Trainer Guide

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

2nd Edition

www.ymsmlgbt.org

Based on the publication:
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The Center of Excellence on Racial and Ethnic Minority Young Men Who Have Sex with Men and Other Lesbian, Gay, Bisexual, and Transgender Populations
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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).

Table of Contents

Foreword 1

Guide to the Curriculum.... 2

Introduction.. 8
- Training Background Information.... 9
- 2015 Training Context and Description.... 12
- Acknowledgments..... 20

Addressing Issues of Cultural Diversity.... 24
- Culture 26
- Cultural Humility. 29
- Values Calrification.... 34
- Provider Considerations..... 37

Addressing the Needs of Lesbian Individuals. 46
- Lesbians..... 48
- Related Health Issues for Lesbians.... 49
- Provider Considerations..... 56

Addressing the Needs of Gay Men and Men Who Have Sex With Men (MSM). 62
- Gay Men..... 64
- Related Health Issues for Gay Men.... 67
- Provider Considerations..... 73
- Men Who Have Sex With Men (MSM). 77
- Related Health Issues for MSMs.... 81
- Provider Considerations..... 85

Addressing the Needs of Bisexual Individuals. 90
- Bisexuality 92
- Related Health Issues for Bisexuals.... 98
- Biphobia in Society 102
- Provider Considerations..... 104

Addressing the Needs of Transgender Individuals. 110
- Defining Transgender.... 112
- Related Health Issues for Transgender.... 115
- Provider Considerations..... 120

Considerations for Clinical Work with LGBT Individuals 132
LGBT Stigma and Stress.. 132
Trauma-Informed Care... 139
Some General Treatment Considerations.. 143
Treatment Considerations... 146
Using Traditional Treatment Approaches with LGBT Populations.. 147
Provider Considerations.. 151

"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.

Guide to the Curriculum

A Provider's Introduction to Substance Abuse Treatment for Lesbians, Gay, Bisexual, and Transgender Individuals.

The purpose of this introductory training is 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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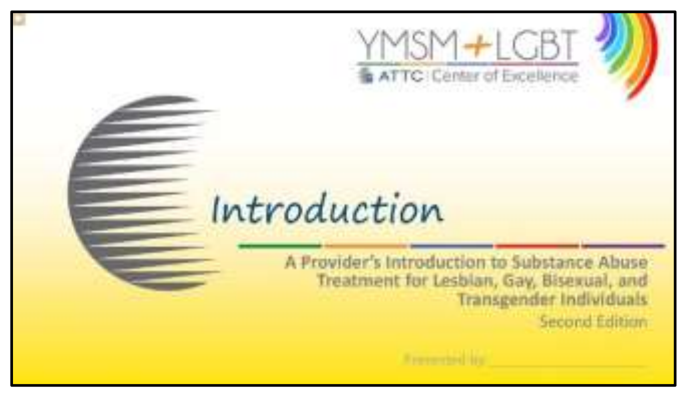
Module 1: Introduction



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.

1-2

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.

1-3

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.

1-4

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.

1-5

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.

Housekeeping:

- Complete necessary paperwork (sign-in, evaluation forms, etc...).
- There will be breaks: mid-morning, lunch and afternoon.
- Manage your electronics – silence phones, take calls outside of the training room.
- Bathrooms are located ____________.
- Suggestions for lunch are____________.

YMSM+LGBT

ATTC Center of Excellence

1-6

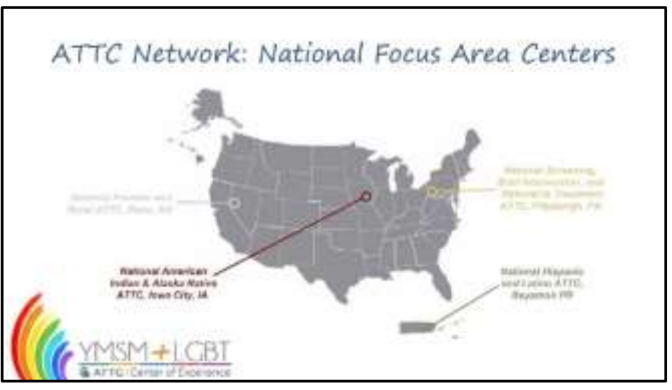
ATTC NETWORK: Regional Centers and the Center of Excellence:

- 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

1-7

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



1-8

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

Training Context and Description

- It is important to recognize that since the inception of this curriculum, equality for the LGBT community has shifted in a more positive direction.
  - *Example: As of June 26, 2015, the Supreme Court has ruled that same-sex marriage is legal in every state.*
- However, shame, stigma, bullying, homophobia, biphobia and transphobia, still create barriers for many LGBT people to access and receive affirming care.

1-9

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

Today's LGBT Curriculum

- The curriculum is designed to develop provider skills in delivering culturally responsive prevention and treatment services for LGBT populations.
- Content focus areas include: physical health, substance abuse treatment, mental health, and other health related concerns for LGBT populations.
- The curriculum also provides treatment strategies and considerations for clinical work that have been effective with LGBT populations.

1-10

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, heath 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.

Today's LGBT Curriculum

- This curriculum does not aim to be the definitive resource, nor does it intend to speak on behalf of all LGBT people.
- We encourage training participants to research and engage local LGBT organizations, providers and constituents.
- Building partnerships with local LGBT entities can help increase your understanding of the LGBT community needs and increase referral options for your clients.

1-11

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

Today's LGBT Curriculum

- The research in this curriculum has been carried out on specific populations, but we cannot explicitly state or assume that people in the transgender community were or were not included.
- This means that although some transgender people may have been included, the LGBT research cannot be generalized to trans people who identify as LGB.

1-12

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

1-13

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

Definition Activity:

Write a definition for the following terms:

- Categories
  - Sex
  - Gender
  - Sexual Orientation
  - Sexual Identity
  - Gender Identity
  - Coming Out
  - Gender Expression
  - Kinsey Scale
  - Klein Scale
- Descriptors
  - Lesbian
  - Gay Male
  - Bisexual
  - Transgender
  - Transsexual
  - Heterosexism
  - MSM
  - WSW
  - Ally
  - Queer
  - Pansexual
  - Intersex
  - Asexual

YMSM+LGBT

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.

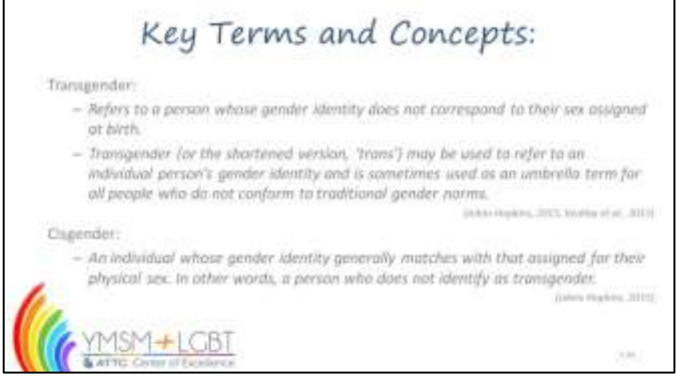
Trainers can explain the need for a common language or a consensus of meaning on definitions and language to understand and more accurately describe who is discussed in this training series. It is still common for many people who are not familiar with LGBT identities, cultures, and lifestyles to be confused 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.

1-16

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



1-17

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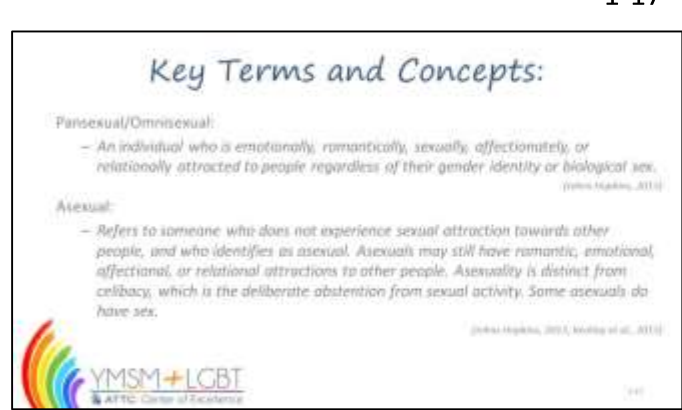

1-18

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:

http://www.hrc.org/resources/entry/sexual-orientation-and-gender-identity-terminology-and-definitions

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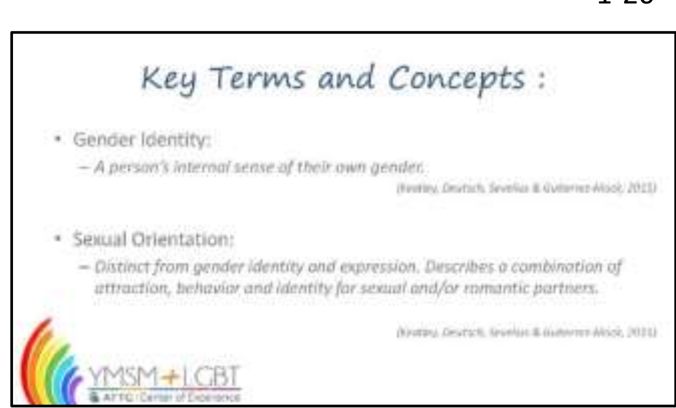
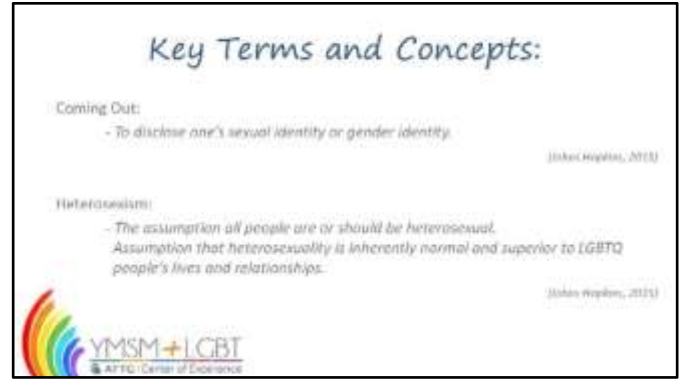
An alternative definition of sexual orientation is a consistent pattern of sexual desire for individuals of the same sex, other sex, or both sexes, regardless of whether this pattern is manifested in sexual behavior. Indicators of sexual orientation can include sexual and romantic desire, attraction,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



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

1-22

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

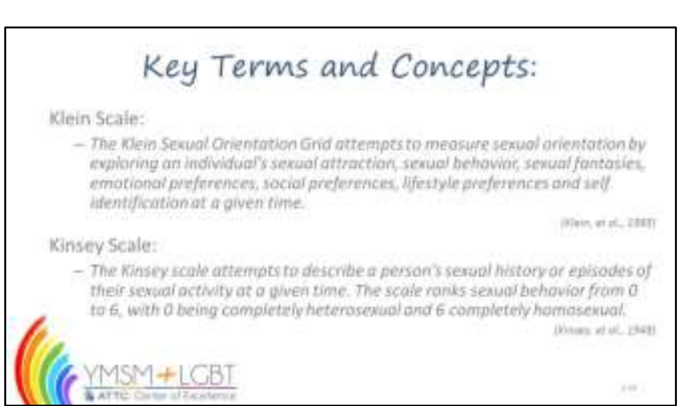


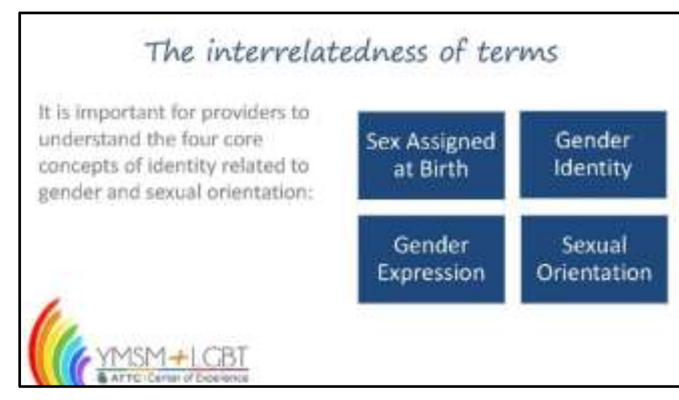
1-23

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

1-24

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





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.

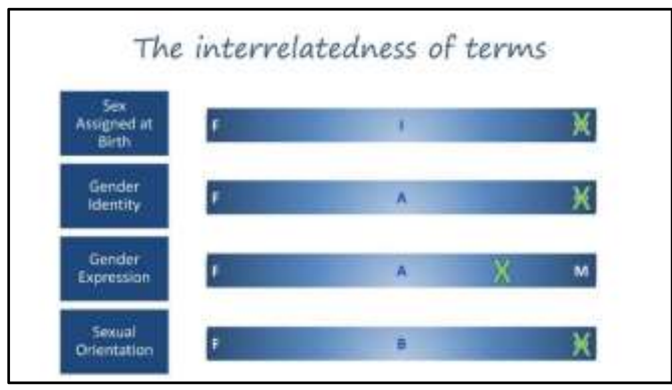
Sex assigned at birth: A combination of biological markers (chromosomes and hormones) and anatomic characteristics (reproductive organs and genitalia). Impacted by legal, policy, cultural and social issues.

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)

1-26



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.

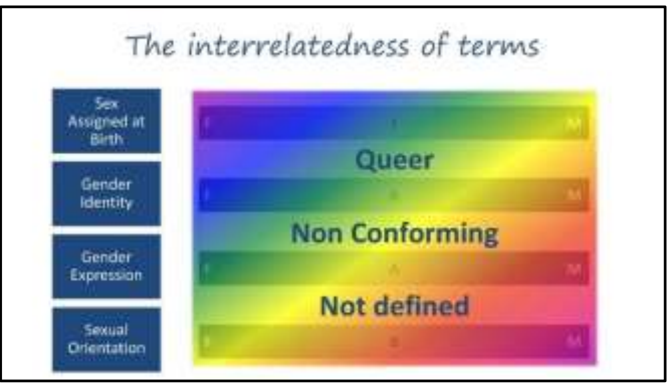
For Gender Identity, we ask a client where they fall on the continuum between male and female in terms of their internal identity. Clients may fall on one end or may identify as genderqueer or somewhere in the middle.

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).

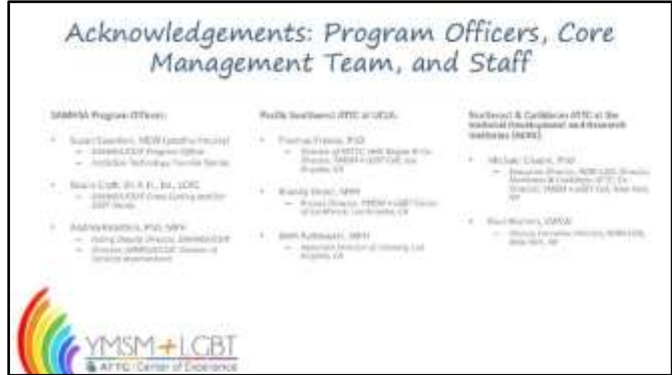
1-27



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.

