questions we might determine not applicable to our clients. An example of this is making the assumption someone over the age of 50 is not sexually active, therefore skipping questions about sex and sexuality. Another example is skipping questions about multiple partners if the client reports they are married.

Providers Considerations:
- When completing a sexual history or sexual health assessment, avoid assumptions and judgments.
- Clients who are married may not be monogamous. It is important to ask about sexual partners outside of marriage.
Read all or selected interventions on the slide and proceed to the next slide.

References:
Resources:

1. Center for Disease Control and Prevention: Gay and Bisexual Men's Health: http://www.cdc.gov/msmhealth/professional-resources.htm
5. COALAGE: Children of Lesbian Parent: http://www.ccoalage.org

Resources:

- The YMSM/LGBT CoE has also developed another curriculum addressing the needs of young men who have sex with men (YMSM). The curriculum includes the latest research-based information to help them decrease the rate of substance abuse and new HIV infections among racial/ethnic minority YMSM (ages 18-26) clients.
- Please visit www.ymmsmlgbt.org for more information!

Resources:

- Human Rights Campaign: Coming Out Resources: http://www.hrc.org/resources/category/coming-out
- The Trevor Project: Coming Out As You: http://www.thetrevorproject.org/section/YOU
- CDC Information Line: 800-CDC-INFO (232-4636)

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References


Module 5: Addressing the Needs of Bisexual Individuals
Welcome participants to module.

Introduce title and trainer(s) for this module.

Identify YMSM/LGBT CoE as the organization who developed curriculum.

It might be helpful to mention the duration of the module, which is approximately 60 minutes in length. The duration of this module depends on the group’s level of participation with any activities, questions, comments and discussion. Also, the duration of the module is impacted by the number of slides presented. Trainer(s) might opt to omit slides/sections due to time constraints, prioritization of content or redundancy of information based on group’s prior knowledge.

If necessary, remind participants of housekeeping details such as, the location of restrooms and silencing cell phones, etc...

These SMART (specific, measureable, attainable, realistic and time-bound) learning objectives provide the participant with key ideas or themes that will be covered in this module.

Example of one form of biphobia is using the term “homophobia” to describe biphobia. Bisexual people have unique issues separate from exclusively homosexual individuals.

Example of one health challenge faced by older bisexual people is the assumption older bisexuals are no longer sexual. Therefore, they may not receive complete sexual health information.

Examples of two ways providers can create affirming and welcoming environments for bisexual people include: 1) adding the word, “bisexual” to policies and programming and 2) ensuring representation from bisexual people on working groups and taskforces.
The purpose of this section is to provide an overview of bisexuality, as well as key terms and concepts to help participants understand the complexity of bisexuals in society.

The purpose of this slide is to give a working definition for “bisexuality.”

Notice the definition includes “emotional, romantic and physical” attraction to one or more sex or gender. This definition also includes those who may or may not actually engage in sexual behaviors.

Read the definitions for “bisexual.” Notice with each definition, there are subtle differences.

In the second definition by Rodriguez-Rust, “identity” is referenced. Keep in mind, not all people who engage in sex with people of diverse genders identify as bisexual.

A third definition is Robin Ochs definition from the Bi Resource Center “A person who has the potential to be attracted romantically and/or sexually to people of more than one sex, not necessarily at the same time, not necessarily in the same way and not necessarily to the same degree”

Again, trainer(s) need to be mindful these definitions do not fit all people in all regions, communities and cultures. Participants may have their own definitions and understandings of bisexual individuals, and those definitions should be validated and respected by the trainer(s).

Additional Resource:

www.biresource.net
Read the key terms on slide. Please note, that individuals who are homo-flexible/hetero-flexible may or may not fall within the spectrum of bisexuality. It is important for Providers to allow their clients to define themselves as they deem fit.

Biphobia will be discussed in detail further in the module.

Biphobia can also be described as an aversion toward bisexuality and bisexual people as a social group or individuals. May be based on negative bisexual stereotypes or irrational fear.

**Timeframe: 10 minutes**

Trainer divide participants into small groups and ask them to discuss words and phrases that come to mind when thinking of bisexuals.

Examples of negative labels can include

Indecisive; Confused; It’s a Phase; Never happy in a monogamous relationship; Promiscuous; Bisexual is non-existent; Greedy; Transition; Unnatural; Unfaithful; Attention Seekers; Deviants; Experimenting;

Examples of impact on health

- This can cause feeling of marginalization and stigmatization which leads to higher substance use, depression, suicide and risky sexual behavior
- Reduced social support
- Increased stress
- Mistrust of providers and the healthcare system thus limiting ones ability to access high quality care
- Develop an intense fear of coming out and being true to themselves
- Develop practice of self-stigmatization
- Delay seeking necessary health care
There may be a perception among service providers and organizations that bisexuals are a minority population in comparison to the larger LGT community. According to several studies, this is not the case. The perception that there are less bisexuals among the larger LGT community might suggest why bisexual-specific programs are few and far between.

**Optional Activity:**
It might be helpful to explore with participants the following question, “How many people in the room work for an organization that provides services specifically for bisexual people? How many people in the room know of services specifically for bisexual people in your community?” If the answer is none to a few ‘yes’ responses, a follow-up question might be, “Why do you think there are only a few ‘yes answers’ given that bisexuals might make up the largest single population?” These questions are intended to get the participants to begin thinking about how to use this module in addressing the needs of bisexuals in their community. Facilitator is encouraged to write these responses down on easel chart or dry erase board so all participants can read and review responses.

The purpose of this slide is to show data that supports the previous slide’s content, “According to several studies, self-identified bisexuals make up the largest single population within the LGBT community in the United States.”
There is some contradictions in the research about this, however. This studies has a lower percentage of self identified bisexuals, compared to Gays/Lesbians.

Read the text on the slide and proceed to the next slide.

It is important to remember:

- Individuals who do not feel compelled to self-label are not captured accurately in research data.

- Historical measurement and conceptualization of sexual identity, in particular, bisexual identity have predominantly focused on the Kinsey scale and the Klein Sexual Orientation Grid.
The purpose of this slide is to provide a general description of the Kinsey Scale.

As pictured, there is a continuum of behaviors ranging from exclusively heterosexual to exclusively homosexual. Rather than divide the world into discrete categories (i.e. homosexual and heterosexual), Kinsey sought to offer a wider range and spectrum to human sexuality.

The original scoring via interviews and evaluation for the Kinsey Scale was not meant to categorize or label individuals as heterosexual, bisexual, or homosexual. Rather, the Kinsey scale was to highlight the complexity of human sexuality.

