Gaining cultural competency for the occupational therapy student & clinician on the lesbian, gay, bisexual & transgender (LGBT) population

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GAINING CULTURAL COMPETENCY FOR THE OCCUPATIONAL THERAPY
STUDENT & CLINICIAN
ON THE LESBIAN, GAY, BISEXUAL, & TRANSGENDER (LGBT)
POPULATION

by

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Submitted to the Occupational Therapy Department
of the
University of North Dakota
in partial fulfillment of the requirements
for the degree of
Master’s of Occupational Therapy

Grand Forks, North Dakota
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Approval Page

This Scholarly Project Paper, submitted by Lindsey Belzer and Jessa Hulteng in partial fulfillment of the requirement for the Degree of Master’s of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Faculty Advisor

May 13, 2009
Date
PERMISSION

Title: Gaining Cultural Competency for the Occupational Therapy Student and Clinician on the Lesbian, Gay, Bisexual, and Transgender (LGBT) Population

Department: Occupational Therapy

Degree: Master's of Occupational Therapy

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ABSTRACT

When considering cultural groups, people in the lesbian, gay, bisexual, and transgender (LGBT) population are rarely considered or discussed as a cultural group. For many people, discussion about the LGBT community and sexuality is uncomfortable or often deemed private in order to avoid discussion. Therapists often state “well it’s none of my business,” but as Harrison (2001) states, it is our job as health professionals to provide therapy settings that are safe for all individuals to openly express themselves. The challenge that arises is in developing a greater understanding around sexual differences in order to be able to provide quality service to future clients of the LGBT community (Harrison 2001).

Harrison (2001) suggests therapists must consider clients’ sexual identity differences as a culture, and that it is our responsibility, as healthcare professionals, to provide therapy settings that are safe for all individuals to express themselves. Kingsley and Molineux (2000) state, “it is now a time that a broader and more thorough understanding of how sexual orientation can influence (how) occupation is developed, so that therapy can be more authentic with people who are gay, lesbian, or bisexual” (p. 207).

The research on LGBT, in occupational therapy, is severely limited. When considering the large numbers of the LGBT cultural group in the U.S., occupational therapists have minimal resources to assist them in gaining cultural awareness and remove the myths and stereotypes that may be negatively affecting the professional’s beliefs and attitudes toward individuals in this group. Researchers have indicated that in
order for occupational therapists to provide authentic care, it is critical that issues surrounding homophobia be addressed (Harrison 2001).

A literature review was conducted regarding: the stereotypes, myths and attitudes of healthcare professionals who are working with this population; the role of therapeutic use of self in regard to service delivery; the needs and rights of this population in regard to the provision of a respectful therapeutic process and; the best evidenced-based practices that are essential for occupational therapist to provide culturally competent quality care to effectively and objectively meet the needs of this population. In addition, the national LGBT Occupational Therapy group was contacted.

The result of this scholarly project is the development of an educational resource guide for clinicians to gain cultural competency in order to work most effectively with members of the LGBT group. Occupational therapists must gain cultural competency related to the LGBT population in order to be aware of personal biases and to provide client-centered care to individuals within this cultural group.
CHAPTER I
INTRODUCTION

In 1995, the American Occupational Therapy Association (AOTA) adopted a policy of nondiscrimination to include sexual orientation. The policy states that all members of the occupational therapy profession have the “right to achieve a productive and satisfying professional and personal life without regard to age, race, disability, culture, sexual orientation, national origin, gender, religion, or employment status” (AOTA, 1995, p. 1009). The following year in 1996, AOTA incorporated a policy of full inclusion into the association stating:

All individuals, regardless of ethnicity, race, age, religion, gender, sexual orientation, or disability should be able to be a part of the naturally occurring activities of society. Full inclusion addresses the need for all individuals to have the same opportunities. It also recognizes the benefits to everyone of being with individuals who are different from themselves. By embracing an attitude of full inclusion, all individuals will benefit from the opportunities afforded by a diverse society (1996, p. 855).

AOTA recognizes that the concept of full inclusion incorporates “perceptions, values, attitudes, expectations, and behaviors for all persons, those with and without disabilities” (1996, p. 856). It is essential to recognize and accept differences in order to “promote human diversity and individual choice” (AOTA, 1996, p. 856).

Discussions of sexuality have been largely omitted in occupational therapy sessions due to decreased comfort levels surrounding the topic (Couldrick, 2005). In
addition, some therapists believe the act of sex is considered an activity rather than an occupation; therefore, questions surrounding the topic, are left out (Harrison, 2001). Other research suggests that therapists are ill equipped with the skills needed to open the conversation about sex or feel that it is a private issue (Jones, Weerakoon, Pynor, 2005). The problem with these reasons of omission is that occupational therapists are not treating the client holistically therefore not providing authentic services to LGBT clients (Jackson, 1995).

One of the most controversial dimensions of diversity is sexual orientation. Based upon these positions of AOTA, the occupational therapy profession acknowledges the importance of addressing the needs of the lesbian, gay, bisexual, and transgender (LGBT) population, but has failed to support this diverse group in topics in the curriculum and in the clinic.

For many people, discussion about the LGBT community and sexuality is uncomfortable or often deemed private to avoid discussion. Therapists often state, “well it’s none of my business,” but Harrison says, it is our job as health professionals to provide therapy settings that are safe for all individuals to openly express themselves (2001).

Issues around homophobia must be addressed if therapy is to be client-centered and to better understand what is meaningful to each individual (Harrison, 2001). The knowledge you will have gained from this resource will assist in developing competency when working with LGBT clients and will educate you on why discussions of sexuality should not be absent from any part of the treatment process.
The challenge that arises is that there is a lack of resources for therapists to access in regard to working with LGBT clients. Resources are needed to develop a greater understanding around sexual differences to provide quality service to future clients of the LGBT community (Harrison 2001). When considering the large numbers of the LGBT cultural group in the United States, occupational therapy has minimal resources and research to assist therapists in gaining cultural awareness and removing the myths and stereotypes. These myths and stereotypes can negatively affect a professional’s beliefs and attitudes toward individuals in this group. Researchers have indicated that in order for occupational therapists to provide authentic care, it is critical that issues around homophobia be addressed (Harrison, 2001).

It is important for the profession to understand the impact of making assumptions in relation to sexuality (Harrison, 2001). Currently, there are no standards of practice to assist occupational therapists when working with LGBT clients. The purpose of this scholarly project is to provide guidelines that can be used to direct students and clinicians in developing LGBT cultural competency. It is important to consider the information provided in this resource as guidelines rather than best practices due to the evolving nature of discussion surrounding this diverse population.

The Adult-learning Theory, also referred to as Andragogy, developed by Malcom Knowles, was used for the development of the resource guidelines. Andragogy is defined as the art and science of adult learning (Bastable, 2006). Since this resource is intended to be used by occupational therapists, it is the therapists and students that are the adult learners. The resource guidelines are organized to follow a natural progression of
learning. It is important to gather information and then learn how to apply the information in a practical manner.

Key Concepts and Terms

The following section presents the key concepts and terms presented throughout this scholarly project. The terms were extracted from the following sources:

- Ohio University LGBT Center: http://www.ohio.edu/lgbt/resources/educate_def.cfm
- Berkley University of California Campus Life and Leadership: http://students.berkeley.edu/osl/geneq.asp?id=1172
- Gender Spectrum Organization: www.genderspectrumfamily.org/terminology.shtml

1. **Advocate**: A person who actively works to end intolerance, educates others, and supports LGBT issues, concerns, equal rights legislation, etc.
2. **Ally**: A heterosexual or LGBT person who supports LGBT people.
3. **Bisexual**: A person who is emotionally, physically, spiritually, and sexually attracted to members of more than one gender. Also can be referred to as omnisexual and pansexual.
4. **Biological Sex**: A binary system (male/female) set by the medical establishment, usually based on reproductive organs. See Intersexed.
5. **Closeted**: One who has not "come out of the closet" or who has come out to only a few people. One who may not be comfortable enough with their own sexuality to share it with others.
6. **Coming Out**: The life-long process of discovering, defining, and proclaiming one's (non-heterosexual) sexuality.
7. **Cross Dressing**: The act of wearing the clothing of the "opposite" sex for performance, sexual encounters, or comfort. Generally, the term cross dresser is preferred to transvestite. See Transvestite.
8. **Drag**: Queen, a person who consciously performs femininity, sometimes in an exaggerated/theatrical manner, usually in a show or theatre setting; King, a person who consciously performs masculinity, sometimes in an exaggerated/theatrical manner, usually in a show or theatre setting.
9. **Dyke**: Derogatory slang terms used to identify lesbians.
10. **Faggot**: Derogatory slang used to identify gay men.
11. **Gay**: Usually, but not always, refers to homosexual men. Also used as an umbrella term for the LGBT community.
12. **Gender Expression**: An external presentation that communicates our gender to others: includes but not limited to clothing, hair styles, body language, mannerisms, play, and roles.
13. **Gender Fluidity**: A flexible range of gender expression with interests and behaviors that may change day to day. A person who is gender fluid does not feel confined by restrictive boundaries of stereotypical expectations of girls or boys.