1-28

Acknowledgements



1-29

Acknowledgements

1-30

Acknowledgements

Acknowledgements: Advisory Board

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1-31

Acknowledgements: Content Experts

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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1-32

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1-33

Authors by Module:

Cultural Diversity:

Bisexual:

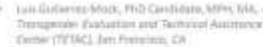
Lesbian:

Gay Men/MSM:

YMSM+LGBT
ATTC Center of Excellence

1-34

Authors by Module:



Transgender:

Treatment Considerations:

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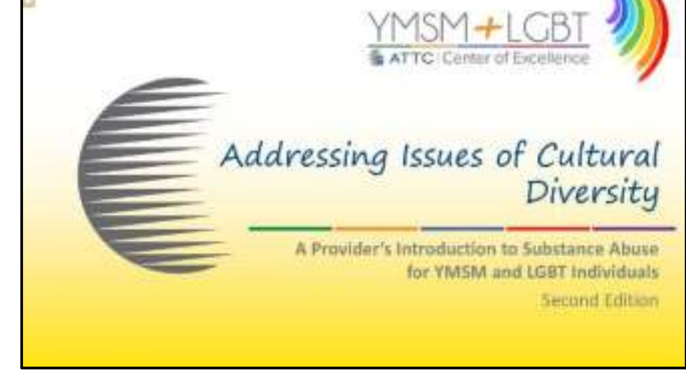
1-35

References

Module 2: Addressing Issues of Cultural Diversity

2-1



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…

2-2

Learning Objectives:

By the end of this module, participants will be able to:

- Define "cultural humility" and explain how it differs from "cultural competency."
- Identify two concepts that contribute to self-awareness.
- Identify two strategies for creating culturally sensitive interactions.

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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.

2-3

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.

2-4

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.

2-5

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.

2-6

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.

Discussion Activity:

- In small groups or pairs list three challenges for you or your organization to effectively engage diverse communities.
- Record notes, and report back to larger group.

2-7

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

Culture:

Dynamics of culture:

- Involves different constructs which interacts at a certain point in time to shapes and guide our behavior, choices, decisions, judgment, beliefs, perceptions and identity.
- These interacting constructs causes us to behave in certain set of ways that are perceived similar to or different from others.
- Sets the limit to which individuals may seek alternatives or ways to achieve goals.

National Center on Cultural Competence, 2001.

2-8

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).

Culture:

Cultural Patterns

- Can be used to understand groups of people.
  - *These patterns are not frozen, or static, but open to exceptions since many individuals have experiences that are not shared by their group.*

2-9

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

2-10

Culture:

Cross-cutting factors in race, ethnicity and culture:

- Language and communication
- Geographic location
- Worldview, values, and traditions
- Family and kinship
- Gender roles
- Socioeconomic status and education
- Immigration and migration
- Acculturation and cultural identification
- Heritage and history
- Sexuality
- Perspectives on health, illness and healing
- Religion and spirituality

SAMHSA, 2014

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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."

Cultural Humility:

Cultural Humility

– "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."

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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)

2-13

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)

Cultural Humility:

Cultural Competency

– *A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.*

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.

2-14

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

Cultural Humility:

Other terms:

- Cultural proficiency
  – *Knowledge, skills, attitudes and beliefs that enable people to work well with, respond effectively to, and be supportive of people in cross-cultural settings.*
- Cultural sensitivity
  – *This term is also used to describe this process.*

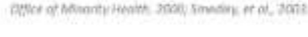
2-15

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

Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Federal Register. 2000;65(247):80865–80879.

Cultural Humility:

- Many "cultural competency," "cultural humility" or "cultural sensitivity" trainings are designed to sensitize providers to the special needs and vulnerabilities of different populations.
- Trainings largely focus on "underserved" populations -- ethnic minority populations most adversely affected by health disparities.
- The goal of cultural humility is to provide accessible and appropriate care and services to all.



2-16

Although they may be called “cultural competency” trainings, many trainings focus on the skills and processes of “cultural humility”.

Cultural Humility:

- Many “cultural competency” trainings are designed to sensitize providers to the special needs and vulnerabilities of different populations.
- Trainings largely focus on “underserved” populations such as ethnic minority populations most adversely affected by health disparities.

Office of Minority Health, 2000; Smedley, et al., 2003

2-17

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:

Cultural humility invites providers to:

- *Engage in self-reflection and self-critique.*
- *Bring into check the power imbalances, by using patient-focused interviewing and care.*
- *Assess anew the cultural dimensions of the experience of each patient.*

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2-18

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

Cultural Humility:

Cultural humility invites providers to cont.:

- *Relinquish the role of expert to the patient, becoming the student of the patient.*
- *See the patient’s potential to be a capable and full partner in the therapeutic alliance.*
- *Redress the imbalance of power inherent in physician-patient relationships.*

Tervalon & Murray-Garcia 1998; Office of Minority Health, (2000); Smedley, et al., 2003

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2-19

These are skills that we use to form trusting relationships.

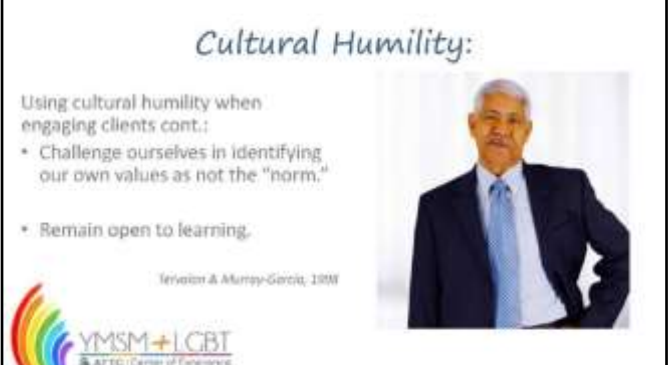
Cultural Humility:

Using cultural humility when engaging clients:

- Recognize we are not better than our clients, and they teach us about their lives and community.
- Develop mutually beneficial, non-paternalistic partnerships with communities on behalf of individuals and defined populations.

2-20

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



2-21

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

Cultural Humility:

Using cultural humility when engaging clients cont.:

- Explore similarities and differences between our own and each patient's priorities, goals and capacities.
- Understand and accept that we can never be truly "competent" in another's culture.

2-22

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.

Cultural Humility:

Cultural humility requires a respect for difference:

– *In practice, cultural humility means bridging perspectives between ourselves and the people with whom we work.*

2-23

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.

Cultural Humility:

Skills for bridging perspective:

- Active listening, by focusing attention on to what the person is saying and use head nods and utterances that indicate you are listening to them.
- Reflecting, by using the client's words to say back to them what it is you heard – "be a mirror".

2-24

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.

Cultural Humility:

Skills for bridging perspective cont.:

- *Reserve judgment by remaining open when given information that reflects values that differ from yours.*
- *Avoid drawing stereotypical conclusions.*

2-25

The trainer shares this key concept and reinforces the life long "journey" that does not have a destination other than understanding and continued learning.

"Cultural humility requires consistent self-reflection; check in with yourself… forever"

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.

2-27

Timeframe: 10 minutes

Group Exercise: Labeling Exercise

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

The Labeling Exercise:

- What are some of the words/phrase used in describing LGBT individuals? (Positive or negative answers are welcomed)
- Read and discuss how these labels can influence the physical, social and mental well-being of a client.

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.

2-28

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.

Values Clarification:

What is value clarification?

- Values clarification is the process to help us gain understanding of our own personal biases and attitudes towards personal, deeply intimate topics.
- When we explore and address our internal values, we can use this insight to provide more thorough, inclusive services to a wider range of people and communities.

Harrison & Huntington, 2000; Shankle, 2008

2-29

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)

Values Clarification

Engagement:

- *It might seem overwhelming trying to understand a culture different from our own and our own experience.*
- *However, there is no denying the importance and influence of a caring, warm and compassionate provider.*

Harrison & Huntington, 2000; Shankle, 2008

2-30

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

Values Clarification:

Engagement Cont.:

- Providers who do not know a lot about the clients they are working with can still offer much value.
- It might be helpful to start with what you know about the presenting problem and take the time to understand the special problems of the community.

Harrison & Huntington, 2000; Shankle, 2008

2-31

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).

Values Clarification:

Exploring our values typically occurs on 3 levels:

- External factors:
  - *Examples: our families, friends, church (spiritual), and media.*
- Personal experiences:
  - *Understand what you are comfortable talking about and what you are not comfortable talking about.*

Harrison & Huntington, 2000; Shankle, 2008

2-32

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.

Values Clarification:

Exploring our values typically occurs on 3 levels cont.:

- Obligations as providers working with clients who have values that are different than our own:
  - *Examples: understanding what are you comfortable talking about what are you NOT comfortable with (example: birth control for teen girls and elderly anal sex HIV prevention messages).*

Harrison & Huntington, 2000; Shankle, 2008

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2-33

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

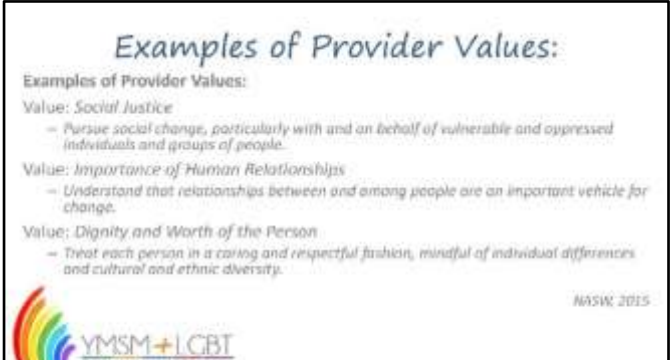
Discussion Activity:

- In small groups or in pairs discuss which values you rely on in order to successfully do your job.
- Record notes, and report back to larger group.

2-34

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.



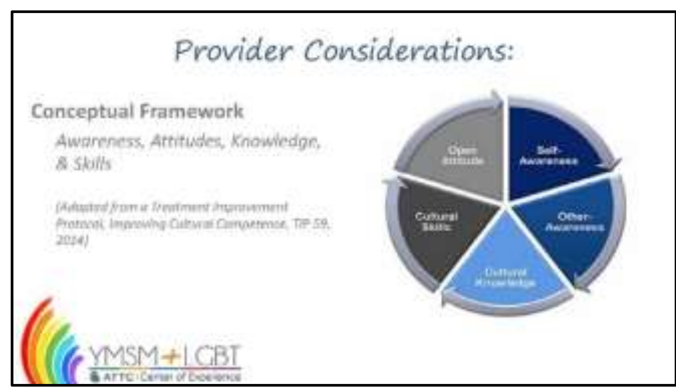
2-35

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.

2-36

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.

Provider Considerations:

- Pedersen (1994) developed a tripartite developmental model to promote cultural and multicultural understanding among practitioners. These competencies include the domains of:
  - *Awareness*
  - *Knowledge*
  - *Skills*

Stith-Williams, & Haynes, 2007

2-38

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.

Provider Considerations:

Awareness:

- Involves recognition of one's own biases as well as awareness of the sociopolitical issues that confront culturally different LGBT individuals.

Stith-Williams & Haynes, 2007; Winkelman, M. 2005.

2-39

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.

Provider Considerations:

Self-Awareness:

- Social science research indicates that our values and beliefs may be inconsistent with our behaviors, and we ironically may be unaware of it.

- Unconscious Bias:
  - *Recognize that as human beings, our brains make assumptions without us even knowing it.*
  - *Consciousness of one's personal reactions to people who are culturally different.*

2-40

Timeframe: 5 minutes

Timeframe: 5 minutes

Conditioning Activity:

Large group activity
– Follow the trainer's instructions

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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: Say “Roast,” Group: “Roast.”
Trainer: Say “Roast,” Group: “Roast.”
Trainer: Say “Roast,” Group: “Roast.”
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.
Trainer: What do cows drink?
Group: (“Milk”. Correcto answer is Water!)

2-41

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

2-42

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,

Provider Considerations:

Self-Awareness cont.:

- Think about populations you have difficulty engaging.
  - *In what ways can you move through the difficulties?*
- Have you had experiences where you were successful in learning more and growing as a provider?

2-43

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.

Provider Considerations:

Knowledge:

- Involves accumulation of factual information about culturally distinct LGBT individuals.
- Primary goal is to become familiar with culturally diverse LGBT client's beliefs, practices, lifestyles, and problem-solving strategies.

2-44

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.

Provider Considerations:

Using Your Knowledge:

- In planning and implementing LGBT affirming prevention and treatment programs.
- To establish therapeutic relationship and build trust in diagnosis and treatment.

2-45

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

Provider Considerations:

Using Your Knowledge cont.:

- Refrain from stereotyping and making generalized assumptions about a client's sexual orientation and gender identity.
- Understand unique challenges faced by LGBT clients as well as differences in their health trends.

2-46

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.

Provider Considerations:

Skills:

- Involves integrating the knowledge and awareness competencies in an effort to develop an appropriate set of culturally competent skills that may be applied to a particular client's needs.

2-47

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

Provider Considerations:

Using Your Skills:

- *Communicating effectively with LGBT clients*
  - *Using appropriate language in communication e.g. pronouns, gender and sexual identity assumptions.*
- *Providing educational programs that reflect understanding of diverse sexual orientations and gender identities and gender expression.*

2-48

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.

2-49

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.

2-50

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."

2-51

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.

2-52

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

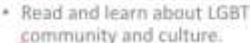
Recommendations:

- 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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2-54

2-55

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Resources:

National Center on Cultural Competence,
http:(/www.nccccurricu la.info/glossary. html

National Center on Cultural Competence. Georgetown University Center for Child and Human Development.
http:(/ nccccu rricula. info/documents/awa reness .pdf

US Department of Health & Human Services, Office of Minority Health,
http://minorityhealth .hhs.gov/templates/browse.aspx?lvl=2&1vlid=1 1

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Module 3: Addressing the Needs of Lesbian Individuals

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ATTC Center of Excellence

Addressing the Needs of Lesbian Individuals

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals
Second Edition

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…

3-2

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.

3-3

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.

3-4

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.

Lesbians:

For this module, when using the term "lesbian," we are referring to:

- *Women who identify as: lesbian, gay, or queer.*
- *However, there are some definitional limitations:*
  - *Not all women who are predominately romantically and sexually attracted to women use the terms: lesbian, gay, or queer.*
- *Example: a qualitative study of lesbian sexuality and family formation, found older participants tended to identify as "gay," "gay woman," or "in the life."*

(Moore, 2011)

3-5

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).