Again, Kinsey’s work did not focus on labels or identities. Kinsey laid the foundation for considering behaviors, feelings and desires with regard to human sexuality.
The purpose of this slide is to put a disclaimer on both Kinsey’s and Klein’s research, highlighting that measurements are not exact because human sexuality is complex and multidimensional.

The concept of sexual orientation as an ongoing dynamic process is necessary if we are to understand a person’s orientation across the lifespan.

Please note that as providers, the purpose of Klein’s grid is to help explain the concept of sexual orientation as an ongoing process and to understand a person’s sexual orientation in its entirety. However, as providers it is not our duty to ask clients what type of bisexual they are.

Please note that as providers, the purpose of Klein’s grid is to help explain the concept of sexual orientation as an ongoing process and to understand a person’s sexual orientation in its entirety. However, as providers it is not our duty to ask clients what type of bisexual they are.
This next section will cover related health issues specific to bisexual individuals and communities. It is important for providers to view the client as a whole being, aiming to increase wellness not just in some areas, but in all areas of the client’s life. When providers work from this approach – the client may experience greater overall health outcomes.

Activity:
It might be helpful to explore with participants the following question, “Why might bisexual people experience greater health disparities than the broader population?”
Facilitator is encouraged to write responses down on easel chart or dry erase board so all participants can read and review responses.
Some of the possible answers might include:
1. Because specific services for them are few and far between
2. Bisexual people may not feel welcome
3. Bisexual people may not know where to go – services for gays/lesbians and services for heterosexual.
The discussion generated might prompt some ideas as to how participants might take steps to address the mental health needs of bisexual people in their community.
This purpose of this slide is to describe an ethical dilemma: do clients have to disclose their sexual orientation in order to receive excellent care from a trusting provider?

It might be likely, if the client does not disclose same-gender sexual behaviors, the provider might be less likely to deliver same-gender sexual health information.

However, in the best case scenario, the provider would not make assumptions about the client’s behavior, and provide complete sexual health information to all clients, regardless of how they identify.

The purpose of this slide is to highlight the unique challenges bisexuals face.

When populations are misunderstood and feared, they can become easy targets. This might explain why bisexuals were to blame for the rise in HIV infections in the early 1980s.

Because of the fear towards bisexuals, it is understandable why bisexuals would remain “in the closet.”

The fear of bisexuals still exists. One way we as providers can combat phobia towards bisexuals is to educate and learn about the unique challenges bisexuals face.

The purpose of this slide is to highlight an example of how bisexual men were not responsible for the rise in HIV infections in the early 1980s.
The purpose of this slide is to highlight additional challenges bisexual people face.

Here are some possible explanations of why MSMWs weren’t mentioned at all:

1. MSMWs might not have been included in the data because there were too few or none who self-identified as MSMWs.
2. Of the MSMWs who did participate, their data had no significance, therefore was not reported on.

As a group, gay and bisexual men have an increased chance of been exposed to HIV than any other group in the United States.

Read the text on the slide and proceed to the next slide.

Although HIV infection incidence is greater in White gay and bisexual men, black/African American gay and bisexual men bear a disproportionate burden of HIV. From 2008 to 2010, HIV infections among young black/African American gay and bisexual men increased 20%.

Providers should make effort to ensure that their sexually active gay and bisexual male clients, are practicing effective HIV preventive measure (such as antiretroviral medications and condom use) every time they engage in anal or vaginal sex.
Optional Activity:

It might be helpful to explore with participants the following question, “Why do you think bisexual men are at higher risk for HIV than bisexual women?”

This question is intended to get participants thinking about the unique challenges bisexual men may face, and how those challenges impact their lives.

Trainer is encouraged to write these responses down on dry erase board so all participants can read and review responses.

This is a great example of research that exclusively highlights health issues for bisexuals separate from lesbians, gay men and transgender individuals.

As you read the top 10 health issues, highlight the top 3: Substance use, alcohol use and sexual health - which is addressed throughout this module.

The purpose of this slide is to highlight some of the unique challenges older bisexuals face.

Some possible reasons why older bisexuals might be at higher risk for isolation might be related to shame and stigma from both the heterosexual and homosexual communities.

Further complicating this is the lack of bisexual-specific services both historically and currently.
The purpose of this slide is for participants to begin thinking about ways they can engage older bisexuals into supportive services.

Given that older bisexuals may feel isolated from both the heterosexual and homosexual communities, providers are encouraged to help identify existing programs or expand/develop programs to address the needs of older bisexuals. This is particularly important for older bisexuals who are “coming out” or new to being out.

Additional Resource:
https://www.lgbtagingcenter.org/

It is helpful for providers to be mindful of any forms of ageism, that is, prejudice based on one’s age.

Some examples of ageism include: making jokes about older people being slow, providers talking past seniors to adult children as if the senior is not in the room, and making assumptions that seniors do not know about modern technology.

Additional Resource:
http://www.alfa.org/alfa/Ageism.asp

The purpose of this slide is to introduce the next 5 slides aimed at examining how biphobia exists in society. Examples of bisexual denial, invisibility, exclusion, marginalization and negative stereotypes will be discussed in detail on each slide.
More examples of bisexual invisibility include:

Referring to same-gender relationships as ‘lesbian relationships’ or ‘gay relationships’ and ‘other gender relationships’ as ‘heterosexual relationships’, as this misses the fact that such relationships may include one or more bisexual people. This applies to words like ‘couples’ and ‘parents’ as well as ‘relationships’.

Assuming people’s sexuality on the basis of their current partnership (straight if they are with someone of an other gender and lesbian/gay if with someone of the same gender).

Questioning a person’s bisexuality unless they have had sex with more than one gender (heterosexuality is rarely questioned before somebody has had sex with someone of an other gender).

Pressuring bisexual people to become lesbian/gay and/or only recognizing their same gender partners.
More examples of bisexual marginalization include:
Prioritizing lesbian and/or gay issues over bisexual issues.
Failing to engage with bisexual individuals or groups in relation to policy and practice.

More examples of negative stereotypes include:
Seeing bisexual people as spreaders of diseases.
Assuming that bisexual people are a threat to relationships/families.
Believing bisexual people to be manipulative, evil or tragic.
Thinking that bisexual people will always leave their ‘same’ or ‘other’ gender partners.
Assuming that bisexual people can pass as heterosexual and are therefore privileged or taking the ‘easy option’.
Denigrating the attractiveness of bisexual people.
Viewing bisexual people only in terms of their sexual practices, for example as objects to fulfill sexual fantasies (such as threesomes).

The purpose of this section is to describe some considerations and key concepts when working with bisexual clients.
These considerations and key concepts may serve as a roadmap for future exploration or future education as they apply to the clients you are working with.
Stigma from disclosing one’s sexual orientation can take many forms including: hostility, bullying, violence and homicide.
Providing clients with a safe space to discuss the challenges they experience with disclosing and engaging in role-playing “coming out” to different people in their lives can be helpful.