14. **Gender Identity**: How a person perceives and what they call themselves; may or may not agree with societal gender roles outlines for their sex; typically masculine/feminine. Coincides with what doctors and/or society have prescribed for that person or can also refer to a multitude of expression like femme, boy, faggot, androgynous, leather, etc.

15. **Genderqueer**: Any LGBT person whose gender presentation is an intentional mixture of gender signifiers, usually a political identity in support of transgender persons and against the binary gender system.

16. **Gender Role**: The societal and cultural expects of people based upon their biological sex.

17. **Hate Motivated Offenses**: Assault, rape, arson, and murder are crimes under any circumstance, but when a victim of such a crime was targeted simply because of their affiliation (or perceived affiliation) with a minority group, the FBI considers the crime a 'hate crime.' In some states, hate crimes carry an additional penalty beyond the standard penalty for assault, murder, etc. Also known as "gay-bashing", acts of intolerance, or hate crimes.

18. **Heterosexual**: A person who has emotional, physical, spiritual, and sexual attractions to persons of the "opposite sex". The sexuality that dominant discourse prescribes.

19. **Heterosexual Privilege**: Advantages that come with heterosexuality in this society and culture; i.e.:> Marriage and all the benefits that go along with it, acceptance from family, safety, and acceptance in their chosen career field.

20. **Heterosexism**: The belief that all people are heterosexual, the assumption and/or belief that heterosexual relationships and behavior are superior, and the actions based on this assumption.

21. **Homosexual**: A person who has emotional, physical, spiritual, and sexual attraction to persons of the "same sex". More of a medical term, it is considered an outdated term when referring to gay people or communities.

22. **Homophobia**: Fear, anger, discomfort, intolerance, or lack of acceptance toward LGBT people, or experiencing these feelings about one's own non-heterosexual preference.

23. **Human Sexual Response**: Behaviors, thoughts, dreams, fantasies; not just behavior.

24. **Intersexed**: People born with "unexpected" genitals. Formerly referred to hermaphrodites, intersexed people are not easily categorized as male or female because of ambiguous genitals. Most intersexed people do not possess "both" sets of genitals, rather a blending or a different appearance that is medically unacceptable to most doctors. Intersexuality is fairly common. Many who identify as intersexed believe that early childhood surgical intervention is not only unnecessary but cruel and advocate counseling and support for children and families.

25. **Lavender**: This association goes back into ancient times and has been strengthened by the fact that lavender, or purple, is the combination of red (pink) and blue, the traditional gender-identified colors.
26. **Lesbian**: A woman who has emotional, physical, spiritual, and sexual attractions to other women.

27. **Lifestyle**: How a person chooses to live and behave. Being LGBT is not a choice, and therefore is not considered a lifestyle (ie: yuppie, vegan, hobbies, rural/urban, etc.).

28. **Normal**: Can refer to what is statistically more common, but is often confused by heterosexuals to refer to whatever it is that they condone morally. Only the individual can decide what is normal for them and it need not be what is normal to others.

29. **Outing**: To declare a person's identity publicly; people can out themselves, or someone can out them either with or without their permission.

30. **Pride**: Not being ashamed of oneself and/or showing your pride to others by coming out, marching, etc. Being honest and comfortable.

31. **Rainbow Flag**: In 1978, San Francisco artist Gilbert Baker designed a flag for the city's Gay Freedom celebration and LGBT movements worldwide have since adopted it as a symbol of gay identity and pride. It has six stripes in the traditional form, but can be seen as streamers, etc, which run in the order of red, orange, yellow, green, blue, purple. The flag also symbolizes diversity within unity.

32. **Questioning**: The process of exploring one's own sexual identity, including but not limited to one's upbringing, expectations from others (family, friends, church, etc.), and inner motivation.

33. **Queer**: Derogatory slang terms used to identify LGBT people. This term has been embraced and reinvented as a positive, proud, political identifier when used by LGBT people among and about themselves. See dyke, faggot.

34. **Sexual Orientation**: To whom a person is erotically attracted. Not to be confused with sexual preference: What a person likes to do sexually.

35. **Stonewall**: On June 28, 1969, NYC police attempted a routine raid on the Stonewall Inn, a working class gay and lesbian bar in Greenwich Village. Unexpectedly, the patrons resisted, and the incident escalated into a riot that continued for several days. Most people look to this event as the beginning of the American Gay Liberation movement and all subsequent LGBT movements.

36. **Transgender**: An umbrella term for people who transgress society's view of gender and biological sex as necessarily fixed, unmoving, and following from one's biological sex. They view gender on a spectrum, rather than a polarized, either/or construct. This can range from identification to cross dressing, to undergoing hormone therapy, to sex reassignment surgery and/or to other forms of dress/presentation. Transgender people can include transsexuals, cross-dressers, drag kings/queens, masculine women, feminine men, and all those who defy what society tells them is appropriate for their "gender". Political trans activists seek to create more space around gender, and to create a space and a society where the choice of gender expression/presentation is safe, sane, and consensual.

37. **Transsexual**: A person whose core gender identity is "opposite" their assigned sex. Transsexuals may live as the opposite sex, undergo hormone therapy, and/or have sex reassignment surgery to "match" their bodies with their gender identity.

38. **Transvestite**: A person who cross-dresses for erotic pleasure or relaxation.
Chapter II presents the review of literature that was used to support the design of the product. Chapter III describes the process used in the design of the product. Chapter IV is an introduction to the product and then the product in its entirety. The Scholarly Project culminates in Chapter V where the conclusions, recommendations and limitations are presented.
CHAPTER II
INTRODUCTION

When considering cultural groups, people in the lesbian, gay, bisexual, and transgender (LGBT) population are rarely part of that consideration. For many people, discussion about the LGBT community and sexuality is uncomfortable or often deemed private in order to avoid discussion. Therapists often state “well, it’s none of my business,” but as Harrison (2001) says, it is our job as health professionals to provide therapy settings that are safe for all individuals to openly express themselves (p. 143).

Harrison (2001) suggests that therapists must consider clients’ sexual identity differences as a culture, and that health disparities within this culture must be addressed in order to provide more authentic care. Kingsley and Molineux (2000) state that “it is now a time that a broader and more thorough understanding of how sexual orientation can influence (how) occupation is developed, so that therapy can be more authentic with people who are gay, lesbian, or bisexual” (p. 207). The same idea applies to individuals who are in the transgender population.

The challenge that arises is developing a greater understanding of sexual differences in order to be able to provide quality services to future clients of the LGBT community (Harrison, 2001). The research on LGBT in occupational therapy is severely limited. When considering the large numbers of the LGBT cultural group in the United States, occupational therapists have minimal resources to assist them in gaining cultural
awareness and to remove the myths and stereotypes. These myths and stereotypes can negatively affect a professional's beliefs and attitudes toward individuals in this group. Researchers have indicated that, in order for occupational therapists to provide authentic care, it is critical that issues surrounding homophobia be addressed (Harrison, 2001).

A core premise, in occupational therapy, is to focus on people's occupations, which are defined as “daily activities that reflect cultural values, provide structure to living, and meaning to individuals; these activities meet human needs for self-care, enjoyment, and participation in society” (Crepeau, Cohn, & Schell, 2003, p. 1031). Sexuality is an occupation that needs to be taken into consideration. It is important for the profession to understand the impact of making assumptions in relation to sexuality (Harrison, 2001). Based on the needs of clients as well as clinicians, the purpose of this review of literature is to:

1. Present the complexities of the membership of this cultural population;
2. Identify the stereotypes, myths and attitudes of healthcare professionals who are working with this population;
3. Present the need for increasing culturally competent care in the profession of occupational therapy when working with individuals of the lesbian, gay, bisexual, and transgender (LGBT) population;
4. Present the role of therapeutic use of self in regard to service delivery and;
5. Present the best evidenced-based practices that are essential for occupational therapists to provide culturally competent quality care to effectively and objectively meet the needs of this population.