Lesbians:

There are research limitations in describing who lesbians are:

- *"Lesbians are often ignored or under-represented in studies of homosexuality."*

(Hughes & Wilsnack 1997)

- *Research tends to focus on younger, college educated, and most visible lesbians.*

(Hughes & Wilsnack, 1997)

- *Mental health research on lesbians and gay men finds that they are "extremely vulnerable to biased interpretations." For example, a provider may view homosexuality as a sin, therefore citing "homosexuality" being the root cause of their mental health problems.*

(Cochran, 2001)

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3-6

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.

Lesbians:

There are also larger, systemic challenges to understanding the health needs of lesbians, such as a limited evidence base for women's health care, which can make it easier for biased cultural assumptions and attitudes that devalue and subordinate women.

(Zimmerman & Hill, 2000)

Specifically, when research is not inclusive of racial/ethnic, gender, and/or sexual orientation diversity, providers might make the mistake of assuming health disparities do not affect those populations.

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.

Lesbians:

Because of these challenges, there might be real and perceived barriers for lesbian women to access health services:

- *Lack of available information on lesbian-specific healthcare risks and screening recommendations.*
- *Fear of receiving biased care and/or history of discrimination from providers in the past.*
- *Concerns about confidentiality and disclosure.*

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3-8

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.

Related Health Issues for Lesbians

3-9

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?"

Related Health Issues for Lesbians:

One way to approach screening and treatment guidelines for lesbian women is to respectfully treat an individual according to their physiology, sexual behavior and the risk they are exposed to.

- *Again, providers should be mindful of real and perceived barriers for lesbian women to access health services, such as homophobia, discrimination, and lack of confidentiality.*
- *Barriers to health services can interfere with health problems getting routinely checked and treated.*
- *Health problems may only be screened at advanced, or late stages of disease progression.*
  - *Example: cervical and breast cancers.*

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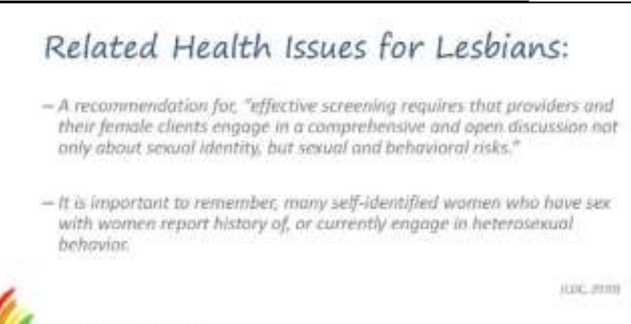
3-10

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.

3-11

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.

3-12

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 LGTB-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.

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

Related Health Issues for Lesbians:

Substance use cont.:

– Compared with heterosexual women, lesbians are less likely to abstain from drinking alcohol, and are more likely to report heavy episodic drinking, negative consequences associated with drinking, symptoms of alcohol dependence, and help-seeking for alcohol related problems.

3-15

Case Example:

Andrea, 23, has been drinking alcohol since she was 12. She also became addicted to her mother's Valium and uses it to "smooth out" her hangovers and to come down from her occasional cocaine highs. Andrea has known since she was about 9 that she is attracted to girls and has been sexually active since the age of 14. She is totally out as a lesbian and says she has no problems about her sexual identity. But she is troubled by her inability to sustain any relationship for longer than a few months. She also says that since she's achieved sobriety, she doesn't know how to meet women who want to date her. She has become shy and uncertain. The counselor needs to help Andrea assess where she is in the development of a sober and clean identity and how that relates to her sexual orientation. She has not been able during her formative years to learn the necessary developmental lessons of adolescence. Furthermore, she tended to act out her feelings when drunk or drugged, including a lot of sexual feelings. She never learned how to date or communicate or relate emotionally to others.

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.

3-16

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

Related Health Issues for Lesbians:

Contraception and safer sex:

- *Lesbians can get the same STIs as heterosexual women.*
- *Lesbians, can give each other STIs by skin-to-skin contact, mucus membrane contact, vaginal fluids, and menstrual blood.*
- *It is important for sexually active lesbians to be screened for STIs, Pap Test, HPV, by a healthcare provider and to use barrier methods where appropriate.*

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

Related Health Issues for Lesbians:

Gynecological cancers:

- Lesbians have higher risks for certain types of gynecological (GYN) cancers compared to heterosexual women. Having regular pelvic exams and pap test can find cancers early and offer the best chance of cure.
- Many lesbian women do not seek screening for cervical and ovarian cancers at recommended rates.
- As stated earlier, lesbians are more likely to access healthcare in later stages of disease progression and less likely to get regular medical/gynecological care than heterosexual women.

(National LGBT Cancer Network, 2015)

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/

3-19

Related Health Issues for Lesbians:

Breast cancer:

- *Some risk factors may be more relevant to lesbians than heterosexual women. For all women, higher breast cancer risk is associated with:*
  - *Clients with no history of full-term birth at an early age.*
  - *Clients who report excessive alcohol use.* (CDC, 2014)
  - *Clients who are obese.* (CDC, 2014)

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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

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3-20

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.

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

Lesbian Smoking Section

Tobacco Use cont.:

- *Compared to heterosexual Latina women in their mid-30s, lesbian Latina women were at elevated risk for problems related to smoking, asthma, and disability.*

(Kim & Fredriksen Goldsen, 2012)

3-22

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.

Related Health Issues for Lesbians:

Heart disease:

- *Heart disease is the leading cause of death for women.*
- *Smoking and obesity are the biggest risk factors of heart disease among lesbians.*
- *All lesbians need yearly medical exams for high blood pressure, cholesterol problems, and diabetes.*
- *Providers can offer support for lesbian clients who wish to quit smoking, increase their physical activity, and control their weight.*

3-23

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.

Related Health Issues for Lesbians:

Body image/weight related health issues:

- *Research shows that lesbians are more likely to be overweight or obese compared to heterosexual women. Obesity is associated with higher rates of heart disease, cancers, diabetes, and premature death.*
- *Lesbians could benefit from competent and supportive advice about healthy living and healthy eating, as well as healthy exercise.*

3-24

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 mico-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.microagressions.com

Related Health Issues for Lesbians:

Mental health and minority stress-related concerns:

- *Lesbians may experience minority stress from discrimination and stigmatization.*
- *Minority stress is defined by chronically high levels of stress faced by members of stigmatized minority groups. (Herek, 2009)*
- *This stress is worse for women who need to hide their orientation, as well as for lesbians who have lost important emotional support because of their sexual orientation.*
- *Minority stress is further discussed in Considerations for Clinical Work with LGBT Individuals.*

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3-25

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.

Lesbian Minority Stress:

Mental health and minority stress-related concerns cont.:

- *American Indian and Alaska Native lesbian women report greater discrimination and trauma within their tribes than do their heterosexual peers.*

3-26

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.

3-27

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.

Provider Considerations:

It is important for providers to remember, contrary to some stereotypes, lesbians do experience violence in their intimate/romantic relationships.

- *However, health care providers might not readily ask lesbians about inter-personal violence/domestic violence as often as they ask heterosexual women.*
- *Lesbians need to be asked about violence (e.g. intimate partner) in their lives and have access to LGBT affirming counseling and shelters when needed.*

3-28

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.

Provider Considerations:

- Providers can foster and encourage positive support systems.
  - *Examples: film festivals, book clubs, grass roots causes, and community coalitions.*
- Providers working with lesbians and other culturally diverse clients should consider disclosure of their own gender, sexual orientation, race/ethnicity. For some groups, this may be important for establishing patient trust.

3-29

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.

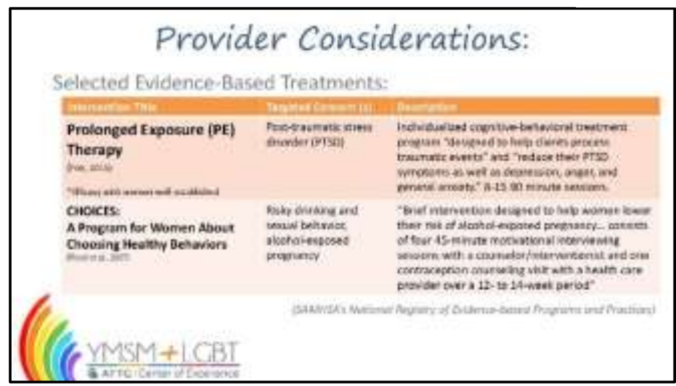
These interventions might serve as a starting point for working with lesbian clients.

Additional Resource:

www.nrepp.samhsa.gov

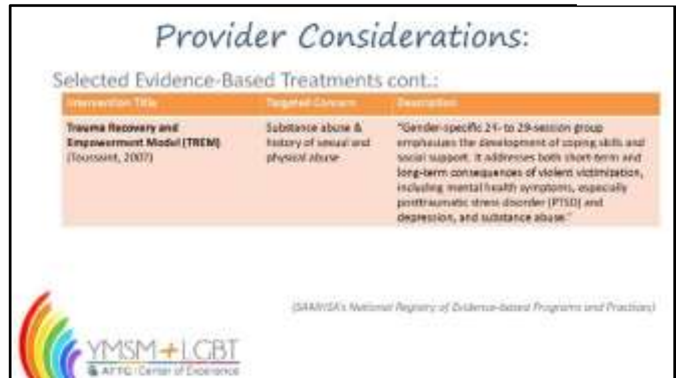
3-30

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



3-31

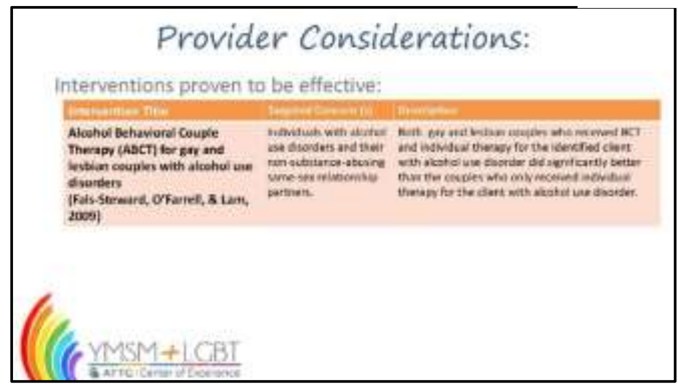
Read all or selected interventions on the slide and proceed to the next slide.



3-32

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

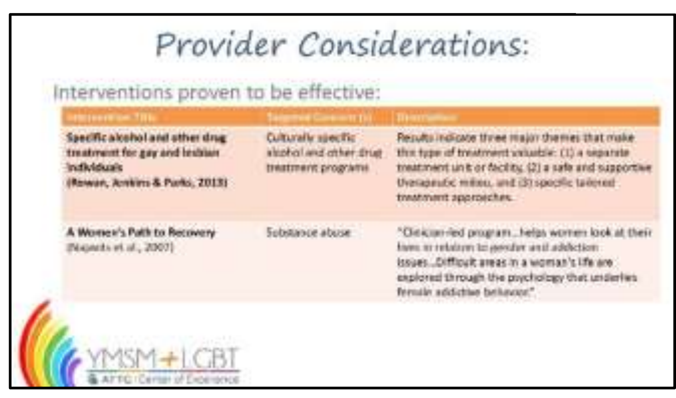
Couples who received BCT and individual therapy for the identified client with alcohol use disorder also had less alcohol consumption and higher levels of adjustments. Important to note, these were the same results as with heterosexual couples .



References:

Fals-stewart, W., O'Farrell, T., Lam, W. K. K. (2009). Behavioral couple therapy for gay and lesbian couples with alcohol use disorders. Journal of Substance Abuse. 37(4): 379 – 387

Rowan, N. l., Jenkins, D. A., Parks, C. A. (2013). What Is Valued in Gay and Lesbian Specific Alcohol and Other Drug Treatment. Journal of Gay & Lesbian Social Services, 25: 56 – 76



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:

Fals-stewart, W., O'Farrell, T., Lam, W. K. K. (2009). Behavioral couple therapy for gay and lesbian couples with alcohol use disorders. Journal of Substance Abuse. 37(4): 379 – 387

Rowan, N. l., Jenkins, D. A., Parks, C. A. (2013). What Is Valued in Gay and Lesbian Specific Alcohol and Other Drug Treatment. Journal of Gay & Lesbian Social Services, 25: 56 – 76

Provider Considerations:

- 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.

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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

3-35

Provider Considerations:

- Lastly, it is recommended providers and organizations adopt an "inviting, person-centered approach" toward lesbians seeking healthcare, assuring 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.

[illegible]

3-36

Questions and Comments?

3-37

This PowerPoint module was developed by:

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3-38

Resources

- Womenshealth.gov lesbian and bisexual fact sheet: http://womenshealth.gov/publications/our-publications/fact-sheet/lesbian-bisexual-health.html
- SAMHSA: Treatment approaches for women: http://store.samhsa.gov/product/Treatment-Approaches-for-Women/DVD206
- Area Resource and Referral Organization for Women: Evidence-Based Lesbian Health: http://arrowlbt.org/wp-content/uploads/2013/10/Evid-Based-Lesb.-Health-Articles.pdf
- American Psychological Association: New data on lesbian, gay and bisexual mental health: http://www.apa.org/monitor/feb02/newdata.aspx
- American Academy of Pediatricians: Gay and Lesbian Parents: http://www.healthychildren.org/English/family-life/family-dynamics/types-of-families/Pages/Gay-and-Lesbian-Parents.aspx
- Gays and Lesbians in Alcoholics Anonymous: http://gal-aa.org/
- COLAGE: People with LGBT Parents: http://www.colage.org/

3-39

Resources

- Womenshealth.gov lesbian and bisexual fact sheet: http://womenshealth.gov/publications/our-publications/fact-sheet/lesbian-bisexual-health.html
- SAMHSA: Treatment approaches for women: http://store.samhsa.gov/product/Treatment-Approaches-for-Women/DVD206
- Area Resource and Referral Organization for Women: Evidence-Based Lesbian Health: http://arrowlbt.org/wp-content/uploads/2013/10/Evid.-Based-Lesb.-Health-Articles.pdf
- American Psychological Association: New data on lesbian, gay and bisexual mental health: http://www.apa.org/monitor/feb02/newdata.aspx
- American Academy of Pediatricians: Gay and Lesbian Parents: http://www.healthychildren.org/English/family-life/family-dynamics/types-of-families/Pages/Gay-and-Lesbian-Parents.aspx
- Gays and Lesbians in Alcoholics Anonymous: http://gal-aa.org/
- COLAGE: People with LGBT Parents: http://www.colage.org/

3-40

References

3-42

References

3-41

References

3-43

References

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…

Learning Objectives:

By the end of this module, participants will be able to:

– Identify one challenge to locating gay male research subjects.