Here are some more recommendations for creating an affirming and welcoming environment for bisexual clients:

Inform yourself about bisexuality and avoid stereotypes about bisexual people.

Include bisexual representation in all relevant working groups and initiatives.

Here are some more recommendations for creating an affirming and welcoming environment for bisexual clients:

Don’t assume a unified bisexual experience. Many different types of relationships and sexual practices are found among bisexual people. The experiences and needs of bisexual people are also affected by their race, culture, gender, relationship status, age, disability, religion, social class, geographical location, etc...

Recognize that bisexual people are also subject to homophobia and heterosexism.
Here are some more recommendations for creating an affirming and welcoming environment for bisexual clients:

Support and commission research addressing the specific needs and experiences of bisexual people.

Support events and spaces for bisexual people financially, through access to venues, and with publicity/promotion.

These data are from the National Intimate Partner & Sexual Violence Survey conducted in 2010. The data demonstrate that bisexual males and females are the most at risk for violence among LGB and heterosexuals. For women, nearly 2/3 of bisexuals have experienced violence, compared to 44% of lesbians and about 1/3 of heterosexual women. For men, just over 1/3 of bisexual men reported experiencing violence, compared to approximate ¼ of heterosexual and gay men.

Violence against trans people, especially trans people of color, is also extremely high. This is covered in the Trans Module. The following report might also be interesting for anyone looking for further information: [http://avp.org/storage/documents/2013_ncavp_hvreport_final.pdf](http://avp.org/storage/documents/2013_ncavp_hvreport_final.pdf).

Read all or selected interventions on the slide and proceed to the next slide.

References:

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Resources:
- BiNet USA: [http://www.binetusa.org/](http://www.binetusa.org/)
- The Bisexual Resource Center: [www.biresource.net](http://www.biresource.net)
- BiSexual.com: [www.bisexual.com](http://www.bisexual.com)
- Shybi.com: [www.shybi.com](http://www.shybi.com) (women), [www.shybi-guys.com](http://www.shybi-guys.com) (men)
- American Institute of Bisexuality: [www.bisexual.org](http://www.bisexual.org)
- Journal of Bisexuality: [www.tandfonline.com/toc/wibi20/current](http://www.tandfonline.com/toc/wibi20/current)
Module 6: Addressing the Needs of Transgender Individuals
Welcome participants to module.

Introduce title and trainer(s) for this module.

Identify YMSM/LGBT CoE as the organization who developed curriculum.

It might be helpful to mention the duration of the module, which is approximately 60 minutes in length. The duration of this module depends on the group’s level of participation with any activities, questions, comments and discussion. Also, the duration of the module is impacted by the number of slides presented. Trainer(s) might opt to omit slides/sections due to time constraints, prioritization of content or redundancy of information based on group’s prior knowledge.

If necessary, remind participants of housekeeping details such as, the location of restrooms and silencing cell phones, etc...

These SMART (specific, measureable, attainable, realistic and time-bound) learning objectives provide the participant with key ideas and themes that will be covered in this module.

Examples of two core concepts related to being transgender are: 1) sex assigned at birth and 2) gender identity.

Examples of two factors associated with substance use among transgender individuals are: 1) depression and 2) sex work

Examples of two ways a provider can create an affirming space for transgender individuals are: 1) educate treatment program staff and enforce policy and 2) allow trans clients to use bathrooms, showers and sleeping facilities based on their current gender identification.
The purpose of this section is to provide an overview of transgender identity, as well as key terms and concepts to help participants respectfully engage transgender clients.

The purpose of this slide is to provide a definition of who is being referred to when using the term, “transgender” or “trans” in this module.

Sex assigned at birth involves classifying people as male or female. Assigning a sex at birth is often based on the appearance of their external anatomy and is documented on their birth certificate.

In actuality, a person’s sex is a combination of biological markers (chromosomes and hormones) and anatomic characteristics (reproductive organs and genitalia). Impacted by legal, policy, cultural and social issues.

Additional Resource:
http://www.glaad.org/reference/transgender
The term “Trans umbrella” includes many different gender identities. For example:

**Trans man:** A person who was assigned a female sex at birth and who now identifies as male. Some clients may use the term FTM (female to male).

**Trans woman:** A person who was assigned a male sex at birth and who now identifies as female. Some clients may use the term MTF (male to female).

**Genderqueer/Gender non-conforming:** Describes someone who blurs or bends the gender binary and/or identifies outside of the gender binary.

**Trans:** Some trans people may use the term trans to describe their gender identity.

**Additional terms:** It’s important to note that these definitions and terms may be regionally/culturally specific and may change over time.

The best way to respect your client is to ask them how they describe their gender identity and use the term that they prefer.

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This is included as a reminder of the terms and is repeated from information contained in the introductory module.

It is important to highlight everyone (including trans clients) has a gender identity, gender expression, sex assigned at birth and a sexual orientation.

The trainer(s) can use themselves or a hypothetical client as an example. “Brian” was born with male sexual reproductive organs at birth, and was assigned “male” at birth. Since he was an adolescent, “Brian” has identified as “male” and expresses his gender as a “male” (e.g. plays sports, wears ‘male’ clothing, plays with other ‘males’) and since adolescence, “Brian” identifies as “heterosexual.” Therefore he has all four core concepts of identity, expression, sex assignment and sexual orientation.

**Sex assigned at birth:** A combination of biological markers (chromosomes and hormones) and anatomic characteristics (reproductive organs and genitalia). Impacted by legal, policy, cultural and social issues.

**Gender expression:** how one externally manifest their gender identity through behavior, mannerisms, speech patterns, dress, and hairstyles.

**Gender identity:** A person’s internal sense of their own gender. (Keatley, Deutsch, Sevelius & Gutierrez-Mock, 2015)

**Sexual orientation:** distinct from gender identity and expression. Describes a combination of attraction, behavior and identity for sexual and/or romantic partners. (Keatley, Deutsch, Sevelius & Gutierrez-Mock, 2015)
The best way to know what pronoun or name a client prefers is to ask them, and then consistently use the proper pronoun until the client says otherwise.

It is important for providers to be aware trans clients may discontinue services if their preferred names and pronouns are not consistently used by staff.

A strategy for providers who find it is difficult to consistently use a client’s preferred gender pronoun might be to practice using the correct pronouns with other staff.

The purpose of this slide is to educate providers on pronouns some clients might prefer to use.

“They/them” is used to refer to one individual person and is gender neutral.

“Ze/Hir” are additional gender neutral pronouns.

Most of the current trans population are estimates or are based off of LGBT studies.

There are currently no statewide or national population-based data that include gender identity measures that accurately capture trans people.