The result of this literature review is the development of resource guidelines for clinicians to gain cultural competency in order to work most effectively with members of the LGBT group.
LGBT Statistics

LGBT Defined

The term LGBT broadly groups together individuals who self-identify as lesbian, gay, bisexual and transgender. One construct used to describe the LGBT population is that they are a cultural group. This is fitting in that sexual orientation and gender identity are components of one’s identity, which is multi-faceted, similar to culture (Harrison, 2001). Culture is considered the “customs, beliefs, values, knowledge, and skills that guide people’s behaviors along shared paths” (GLMA & LGBT Health Experts, 2001, p. 21). Culture is intertwined with factors influencing health, but it should be noted that the use of the culture construct is not without debate (GLMA & LGBT Health Experts, 2001). Like using any label to describe a population, there can be negative consequences. It needs to be recognized that, while some similarities are shared among various members of this group, there are far more differences and unique health disparities that each member faces individually (Dean et al., 2001; GLMA & LGBT Health Experts, 2001). Research has indicated that the stigma placed upon them and the discrimination that results may be the only similarity held among this population (GLMA & LGBT Health Experts, 2001). People in the LGBT population are diverse in terms of “cultural background, ethnic or racial identity, age, education, income, and place of residence” (Dean et al., 2000, p. 102). Furthermore, the “degree to which sexual orientation or gender identity is central to one’s self-definition, the level of affiliation with other LGBT people, and the rejection or acceptance of societal stereotypes and prejudice vary greatly among individuals” (Dean et al., 2000, p. 102).
Similar to other cultural groups, there are many complexities that influence and impact the dynamics within the population. It cannot be assumed that everyone fits into the same mold, which is the prevalent assumption of western healthcare ideals (Iwama, 2003). There are intricate subcultures within the LGBT population, and it can be difficult to determine where to begin when developing a greater cultural competency toward working with this population. To be more prepared to address issues that may emerge when working with individuals of the LGBT population, therapists must have a basic understanding of the language used within this group of individuals.

Though individuals of this population are broadly defined as LGBT, they may not use the terms lesbian, gay, bisexual, or transgender to define themselves (GLMA, 2002). This may be more evident with older clients who have same-sex partners, but have never ‘came out’ to family and friends (Harrison, 2001). In addition, individuals may choose not to use a label to define themselves. Regardless of how a person self-identifies, healthcare providers must have a basic understanding of the terminology used within the population in order to provide culturally competent care. In addition, therapists must also respect their clients’ choice of terminology and not make assumptions before clarifying with clients what terms they use to define themselves (GLMA, 2002).

Most often, lesbian, gay, and bisexual (LGB) people are defined based on their sexual orientation. Sexual orientation describes both sexual preference and emotional attraction, and can be directed toward members of the same sex, the opposite sex, both sexes, or neither sex (Lev, 2004). Additionally, sexual orientation is an individual’s self-perception of being gay, lesbian, bisexual, or heterosexual (Council on Scientific Affairs, AMA, 1996). Sexual orientation does not always coincide with sexual behavior, and
these perceptions may vary over time (Council on Scientific Affairs, AMA, 1996). A generally accepted definition of a person who is LGB is someone with an “orientation toward people of the same gender in sexual behavior, affection, or attraction, and/or self-identity as gay/lesbian or bisexual” (Dean et al., 2000, p. 102).

The transgender population is commonly defined based on gender identity. Gender is a social construct used to determine whether one is male or female, and is dependent on culture, meaning that we learn to act appropriately in our assigned gender roles (Brown & Rounsley, 1996). This can differ from ones’ gender identity, which is defined as the “internal experience of gender” or a “person’s self-concept of his or her gender” (Lev, 2004, p. 81). For most people, gender identity is congruent with their assigned sex; however, for some, their gender identity does not match their biological sex (Lev, 2004). People whose gender identity differs from their biological sex are often referred to as transgender. Transgender is an umbrella term used to “describe the full range of individuals who have a conflict with or question about their gender” (Brown & Rounsley, 1996, p. 18). People included under the transgender umbrella may be transsexual, transvestite, gender-variant, drag queens or kings, gender benders, cross-dressers, or people who are experiencing gender confusion (Brown & Rounsley, 1996). This population may live part-time or full-time as members of the opposite gender (Lev, 2004). In other words, transgender individuals may choose to work or participate in certain community activities as the gender they were born or assigned with, while participating in other activities as the gender which they identify themselves to be. In addition, people may identify themselves based on their gender vector. Male-to-female (MTF) are people who have been assigned a male gender at birth, but who identify their
gender as female; and female-to-male (FTM) are individuals who are biologically assigned females, but identify with the male gender (Lev, 2004). Not everyone with a gender variance considers themselves under the transgender umbrella. It is the duty of the healthcare provider to use the terminology that the individual prefers.

These definitions only skim the surface of the LGBT population, but they can assist therapists to begin the necessary skill development toward cultural competency for working with the LGBT population. Understanding terminology provides therapists with a starting point that will assist them in providing valuable therapeutic experiences to clients who identify as LGBT.

**Population Size**

As stated previously, many components influence how individuals define themselves. This has an effect on the ability to determine the number of individuals in the U.S. that make up the LGBT population. Current research, focused on the number of LGBT people, is limited because of factors such as self-definition, stigma, and fear of discrimination (Dean et al., 2000). Most of the data that has been collected does not include transgender and only represents people who identify as lesbian, gay, and bisexual. In addition, there is no clear-cut way to define or count people in this population because people define themselves differently (Lev, 2004; Dean et al., 2000). Despite these issues, some statistics exist that attempt to find a representative estimate of the LGBT population. Most of the statistics have been gathered through convenience sampling (GLMA & LGBT Health Experts, 2001).

Perhaps the most widely accepted estimate is that LGBT individuals make up 10% of the U.S. population; this figure came out of the 1948 Kinsey Survey, in which
10% of the male population and 5 to 6% of the female population identified as gay and lesbian (GLMA & LGBT Health Experts, 2001). More recent surveys find this estimate to be high (Council on Scientific Affairs, AMA, 1996). One study, completed in 1994 by The Social Organization of Sexuality, suggests that between 1.4% to 4.3% of women and 2.8% to 9.1% of men in the United States identify as lesbian, gay, or bisexual, though the researchers note these numbers may be low due to the difficulty of obtaining sensitive information from sexual minorities (Dean et al., 2000). The 1990 U.S. Census data found that 1.63% of people 15 years of age and older reported themselves as an unmarried same-sex partner in the household (GLMA & LGBT Health Experts, 2001). In the 2000 U.S. census, data shows that “same-sex couples can be found in 99.3% of U.S. cities (More, Whitehead, & Gonthier, 2004).

An estimate of the number of people who are transgender is virtually non-existent due to factors such as how individuals define themselves, social stigma, and discrimination (Dean et al., 2001). One estimate is that people who identify as transgender comprise 2-3% of the LGBT population (Burdge, 2007). Healthy People 2010 indicate that 25,000 U.S. citizens have undergone sexual reassignment surgery and approximately 60,000 individuals consider themselves candidates for sexual reassignment surgery (GLMA & LGBT Health Experts, 2001).

Healthy People 2010 (2001) advocates that more must be done to gain a more accurate number of LGBT in the United States in order to better address and treat health concerns and issues related to this demographic group. Whether an accurate depiction of the LGBT population size is ever portrayed, it is evident that LGBT people make up a
strong portion of the U.S. population, and healthcare professionals must consider this when treating clients.

People of the LGBT population are becoming increasingly more visible in American society through advocacy, media attention, and people's comfort level with those outwardly identifying as LGBT (Hobbs, 2004; Dean et al., 2000). A survey completed by CIRCLE, the Center for Information & Research on Civic Learning & Engagement, found that young Americans are the most tolerant age group and are becoming more tolerant over time (Olander, Hoban Kirby, & Schmitt, 2005). Eighty-five percent of those surveyed between 15 and 25 years of age felt that gay and lesbian people should have equal protection in housing and employment, and from hate crimes (Olander et al., 2005). Of the people surveyed, 50-63% were in support of civil unions, legal marriages, and the ability to adopt children for people who are gay or lesbian (Olander et al., 2005). Overall, this survey found that the majority of people surveyed were supportive of gay rights, though people 38 years old and over were less supportive (Olander et al., 2005). These statistics suggest that the views of American society are shifting toward providing all citizens with equal rights, which must be taken into consideration in the healthcare system as well.

Despite the increase in visibility and an apparent increase in tolerance in the US, there is continued opposition to providing this population with rights that are congruent with the heterosexual majority (Hobbs, 2004). Society perpetuates heterosexism through its major institutions like law, policy, religion, and the economy (Kingsley & Molineux, 2000). Barriers to quality care result from a lack of national protection, inadequate state laws, and insufficient education within the healthcare system (The Human Rights
Campaign, 2008). Currently, states are not required to have anti-discrimination laws regarding sexual orientation and gender identity, or laws on hate crimes related to sexual or gender identity. This population must be better served by the healthcare system, and in order to do that, knowledge of specific healthcare needs must be gained by healthcare providers.

**Stereotypes/Myths and Attitudes**

Violence against gay males and lesbians has emerged as a significant social problem (Van De Ven, 1995). Negative attitudes and behaviors toward LGBT individuals are caused in part by false assumptions about this minority group. To ensure the safety and well-being of the LGBT community, false myths and negative attitudes must be changed. Listed below are only a few of the common themes identified in the research (Van De Ven, 1995; PFLAG, 2006). It is important to seek clarification, reflect on personal bias, and become informed on issues related to the LGBT community before assuming stances on these topics.