– Identify two health issues/behaviors for which gay men have a higher risk.

– Outline two differences between Gay Men and MSMs.

– Identify one example of how providers can work effectively with MSMs.

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.

4-3

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.

4-4

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.

Gay Men:

Challenges to understanding who contemporary gay men are:
- Definitional Challenges:
  - Almost all studies define sexual orientation based on attraction, behavior, or identity.
  - When reviewing research, it is essential to understand how the study is defining sexual orientation (e.g. attraction, behavior, or identity).

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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.

4-5

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.

Gay Men:

Challenges to understanding who contemporary gay men are cont.:
- Is a male gay, if he has a strong attraction to other men but is married to a female and has never engaged in same-sex sexual activity?
- Is a man who has sex with other men, and identifies as "straight" really gay?
- Does simply labeling oneself a gay man make one so?

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.

4-6

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 s 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.

Gay Men:

Challenges locating research subjects:

- Studies tend to focus on easily accessible gay men, typically those who are publically out and living in large urban areas.
  - Example: gay bars and businesses, cultural LGBT groups and LGBT community centers.

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4-7

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.

Gay Men:

Challenges locating research subjects cont.:

- The second largest group of research participants consists of gay college students.
- Recruiting LGBT individuals outside college campuses and LGBT community centers, are often time consuming and costly to undertake.
- Individuals who choose not to attend college, who enlist in the military, and who are enrolled in trade schools are not being captured in the data. Therefore the information obtained would not reflect the larger gay male population.

Gay Men:

- Furthermore, despite tremendous progress for LGBT rights, many gay men keep their sexual orientation hidden.
- Many states do not have LGBT nondiscrimination protections. While marriage equality exists in all states and territories (except for American Samoa and some tribal communities), LGBT people in many states can still be fired from their jobs and/or evicted from their homes.

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

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Gay Men:

- A 2014 national survey found that over half of LGBTs were not open in the workplace. Reasons included the following:
  - *Possibility of damaging relationships with co-workers.*
  - *Workers fear possibility of being negatively stereotyped.*
  - *Concern other people might feel they are coming on to them.*

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.

4-10

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.

4-11

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.

Related Health Issues for Gay Men:

Substance use:

– *Studies show that gay men use substances, including alcohol and drugs, at a higher rate than their heterosexual counterparts.*

(Blackwell, 2012)

– *Studies also indicate that gay men use tobacco at much higher rates than straight men—reaching nearly a 50 percent difference in some cases.*

(Green & Feinstein, 2012)

4-12

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.

Related Health Issues for Gay Men:

Substance use cont.:

– *Alcohol, tobacco, and cocaine use rates are in decline, but there are still higher rates in gay men compared to the general population.*

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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.

Related Health Issues for Gay Men:

Substance use cont.:

- A study on methamphetamine use in urban gay and bisexual population estimated that, methamphetamine use is 5 to 10 times more common in gay and bisexual men than in the general population.
- Meth use is associated with high rates of HIV.

Additonal 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.

Related Health Issues for Gay Men:

Mental health:

- 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 gay men who are yet to "come out".
- Social stigma has a negative impact on mental health.
  - Depression in gay men 4.5-7.6 times higher than heterosexual peers.

4-15

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.

Related Health Issues for Gay Men:

Prevalence of some psychological disorders among gay men vs. heterosexual men:

	Gay/Bi Men	Heterosexual
– *Major depression*	31%	10.2%
– *Generalized anxiety disorder*	2.9%	1.8%
– *Panic Disorder*	17.9%	3.8%

4-16

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:
http://www.sprc.org/sites/sprc.org/files/library/AI_AN%20Sheet%20Aug%2028%202013%20Final.pdf

Related Health Issues for Gay Men:

Self-harm and suicide:

– *Gay men 7x more likely to have attempted suicide.*
– *Gay youth comprise 30% of completed suicides annually.*
– *Gay and bisexual men have higher rates of deliberate self-harm.*

4-17

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.

Related Health Issues for Gay Men:

Self-harm and suicide cont.:

– *The following contribute to higher rates of suicidal attempts and completions among gay men and youth than among other populations.*
  - *Verbal and physical harassment;*
  - *Negative experiences related to "coming out" (including level of family acceptance), substance use, and isolation.*

4-18

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.

Related Health Issues for Gay Men:

Injury and violence:
- Data show that gay men generally experience two types of violent victimization:
  - Criminal violence based on their sexual minority status; and
  - Violence from an intimate male partner.
- 74% of gay men report having been target of physical violence or property destruction.
- 32% of gay men report being the target of physical violence or property destruction because of their sexual orientation.

4-19

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.

Related Health Issues for Gay Men:

HIV/AIDS:
- In 2010, an estimated 1.1 million people aged 13 years or older were living with HIV infection in the United States.
- 76% of those living with HIV were male, and 69% of males were gay, bisexual, and other men who have sex with men

(CDC, 2013)

4-20

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Related Health Issues for Gay Men:

HIV/AIDS:
- In 2010, men accounted for 80% (38,000) of the estimated 47,500 new HIV infections.
- In 2010, Gay and bisexual men accounted for 63% of new HIV infections in the United States and 78% of infections among all newly infected men.
- Young gay and bisexual men are at increased risk, a study estimated that from 2008 to 2010, new HIV infections increased 22% among young (aged 13-24) gay and bisexual men and 12% among gay and bisexual men overall.

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

4-22

For more information on this, please see the CoE website for more resources: www.ymsmlgbt.org

Additional Resource:

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

Related Health Issues for Gay Men:

HIV/AIDS cont.:

– Among gay men overall, more young black men (ages 13–29) became infected with HIV than did any other age/racial group.

– Hispanics represent approximately 16% of the total U.S. adult population, and account for 21% of new HIV infections.

– The rate of new HIV infections for Hispanic males was 2.9 times that for white males.

4-23

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.

Related Health Issues for Gay Men:

Cancer:

– Gay men are at higher risk for anal cancer due to an increased risk of becoming infected with human papillomavirus (HPV), the virus that causes genital and anal warts.

– Gay men who are transgender may be exposed to other forms of cancer such as prostate cancer, breast cancer and cervical cancer.

Additional Resource:

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

4-24

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

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4-25

Related Health Issues for Gay Men:

Body image and eating disorders:

– Problems with body image are more common among gay men than among their straight counterparts.

– In addition, gay men are much more likely to experience an eating disorder such as bulimia or anorexia nervosa.

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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.

Related Health Issues for Gay Men:

Body image and eating disorders:

- *Gay men 3x more likely than heterosexual men to have an eating disorder.*
- *Body image and eating disorders may take the form of compulsive exercise.*
- *Steroid abuse due to body image problems.*

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.

4-28

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 electric shocks or the ingestion of nausea-inducing drug.

Provider Considerations:

It might be helpful to consider past approaches to health and wellness for gay men, as a way to help navigate future efforts:

- *Until 1973, much of the research focused upon "curing" or treating the condition of homosexuality.*
- *Organizing at local and national levels led to the delisting of homosexuality as a disorder by the American Psychological Association (APA) in 1973.*

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.

4-29

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.

Provider Considerations:

After 1973, the movement was towards:

- *Assisting individuals to successfully work through their coming out process.*
- *Creating gay-affirmative therapies assisting men and women to thrive in inhospitable and unsupportive environments.*
- *Assisting gay men and lesbians to recognize, process, and overcome their internalized homophobia.*

4-30

Provider Considerations:

Moving forward affirmatively:
- Educate yourself on emerging gay male health issues and HIV prevention efforts.
- Speak up when you see discrimination, insensitivity, gaps in knowledge and action.
- Strive to respect and uphold clients' confidentiality.

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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:

http://www.hrc.org/resources/entry/an-allys-guide-to-issues-facing-the-lgbt-community

4-31

Provider Considerations:

Moving forward cont.:
- Best practice is to include significant others in at least one session of treatment.
- Support clients on their choice to come out or not. Respect their sense of where they are in this process and their need to feel safe in treatment.
- It is of note that attempts to change sexual orientation using "reparative therapy" persisted throughout the 90s and early 2000s. In August 2014, the American Psychological Association disavowed the practice stating that there is " insufficient evidence to support the use of psychological interventions to change sexual orientation."

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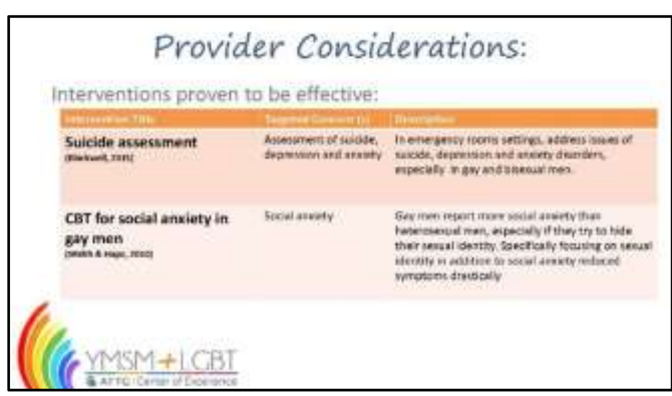
It is the provider's role to help address and resolve the client's presenting problem(s). This may or may not involve including spouses or significant others. This is achieved via mutually agreed upon goals set between the provider and client. Goals may or may not involve issues related to "coming out." 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.

http://www.apa.org/about/policy/sexual-orientation.pdf

4-32



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

References:

Blackwell, C. W. (2015). Assessment and Treatment of Depression in Gay and Bisexual Men in Emergency Settings. Advance Emergency Nursing Journal. 37(2): 116 – 124

Walsh, K., Hope, D. A. (2010). LGB-Affirmative Cognitive Behavioral Treatment for Social Anxiety: A Case Study Applying Evidence-Based Practice Principles. Cognitive and Behavioral Practice. 17 (1): 56–65

4-33

Provider Considerations:

Interventions proven to be effective:

Behavioral couple therapy (BCT) for gay and lesbian couples with alcohol use disorders

Specific alcohol and other drug treatment for gay and lesbian individuals

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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 .

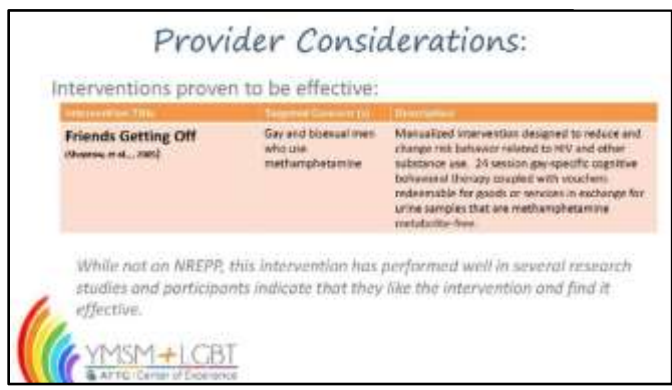
References:

Fals-stewart, W., O’Farrell, T., Lam, W. K. K. (2009). Behavioral couple therapy for gay and lesbian couples with alcohol use disorders. Journal of Substance Abuse. 37(4): 379 – 387

Rowan, N. l., Jenkins, D. A., Parks, C. A. (2013). What Is Valued in Gay and Lesbian Specific Alcohol and Other Drug Treatment. Journal of Gay & Lesbian Social Services, 25: 56 – 76

4-34

http://www.friendscommunitycenter.org/documents/Getting_Off_Treatment_Manual.pdf



4-35

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

4-36

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

MSMs:

- MSM: an abbreviation for men who have sex with men. This term focuses on behaviors.
- The term does not indicate sexual orientation.
  - *Example: a male who identifies as heterosexual in the community, but also engages in same-gender sexual interactions while in jail.*

(Johns Hopkins University, 2013)

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4-37

Discussion Exercise:

In small groups or a pair, discuss the following, record notes, and share with the larger group:

- *What have you heard about MSMs in your community?*
- *What biases have you heard regarding MSM populations?*

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

4-38

MSMs:

How was this term first used?

- Early on in the AIDS epidemic, many gay men were the first to become sick.
- During this period, providers wanted to distinguish those who identified as gay because of the higher risk.

"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.

MSMs:

Term used cont.:

- Outreach was then specifically directed towards gay men.
- During this period many grass root community groups became the first to offer assistance to men who were sick and quickly dying.
- These programs worked with very limited budgets and existed mostly on contributions and charity fundraising.

4-40

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

MSMs:

- Term used cont.:
  - The response and financial support from elected officials was at best, slow and minimal.
  - When some federal or state funding did become available oppositional political leaders questioned if federal or state funds were being used to promote a "homosexual lifestyle."

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 …that AIDS is now an epidemic and has over 600 cases?" The spokesperson responded - **"What's AIDS?"** (Avert, 2015)

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4-41

"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

MSMs:

Term used cont.:

- As a strategy, agencies applying for funding began to utilize the term that researchers initially used specifically to address behavior of men who had sex with men (MSM).
- Thus, agencies avoided having grant applications automatically rejected.

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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.

MSMs:

- Today, a way to avoid bias and judgment towards male clients who engage in sex with other males is to avoid labeling client's sexual orientation based on their behavior only.
  - *Example: "he must be gay if he sleeps with men."*
- We aim to respect and affirm clients' identities, regardless of our opinions and judgments.
- Whatever word, description and or term client's use, we reflect that wording in our interactions with that client.

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.

MSMs:

- One way to help reduce the spread of HIV is to educate all male clients on behaviors that might put them at risk, regardless of whether or not we think it applies to them.
- Behaviors include: unprotected vaginal and anal sex, as well as sharing used syringes.

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.

MSMs:

- For some men, their same-sex sexual encounters may be restricted by institutional settings.
  - *Examples: military, prisons, sleep away camp, boarding schools, college, seminary, fraternities or other predominantly gender-specific environments.*

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.

MSMs:

- Some men seek sexual gratification with other men because they consider it to be more accessible at:
  - *Sex clubs, adult bookstores, gyms, saunas or via social internet platforms.*
- These men still might consider themselves to be heterosexual.
- Again, we are focused on risk behaviors in an effort to reduce health risks and promote health and 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.

Related Health issues for MSMs

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 researcher s 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.

Related Health Issues for MSMs:

Research considerations:

- It is important to remember the challenges of data collection on a population that doesn't have a universally understood agreement on the term "MSM."
- The lack of inclusion of trans men and the historical inclusion of trans women in MSM-related research poses additional challenges.