The Massachusetts landline survey is the ONLY population based study in the U.S.

28,662 residents ages 18-64

Respondents were asked: “Some people describe themselves as transgender when they experience a different gender identity from the birth sex. For example, a person born into the male body, but who feels female or lives as a woman. Do you consider yourself to be transgender?” The survey was limited to people with landlines.
This next section will cover related health issues specific to trans individuals and communities. It is important for providers to view the client as a whole being, aiming to increase wellness not just in some areas, but in all areas of the client’s life. When providers work from this approach – the client may experience greater overall health outcomes.

It is important for providers not to assume that transgender clients do not need services such as pelvic exams or contraception, or that understanding transgender sexual and reproductive health is too complex. Each transgender client has unique health care needs. Providers should become familiar with clinical guidelines for transgender people and find a way to engage in discussion with clients about their sexual and reproductive health experiences.

Read the text on the slide and proceed to the next slide.
Among the trans men in the Reisner study, 65% of respondents reported regular alcohol use (5+ drinks per week); 17% reported marijuana use; 13% smoked cigarettes; 9% reported stimulant use and 9% reported injection substance use. Types of substances used vary regionally.

Optional Activity:

It might be helpful to explore with participants the following question, “Why do you think substance use rates are high for transgender individuals?”

This question is intended to get participants thinking about the unique challenges transgender individuals face, and how those challenges impact their lives.

Trainer is encouraged to write these responses down on easel chart or dry erase board so all participants can read and review responses.

Substance use is an issue in trans communities, especially because many trans people use substances in order to cope with experiences of transphobia.

Transphobia is defined as: fear, dislike and/or prejudice of transgender individuals. More about transphobia will be discussed in the final section of this module.
HIV is treated using a combination of medications to fight HIV infection, referred to as antiretroviral therapy (ART). ART isn’t a cure, but it can control the virus so that HIV-positive individuals can live a longer, healthier lives. ART can also reduce the risk of transmitting HIV to others.

Read the text on the slide and proceed to the next slide.

Additional Resource:

There are only estimated prevalence numbers for HIV among trans communities. Not all health jurisdictions choose to collect surveillance data that captures both sex assigned at birth and current gender identity.

A 2008 meta-analysis from the CDC found an estimated prevalence of 28% among all studies that reported HIV status, in comparison to only a 12% average prevalence when participants self-reported their HIV status.

This figure tells us that there are opportunities to increase HIV testing among this population.

Additionally, when analysis was broken out by race/ethnicity, there was a 56% estimated prevalence among Black trans women, highlighting the community that desperately needs additional resources.

All of the data that has collected HIV status among trans men show a low prevalence between 0-3%. Trans men who have sex with non-trans men (TMSM) report engaging in high risk sexual behaviors, however we do not yet see a high rate of HIV. In order to keep these numbers low, organizations that serve gay and bisexual men could ensure that their services and prevention messaging are inclusive of trans men.
The purpose of this slide is to highlight the need for culturally appropriate mental health services for trans people.

Additionally, a trans person’s gender identity may or may not be an issue in their lives. It is important for providers to be aware “gender” should only be discussed if the client reports that as an issue they are dealing with.

It is important for providers to be aware of the importance of hormone therapy, if the client identifies hormone therapy as a need/goal.

The research indicates that access to trans related care, including hormone therapy, can improve the mental health status of trans individuals.
Puberty blockers are used to block hormone-induced biological changes (such as vocal chord changes, the development of breast tissue or changes in facial structure) can be especially distressing to children who are gender-non conforming or transgender. It is important to note that these changes are irreversible.

There have been some concern on the decrease in bone density during treatment with puberty suppression. This is because, estrogen and testosterone, the hormones blocked by these medications, also play a role in a child’s neurological development and bone growth.

Endocrine guidelines recommend that after 1 year of hormone treatment, the transsexual individual, the attending endocrinologist, and the mental health care professional may consider sex reassignment surgery. Although studies have shown this procedure to be relatively safe and effective, little is known about the long-term effects of stalling puberty at the age when children normally go through it and the implication of taking medication for long period of time. Providers should engage in research to ensure safe transition of their transgender clients.

One important consideration for providers is that trans man or woman who receives Sex Reassignment Surgery should be consistently supervised and evaluated to ensure all forms of risk is drastically decreased.
The purpose of this slide is to highlight the prevalence of bullying, physical assault, sexual abuse, harassment and school expulsion for trans people.

Because of the heightened risk for assault, trans clients may turn to drugs and alcohol as a way to cope with assault, or to mitigate the fear of being assaulted.

Structural and interpersonal racism can have negative, lasting effects on individuals. This is further compounded for trans individuals who also experience transphobia.

It is critical for providers to be mindful of how both racism and transphobia can impact clients' lives.

The purpose of this section is to describe some considerations and key concepts when working with trans clients.

These considerations and key concepts may serve as a roadmap for future exploration or future education as they apply to the clients you are working with.
The purpose of this slide is to introduce the ecological model of health, which will be discussed over the next 5 slides.

This model will be used as a framework to explain how stigma and transphobia impact trans people throughout all areas of their lives.

The five levels of the ecological model of health include:

1. Intrapersonal – knowledge, attitudes, behavior, beliefs, skills and self-esteem
2. Interpersonal – social networks, support systems, family, friends and co-workers
3. Institutional – social institutions
4. Community – networks and organizations
5. Policy – local, state, national and global policies and law

First, what does intrapersonal stigma and transphobia look like?

At an individual level, the negative images and beliefs about trans people can be internalized by trans people, leading to internalized transphobia, low self-esteem, depression and self-harm.

Additionally, trans people may attempt to seek gender identity validation through external sources, such as sex partners, which may place them at risk for HIV/AIDS.

Second, what does interpersonal stigma and transphobia look like?

At the interpersonal level, stigma and transphobia are particularly evident among peer groups.

Peer groups can include: students, co-workers, family members and sexual/romantic relationships.
Third, what does institutional stigma and transphobia look like?

At the institutional level, transphobia impacts health care, educational settings, employment, housing, public accommodations, correctional settings and religion.

Fourth, what does community stigma look like?

At the community level, trans people are disproportionately impacted by violence, compared to non-trans people.

Additionally, in some trans communities there may be a norm of sex work and substance use.

Social stigma can permeate all aspects of a trans person’s life.
Lastly, what does policy stigma and transphobia look like?

Although the American Bar Association passed a resolution in 2013 discouraging the use of “trans panic” defenses, state and local governments must pass legislation that does not allow the use of trans panic defenses.

This type of defense is used to exonerate people who commit violence against trans people solely based on a person “panicking” when they become aware of someone’s trans status.