**Myth I:** A person’s sexual orientation or gender identity can be changed.

**Fact:** Individuals may hide their interests and feelings from disapproving parents, religious rules, or co-workers because they want to be loved and accepted by them. This does not mean that the individual’s core sense of self has changed. This conforming behavior supports the idea that the individual has to live a lie in order to be accepted (Tuerk, Menvielle, De Jesus, 2003). Homosexuality is not “chosen;” therefore, practices such as “ex-gay” ministries and “reparative therapy” do not work (PFLAG, 2006). Treatments used to change a person’s identity actually can...
cause serious damage and lead to suicide (American Psychological Association, 1990).

**Myth II:** Homosexuality is an illness.

**Fact:** In December 1973 the American Psychiatric Association voted unanimously that homosexuality should no longer be listed as a mental disorder. Attitudes may vary, but homosexual practices occur across all cultures and societies (Gramick, 1983; Weinrich & Williams, 1991). Condemnation of gay and lesbian people for their "biologically unnatural sexual behavior" is based on a false premise (Kirsch & Weinrich, 1991). Homosexuality and heterosexuality are equally biologically natural (Kirsch & Weinrich, 1991).

**Myth III:** Homosexuals and Transgender individuals have distinct mannerisms in the ways they dress, speak, and walk.

**Fact:** Just as heterosexual individuals have a wide range of self-expressions, LGBT individuals should be given the same freedom to present themselves in ways that define who they are. Non-threatening exposure to a range of lesbians and gay males who do not fit particular stereotypes should help to eliminate this myth (Herek, 1991).

**Myth IV:** Being homosexual is only about the sex.

**Fact:** Sexuality and sex are two separate concepts. Sexuality is central to an individual's personal identity and feelings of self-worth. It is tied to the intimate personal relationships that meet deeply felt needs for love, attachment, and intimacy (APA, 2008). In addition to sexual behaviors, these bonds include nonsexual physical affection between partners, shared goals and values, mutual support, and ongoing
commitment (APA, 2008). In contrast, sex generally refers to the physical dimensions only of sexuality. Being gay or lesbian is not purely a matter of sexual orientation; rather, it is a matter of identity which is a broader holistic concept of self (Taylor, 1999).

*Myth V:* Homosexuals are responsible for the spread of AIDS.

*Fact:* Homosexuals as a group have been proactive about practicing safe sex behaviors and are leading the fight in our society against the spread of AIDS (Gonsiorek & Shernoff, 1991). Despite reductions in HIV incidence, they are still disproportionately affected (GLMA, 2006). Support and education within the healthcare system must occur to reduce the risk of infection and promote quality care for individuals living with the disease. Efforts to turn the AIDS crisis into a fight against homosexuals and homosexuality will only delay and frustrate attempts to control the disease (Poirier, 1988).

Eliminating myths and stereotypes may reduce much of the defensiveness associated with anti-homosexual attitudes (Van De Ven, 1995). These false perceptions impact a variety of facets of life, and are detrimental to successful functioning in the world. One of these areas is receiving appropriate, free-of-judgment healthcare. LBGT populations have the same basic health needs as the general population, but they often avoid accessing healthcare due to real and perceived homophobia and negative attitudes held by health professionals (GLMA & LGBT Health Experts, 2001).

**Healthcare Needs**

In general, people in the LGBT population share the same health risks of those who are heterosexual; however, there are some specific health issues that are of particular
concern for individuals in the population. Specific health areas of the LGBT population include cancer, family planning, HIV/AIDS and other sexually transmitted diseases (STDs), mental health, substance abuse, and violence and assault. Each section will be briefly discussed to provide a broader understanding of the health care issues faced by the LGBT population. A common theme identified throughout LGBT health issues is that there is little to no research on these issues.

Lack of research and limited discussion around LGBT issues reinforces the cycle of invisibility of this population in U.S. society (Harrison, 2002). A devastating consequence of the lack of discussion is that the life histories of older LGBT people may not be shared to their fullest. In addition, fear often overpowers discussion, and the need for addressing advocacy, policy, networking, home support, and legal issues is missed (Harrison, 2002). Advocacy for LGBT people is essential in healthcare because all individuals deserve to be given the best possible care. Some of the medical issues that LGBT people may encounter are the female to male perspective of menopause, osteoporosis, breast and ovarian cancer, as well as the male to female perspective of prostate cancer (Harrison, 2002). Issues such as these indicate that there is a strong need for research and advocacy (Harrison, 2002). In addition, examples of social discrimination and violence include denying services, not allowing persons to crossdress, and causing physical violence when external anatomy and expressed gender identity are different (Harrison, 2002).

**Cancer in LGB individuals**

Research indicates that lesbian women are at higher risk for breast cancer than heterosexual women due to risk factors such as "obesity, alcohol consumption, nulliparity,
and lower rates of breast cancer screening” (Dean et al., 2000, p. 111). Lesbian women report less adequate screening for breast and cervical cancer and often feel that they receive substandard care in comparison to heterosexual women (Council on Scientific Affairs, AMA, 1996).

Some studies suggest that lesbian women may have a higher risk for cervical cancer because many lesbian women do not receive screenings as regularly as heterosexual women (GLMA & LGBT Health Experts, 2001). Another view is that lesbian women have less of a risk of developing types of cervical cancer that are caused by the human papillomavirus (HPV) than women in opposite-sex relationships (Council on Scientific Affairs, AMA, 1996). These opposing views support the claim that there is inadequate research regarding the health issues of the LGBT population.

Gay and bisexual men are at higher risk for anal cancer, non-Hodgkin’s lymphoma, and Hodgkin’s disease (Dean et al., 2000). Though non-Hodgkin’s lymphoma and Hodgkin’s disease have been directly related to an increased incidence of HIV/AIDS, there has been no correlation noted with anal cancer.

Family Planning

Estimates of the number of children being raised by gay and lesbian parents in the U.S. range from 6 to 14 million (Dean et al., 2000). Increasingly, LGBT individuals are choosing to have children, whether it is by artificial insemination, adoption, or foster care. In 1990, it was estimated that 5,000 to 10,000 lesbians had chosen to have children after coming out, and this number continues to rise (Dean et al., 2000).

Gay and lesbian parents have few legal rights in regards to parenting issues. In many cases, one parent is the biological parent and the other parent is not. Issues created
in this circumstance can mean that the non-biological parent has no say in the child’s medical care and may not be acknowledged as a parent in school settings. It is thought that these legal inequalities may have a direct impact on the stress levels of gay and lesbian parents, though there has been little research to explore this (Dean et al., 2000). Available research has often focused on determining if there are adverse effects to being raised by same-sex parents (Dean et al., 2000).

HIV/AIDS and STDs

HIV is a major health concern for the gay community, and men who have sex with men account for more cases of AIDS than any other category in research (Council on Scientific Affairs, AMA, 1996). During the height of the HIV/AIDS wave in the U.S., initiatives were taken to educate the gay public on safe sex measures and the AIDS disease. As the rates of HIV/AIDS infected people began to drop, so did the health initiatives (Dean et al., 2001; GLMA & LGBT Health Experts, 2001).

Since 1981, “it is estimated that more than 702,000 Americans have been diagnosed with AIDS, of those, 54% are reported to be men who have sex with men” (Dean et al., 2000, p. 113). There is limited research on the relationship of HIV and lesbian women. In addition to HIV/AIDS, men who have sex with men have an increased risk for certain STDs such as urethritis, proctitis, pharyngitis, hepatitis A and B, syphilis, gonorrhea, and Chlamydia (Dean et al., 2000).

Mental Health Concerns

In addition to physical health issues, people in the LGBT population have specific mental health concerns. The Council on Scientific Affairs states, “All clients, regardless of their sexual orientation, have a right to respect and concern for their lives and values”
Emotional disturbance related to sexual identity is due more to a sense of alienation from an unaccepting environment than any other cause (Council on Scientific Affairs, 1996). Research is limited in this area, and there is no clear-cut evidence that sexual orientation is related to mental health status. According to Willging, Salvador, and Kano, individuals in the lesbian, gay, bisexual, and transgender (LGBT) population are at a higher risk for mental illness due to continued exposure to "psychosocial stressors associated with anti-LGBT attitudes and behaviors, including discrimination, stigmatization, and violence" (2006, p. 867).

Individuals living in rural areas may experience an increase in these stressors, as mental health resources are often insufficient or difficult to access in rural communities (Willging et al., 2006). Barriers to healthcare in rural areas vary from geographic isolation, lack of insurance, and confidentiality concerns (Willging et al., 2006).

Two other areas of concern in mental health are body image and eating disorders. Gay men and youth have been noted to have a higher rate of perceiving their body image as poor and more frequently have eating disorders in proportion to heterosexual males (Dean et al., 2000). Overall, women, both lesbian and heterosexual, have a higher incidence of eating disorders and dissatisfaction with body image (Dean et al., 2000).