4-48

Related Health Issues for MSMs:

Methamphetamine (meth) use:
- In 2009, National Survey on Drug Use and Health estimated that 1.2 million Americans ages 12 and older had tried methamphetamine at least once throughout the year.
- Numerous studies have shown increased use of methamphetamine among MSM across the US, and have found it to be associated with HIV infection.

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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.

Additional Resource:

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

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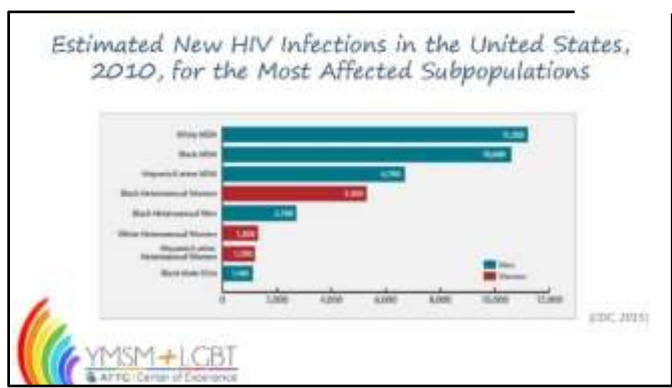
4-49



4-50

Related Health Issues for Young MSMs:

- HIV/AIDS:
  - In 2011, for adolescent males aged 13–19 years, about 93% of all diagnosed HIV infections were from male-to-male sexual contact.
  - From 2008–2011, YMSM aged 13–24 years had the greatest percentage increase (26%) in diagnosed HIV infections.
  - In 2011, among all YMSM aged 13–24 years with HIV infection, an estimated 58% were black; 20% were Hispanic/Latino.
  - Black YMSM also had the largest increase of all racial/ethnic groups in diagnosed HIV infections—from 3,762 diagnoses in 2008 to 4,619 diagnoses in 2011.

(CDC 2014)

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

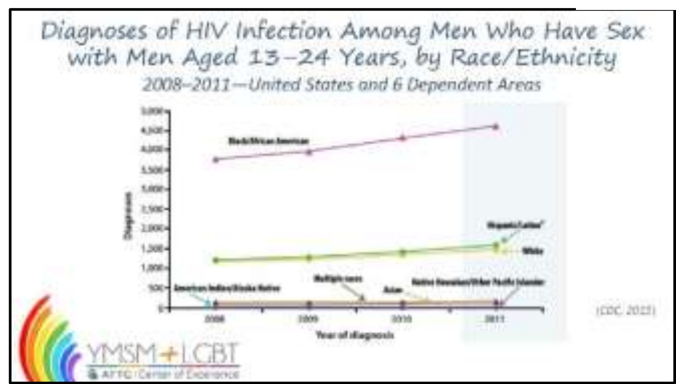
Optional Activity:

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.

4-51



4-52

Nearly half of the estimated people living with HIV in the United States are African-American.

Additional Resources:

http://www.gmhc.org/files/editor/file/a_pa_msm_report_090710.pdf

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

4-53

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:

Related Health Issues for MSMs:

- HIV/AIDS cont.:
  - Many HIV prevention campaigns for youth often only talk about the risks of heterosexual sex, and there is little appropriate information available to men who have sex with men, which can give them the false impression that they are not at risk.

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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.

Related Health Issues for MSMs:

Syphilis:

– In 2012, men who have sex with men (MSM) accounted for 75% of primary and secondary syphilis cases in the United States.

– Syphilis, which is a genital ulcerative disease, can cause significant health complications and can facilitate the transmission of sexually transmitted infection.

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

4-56

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

Related Health Issues for MSMs:

Syphilis cont.:

- *Over the past several years, an increase and outbreaks in Syphilis among MSMs has been reported in various cities and areas:*
  - *Chicago, Seattle, San Francisco, Southern California, Miami, and New York City.*
  - *These areas have experienced high rates of syphilis and HIV co-infection, ranging from 20 to 70 percent.*

4-57

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.

4-58

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).

Provider Considerations:

- We cannot always rely on patients' self-reported identities to appropriately assess risk for HIV infection and sexually transmitted diseases.
- We must inquire about behavior in a cultural appropriate manner
- Public health prevention messages must be crafted to explain the dangers of risky sexual behaviors in a manner that is effective with the targeted audience.

4-59

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.

4-60

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.

4-61

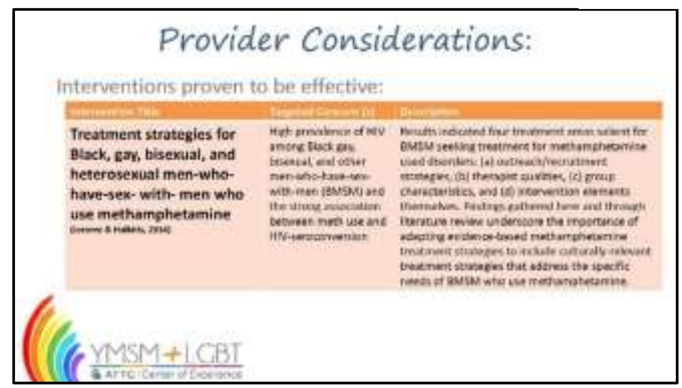
It might be easy to skip or hurry though questions we might determine not applicable to our clients.

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:

Jerome, J. C., Halkitis, P. N. (2014). An Exploratory Investigation of Treatment Strategies for Black, Gay, Bisexual, and Heterosexual Men-Who-Have-Sex- With-Men Who Use Methamphetamine. Journal of LGBT Issues in Counseling. 8(1): 2 – 24

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4-65

Resources:

1. Center for Disease Control and Prevention: Gay and Bisexual Men's Health: http://www.cdc.gov/msmhealth/professional-resources.htm
2. National Coalition for LGBT Health: http://www.healthhiv.org/sites-causes/national-coalition-for-lgbt-health/
3. Gay and Lesbian Medical Association: http://www.glma.org
4. Gays and Lesbians in Alcoholics Anonymous: http://gal-aa.org/
5. COLAGE: Children of LGBT Parents: http://www.colage.org
6. Trevor Project: http://www.thetrevorproject.org

4-66

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.ymsmlgbt.org for more information!

4-67

Resources:

- GLBTQ: An Encyclopedia of Gay, Lesbian, Bisexual, Transgender, & Queer Culture: "Straight Men Who Have Sex with Men": http://www.glbtq.com/social-sciences/straight_men_who.html
- AVERTing HIV and AIDS: Men Who Have Sex with Men (MSM) and HIV/AIDS: http://www.avert.org/men-who-have-sex-men-msm-hiv-aids.htm
- 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)

4-68

References:

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References

References

Module 5: Addressing the Needs of Bisexual Individuals

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Addressing the Needs of Bisexual Individuals

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals
Second Edition

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…

5-2

Learning Objectives:

By the end of this module, participants will be able to:

- Describe biphobia and describe one form of biphobia.
- Outline one health challenge faced by older bisexual people.
- Identify two ways service providers can create affirming and welcoming environments for bisexual people.

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.

5-3

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.

5-4

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.

Bisexuality:

There can be some confusion about what "bisexuality" means, therefore it is important to discuss some key terms:

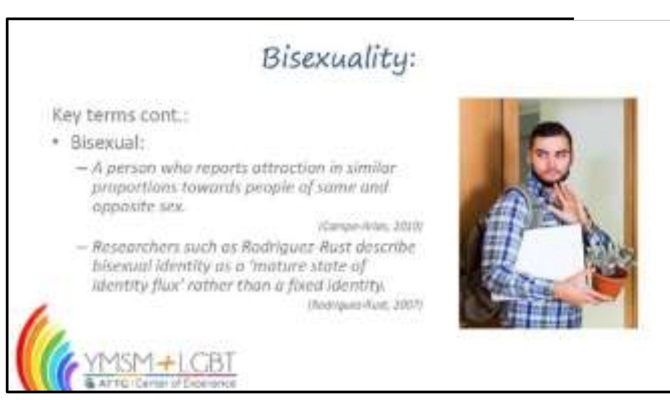
- Bisexuality:
  - *The capacity for emotional, romantic and/or physical attraction to more than one sex or gender. That capacity for attraction may or may not manifest itself in terms of sexual interaction.*

5-5

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

In the second definition by Rodriquez-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.

5-7

Labeling Exercise:

- In groups or pairs, discuss some words/phrases that people may use to describe people who are bisexual.
- Discuss how these words/phrases can influence the physical, social and mental well-being of a client.

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.

Bisexuality:

- According to several studies, self-identified bisexuals make up the largest single population within the LGBT community in the United States.
- In each study, more women identified as bisexual than lesbian, and fewer men identified as bisexual than gay. Indicates gender differences in bisexual identity.

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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.

5-9

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."

Bisexuality:

- Example: A study published in 2010 by the Journal of Sexual Medicine

Out of 5, 042 Adults:	
Self-Identified Bisexual	Self-Identified Gay/Lesbian
3.1%	2.5%

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5-10

This slide gives evidence from several studies that supports the claim stating that, “self-identified bisexuals make up the largest single population within the LGBT community in the United States.”

This information is categorized by gender differences.

5-11

There is some contradictions in the research about this, however. This studies has a lower percentage of self identified bisexuals, compared to Gays/Lesbians.

5-12

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

Bisexuality:

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.

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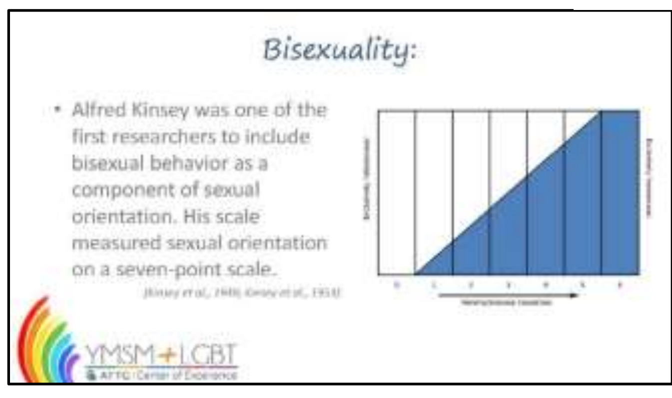
5-13

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.

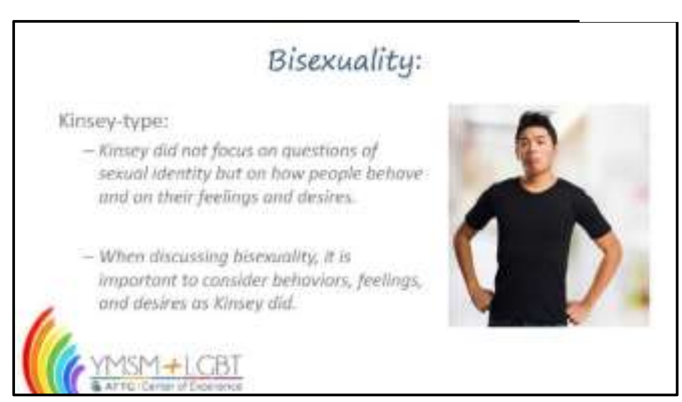


Rather, the Kinsey scale was to highlight the complexity of human sexuality.

5-14

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.



5-15

5-16

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.

Bisexuality:

- Klein himself acknowledges, any measurement is unlikely to be exact because sexual orientation is complex and can change over time.
- Important to note, Klein's grid complicates the question of what makes up a person's sexual identity.
- Klein's grid explicitly includes the person's self-identification, as well as their behaviors and desires.

5-17

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.

Bisexuality:

Furthermore, Klein (1993), identified 4 main types of bisexual people:

- ***Transitional Bisexuals:***
  - *Individuals moving from a heterosexual identity to a lesbian or gay one, or, less commonly, from a lesbian or gay identity to a heterosexual one.*
- ***Historical Bisexuals:***
  - *Those who are now either homosexual or heterosexual but whose pasts include bisexual relationships.*

5-18

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.

Bisexuality:

Klein's 4 main types cont.:

- **Sequential Bisexuals:**
  - *Those who have had partners of different sexes at different times in their life.*
- **Concurrent Bisexuals:**
  - *Those who are sexually active with both men and women in the same time period.*

5-19

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.

5-20

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.

Related Health Issues for Bisexuals:

- Bisexual people experience greater health disparities than the broader population, including a greater likelihood of suffering from depression and other mood or anxiety disorders.

Group Discussion:
– *Why is this so?*

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This purpose of this slide is to describes 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.

Related Health Issues for Bisexuals:

- When bisexuals do not disclose their sexual orientation, this can result in receiving incomplete health information.
  - *Example: safer sex practices with both male and female partners.*
- Unfortunately, most HIV and STI prevention programs don't adequately address the health needs of bisexuals.
  - *Examples: Bisexual men are often lumped together with gay men.*

The purpose of this slide is to highlight some of 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.

Related Health Issues for Bisexuals:

There have been challenges to addressing health issues for bisexuals:

- *In the 1980s and 1990s, bisexuals were blamed for the spread of HIV among heterosexuals, even though the virus was primarily spread via sharing used syringes and unprotected anal sex.*
- *This might be one reason why the health needs of bisexuals have not been adequately addressed.*
  - *Individuals may not want to disclose bisexual behaviors for fear of shaming and blame.*

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.

Related Health Issues for Bisexuals:

- Important to note, a 1994 study of data from San Francisco found bisexually identified MSMW (men who have sex with men and women) were not a "common 'bridge' for spreading HIV from male partners to female partners."
- This is due to high rates of using barrier protection and extremely low rates of risky behaviors.

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.

Related Health Issues for Bisexuals:

HIV/AIDS:

– According to CDC, in 2010, gay and bisexual men in the US, accounted for 63% of estimated new HIV infections in the United States and 78% of infections among all newly infected men.

– In 2013, Gay and bisexual men accounted for 81% of the 37,887 estimated HIV diagnoses among all males aged 13 years and older, and 65% of the 47,352 estimated diagnoses among all persons receiving an HIV diagnosis that year

(CDC, 2012; CDC, 2015)

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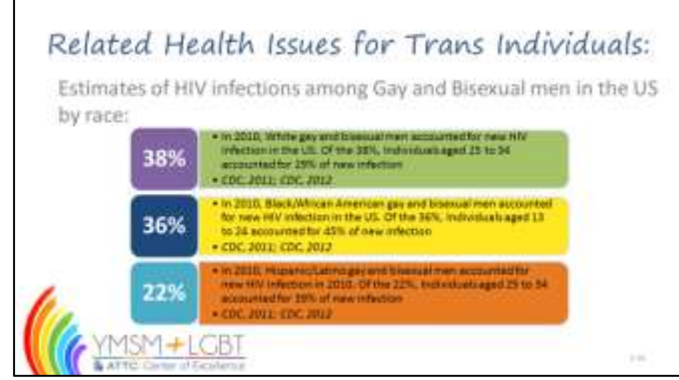
Read the text on the slide and proceed to the next slide.