Additionally, there are many local and state governments in the United States that do not include gender identity or gender expression in non-discrimination laws. This means that trans people can be denied housing, employment and public accommodations solely on the basis of their gender identity or gender expression.

Name and gender change laws are complex and vary from state to state. Some states do not allow a person to change their sex designation on their birth certificate, meaning that a trans person may always have to be “out” as trans to potential employers.

Finally, trans people frequently immigrate to the U.S. to escape gender-based violence in their countries of origin, but upon arrival experience transphobic immigration laws, such as denial of asylum.

Facilitator should be check before the training to see if this is the most current map. Please check, http://www.lgbtmap.org/equality-maps/non_discrimination_laws to verify.

This map displays the states that currently ban discrimination based on sexual orientation, gender identity and/or expression. Only 20 states and the District of Columbia have state-wide non-discrimination laws.

There are also local non-discrimination laws in the states that do not have a state-wide ban. Participants will notice the majority of the states do not ban discrimination based on gender identity or gender expression.

Facilitator should be check before the training to see if this is the most current map. Please check, www.thetaskforce.org to verify.
The purpose of this slide shows some of the factors that protect trans people against negative health outcomes associated with transphobia.

Range of protective factors: intrapersonal level – being able to find a sense of gender affirmation from within oneself can be a protective factor. This is one of the reasons why it’s so important for substance use programs to have trans-specific components.

Protective factors on the policy level include: non-discrimination policies protect trans people against negative health outcomes. These types of policies can be implemented in your programs in order to better serve trans clients.

Trainer(s) will need to review the explanation of “Intersectionality” prior to delivering training.

The concept of intersectionality (Crenshaw, 1989) describes the intersections of gender and race in the context of violence against women of color.

The concept of intersectionality can also describe the complex experience of the transgender and gender nonconforming persons of color.

The concept of intersectionality according to Olena Hankivsky (2014) states that “intersectionality” promotes an understanding of human beings as shaped by interaction of different social locations – race/ethnicity, gender, class, etc. And these interactions take place within what Havinsky refers to as structures of power and systems (i.e. laws, policies, government, and/or religious institutions), thus resulting in the formation of privilege and oppression shaped by colonialism, racism, and homophobia.
It is important for providers to be aware of how intersectionality can help to frame various interactions between race, gender, sexuality and class in the context of trans people’s life experiences.

Trans people experience stigma and discrimination based on their whole selves, including their socio-economic status, race/ethnicity, sexuality and gender identity.

Intersectionality helps to explain the disproportionate HIV prevalence among trans women of color, particularly among Black trans women. The intersection of racism, classism and transphobia are the root causes behind many negative health outcomes.

It is important for providers to consider how gender segregated facilities may impact trans individuals and to integrate trans people in their current gender.

Additionally, identity documents may not match a person’s preferred name or gender, requiring that files and records clearly indicate preferred name and gender.

Staff competence is incredibly important in service settings, as transphobic staff are a barrier to necessary treatment and care.

For appropriate clinical assessments, staff must be certain that they are asking clinically relevant questions rather than questions based on their own ignorance or curiosity. This is particularly important for questions regarding a trans person’s anatomy.

Trans people also experience bullying and victimization from other clients, which can be lessened by non-discrimination policies that are actively enforced and staff who are culturally competent.

Finally, electronic health records that do not have transgender-specific options make it difficult for trans people to change the sex designator under which they will be classified. Some EHRs may permit a change but will retain a record of that change, which is visible to numerous people outside of the client’s control, leaving trans clients vulnerable to discrimination. Service settings are encouraged to adopt flexible systems or develop a workaround, such as utilizing a visible notes section that display a person’s current name and gender.
It is helpful for providers to be aware that questions regarding a client’s anatomy should only be asked if it is clinically relevant.

Clients should be placed or housed according to their current gender identity, not according to their anatomy.

It should not be necessary to ask a trans person about their anatomy in order to place them in a sex-segregated facility.

The purpose of this slide is to describe recommendations for research or data collection purposes (i.e. intake form) that is respectful and sensitive to the needs of trans clients.

Visual example of the recommendation on the previous slide. Proceed to the next slide after reviewing with participants.
All of these experiences are barriers to substance use treatment programs for trans people.

Provided Considerations:
In treatment programs, trans clients report:
- Experiencing more transphobia from treatment program staff than from other clients.
- Programs do not address trans issues.
- Being required to use sleeping and shower facilities inconsistent with their current gender identity.

Additional recommendation: use the client’s preferred pronouns (example: zir/hir and them/they) and name when talking to/about transgender individuals.

Provided Considerations:
Provider considerations cont.:
- Educate treatment program staff and enforce policy.
- Allow trans clients to use bathrooms, showers and sleeping facilities based on their current gender identification.
- Allow trans clients to continue the use of hormones in treatment.
- Advocate for trans client using “street” hormones to receive immediate medical care and legally prescribed hormones.

Read the text on the slide and proceed to the next slide.

Provided Considerations:
Provider recommendations cont.:
- Seek clinical supervision if there are issues or feelings about working with trans individuals.
- Post a nondiscrimination policy in the waiting room that explicitly includes sexual orientation and gender identity.
Timeframe: 10 minutes

Trainers should go through the following myths and facts, and ask participants how believing each myth might negatively influence or impact how a counselor would treat a transgender client.

Examples of interventions:

• Use the proper pronouns based on their self-identity when talking to/about transgender individuals.

• Get clinical supervision if you have issues or feelings about working with transgender individuals.

• Allow transgender clients to continue the use of hormones when they are prescribed. Advocate that the transgender client using “street” hormones get immediate medical care and legally prescribed hormones.

• Require training on transgender issues for all staff.

• Find out the sexual orientation of all clients.

• Allow transgender clients to use bathrooms and showers based on their gender self-identity and gender role.

• Require all clients and staff to create and maintain a safe environment for all transgender clients. Post a nondiscrimination policy in the waiting room that explicitly includes sexual orientation and gender identity.

Read all or selected interventions on the slide and proceed to the next slide. It should be noted, this is not a transgender-specific study, however, the findings for including significant others into treatment for one session might be beneficial for transgender clients.
This PowerPoint module was developed by:

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Resources:

- ALASHO Transgender Network:
  - [http://www.alasho.org/resources](http://www.alasho.org/resources)

- Transgender Transitions of America:

- National Center for Transgender Equality:
  - [http://nctequality.org/](http://nctequality.org/)

- Transgender Care Health Information Archive:

- Center of Excellence for Transgender Health:
  - [http://www.transhealth.ucsf.edu/](http://www.transhealth.ucsf.edu/)

- American Congress of Obstetricians and Gynecologists:
  - [Women's Health Care Providers: Health Care for Transgender Individuals](http://www.acog.org/ResourcesAndPublications/CommitteeOpinions/CommitteeOnHealthCareForWomen/Health-Care-for-Transgender-Individuals)

- Transgender Health Services of the OBGYN Group, DIY and County of San Francisco, (2007), Transgender Health Services Patient Program Guidelines. Accessed online January 15, 2010 from:
References:
Module 7: Considerations for Clinical Work with LGBT Individuals
Welcome participants to module.