Lastly, an area of particular interest to the occupational therapy profession is coping skills. Research is mixed on the rates of suicide among LGB individuals, though studies have found that suicidal ideation and attempts have been higher in gay men and lesbians (Dean et al., 2000). Research indicates that having a social support network can reduce the effects of stress in the LGBT population (Dean et al., 2000). Healthy coping skills are essential for individuals to deal with issues in a healthy manner.
Substance Abuse

Though the research is not fully representative of this population, it is proposed that LGBT individuals may use substances as a means to cope with underlying mental health issues and societal discrimination (Council on Scientific Affairs, AMA, 1996). Research on substance use, for the most part, does not take into consideration sexual and gender orientation, so the estimates have been gathered through convenience sampling (Dean et al., 2000). Estimates suggest that approximately 30% of gay men and lesbians consume alcohol (Dean et al., 2000). One study estimates the rate of illicit drug use among gay men ages 18 to 25 at 87.1% (Dean et al., 2000, p. 122). Approximately 80% of young lesbians have been reported to use substances (Dean et al., 2000, p. 122). The Council on Scientific Affairs identifies LGBT adolescents as a population that is at a much higher risk for substance abuse issues (AMA, 1996). Often adolescents do not have the support system they need to deal with their emotions related to LGB issues, and they may feel that they are not socially accepted in their community (AMA, 1996).

Violence and Sexual Assault

The LGBT population is among the “most frequent victims of hate violence in the U.S.” (Dean et al., 2000, p. 123). Moreover, violence and hate crimes against individuals in this population are typically more brutal and severe than those seen in other cultural groups (Dean et al., 2000). It is difficult to determine the prevalence of sexual abuse among the LGBT population; however, it is estimated that individuals in this population are at a higher risk for abuse (Dean et al., 2000). In addition, little is known of the rates of abuse among intimate partners in the LGBT community (Dean et al., 2000).
Transgender Mental Health Needs

The Gender Identity Diagnosis is much disputed and will be discussed in further detail later in this review. There is insufficient research that examines the relationship between mental health issues and transgender individuals, though it is suggested that depression associated with gender transition may be underdiagnosed (Dean et al., 2000). It is also suspected that transgender individuals are likely to experience victimization, and this may correlate with disorders such as post-traumatic stress disorder (Dean et al., 2000). In addition, suicide attempts and completed suicides are higher in the transgender population (Dean et al., 2000).

Transgender Health Issues

Health issues surrounding the transgender population are less researched than in the LGB population. Additionally, “it is difficult to distinguish transgender issues from those related to sexual orientation since the affected groups overlap so significantly” (Dean et al., 2000, p. 126).

Transgender Barriers to Care

One of the main barriers to transgender individuals receiving adequate health care is prejudice and discrimination. This is influenced by lack of education among society and more specifically, healthcare providers (Dean et al., 2000). “Transgendered persons frequently experience social and economic marginalization” (Dean et al., 2000, p. 127). Often families do not know how to accept their transgender family member and transgender individuals find themselves dealing with these issues on their own. Health insurance does not cover reassignment surgeries. Transgender individuals find that
healthcare providers do not have adequate knowledge to address their needs (Dean et al., 2000).

**Access to Healthcare Services**

Social constructs impact the health of the LGBT population in a multitude of ways (Taylor, 1999). This can range from stigma and discrimination to inadequate health care services (Willging et al., 2006). One of the main concerns is that there is limited research on health issues pertaining to the LGBT population (Dean et al., 2000). In addition, quality of care and access to care has an impact on LGBT health. “LGBT individuals face financial, structural, personal, and cultural barriers as they attempt to access competent, sensitive, health care services. These barriers and anxiety about facing them prevent LGBT individuals from receiving the screening and prevention services they need, and cause delays in receiving care for acute conditions” (Dean et al., 2000, p. 106). The impact that social constructs have on LGBT health can potentially be devastating to the forward process of creating equal health care for all individuals (GLMA & LGBT Health Experts, 2001).

A significant factor that limits access to health care is that many LGBT couples do not have health insurance for their partners because many insurance providers and employers do not offer benefits to unmarried partners (Dean et al., 2000). The decision not to cover same-sex partners can imply a heterosexist bias in the U.S. healthcare system. A trend seen in the workforce is that employers are now opting to self-insure, which means that they have access to employee health records (Dean et al., 2000). Implications are that LGBT individuals may not disclose to their healthcare provider their sexual or gender orientation for fear of their employer finding out and discriminating against them.
and they have minimal to no legal recourse (Dean et al., 2000). Furthermore, many individuals in the LGBT community are self-employed or part-time workers who do not have health insurance benefits (Dean et al., 2000). Many issues exist within the healthcare infrastructure related to insurance coverage, as well as in other areas.

Another heterosexist bias is found in “regulations allowing for one member of a married heterosexual couple to retain a jointly owned house without jeopardizing the other’s right to Medicaid coverage” (Dean et al., 2000, p. 106). Not being recognized as a legally married couple excludes LGBT partners from obtaining Medicaid coverage when issues such as this arise. In addition, married heterosexuals receive their spouse’s Social Security payment after his or her death, which is not the case for same-sex partners who are in committed relationships (Dean et al., 2000). Couples in committed relationships typically share the financial obligations, and when one partner dies, their Social Security check is used to supplement the income that the partner shared. Same-sex couples are not given that option, which would result in lost income if a partner were to die. This could limit access to health care because of the financial burden placed on the living partner. These factors may be taken for granted in heterosexual marriages, but are of serious concern in same-sex relationships.

Laws at the state level prohibit recognition of same-sex marriages, which can impact an individual’s ability to make decisions for their partner in emergency health situations (Dean et al., 2000). LGBT partners must seek legal assistance to appoint their partner as a power of attorney to assure that he or she will have the power to make medical decisions and be included in the decision making process (Harrison, 2002). If
legal papers have not been signed by the couple, blood relatives will be able to override the partner’s decision-making ability (Dean et al., 2000).

**Healthcare Disparities**

It is documented that there are disparities for LGBT clients accessing medical services, largely due to the historical context these individuals have had to struggle through (GLMA & LGBT Health Experts, 2001). Eliminating health care disparities is a priority in ‘Healthy People 2010’ and is a concern at all levels within the public health infrastructure (GLMA & LGBT Health Experts, 2001).

Historically, medical research has not recognized LGBT clients as having health issues outside of a framework of sexual deviance or STD’s (Boehmer, 2002). In 1973, the American Psychiatric Association removed homosexuality from its Diagnostic and Statistical Manual of Mental Disorders (DSM), indicating that sexual orientation was not a mental illness (Taylor, 1999). Even though homosexuality has been removed from the DSM, gender identity disorder (GID) still remains a diagnostic disorder in the manual. By allowing GID to remain in the DSM, the American Psychiatric Association implies that transgender individuals have a “mental disorder” (Brill & Pepper, 2008). Currently transgender individuals must have this diagnosis for insurance to cover psychotherapy, which also prevents insurance coverage related to gender-related medical care (Brill & Pepper, 2008; Burdge, 2007). Based on the diagnostic criteria, gender identity disorder is viewed as a psychological diagnosis rather than a physical health diagnosis.

Several social work studies (Burgess, 1999; Langer & Martin, 2004) have identified the need to eliminate GID from the DSM-IV because it enforces role conformity and was developed to treat suspected homosexuals (Brooks, 2000). The
changing paradigm is to provide accurate information about gender, hormones, and sex reassignment surgery and help them to love and accept their gender variance (Burgess, 1999; Cooper, 1999; Langer & Martin, 2004). Providing open lines of communication by giving transgender clients permission to identify themselves outside of the binary system would be liberating.

Unclear understanding surrounding sexuality and gender identity has resulted in manifestations of discrimination and bias within the healthcare system (LGBT Tool Kit, p. 33). Nystrom (1997) surveyed gays and lesbians receiving mental health services and 46% reported that they had experienced homophobia (as cited in Beatty, Lewis, 2003, p. 4). A 1995-1996 survey of 116 LGB clients, across 36 states, reported the following experiences: 1) have experienced a therapist trying to change or convert them to heterosexual (23%); 2) have been harassed for being LGB by a health professional (29%) and; 3) have experienced discrimination based upon sexual orientation (64%) (Lucksted, 1996, p. 23-24). Transgender people are among the most misunderstood and overlooked groups in our society (Burgess, 1999). This population is vulnerable to discrimination and oppression due to not conforming to societal norms (Burdge, 2007).

One study examined the ability of medical students to care for LGBT clients and found that students with increased clinical exposure to LGBT clients generally had greater knowledge surrounding LGBT health concerns. They also had positive attitudes toward LGBT clients, and more comprehensive histories of LGBT clients were completed (Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006). Currently, gender issues are not included in the mandatory curriculum of any medical school in the country.
Limited exposure to topics of sexuality and gender hinders the ability to treat clients holistically and without predisposed biases.