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.

Related Health Issues for Bisexuals:

HIV/AIDS cont.:

– In 2013, gay and bisexual men accounted for 55% of the estimated number of persons diagnosed with AIDS among all adults and adolescents in the United States.

– of the estimated gay and bisexual men diagnosed with AIDS, 40% were Black/African American, 32% were Whites, and 23% were Hispanics/Latinos.

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5-28

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.

Related Health Issues for Bisexuals:

HIV/AIDS cont.:

- As at 2011, an estimated 311,087 gay and bisexual men with AIDS had died in the United States since the beginning of the epidemic. This represents 47% of all deaths of persons with AIDS.

(CDC 2011; CDC 2012)

- Little is known about the prevalence of female-to-female sexual transmission of HIV. However, bisexual women who have sex with men are at a greater risk of contracting HIV than those who do not.

5-29

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.

Related Health Issues for Bisexuals:

Below are the top 10 bisexual health issues based on research that explicitly includes bisexuals as their own category

1. substance use
2. Alcohol use
3. Sexual health
4. Tobacco use
5. Cancer
6. Nutrition, fitness and weight
7. Heart Health
8. Depression and anxiety
9. Social support, general emotional well-being and quality of life
10. Self-harm and suicide attempts

(Miller et al, 2007)

5-30

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.

Related Health Issues for Bisexuals:

There are health considerations for older bisexuals:

- Older bisexuals might be at higher risk for isolation from their community, which may eventually lead to depression.
- Older bisexuals may have identified as heterosexual or homosexual for a long time and may find it difficult to engage with the rest of the bisexual community.

(San Francisco Human Rights Commission, 2010)

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/

Related Health Issues for Bisexuals:

For older bisexuals cont.:

- Existing social groups and coming out groups often times focus on younger people and gay men/lesbians.
  - *Possibly leaving the aging bisexual population out of their programming.*

5-32

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

Related Health Issues for Bisexuals:

For older bisexuals cont.:

- There may be increased invisibility due to assumptions that older people are no longer sexual.
- While there is a growing body of research into the impact of aging on LGBT people in general, there is limited research on aging bisexuals specifically.

5-33

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.

Biphobia in Society

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

Biphobia in Society:

- Bisexual Denial:
  - Questioning the existence of bisexuality in certain groups (e.g. bisexual men, bisexual people of color).
  - Believing that bisexual people should 'make their mind up' or 'stop sitting on the fence'.
  - Seeing bisexual people as 'confused' about their sexuality.

(The Bisexuality Report, 2012)

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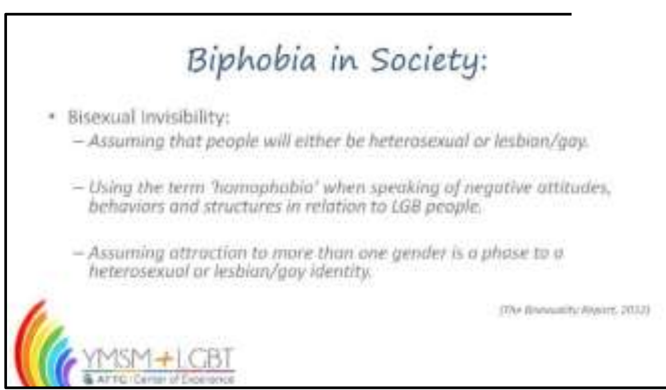
5-35

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'.



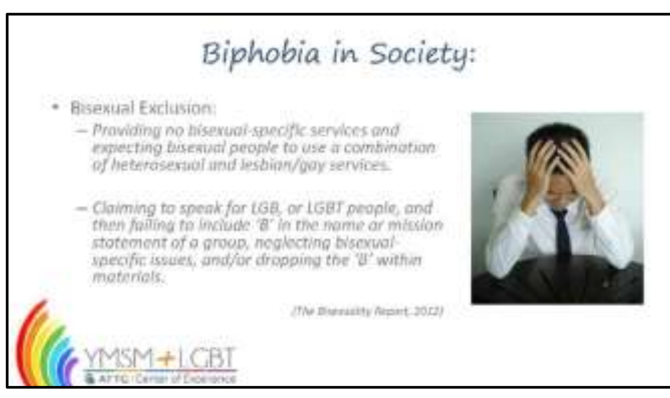
Assuming people's sexuality on the basis of their current partnership (straight if they are with someone of an other gender and lesbian/gay if with someone of the same gender).

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.

5-36

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



5-37

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.

Biphobia in Society:

- Bisexual Marginalization:
  - Allowing biphobic comments to go unchallenged when homophobic comments would be challenged.
  - Assuming that bisexuality is an acceptable topic for humor in a way that lesbian/gay sexualities are not.
  - Asking lots of questions about a person's bisexuality in ways which would be offensive to heterosexual, lesbian or gay sexuality.

(The Bisexuality Report, 2012)

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5-38

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).

Biphobia in Society:

- Negative stereotypes:
  - Viewing bisexual people as greedy, or wanting to 'have their cake and eat it too'.
  - Assuming that bisexual people are promiscuous or incapable of monogamy.
  - Assuming that bisexual people will be sexually interested in 'anything that moves'.

(The Bisexuality Report, 2012)

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5-39

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.

5-40

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

Provider Considerations:

Disclosure of one's sexual orientation can be an important component for one's overall health and wellness:

- *All clients, including bisexual clients, have a desire to be seen as a whole person, with sexuality being part of their life.*
- *Disclosure can improve client/provider relationship, therefore can increase in trust.*

5-41

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

Provider Considerations:

Disclosure cont.:

- *When a client is able to disclose to a provider, that provider can respond with more sensitivity to the issues faced, and provide appropriate resources referrals.*
- *Disclosure can improve mental health and emotional wellness on behalf of the client.*

5-42

Stigma from disclosing one's sexual orientation can take many forms including: hostility, bullying, violence and homicide.

Provider Considerations:

Stigma management for clients may be an on-going process:

- *Stigma management has to do with the continuous process of "coming out" to different people, in different situations and contexts.*
- *Stigma management is a strategy that should be discussed with clients in order to assist them with day to day transgressions over identity disclosure across the lifespan.*

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.

Additional Resource:

http://www.hrc.org/campaigns/coming-out-center

Provider Considerations:

Stigma management cont.:

– *Providers are encouraged to discuss the ramifications of coming out to people who may not be ready to accept either their bisexual identities or substance use history.*

5-44

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.

Provider Considerations:

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

– *Liaise with bisexual communities on issues of equality and diversity in the same way that you liaise with lesbian, gay and trans communities.*

– *Ensure bisexual people are included amongst the speakers on panels and forums relating to LGBT communities.*

– *Include bisexual representation in all relevant working groups and initiatives.*

5-45

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.

Provider Considerations:

Further recommendations:

– *Include bisexuality in all policies and procedures, explicitly within the diversity implications section of every document and policy.*

– *Separate biphobia out from homophobia, recognizing that there are specific issues facing bisexual people.*

- *Examples: lack of validation of their existence, stereotypes of promiscuity, and pressure to be either gay or straight.*

5-46

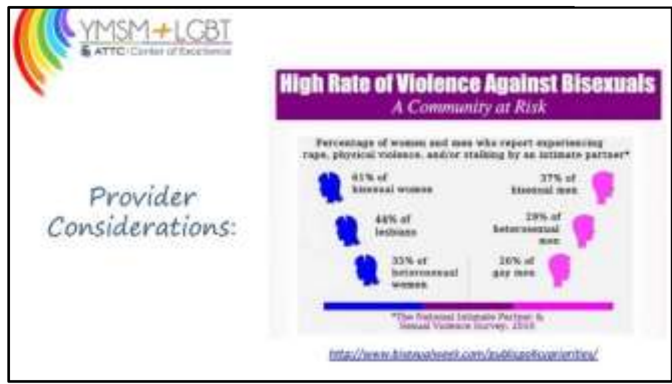
Here are some more recommendations for creating an affirming and welcoming environment for bisexual clients:

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.

5-47

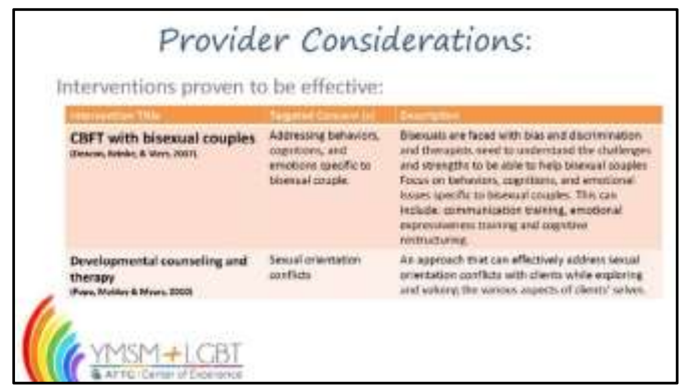
These data are from the National Intimate Partner & Sexual Violence Survey conducted in 2010. The data demonstrate that bisexual males and females are the most at risk for violence among LGB and heterosexuals. For women, nearly 2/3 of bisexuals have experienced violence, compared to 44% of lesbians and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

5-48

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



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5-49

5-50

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5-51

Resources:

- BiNet USA: http://www.binetusa.org/
- The Bisexual Resource Center: www.biresource.net
- Bisexual.com: www.bisexual.com
- Shybi.com: www.shybi.com (women), www.shybi-guys.com (men)
- American Institute of Bisexuality: www.bisexual.org
- Journal of Bisexuality: www.tandfonline.com/toc/wjbi20/current

5-52

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5-55

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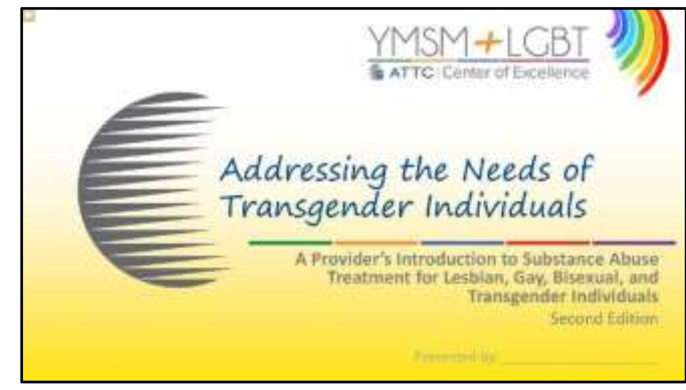
Module 6: Addressing the Needs of Transgender Individuals

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.

6-3

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.

6-4

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

Defining Transgender:

What do we mean when we say, "transgender?"

- *Refers to a person whose gender identity does not correspond to their sex assigned at birth.*
- *Transgender (or the shortened version, 'trans') may be used to refer to an individual person's gender identity and is sometimes used as an umbrella term for all people who do not conform to traditional gender norms.*

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.

6-6

Defining Transgender:

It is important for providers to understand the four core concepts of trans identity:

Sex Assigned at Birth

Gender Identity

Gender Expression

Sexual Orientation

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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 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)

6-7

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.

6-8

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.

6-9

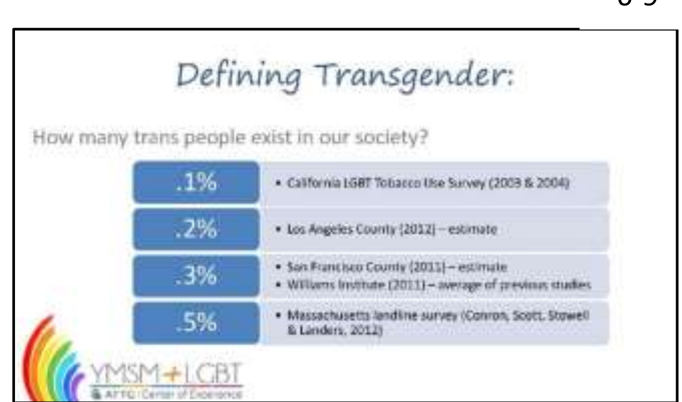
Most of the current trans population are estimates or are based off of LGBT studies.

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.



6-10

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.

6-11

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 clients have 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.

Related Health Issues for Trans Individuals:

Sexual and Reproductive Health:

- Transgender people might have sexual partners who are men, women or both
  - *A transgender person's sexual history cannot be assumed based on their gender identity or sex assigned at birth.*
- Transgender people who have sex with men are at risk for unintended pregnancy as well as STIs.
  - *Transgender men who have sex with men report high rates of unprotected vaginal and anal intercourse*

6-12

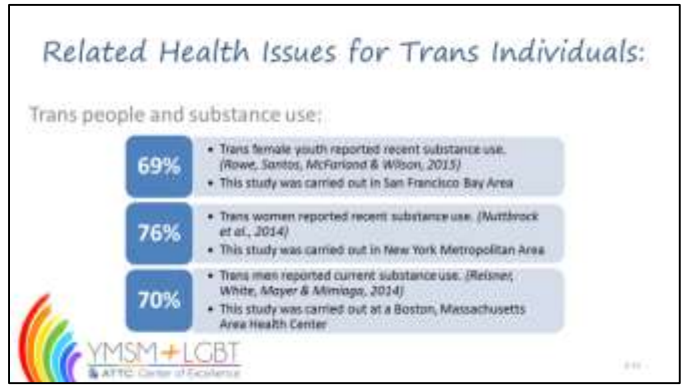
Read the text on the slide and proceed to the next slide.

Related Health Issues for Trans Individuals:

Sexual and Reproductive Health Cont.:

- Transgender people may be reluctant seeking sexual and reproductive health care.
  - *A study showed that one in three transgender people, and 48% of transgender men, have delayed or avoided seeking preventive health care such as pelvic exams or STI screening due to fear of discrimination and insolence.*

6-13



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.

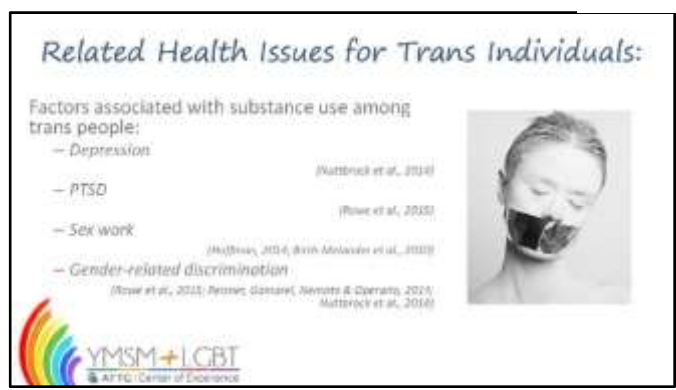
Optional Activity:

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.