Introduce title and trainer(s) for this module.

Identify YMSM/LGBT CoE as the organization who developed curriculum.

It might be helpful to mention the duration of the module, which is approximately 60 minutes in length. The duration of this module depends on the group’s level of participation with any activities, questions, comments and discussion. Also, the duration of the module is impacted by the number of slides presented. Trainer(s) might opt to omit slides/sections due to time constraints, prioritization of content or redundancy of information based on group’s prior knowledge.

If necessary, remind participants of housekeeping details such as, the location of restrooms and silencing cell phones, etc...

These SMART (specific, measureable, attainable, realistic and time-bound) learning objectives provide the participant with key ideas and themes that will be covered in this module.

Examples of two most understood causes of minority stress are: 1) prejudice and 2) discrimination.

Example of one principals of trauma-informed care is: safety, to ensures that each person feels secure/non-threatened physically and in their role.

Example of one treatment approach shown effective with LGBT populations is: Cognitive Behavioral Therapy (CBT)

The purpose of this section is to provide an overview of stigma and stress, and the negative effects both have on LGBT individuals, which can lead to unhealthy coping behaviors.
Minority stress results from daily and on-going negative social conditions experienced by LGBT individuals. This stress is perpetuated by general social prejudices against LGBT individuals and communities, as well as discriminatory systems and laws.

Additional Resource:

Homophobic, biphobic and transphobic prejudices often stem from the belief that being LGBT is bad or wrong.

Examples of how these beliefs are expressed include:

1. A person asking a gay male couple with a child which man is the “real” parent.
2. Two women embracing in public getting taunted with homophobic remarks.
3. Transgender person being asked about their anatomy and other invasive questions.

Additional Resource:

Additional examples of minority stress in literature and research:

Same-sex individuals twice as likely than heterosexuals to have experienced discrimination in their lifetime.

Five times more likely to indicate that discrimination had interfered with having a full and productive life.

Perceived discrimination correlated with mental disorders including substance use disorder.
Perceived or actual discrimination, shame and stigma from behavioral health providers directed towards LGBT people can cause an avoidance or delay in screening and care, which can exacerbate problems and create more harm.

For example, the connections between minority stress, depression, weight gain and obesity, diabetes, smoking, cortisol levels and inflammation among a lesbian individual – who avoids healthcare services because she perceives “all healthcare providers to be homophobic” exacerbates her health problems and her symptoms become worse.

A theme throughout this training is the need for improved behavioral health care systems to meet the needs of LGBT people.

The purpose of this slide is to introduce “unconscious bias,” which a brief overview will be provided on the next three slides.
Research shows that our brains jump to assumptions and conclusions without us even knowing it. This is the science of “unconscious bias”. Unconscious bias applies to how we perceive other people. We are all biased and becoming aware of our biases will help us mitigate them in the workplace and in society.

Societal examples of unconscious bias about gender:
1. Assuming the husband’s job caused the family to relocate.
2. And “Does your wife work?” vs. “What does your wife do?”

Work examples of unconscious bias about gender:
1. If a woman in leadership is introduced as, “This is one of our senior/executive Women in leadership...” vs. “This is one of our senior leaders...”. We never say “This is one of our senior men in leadership.”

Additional Resource:
https://implicit.harvard.edu/implicit/aboutus.html

Examples of unconscious bias about sexual orientation and gender identity:
1. When asking a man if married, responding “What does your wife do?” To a woman: What does your husband do?
2. Asking a man if he has a girlfriend? Asking a woman if she has a boyfriend?
3. Asking an openly identified transgender person upon meeting them personal questions about surgeries or when they changed their sex, questions that within most social conventions are deemed too personal to ask when first meeting.
The purpose of this slide is to introduce and provide an overview of trauma on the next six slides.

The purpose of this slide is to highlight traditional or historic understandings of trauma. There is a contrast between traditional and contemporary understandings of trauma which will be explored on the next slides.

Here are some additional examples of traditional understandings of trauma:

1. Clients are joined with an issue and defined by the issue.
2. Consumer is a passive recipient of services & services are hierarchal.

The purpose of this slide is to show the contrast between contemporary understandings of trauma versus historic understandings.

Here are some additional contemporary understandings of trauma:

Trauma is an event that “is outside the scope of everyday human experience and it is notably distressing to almost anyone.” (Green, 2010).

Trauma characterized by feelings of fear, loss, threat, and vulnerability.

Trauma is different for each person, and therefore, the effects of trauma cannot be generalized.

Here is an example of how the effects of trauma can be unpredictable, non-linear, nor directly observable: If a student is verbally harassed in a classroom by his peers and the teacher does not correct the peers, the student will not only not want to be in that class, but may also take this experience to other classrooms, may not want to go to school, college, may not trust authority, etc.
Here is an example of how an LGBT clients might experience additional trauma:

A bisexual woman is currently in an abusive, same-sex romantic relationship.

The woman does not access supportive services for the domestic violence because she feels counseling programs would not understand her relationship with another woman. This perception is based on her experiences with her family and friends, who have a hard time understanding and accepting it.

There were a few times she sought support from her family after she was badly beaten. The family blamed her for being in a same-gender relationship and cited her same-sex relationship as the root cause of the abuse.

They continuously pressure her to get back together with her ex-boyfriend, because she would be much happier, safer, and sexually satisfied.

“Coming out” can be good for one’s health. Measures of psychiatric symptoms, hormone levels throughout the day, and a battery of over twenty biological markers found lesbians, gay men, and bisexuals who were out to family and friends had lower levels of psychiatric symptoms anxiety, depression and burnout. However, it is important to note the opposite may be true if people come out in hostile or dangerous environment.

Additional Resources:

www.glaad.org/news/gay-good-coming-out-improves-mental-health-say-researchers

www.psychosomaticmedicine.org/content/early/2013/01/18/PSY.0b013e3182826881.abstract
Additional examples of LGBT-related traumas:
Institutions that stigmatize LGBT individuals and identities such as some religious or faith-based communities, military, and/or educational settings. Also, dealing with misconceptions and invalidation from a wide range of service providers including: social service, behavioral health and medical providers.

The purpose of this graphic is to illustrate the impact of minority stress, unconscious bias and trauma for an LGBT individual.