LGBT clients have frequently witnessed health care inconsistencies related to their sexual identity and behavior (Jackson, 1995). The topic of sexuality has been largely absent from professional literature, and it is argued that our healthcare system is ill-equipped to work effectively with this population (Jackson, 1995). Research over the last 25 years has indicated evidence of homophobia within a variety of health professions, including physicians, psychologists, counselors, therapists, nurses, and social workers (GLMA & LGBT Health Experts, 2001).

Often healthcare providers feel they are not equipped with the skills needed to address culturally specific issues relevant to the LGBT population (Jones, Weerakoon, & Pynor, 2005; Harrison, 2001). Currently, the challenge is to develop understanding around sexual and gender differences in order to provide quality services to future clients of the LGBT community, who need non-judgmental care and support (Harrison, 2001).

Research is emerging throughout the United States healthcare system which indicates a need for healthcare professionals to be knowledgeable in issues affecting the LGBT population (Bass-Haugen, 2009; Weerakoon and Stiernborg, 1996). In 2007, the American Medical Association amended its policies to include non-discriminatory language and ensure protection and equality to gender identity issues (Brill & Pepper, 2008). This limits the physician’s ability to deny services based on gender identity and will inevitably have a positive effect on care for this population (Brill & Pepper, 2008). Research from other health professions has also found that more education must be provided to healthcare students and providers (AMA Council on Scientific Affairs, 1996;
Studies conducted in the medical field have found that it may be beneficial to bring these discussions and learning opportunities to the college level to better prepare future healthcare providers (Sanchez, et al., 2006).

**Healthcare Cultural Competency**

Healthcare providers are in constant contact with people who have significantly different views from their own and must be able to respond to these differences appropriately. It is assumed that in order to manage sexual discussions appropriately, health professionals need to be aware of their own sexuality and have the confidence to deal with the spectrum of sexual variance (Jones, Weerakoon, & Pynor, 2005). The ability to discern negative perceptions or beliefs through self assessment and reflection is paramount when delivering optimal and equitable care (Jones et al., 2005; Kirsh, Trentham, & Cole, 2006). Increased awareness about the self and other cultures will promote a higher standard of practice that will enhance service delivery within the U.S.

Cultural competency is essential for therapists to provide authentic care because different populations have specific needs. The concept of cultural competence has evolved beyond knowledge and sensitivity to include a greater awareness of cultural biases both individually and professionally (Kirsh et al, 2006). In a study evaluating medical students’ ability to care for clients who are lesbian, gay, bisexual, and transgender, researchers stressed the importance of gaining culturally competent skills to work with this population (Sanchez et al., 2006). Numerous documents have been developed that outline the need for developing cultural competency in order to eliminate health disparities related to the LGBT population (GLMA & LGBT Health Experts, 2001).
Standard of Practice

Currently, much of the research for Standard of Practice lies within the social work realm. The Child Welfare League of American (2006) has outlined best practice guidelines when serving LGBT youth in out-of-home care contexts. The eight guidelines address both sexual orientation and gender identity for the child welfare and juvenile justice professionals and are as follows (Wilber, Ryan, & Marksamer, 2006, p. xv):

- Guideline 1: defines the process by which LGBT youth become aware of their identity and aims to explore the experiences and social conditions related to involvement within the child welfare and juvenile justice system. Mistreatment and discrimination, to which they are frequently subjected to within these systems, is also discussed.
- Guideline 2: looks at specific practices and policies systems must create to maintain an inclusive culture ensuring the respect and dignity of every person.
- Guideline 3: emphasizes the importance of family connections or other supports and the steps professionals must take to create and maintain these relationships.
- Guideline 4: addresses the obligation of agencies to promote the health and well-being of LGBT youth including healthy social and recreational outlets.
- Guideline 5: discusses the management of confidential information including creating a safe place for LGBT youth to self-identify.
- Guideline 6: discusses strategies for connecting LGBT youth to safe placements with supportive and committed caregivers.
- Guideline 7: ensures that safety and well-being within institutional settings is enforced by making sound decisions about housing, addressing specific risks, and employing safety measures.
- Guideline 8: addresses how the child welfare and juvenile justice system is obligated to provide inclusive non-discriminatory health and education to LGBT youth in their custody

Burdge (2007) defines other areas in which social workers can assist specifically transgender clients. These areas include the: 1) facilitation healthy discussion and relationships between transgender individuals and their families; 2) creating safe school environments for transgender youth, providing one-to-one therapy after sex re-
assignment surgery and; 3) advocating for the civil rights of the transgender community (p. 245). Other implications within the social work practice include challenging the rigid gender binary classification system (Burdge, 2007, p. 247).

Steps to ending gender oppression is discussed in “Bending Gender, Ending Gender: Theoretical Foundations for Social Work Practice with the Transgender Community” (Burdge, 2007). Professionals must be prepared to challenge gender stereotypes, request clarification when gender stereotype jokes are heard, and provide education to the public on gender diversity. Future research to develop standards of practice is also highlighted. Earlier studies have documented high levels of homophobia and heterosexism among social workers, and these behaviors are currently found in the treatment setting (Berkman & Zinberg 1997; Wisniewski & Toomey, 1987).

In a handbook by Brill and Pepper (2008), valuable information is outlined regarding issues related to transgender children for parents, teachers, counselors, and other health professionals. Topics in addition to the areas discussed above, include specific parenting techniques, disclosure of information, and suggestions for creating a safe educational environment. Medical issues are well defined and involve the mental and physical changes transgender individual’s experience. Ethical issues that arise are paired with solutions or ways people can advocate for social justice for this population. Helpful resources are located throughout the handbook, including websites, books, support networks, and sample doctors’ notes.

These standards of practice can relate to all ages within the LGBT community and match the scope of occupational therapy. The goals and objectives of this project aim to collaborate these best practices for occupational therapy practitioners to ensure that
graduates from the University of North Dakota will obtain competency in LGBT practices.

**Occupational Therapy Cultural Competency**

Therapists must consider all aspects of an individual’s life when providing care. This is achieved by providing authentic occupational therapy to clients. In order for therapists to provide authentic care, they must consider what is meaningful to the client and understand how meaning in plays out in each person’s life through occupational engagement (Jackson, 1995; Yerxa, 1967).

It must be clearly stated that sexuality and gender expression are occupational activities that merit the same priority as any other aspect of daily living (Couldrick, 1999). Therapists must consider clients’ sexual identity differences as part of their culture (Harrison, 2001). Therapists must also realize that our responsibility as healthcare professionals is to provide therapy settings that are safe for all individuals to express themselves. Development of a broader, more thorough understanding of how sexual orientation can influence occupation must be prioritized so that occupational therapy can be more authentic with people who are gay, lesbian, or bisexual (Kingsley & Molineux, 2000). “Core texts, models of practice, assessment tools and the professional literature need to resonate with a professional belief that sexual activity is as much at the heart of occupational therapy as personal care, work, and leisure” (Couldrick, 1999, p. 28). Along with these materials in place, the practitioner needs self-awareness, knowledge, skills, and support to put that into practice (Couldrick, 1999).

When considering the large number of people in the LGBT community, occupational therapists have had limited resources to assist them in gaining cultural
competency when working with this population. Therapists often only have personal experience to draw from and are unaware of the cultural implications that have shaped their own ideas about sexuality (Couldrick, 1999). In order for occupational therapists to provide authentic care, it is critical that issues surrounding homophobia be addressed to provide client-centered care (Harrison, 2001). The problem that arises is that some professionals find it hard to work with or accommodate a LGBT client when these circumstances arise (Hobbs, 2004; Javaherian, Christy, & Boehringer, 2007).

**AOTA’s Policy**

In 1995, the AOTA adopted a policy of nondiscrimination to include sexual orientation, stating that all members of the occupational therapy profession have the “right to achieve a productive and satisfying professional and personal life without regard to age, race, disability, culture, sexual orientation, national origin, gender, religion, or employment status” (AOTA, 1995, p. 1009). Furthermore, this nondiscrimination policy does not only refer to nondiscrimination among occupational therapists but also among the individuals served by the profession (AOTA, 1995). In 1996, the AOTA adopted a position on full inclusion, which means that:

All individuals, regardless of ethnicity, race, age, religion, gender, sexual orientation, or disability should be able to be a part of the naturally occurring activities of society. Full inclusion addresses the need for all individuals to have the same opportunities. It also recognizes the benefits to everyone of being with individuals who are different from themselves. By embracing an attitude of full inclusion, all individuals will benefit from the opportunities afforded by a diverse society (1996, p. 855).
The AOTA recognizes that the concept of full inclusion incorporates “perceptions, values, attitudes, expectations, and behaviors for all persons, those with and without disabilities” (1996, p. 856). Professionals in social work have been at the forefront of opening LGBT discussions into their realm of practice (Burgess, 1999). These changes can be matched to what is defined in the AOTA core values and attitudes of practice; working for the safety and social rights of the LGBT community by promoting equality, freedom, justice, dignity, truth, and prudence.