6-14



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.

6-15

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:

https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/treatment-options/overview-of-hiv-treatments/

Related Health Issues for Trans Individuals:

Cross-Sex Hormone Therapy (csHT):

– Not all trans people desire csHT and/or surgical intervention.

– csHT is safe, with few long-term side effects.

– csHT is not contra-indicated for HIV antiretroviral therapy (ART) .

– Clients should be allowed to continue (or start) csHT in treatment programs.

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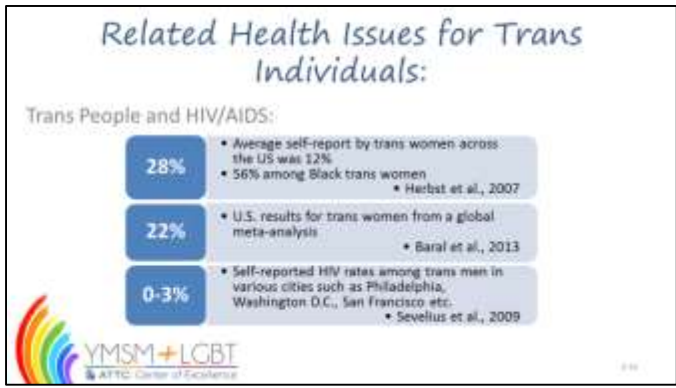
6-16



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.

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

Quote is from the referenced article.

Related Health Issues for Trans Individuals:

Trans People and HIV/AIDS cont.:

– *MTF transgender youth of color have many unmet needs and are at extreme risk of acquiring HIV/AIDS.*

"Although limited data exist on the experiences of transgender youth from communities of color, anecdotal evidence suggests that they are not only at risk of acquiring HIV, but also face enormous challenges navigating adolescent and gender identity development without readily available, culturally appropriate health care and social support services."

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.

Related Health Issues for Trans Individuals:

Mental health:

– *Trans people report significantly worse mental health than non-trans people*

(Newfield, Hart, Dibble & Kohler, 2006; Reisner et al., 2014)

– *Negative mental health outcomes are associated with transphobia, including physical and psychological abuse and family rejection.*

(Nuttbrock et al., 2014; Simons et al., 2013)

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.

Related Health Issues for Trans Individuals:

Mental health cont.:

– *Hormone therapy improved quality of life scores among a sample of trans men.*

(Newfield, Hart, Dibble & Kohler, 2006)

Related Health Issues for Trans Individuals:

Hormone Blockers:

- Used to treat children who are transgender or gender non-conforming. The medications suppresses the body's production of estrogen or testosterone, and essentially pause the changes that would occur during puberty.
- The Endocrine Society's guidelines suggest starting puberty blockers for transgender children around 10 or 11 years old for a girl and 11 or 12 years old for a boy.

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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 change 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.

6-21

Related Health Issues for Trans Individuals:

Sex Reassignment Surgery:

- This is an irreversible surgical procedure used in changing genital organs from one sex to another.
- Male to female genital surgery have been found to be generally more successful and less risky compared to female to male genital surgery.
- Clients exposed to such procedures are at increased risk for myocardial infarction, bleeding and mortality, cervical cancer, cardiovascular disease, suicidal behavior, psychiatric morbidity than the general population.

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.

Related Health Issues for Trans Individuals:

Assault:

- A 2011 national survey titled, "Injustice at Every Turn" surveyed 6450 transgender and non-gender conforming people:
  - 71% of multiracial respondents reported having experienced bullying, physical abuse, sexual assault, harassment, and even expulsion from school.
  - When comparing these types of abuses in different geographical areas, 58-65% of transgender and non-gender conforming people had experienced assault.

(Grant, Mottet, & Tanis, 2011)

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.

Related Health Issues for Trans Individuals:

Assault cont.:

- A critical finding from the survey concluded transgender and gender non-conforming people of color experience particularly devastating levels of discrimination when anti-transgender bias is combined with structural and interpersonal racism.

(Grant, Mottet, & Tanis, 2011)

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.

Provider Considerations

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

Provider Considerations:

Policy
Community
Institutional
Interpersonal
Intrapersonal

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6-26

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.

6-27

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.

Provider Considerations:

What does interpersonal stigma and transphobia look like?
– Family rejection
– Peer harassment/bullying
– Harassment from co-workers
– Rejection from potential romantic/sexual interests

6-28

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.

6-29

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.

Provider Considerations:

- What does community stigma and transphobia look like?
  - Violence
  - Norm of substance use
  - Norm of sex work
  - Social stigma

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Provider Considerations:

- What does policy stigma and transphobia look like?
  - Trans panic defense
  - Non-Discrimination Policies
  - Name and gender changes
  - Immigration laws

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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.

6-31

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.
acilitator should be check before the training to see if this is the most current map. Please check, www.thetaskforce.org to verify.

6-32

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.

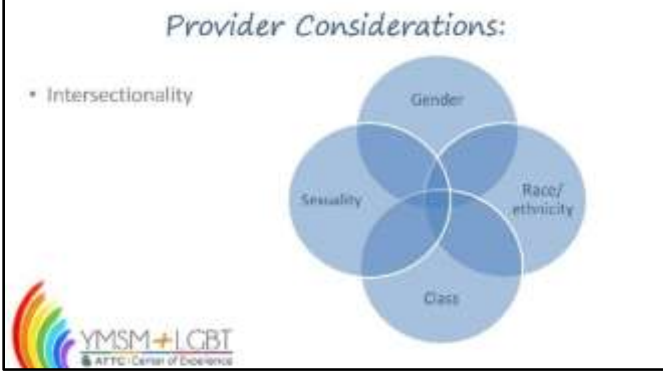
6-33

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 peoples 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.

6-35

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.

Provider Considerations:

Provider recommendations:

– *A client's anatomy should only be discussed if relevant to their treatment.*
– *Provide care for anatomy that is present while affirming the patient's current gender identity.*

(Center of Excellence for Transgender Health, 2011)

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.

Provider Considerations:

Provider recommendations cont.:

– *The Center of Excellence for Transgender Health makes the following recommendation for trans-inclusive data collection:*
  - *Asking current gender identity*
  - *Asking assigned sex at birth*

(Center of Excellence for Transgender Health, 2011)

Visual example of the recommendation on the previous slide. Proceed to the next slide after reviewing with participants.

Provider Considerations:

CETH Recommended Trans/Gender Expression Inclusive Intake Questionnaire

1. What is your current gender identity? (Check and/or circle ALL that apply)
   - ☐ Male
   - ☐ Female
   - ☐ Transgender Male/Transman/FTM
   - ☐ Transgender Female/Transwoman/MTF
   - ☐ Genderqueer
   - ☐ Additional category (please specify): ____________________
   - ☐ Decline to answer

2. What sex were you assigned at birth? (Check one)
   - ☐ Male
   - ☐ Female
   - ☐ Decline to answer

3. What pronouns do you prefer? ____________________

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6-39

All of these experiences are barriers to substance use treatment programs for trans people.

Provider 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.*

6-40

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

Provider Considerations:

Provider recommendations 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.*

6-41

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

Provider 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.*

6-42

Discussion Exercise:

In small groups or in a pair, answer the following question, record notes, and share with the larger group:

- *What do you or your organization need in order to build, enhance, and refine services for trans clients?*

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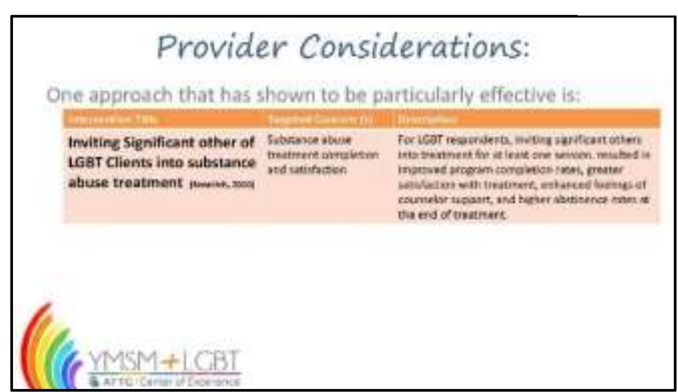
Timeframe: 10 minutes

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.

6-43



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.

6-44

6-45

This PowerPoint module was developed by:

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  - *Transgender Evaluation and Technical Assistance Center (TETAC) Coordinator UCSF Center for AIDS Prevention Studies San Francisco, CA*

6-46

Resources:

- GLAAD Transgender Resources: http://www.glaad.org/transgender/resources
- Transgender Foundation of America: http://www.tgctr.org/about/
- National Center for Transgender Equality: http://transequality.org/
- Transgender Care Health Information Archive: http://www.transgendercare.com/medical/resources/
- Center of Excellence for Transgender Health: http://transhealth.ucsf.edu/trans?page=protocol-evidence
- American Congress of Obstetricians and Gynecologists: Women's Health Care Physicians: Health Care for Transgender Individuals: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals
- Transgender Health Services Working Group, City and County of San Francisco. (2007). *Transgender HIV Health Services Best Practices Guidelines*. Accessed online January 15, 2010 from: http://careacttarget.org/library/tgguidelines.pdf

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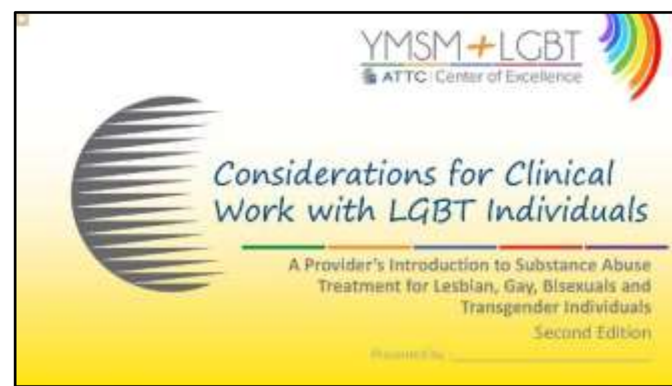
6-47

6-48

6-49

6-50

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…

Learning Objectives:

By the end of this module, participants will be able to:

- Identify two causes of minority stress.
- Identify one of the five principals of trauma-informed care.
- Identify one treatment approach that has been shown effective with LGBT populations.

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.

7-4

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:

https://www.americanprogress.org/issues/lgbt/report/2012/03/09/11228/why-the-gay-and-transgender-population-experiences-higher-rates-of-substance-use/

LGBT Stigma and Stress:

Foremost, it might be helpful for providers to gain insight on how stigma can impact LGBT individuals.

– *One way to describe the impact of stigma is referred to as "minority stress:"*
  - *Defined as chronically high levels of stress faced by members of stigmatized minority groups.*
  - *Minority stress can be experienced from enacted stigma, violence, and an ongoing sense of real and perceived threat to one's safety and well-being.*

7-5

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:

https://www.americanprogress.org/issues/lgbt/report/2012/03/09/11228/why-the-gay-and-transgender-population-experiences-higher-rates-of-substance-use/

LGBT Stigma and Stress:

- Minority stress may be caused by a number of factors, such as poor social support and low socioeconomic status.
- However, the most understood causes of minority stress are:
  – *Interpersonal prejudice or biased attitude toward another.*
  – *Discrimination biased behavior toward another.*

7-6

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.

LGBT Stigma and Stress:

In 2014, the Centers for Disease Control and Prevention listed the following impact of minority stress and risk factors on the Healthy People 2020 Report:

– *LGBT youth are 2 to 3 times more likely to attempt suicide.*

– *LGBT youth are more likely to be homeless.*

7-7

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.

LGBT Stigma and Stress:

Impact of minority stress and risk factors cont.:
– *Lesbians are less likely to get preventive services for cancer.*
(Buchmueller & Carpenter, 2010; Dilley et al., 2010)
– *Lesbians and bisexual females are more likely to be overweight or obese.*
– *Gay men are at higher risk of HIV and other STDs, especially among communities of color.*

7-8

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

LGBT Stigma and Stress:

Impact of minority stress and risk factors cont.:
– *Transgender individuals have a high prevalence of HIV/STDs victimization, mental health issues and suicide.*
– *LGBT populations have the highest rates of tobacco, alcohol and other drug use.*

7-9

The purpose of this slide is to introduce "unconscious bias," which a brief overview will be provided on the next three slides.

LGBT Stigma and Stress:

- In addition to understanding minority stress, it is also helpful for providers to learn about unconscious biases.

7-10

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.

7-11

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.”

LGBT Stigma and Stress:

Unconscious bias cont.:

– May or may not involve microaggressions, or “brief, everyday exchanges that send denigrating or damaging messages to [racial/ethnic and sexual minorities].”

– May often seem like benign comments to the perpetrator.

– Often unintentional or if intentional, harmful consequences are unknown.

Additional Resource:

http://www.cookross.com/products/UnconsciousBiasWorkbookSample.pdf

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

7-12

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.

LGBT Stigma and Stress:

Examples of unconscious bias:

– “I have no problem with gay people when they don’t wear it on their sleeve.”

– “She’s really pretty, I couldn’t tell she was transgender.”

– “How do you know you’re gay if you’ve never been with [a person of the opposite sex]?”

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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:

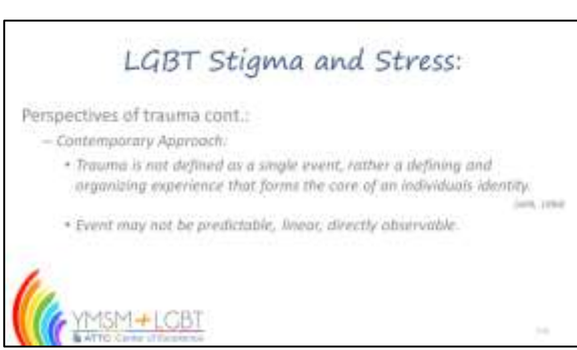
1. Clients are joined with an issue and defined by the issue.
2. Consumer is a passive recipient of services & services are hierarchal.

LGBT Stigma and Stress:

Trauma can be viewed from both a traditional and contemporary perspective.

Traditional Approach:
- "A single event with one impact."
  - *May involve an actual or threatened death, serious injury, serious harm, or a threat to one's personal integrity.* (APA, 1994)
  - *May be predictable, linear and/or observable.*

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.

LGBT Stigma and Stress:

- LGBT clients may experience all the same traumatic events as heterosexual individuals:
  - *Examples: domestic violence growing up, childhood abandonment, adult sexual violence, and other events.*
- However, there may be specific, additional traumas related to a client's sexual orientation or gender identity.

"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.