The purpose of this slide is to introduce trauma-informed care, which will be discussed on the next eight slides.
It is important for providers working from a trauma-informed approach to view the client as a whole being with the understanding their behaviors might be a means to survival from the harms, violence, abuse, stigma and prejudice clients have experienced.

In working from a trauma-informed approach, clients are the expert on their lives, clinician are there to help guide.

Decisions are made collaboratively and counselor knows that trust must be earned.

Again, trauma should not be viewed as a single event with a linear impact. Instead it should be viewed as a defining and organizing experience that forms the core of an individual’s identity.

The purpose of this visual graphic is to compare and contrast between traditional and trauma-informed approaches to care.

Additional examples of how trauma-dynamics can be repeated in a therapeutic setting:

1. Coercive approaches, including involuntary medications and hospitalizations
2. Presumed incompetence and need for guardianship
3. Fear of client violence, using restraint and seclusion
4. Negative interactions with staff, including inconsistent rules, disrespect, and humiliation
The purpose of this slide is to introduce and briefly describe the five principals of trauma-informed care. Examples of each principal will be described on the next four slides.
With regard to cross-disciplinary collaboration, this can be as simple as learning what your co-workers do, or learning about the current projects they are working on.

Unfortunately, factors such as busy schedules and format of staff meetings may offer little time to learn about new projects others are working on.

Opportunities to share not only benefit the organization as a whole, but identifying resources with other staff can benefit clients too.

**Trauma-Informed Care:**

Examples of collaboration:
- Demonstrate commitment to LGBT equity and inclusion in recruitment and hiring.
- Add LGBT-inclusive language to job notices.
- Train human resources employees on LGBT-inclusive nondiscriminatory statement, benefits, and policies.
- Update training and educational material on a regular basis.
- Encourage cross-disciplinary collaboration.
- Incorporate LGBT patient care information in new or existing employee staff training.

**Discussion Activity:**

Generate ideas on how each principle can apply to LGBT individuals:

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment

**Timeframe: 10 minutes**

Trainers divide participants into five groups. Each group is assigned one of the five principles of Trauma-Informed Care. Generate ideas how to customize your group's principle to the LGBT people. Come back and share with the group. Trainers conduct a large group discussion on the ideas generated and how they can improve care.
An example of developing LGBT-sensitive assessment strategies is not making assumptions about one’s sexual orientation or gender identity.

An example of asking questions in an affirming way: “do you have a significant other?” and if the client responds yes, “what is the gender-identity of your significant other?”

An example of how to validate strength and resilience with clients is by normalizing unhealthy coping behaviors as a result of life’s challenges, stigma and stress.

Providers should not make any assumptions and assess for same-sex domestic violence issues and previous traumatic experiences with the coming out process.

Providers should also assess family and social related issues, their family of origin, their chosen family, any social involvement and possible social isolation.

Provider can also assess any current or past connection to ethnic or cultural groups for support.
Sexual Milestones: As we develop, we naturally practice the behaviors of adulthood. This includes practicing behaviors that lead to health sexual interactions. For example, children hold hands with each other and kiss. As they move into adolescence, kissing and touching may take on a more intimate, sexualized quality. Heterosexual youth can practice behaviors such as hand-holding or kissing in public without fear of significant public reaction. LGBT youth may face negative reactions. Therefore, they may engage in these behaviors in secret progress through initial sexual milestones early, engaging in more adult behaviors, up to and including sex, before they are emotionally ready to do so. This may lead to increased feelings of shame or guilt, and/or negative reactions from family or loved ones.

Family Dynamics
Younger MSM were crossing sexual milestones at earlier ages which often coincides with when they are highly dependent on their families for food, shelter, and social/emotional support.

Coming out “early” has been connected with experiencing forced sex and gay- related harassment before adulthood, HIV seropositivity, partner abuse, and depression during adulthood.

Negative outcomes likely driven in part by family rejection, evidenced as poor familial support, being harassed by family members because of sexual identity, and/or being kicked out of the home.
Racism coupled with homophobia, biphobia, cissexism, and transphobia can lead to negative health outcomes. Youth of color face special challenges in a society which often presents heterosexuality as majorly the acceptable orientation and in which non-whites have disproportionately higher rates of negative sexual outcomes.

**The Impact of Homophobia and Racism on LGBT Clients**

- Youth of color are significantly less likely to have told their parents they are LGBTQ
  - 80% of GLBTQ whites are out to parents vs. 71% of Latinos, 63% of African Americans, and 51% of Asians/Pacific Islanders
  - African American same-sex attracted youth were more likely to have low self-esteem and experience suicidal thoughts than other ethnic counterparts
  - African American same-sex attracted young men were also more likely to be depressed

(Bligh, J. 2015)

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**Trainer Notes:**
The trainer will use this slide to reinforce the concept that actions don’t always match values & beliefs because of conditioning and blind spots and that self-awareness and subsequent actions are required to move toward congruent cultural proficiency.

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**Practitioner Awareness – YOU**

- Consciousness of one’s personal reactions to people who are culturally different.
- Social science research indicates that our values and beliefs may be inconsistent with our behaviors, and we ironically may be unaware of it.


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**Trainer Notes:**
As this module comes to a close the trainer reviews the content on this slide and reminds participants that moving toward cultural competence/humility/proficiency is an the active process and actions are required.

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**Culturally-Informed Strategies**

- Refrain from making assumptions
- Recognize that as human beings, our brains make mistakes without us even knowing it
- Communication can be as unique as a person’s cultural perspective
- Support & encourage positive images of persons of color, YMSMs, women, LGBTQ, Spirit, gender variant/non conforming, elderly, other-abled, and not written here, in conversation and all environments
To treat me...you have to know who I am......

- https://www.youtube.com/watch?v=NUJvJxgAac

LGBT Assessment Checklist

- Alcohol, tobacco, and other drug use
- The adolescents’ social environment
- Sexual identity development
- Stage of coming out
- Level of disclosure about sexuality
- Level of disclosure about gender identity
- Gender identity
- Gender identity development
- Family and social support network
- Impact of multiple identities, gender/ethnic/cultural/sexual orientation
- Knowledge and use of safer sex practices
This next section will describe treatment approaches as they apply to LGBT populations. The following will be reviewed over the next 11 slides: Assessment, Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Art Therapy, Mutual Self-Help Groups, and Aftercare.

Motivation is key to change and is multidimensional. Motivation is dynamic and fluctuates. The provider’s style and approach has a strong influence on the client’s motivation. MET is based on Prochaska and DiClemente’s Transtheoretical Model of Change which will be discussed on the next slide.
The Transtheoretical Model of Change has been applied to a wide variety of problematic behaviors such as: smoking, drug and alcohol use and risky sexual behaviors.