It is essential to recognize and accept differences in order to “promote human diversity and individual choice” (AOTA, 1996, p. 856). Based upon these positions of the AOTA, the occupational therapy profession acknowledges the importance of addressing the needs of the LGBT population. Beyond acknowledging the implications occupational therapy has when working with this diverse group, education must take place at all entry points of the profession.

**Educational Preparation**

Currently LGBT is not a mandated topic in education, academic or clinical. Kingsley & Molineux (2000) supported the need to further educate occupational therapists on topics important to LGBT clients, and this education should involve practicing clinicians, occupational therapy educators, and students entering the profession. When considering the need for increased education in LGBT issues, it is important to review the Accreditation Council for Occupational Therapy Education (ACOTE) Standards that are applicable. These standards reflect all individuals including the LGBT with educational topics that have the potential to be accessed by all occupational
therapists. The following ACOTE Standards could support the provision of knowledge about this cultural group in the curriculum.

**Table 1: Applicable ACOTE Standards**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>B.1.6</td>
<td>Demonstrate knowledge and understanding of the concepts of human behavior to include the behavioral and social sciences.</td>
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<tr>
<td>B.1.7</td>
<td>Demonstrate knowledge and appreciation of the role of sociocultural, socioeconomic, diversity factors, and lifestyle choices in contemporary society.</td>
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<tr>
<td>B.1.8</td>
<td>Articulate the influence of social conditions and the ethical context in which humans choose and engage in occupations.</td>
</tr>
<tr>
<td>B.1.9</td>
<td>Demonstrate knowledge of social issues and prevailing health and welfare needs.</td>
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<tr>
<td>B.2.10</td>
<td>Express support for the quality of life, well-being, and occupation of the individual, group, or population to promote physical and mental health and prevention of injury and disease considering the context (cultural, physical, social, personal, spiritual, temporal, virtual).</td>
</tr>
<tr>
<td>B.4.2</td>
<td>Select appropriate assessment tools based on client need, contextual factors, and psychometric properties of tests.</td>
</tr>
<tr>
<td>B.4.7</td>
<td>Consider factors that might bias assessment results, such as culture, disability status, and situational variables related to the individual and context.</td>
</tr>
<tr>
<td>B.5.18</td>
<td>Effectively interact through written, oral, and nonverbal communication with the client, family, significant others, colleagues, other health providers, and the public in a professionally acceptable manner.</td>
</tr>
<tr>
<td>B.5.23</td>
<td>Refer to specialists both internal and external to the profession for consultation and intervention.</td>
</tr>
<tr>
<td>B.6.2</td>
<td>Discuss the current policy issues and the social economic, political, geographic, and demographic factors that influence the various contexts for practice of occupational therapy.</td>
</tr>
<tr>
<td>B.8.3</td>
<td>Use professional literature to make evidence-based practice decisions.</td>
</tr>
<tr>
<td>B.9.1</td>
<td>Demonstrate a knowledge and understanding of the American Occupational Therapy Association (AOTA) Code of Ethics, Core Values and Attitudes of Occupational Therapy, and AOTA Standards of Practice and use them as a guide for ethical decision making in professional interaction, client treatment, and employment settings.</td>
</tr>
<tr>
<td>B.9.4</td>
<td>Discuss professional responsibilities related to liability issues under current models of service provision.</td>
</tr>
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</table>

Standards are in place to set the stage for ethical decision-making and ensuring the therapist is accountable for the treatment provided to all clients. AOTA is obligated to support their stance on diversity with action and take responsibility by implementing these discussions at conference, online, in the classroom, and in the clinic.
Current Resources and Research

The need for further research and education regarding how occupations are affected with LGBT people is evident though limited available resources. The research that is available specific to occupational therapy is presented in the following sections.

Jackson (1995) specifically looked at how sexual orientation relates to occupational therapy as an integral part of occupations. Focusing on sexual orientation, Jackson (2000) aimed to provide a better understanding of the non-inclusive environments occupational therapists are maintaining by drawing on experiences of lesbian or bisexual occupational therapists. Perspectives on how the workplace can prevent inclusiveness not only to LGBT clients but also to staff were identified. Discussions of heterosexual themed topics such as getting married and having children, as well as degrading homophobic comments occasionally occurring at team meetings, were subtle signs that staff assumed heterosexuality for all their fellow co-workers (Jackson, 2000).

Walsh and Crepeau (1998) discussed the importance for occupational therapy practitioners to recognize the influence that homophobia and internalized homophobia have on therapeutic interventions. Jones et al. (2005) researched occupational therapy students’ attitudes towards sexual issues in clinical practice. Areas addressed within the questionnaire included sexual remarks, masturbation, sexual orientation, AIDS, abortion, and contraception. Of these, a high percentage of discomfort was noted across the board and was consistent with other clinical contexts (Guthrie, 1999; Herson et al., 1999; Evans, 2000). In addition to researching comfort levels, perceived education preparedness was
also assessed. Researchers found that at least half of senior students believed that their program had not adequately addressed the issue of sexuality (Jones et al., 2005).

Harrison (2002) indicates a deficiency in Australian literature and its impact on the lesbian, gay, bisexual, transgender, and intersex (LGBTI) geriatric clients. Historical findings in the gerontology literature suggested that heterosexist assumptions directly impact the invisibility of sexual and gender minorities among consumers in the aged care sector (Harrison, 2002). The lack of discussion and action around the aging issue from within LGBT organizations serves to reinforce the cycle of invisibility (Harrison, 2002). The need to access healthcare likely increases as people age; therefore, there is a greater need for research, consultation, and advocacy when working with aged LGBTI clients (Harrison, 2002). Providing LGBTI clients opportunities to ‘come out’ while respecting diversity surrounding identity, life history, and self-understandings set the stage for holistic care of this population (Harrison, 2002).

In 2001, Harrison focused on the notion of privacy and how it serves as a barrier to understanding a client’s life experiences and understandings. Failing to recognize diversity regarding sexuality has an impact on the value of therapeutic interventions (Harrison, 1999). Sexual orientation is neglected in occupational therapy literature and within the curriculum despite its relevance to authentic occupational therapy (Kingsley & Molineux, 2000; Jackson, 1995).

Requiring LGBT related research to be conducted so professional literature is present to build awareness and visibility in the field of occupational therapy must occur. Occupational therapists need to take an active role in the development of research, assessments, and cultural competency for this group. At the forefront of this movement in
the U.S., *The Networker*, an official newsletter for LGBT concerns in occupational therapy, has been established. It is important to acknowledge that the Networker is not formally connected to AOTA in any manner.

*The Networker*

There is a LGBT occupational therapy advocacy group called the Networker. The co-Chair of the Networker, Kay Blouse, was contacted in March 2008. She indicated that a Standard of Practice for this population has not been developed. Since there are no clear Standards of Practice, occupational therapists are not equipped with the tools needed to treat LGBT clients effectively. The lack of resources indicates a need for the profession to look more seriously into the philosophy and theoretical underpinning of occupational therapy (Kingsley & Molineux, 2000). In order to provide effective care, occupational therapy must take an ethical stance and believe in a future free of heterosexism (Kingsley & Molineux, 2000).

The relationship between the therapist and client is also a key component of effective therapy. A strong influence on the empathetic process by which therapists come to truly understand the clients’ life stories and to respect and trust in the clients’ perspectives on their experience has emerged through a term ‘therapeutic use of self’ (Taylor, 2008, p. 5).

**Therapeutic Use of Self**

In a 2007 study by Taylor, Lee, Kielhofner, & Ketkar, 80% of 568 US occupational therapy clinicians rated therapeutic use of self as the most important influence of the outcome of therapy, however, less than half felt equipped with the skills upon graduation (as cited in Taylor, 2008, p. 3). The foundation of therapeutic use of self
occurs through self-reflection and being mindful of one’s strengths and weaknesses (Taylor, 2008). Development of this intuition is a lifelong endeavor and is difficult to teach. The therapeutic use of self-intervention is new to the practice framework (AOTA, 2002) but it has been widely used in practice for decades (Taylor, 2008). It has been argued as being so important in our profession yet few guided descriptions of how to practice the skills exist (Taylor, 2008). Even fewer descriptions of therapeutic use of self exist when working with specific populations such as LGBT clients.