LGBT Stigma and Stress:

Examples of LGBT-related traumas:
- *Bullied as a child or teen because of presumed sexual orientation or gender expression.*
- *Anxiety, distress, and negativity experienced in the initial coming out experience.*
  - *Example: being "outed" in an unsafe environment.*

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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.

LGBT Stigma and Stress:

LGBT-related traumas cont.:

- *Continuing to come out and anxiety associated with potential negative social, professional, and familial reactions.*
- *Anti-LGBT verbal, physical or sexual assault (gay bashing).*
- *Prior therapy or healthcare focused on trying to "cure" or in invalidate LGBT sexual orientation or gender identity.*

7-19

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

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7-20

The purpose of this slide is to introduce trauma-informed care, which will be discussed on the next eight slides.

7-21

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.

7-22

Trauma-Informed Care:

	Traditional Approach	Trauma-Informed Approach
How Clients are Viewed	Clients are joined and defined by their presenting issue.	Clients are viewed as a whole being, separate from their presenting issue.
How Services are Designed	Services designed with the most cost-effective and quickest way in mind. Goal is stabilization.	Services are designed around restoring power to the client and providing adequate coping skills to manage the problem as a whole.
How the Therapeutic Relationship is Understood	Therapist is thought to be the expert. The therapist knows best and recommendations should be followed, without question.	The client and therapist are viewed as equals. Treatment planning is a collaborative effort. Therapist understands that trust must be earned.

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

7-23

Trauma-Informed Care:

Why Use Trauma-Informed Care?

- *Trauma dynamics can be repeated both knowingly or unknowingly in a therapeutic setting.*
  - *Example: disbelief or lack of interest in trauma history.*
- *Prevents re-traumatization and builds increased coping and interpersonal skills for the future.*
- *Ensures greater support for populations that experience minority stress or trauma.*
- *Encourages a healthy lifestyle/atmosphere.*

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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

7-24

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.

Trauma-Informed Care:

Five Principles of All Trauma-Informed Care:

- ***Safety:*** *Ensures that each person feels secure/non-threatened physically and in their role.*
- ***Trustworthiness:*** *Stresses that a person feels as though they can completely rely on an organization and its staff.*
- ***Choice:*** *Provides treatment options for consumers.*
- ***Collaboration:*** *Stresses consideration of support options and mutual decision-making.*
- ***Empowerment:*** *Ensures the recognition and utilization of client strengths.*

7-25

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

Trauma-Informed Care:

Examples of safety and trustworthiness:

- *Workplace protections:*
  - *Both staff and clients feel safe.*
  - *Confidential and reliable systems for reporting bias related incidents.*
  - *Display "safe-space" signs in a visible place (or multiple places).*
  - *Provide the option for gender-neutral restrooms.*

7-26

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

Trauma-Informed Care:

Examples of choice:

- *Honor LGBT clients' and staff members' freedom to disclose or not disclose their sexual orientation/gender identity.*
- *Provide clients and staff the opportunity to choose their name and preferred pronoun on forms, nametags, documents, etc.*
- *Provide options for safe living spaces, options for trained counseling staff, offer choices for safe spaces within agencies.*
- *Have medical providers trained in inclusive practices to offer options for treatment and therapy.*
- *Have a list of LGBT 12-Step Meetings and LGBT Affirmative Health Care Providers.*

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.

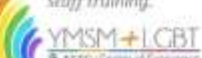
Unfortunately, factors such as busy schedules and format of staff meetings may offer little time to learn about new projects others are working on.

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



7-28

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

Trauma-Informed Care:

- Examples of empowerment:
  - *Provide a space for "out" staff members to become positive LGBT role models.*
  - *Focus on strengths in treatment.*
  - *Support forums for employees to freely and openly discuss issues.*
  - *Provide positive feedback during the assessment process.*
  - *Be aware of developmental needs, especially related to LGBT-identity.*
  - *Encourage growth, exploration, questions.*

7-29

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.

Discussion Activity:

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

- *Safety*
- *Trustworthiness*
- *Choice*
- *Collaboration*
- *Empowerment*

7-30

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.

7-31

Assessment Process

- Developing LGBT-sensitive assessment strategies is important for developing rapport with the client.
- Asking questions in an affirming way (avoiding unconscious bias).
- Assessing strengths and resilience.
- In emergency room settings:
  - *Address issues of suicide, depression and anxiety disorders, especially in transgender people, gay and bisexual men.*

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Provider can also assess any current or past connection to ethnic or cultural groups for support.

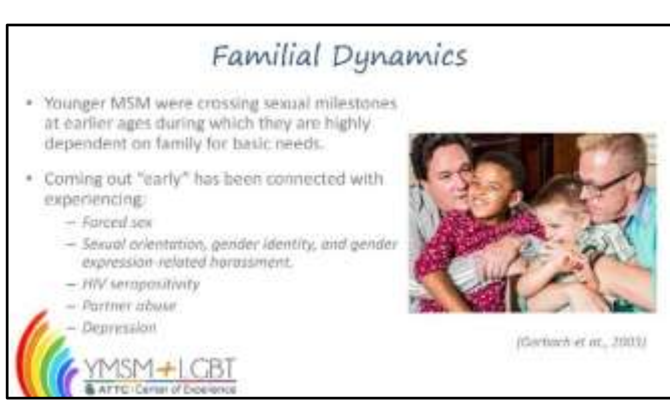
7-32

The term "coming out" refers to the experiences of LGBT individuals as they work through and accept a stigmatized identity, transforming a negative self-identity into a positive one.

"The loneliness of the closet was sucking all the life out of my body...I needed to come out...but was terrified of losing my family and friends and of facing up to my own homophobia. Then one day, when I was feeling feisty, I gathered all of the courage I could find (even from my eyelids I think) and began to tell my long-kept secret. I felt so relieved I no longer had to spend my life in hiding..."

- 20 year Latino man

7-33



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 emotional 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, 61% 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 of suicidal thoughts than other ethnic counterparts*
  - *African American same-sex attracted young men were also more likely to be depressed*

(Bridges E. 2017)

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.

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.

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.

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, LGBTQI2-Spirit, gender variant/non conforming, elderly, other-abled, and not written here, in conversation and all environments

7-37

To treat me....you have to know who I am......

- https://www.youtu be.com/watch ?v= NU hvJgxgAac

(http://www.cancer-network.org/)

7-38

7-39

LQBT *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/sexua l **orientation**
- ./ Knowledge and use of safer sex **practices**

7-40

Taking a Family History

All Clients:

- What were the **rules** of the family system?
- Was there a history of physical, emotional, spiritual, or sexual **trauma**?
- Were all family members **expected to behave** in a certain way?
- What were the family's expectations in regard to **careers, relationships, appearance, status, or environment**?
- **Was sex ever discussed**?

LGBT Clients:

- **Who** is the client's **family**?
- **Is the client out** to his or her family?
- **How did the family respond** to other individuals coming out or being identified as LGBT individuals?
- Was **anyone else in the family** acknowledged to be or suspected of being a lesbian, gay, bisexual, or transgender individual?
- If the client is out, what type of response did he or she receive?

7-41

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.

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Using Traditional Treatment Approaches with LGBT Populations

7-42

Motivation is key to change and is multidimensional.

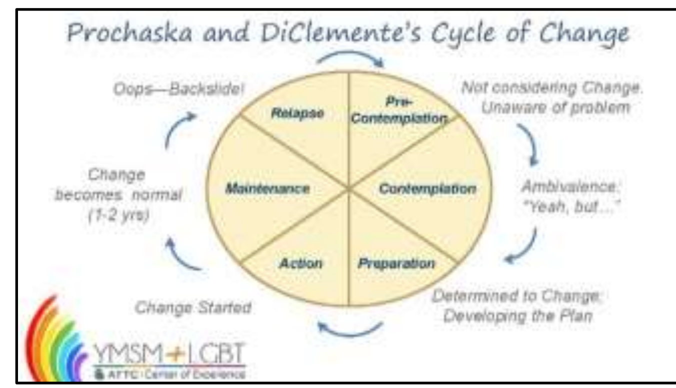
Motivation is dynamic and fluctuates.

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.

Motivational Enhancement Therapy

- MET is a style of communication with the goal of helping clients move toward their own vision/goal by committing to a plan of action.
- A client may be in different stages of change with regard to:
  - *Their coming out process.*
  - *Their mental health issues and trauma.*
  - *Their substance use issues.*
  - *Their HIV status and other health issues.*



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.

Cognitive Behavioral Therapy (CBT)

- CBT for social anxiety in gay men:
  - Gay men report more social anxiety than heterosexual men, especially if they try to hide their sexual identity.
  - Specifically focusing on sexual identity and social anxiety reduced symptoms drastically.
- CBT approaches also used with meth dependence and HIV-related sexual risk behaviors in gay and bisexual men.

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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.

Cognitive behavioral treatment family therapy

- CBT family therapy (CBFT) used following a child's coming out.
- Topics for the CBFT and family adjustment after a child has come out:
  - *Parents' attitudes, beliefs, and expectations are explored*
  - *Increasingly more salient topics are discussed*
  - *Specific listening and problem solving skills enhance the family's communication.*

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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).

Cognitive behavioral family therapy

- CBFT with bisexual couples:
  - *Bisexuals are faced with bias and discrimination and the therapists need to understand the challenges and strengths to be able to help bisexual couples .*
  - *Focus on behaviors, cognitions, and emotional issues specific to bisexual couples.*
  - *Communication training for couple.*
  - *Emotional expressiveness training for couple.*
  - *Cognitive restructuring for individuals in relationship.*

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:

http://www.plumeriacounseling.com/coming-out-through-art-a-review-of-art-therapy-with-lgbt-clients/

Art Therapy with LGBT clients

- Integration of Art Therapy in counseling with LGBT populations especially during the coming out process was associated with a increase in emotional and physical wellbeing.
  - *Growing evidence in support of the use of personal creative expression and sexual identity.*
  - *There is a growing acknowledgement of the relationship between artistic expressiveness and physical and emotional health.*

7-48

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.

Mutual Self-help groups

- Providers need to be knowledgeable of local groups that are LGBT affirming and culturally specific. A resource list should be made readily available to all clients.
- Encourage shopping around for the right self-help group.
- Encourage engagement with a LGBT affirming sponsor.

7-49

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.

Aftercare and Access to Sustainable Services

- Behavioral Health Disorders are chronic and relapse occurs:
  - *Often requires continued and ongoing focus on coping skills.*
- Regular access to affirming and supportive services is crucial for success.
- Engage with families and significant others in the aftercare process.

7-50

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.

Aftercare cont.

- Assisting the client in maintaining LGBT affirming and supportive relationships:
  - *Assist in rebuilding LGBT social networks.*
  - *Support rebuilding trust and connections with loved ones.*
- Support seeking education and employment in LGBT affirming institutions.

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.

Provider Considerations:

Providers need to be aware of harmful treatment practices:

- "A [provider] who harbors prejudice or is misinformed about sexual orientation, gender identity and gender expression may exacerbate a client's distress.
- The most dramatic instance…occurs when a therapist…attempt[s] to change [the client's] sexual orientation or gender identity and expression."

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.

7-53

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.”

Provider Considerations:

- Many professional organizations have official policies against treatment practices aimed at changing sexual orientation, also known as “conversion” or “reparative” therapies.
  - American Medical Association (AMA)
  - American Academy of Pediatrics
  - National Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and their Allies (NALGAP)
  - American Psychological Association (APA)
  - American Psychiatric Association (APA)
  - National Association of Social Workers
  - American Association for Marriage and Family Therapy (AAMFT)
  - American College of Physicians
  - Gay and Lesbian Medical Association (GLMA)
  - National Coalition for LGBT Health

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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:

http://www.lambdalegal.org/publications/health-and-med-orgs-stmts-on-sex-orientation-and-gender-identity

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7-54

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

Provider Considerations:

- As stated before, it is helpful to understand unique risk factors that exist for LGBT individuals as a response to minority stress and other challenges posed by living in a heterosexist/transphobic society.
- Strive to understand culturally-specific challenges experienced by individuals from diverse, racial/ethnic communities - and the resulting conflicts for being LGBT-identified.

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7-55

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

Necessary qualities to perform affirming treatment with LGBT Populations (TAP 21, CSAT 2006)

- Knowledge:
  - Understand etiology of disorders developed in the LGBT population based on minority stress.
  - Understand that sexual and gender identities are not diseases, but rather identities expressed in different ways.
- Skills:
  - Ability to provide competent, affirming and supportive services for the LGBT identified client and their families, partners, community etc.
- Attitudes:
  - Ability to have and show a genuine affirming and supportive attitude towards the LGBT identified client and their families, partners, communities etc.

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7-56

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.

Provider Considerations:

Common elements of LGBT-affirming interventions:

- Normalizing adverse impact of minority stress.
- Facilitate emotional awareness, regulation, and acceptance.
- Reduce avoidance.
  - *Example: Helping clients confront painful minority stress encounters in safe contexts.*

7-57

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.

Provider Considerations:

Common elements of LGBT-affirming interventions cont.:

- *Empower assertive communication.*
- *Restructure minority stress cognitions.*

YMSM+LGBT

7-58

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.

Provider Considerations:

Common elements of LGBT-affirming interventions cont.:
- *Validate LGBT individual's unique strengths.*
- *Foster supportive relationships.*
- *Affirm healthy, rewarding expressions of sexuality.*

(Society of Clinical Psychology, 2015)

7-59

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

Provider Considerations:

We must address the needs of ethnic minority YMSM. Recommendations from AMFAR include the following:
- *Make HIV testing widely available in clinical settings.*
- *Train providers about the importance of more frequent HIV testing for gay men.*
- *Use technology to communicate and help clients access services*
- *Help ensure clients get access to insurance, if available, and are linked to knowledgeable providers*

(AMFAR, 2012)

7-60

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.

Provider Considerations:

- Clinical Supervision:
  - *Clinical supervision needs to be institutionalized in all agencies treating behavioral health disorders in LGBT populations to:*
    - *Address transference and counter-transference issues.*
    - *Ensure staff uses ethical and evidence-based practices.*

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

7-62

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.

Provider Considerations:

An affirmative approach is supportive of clients' identity development without a prior treatment goal for how clients identify or live out their sexual orientation, gender identity and expression.

NALGAP opposes the use of "reparative" and "conversion" therapies that are based upon the assumption that homosexuality or bisexuality is a mental disorder and/or relies on the belief that the individual seeking treatment should change their sexual orientation.

7-63

7-64

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7-65

Resources:

7-66

References:

7-67

References:

YMSM+LGBT

7-68

7-69

7-70

The Center of Excellence on Racial and Ethnic Minority Young Men Who Have Sex with Men and Other Lesbian, Gay, Bisexual, and Transgender Populations
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