Prochaska and DiClemente identified six stages to behavior change:

1. Pre-contemplation stage: no awareness of problematic behavior(s).
2. Contemplation stage: characterized by ambivalence. An example of a client’s ambivalence might be if he/she stated, “One the one-hand it might be good to quit, but on the other hand I like to use and have fun.”
3. Preparation stage: client has decided change will happen and has started to gather information, support, and put a plan together.
4. Action state: client is “working the plan” – the change is new and client may need a lot of support and encouragement.
5. Maintenance stage: client has maintained new behavior for 6 months, usually 1 or two years. Providers may need to keep reinforcing support, motivation and treatment plan.
6. Relapse stage: client has returned back to the problem behavior (can be for a very short time or a long time). Client may return to any of the previous stages and begin again.

CBT focuses on how to manage life, sexual identity, anxiety and depression, substance abuse (Chesney et al. (2003).

CBT also help systematic desensitization. Some areas for systematic desensitization might include: social anxiety associated with coming out process, living with HIV, socializing in general in the LGBT community.

CBT also helps with relapse prevention, such as developing coping skills to reduce relapse into mental and/or substance use disorders.
Specifically, the case study by Willoughby and Doty (2010) detailed how they explored and challenged the parents’ expectations, beliefs and attributions. They also increased the frequency of positive family experiences and facilitated family problem solving.

Another treatment approach used for gay and lesbian couples with alcohol use disorders is Behavioral Couple Therapy (BCT).

Both Gay and Lesbian couples who received BCT and individual therapy for the identified client with alcohol use disorder did significantly better than the couples who only received individual therapy for the client with alcohol use disorder. Reported less alcohol consumption and higher levels of adjustments, which were the same results as with heterosexual couples (Fals-Steward, O’Farrell, & Lam, 2009).

One example of an activity: “Inside Me, Outside Me” instructs the client to create two self-portraits. One portrait is of the publicly presented self. The other portrait is the private, internal self. Clients in the stages of coming out might have two very different portraits. These portraits can be used as a for discussion and reflection.

Additional Resource: 
Important for providers to update resource list on an on-going basis. In addition to updating, reach out, visit, talk with group facilitators and coordinators ahead of time.

LGBT aftercare services may not exist in all communities. Providers might consider working in partnership with other providers/organizations to create new opportunities for services addressing aftercare.

It is important for providers to be mindful of other topics clients may be negotiating such as: obtaining housing, finding employment, dealing with health issues, addressing debt, other addictions (i.e. smoking), child custody issues, etc...

The provider and client can collaborate and identify the immediate priorities and concerns. Then the provider and client can map out a plan to address the other issues.

This process is offering additional skills of managing life.
The purpose of this section is to describe some considerations and key concepts when working with LGBT clients.

These considerations and key concepts may serve as a roadmap for future exploration or future education as they apply to the clients you are working with.

As discussed in the Gay Men/MSM module:

Prior to 1973, goals for those seeking treatment for homosexuality were to decrease the intensity and frequency of homosexual thoughts, feelings, and behaviors while simultaneously increasing heterosexual thoughts, feelings, and behaviors.

There were aversive therapies and other attempts at counter conditioning, including electric shocks when a patient became aroused to pictures of the same sex or the ingestion of a nausea-inducing drug prior to examining these pictures.

Gay men, lesbians, and those with attraction to both genders volunteered for psychosurgeries and hormonal treatments that would theoretically masculinize gay men or feminize lesbians.

Families had their same-sex attracted individuals involuntarily committed to mental health facilities, often for years.

Celibacy was ultimately a common suggestion after other treatments inevitably failed.
Here are some examples of direct quotes on reparative therapies:

American Medical Association: Policy Number H-160.991, Health Care Needs of Homosexual Populations (2015): “[B]elieves that the physician’s nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness[,]” and “opposes the use of ‘reparative’ or ‘conversion’ therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation.”

American Psychological Association: Policy on Transgender, Gender Identity and Gender Expression Non-Discrimination (2015): As stated in the Policy on Transgender, Gender Identity & Gender Expression Non-Discrimination, the APA “opposes all public and private discrimination on the basis of actual or perceived gender identity and expression and urges the repeal of discriminatory laws and policies” and “calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment to transgender and gender variant individuals and encourages psychologists to take a leadership role in working against discrimination towards transgender and gender variant individuals[.]”

Additional Resource:

Read the text on the slide and proceed to the next slide.
For more information, providers can review SAMHSA’s Technical Assistance Publication (TAP) Series 21, “Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice.”

Additional Resource:
https://store.samhsa.gov/shin/content/SMA12-4171/SMA12-4171.pdf

Given evidence that minority stress taxes individuals’ emotional regulation resources and thereby confers risk for psychopathology, helping clients learn strategies for mindful awareness of minority stress reactions can facilitate positive mental health.

Providers can also help clients reduce avoidance. Chronic stress exposure can lead to maladaptive forms of cognitive, affective, and behavioral avoidance.

Helping clients confront painful minority stress memories, emotions, or interpersonal encounters in safe contexts can potentially weaken the ongoing influence of those events on poor mental health.

Providers can help clients build skills on assertive communication in situations in which it is safe and healthy to do so using role play exercises. Unfortunately, previous exposure to stigma can lead LGBT individuals to self-silence, even in situations in which it would be most adaptive to openly express one’s needs, opinions, wants, and desires.

Minority stress can also lead LGBT individuals to internalize rejection or chronically and anxiously expect it. Cognitive therapy exercises can be modified to reduce the ongoing impact of minority stress-driven cognitive biases.
Validate sexual minority individuals’ unique strengths helps LGBT clients appreciate their unique personal strengths and experiences and to draw on those strengths as sources of pride and optimism.

Providers can affirm healthy, rewarding aspects of sexuality among LGBT clients as a way to promote mental, sexual, and behavioral health.

These recommendations from The Foundation from AIDS Research can help providers address the needs of ethnic minority YMSM.

Some factors influencing therapy can be the therapist’s counter transference issues. It is helpful for providers to explore unconscious attitudes that can negatively influence the therapeutic process. Therapists may also want to examine what hinders their ability to have empathy and show genuine positive regard.

Other factors that influence therapy can be the client’s transference issues. Clients might need to examine past influences that shape his/her attitudes toward the behavioral health provider. Provider may also need to examine signs of sexual minority and gender identity-related oppression.
It might be necessary for participants to consider what future education and training needs their organization may benefit from. Topics can include: working with racially and ethnically diverse populations, addressing the needs of substance users (or a drug-specific training such as on ‘meth’), and addressing the needs of youth or aging populations.

Additional Resource:
www.ymsmlgbt.org

Lastly, read the quote on the slide and proceed to the next slide.

Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment.
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