Enhancing client-practitioner relationships requires occupational therapists to be aware of personal tendencies towards inappropriate inferences and evaluate behaviors that challenge their own world views (Neslen & Neslen, 1996). Both Jackson (1995) and Harrison (2001) present the need for occupational therapists to gain greater knowledge to work with the LGBT population. The following ACOTE Standards outline areas applicable to service provision, using therapeutic use of self, when working with LGBT clients:

| B.2.9.  | Express support for the quality of life, well-being, and occupation of the individual, group, or population to promote physical and mental health and prevention of injury and disease considering the context (e.g., cultural, physical, social, personal, spiritual, temporal, virtual). |
| B.5.6.  | Provide therapeutic use of self, including one’s personality, insights, perceptions, and judgments as part of the therapeutic process in both individual and group interaction. |
| B.9.1   | Demonstrate a knowledge and understanding of the American Occupational Therapy Association (AOTA) Code of Ethics, Core Values and Attitudes of Occupational Therapy, and AOTA Standards of Practice and use them as a guide for ethical decision making in professional interaction, client treatment, and employment settings. |
| B.9.4.  | Discuss strategies for ongoing professional development to ensure that practice is consistent with current and accepted standards. |
| B.9.6.  | Discuss and evaluate personal and professional abilities and competencies as they relate to job responsibilities. |
| B.9.10. | Explain strategies for analyzing issues and making decisions to resolve personal and organizational ethical conflicts. |
Therapeutic use of self is subjective when assessing its effectiveness in the clinic. Kirsh et al. (2006), interviewed occupational therapy consumers, who identified themselves as minority group members, to gain a better understanding of their experience of the occupational therapy process. Five primary themes emerged from the data that could be linked to more thoroughly understanding how therapeutic use of self can be used when working with LGBT clients:

- **Theme 1:** describes the ability for a client to gain a sense of community with the therapist, for example, same sex, culture, or sexual orientation. Some participants were distinguished from this ‘insider’ phenomenon and were concerned with areas regarding privacy and confidentiality within their particular culture.
- **Theme 2:** conveyed the positive effects of having a therapist who could be understanding and considerate of other’s culture regardless if it was different from their own.
- **Theme 3:** identifies looking at the client holistically and enabling them to share themselves fully free of judgment. Sexuality, physical aspects and orientation alike, were seen as primary areas of omission.
- **Theme 4:** participants felt they were ‘locked in’ to particular roles or expectations and identified their roles as constantly changing rather. The need to recognize sex as an occupation for persons with disabilities across cultures was also re-addressed.
- **Theme 5:** some participants felt discriminated against related to their minority status. Examples such as using unfamiliar language, excluding from the decision making process, and sexual orientation were all identified with these discriminatory behaviors.

Cultural and sexual identities influence occupational choices therefore have an impact on the therapeutic process. Practice models that outline how culturally constructed meanings of occupation guide treatment in an increasingly diverse practice environment must be developed (Kirsh et al., 2006). There is a need to examine how minorities, beyond ethno-cultural or race, connect their lives to occupation through their lived experiences and life narratives.
Occupational therapists are equipped to help people transform their lives through, “enabling them to do and to be through the process of becoming” (Wilcock, 1999, p. 5). The profession of occupational therapy is applicable when working with this population because of the profession’s focus on people’s occupations, which includes sexuality (Harrison, 2001). Occupational therapists must gain cultural competency related to the LGBT population, in order to be aware of personal biases and to provide client-centered care to individuals within this cultural group. Identifying best educational practices for teaching about gender and gender theory to develop cultural competence is paramount.

Kingsley and Molineux (2000) provide two primary recommendations to build on within the occupational therapy profession:

1. Expand a knowledge base building cultural competency of gay, lesbian, and bisexuals. Including this topic within the curriculum will increase awareness and comfort levels when working with someone of a different sexual orientation.
2. Understanding the relationship between sexual orientation and occupation within the profession of occupational therapy. This involves conducting more research into the link between sexual orientation and occupation and its relevance to the profession (p. 209).

It should be every occupational therapist’s aim to provide what Yerxa (1967) calls ‘authentic occupational therapy,’ or in other words, allowing a client, through the therapeutic process, to discover his or her own personal meaning (Kingsley & Molineux, 2000, p. 205). Education must take place among practicing occupational therapists, occupational therapy educators, and occupational therapy students in order to develop greater knowledge and competency when working with this population.

All of this literature research has culminated into development of a guide that occupational therapy students and clinicians can use to begin the process of gaining
cultural competency. It is the aim of the project that the guidelines will be a resource that is easily accessible and relevant to a multitude of clinical practices.

Gaining Cultural Competency for the Occupational Therapy Student & Clinician: On the Lesbian, Gay, Bisexual, & Transgender (LGBT) Population

Introduction

The Occupational Therapy Cultural Competency Resource was created through the process of this project with one main goal: to provide a condensed list of resources and information that clinicians and students can use to facilitate individual development of LGBT cultural competency in order to meet the needs of their clients.

Theory

Theoretical models provide the occupational therapy profession with a knowledge base to guide practice. The combination of theoretical knowledge with personal and professional experiences form a basis for professional development (Crepeau, Cohn, Schell, 2003). After researching various models of practice, it was decided that the Adult-learning Theory, also refereed to as Andragogy, by Malcom Knowles (1990), is the most appropriate to use for this project. Andragogy is defined as the art and science of adult learning (Bastable, 2006).

The scope of this scholarly project is to educate occupational therapists on LGBT issues in healthcare and to provide therapists and students with information and resources to gain cultural competency in this specified area of practice. Since the product is intended to be used by occupational therapists, the therapists and occupational therapy students are the adult learners. The purpose of using this model is to provide therapists
and students with a tool that meets the users of this guide at the appropriate level of
learning.

Knowles identifies five basic assumptions of the adult learning process (Smith, 1996; 1999; Bastable, 2006). These basic assumptions will be defined and related to the
product of this scholarly project:

1. Self-concept: As a person matures, he or she moves from dependent learning to self-directed learning. Both students and clinicians are the target population for
the resource guidelines and it is assumed that the students who access this
resource will be near the end of their schooling and will be transitioning into self-directed learning roles as entry-level therapists (Bastable, 2006, p. 124). The
resource guidelines are intended to provide occupational therapists with
knowledge and resources to prepare them for working with the LGBT population.
The guidelines have been developed based on current literature and should be
adapted to reflect new literature as it arises. The guidelines are intended to expand
cultural competence and should be adapted to meet the cultural needs of all
individuals.

2. Experience: Adults accumulate personal learning experiences throughout their
lives, which they draw from to aid in self-directed learning (Bastable, 2006, p.
124). As clinicians and students interact with colleagues and clients they are faced
with a multitude of culturally different views. The users of the resource guidelines
can draw on past professional and personal experiences related to cultural issues.
The guidelines are meant to assist occupational therapists to challenge current
perceptions, attitudes, and beliefs to develop greater cultural competency to meet
the needs of the LGBT population. In addition, it is intended that the guidelines
assist therapists in developing a basis of knowledge to guide future experiences
with the LGBT population.

3. Readiness to learn: Adults’ readiness to learn is motivated by his or her social
roles (Bastable, 2006, p. 124). Typically, occupational therapists, like other
professionals, want to provide the best care to their clients. This is a motivator to
learn about client populations in order to provide client-centered care. It can be
assumed that occupational therapists will work with a LGBT client at some point
throughout his or her career. The guidelines are an easy tool to access; thus, when
a therapist encounters a situation and makes the decision to gain further
knowledge about the LGBT population, there is a guide that will be accessible to
aid in the learning process. Therapists and future therapists need to consider how
sexual and gender orientation are a part of social roles and occupations, and be
willing to learn how individual clients emphasize these roles within personal
contexts.

4. Orientation to learning: Adults’ primary motivation to learn is finding solutions to
problems (Bastable, 2006, p. 124). In other words, adults want to know the benefit
of what is being learned. This product was developed to meet the current needs
outlined in the literature and provides a straightforward approach to applying the information in clinical settings. The resource guidelines help students and clinicians with resources to find solutions to difficult situations that arise in practice. This product is also intended to be used by occupational therapists who wish to gain cultural competency before problems or difficult situations arise.

5. Motivation: Adults are intrinsically motivated to learn (Bastable, 2006, p. 124). Learning is seen as a life-long process which complements research on cultural competence. Resources that can assist therapists in gaining cultural competency throughout their careers have been provided in this product.

**Organization**

The guidelines have been organized in a manner that follows a logical order of skill development. The sections are clearly defined so that users can easily access information that is relevant to his or her specific practice. The following is the table of contents of the product.

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1. Introduction
2. Demographics
3. Language
4. Gaining Cultural Competency for the Occupational Therapy Student and Clinician
5. Therapeutic Use of Self
6. Creating a Welcoming clinical environment for LGBT clients
7. General Guidelines for Client-Provider Discussions
   a. Specific Issues to Discuss with LGBT clients
8. Additional Recommendations
9. Advocacy and Legislation
10. Resources
11. Glossary of Terms
12. References

**Conclusion**

The review of literature has provided a picture of the healthcare issues related to working with the LGBT population. Overwhelmingly, there is a significant lack of research in regards to LGBT health. The profession of occupational therapy promotes an
all-inclusive environment, which must include and support individuals in the LGBT population. It is the responsibility of the therapist to examine how occupational roles impact one’s life. The research indicates that sexual and gender orientation may impact an individual’s role performance, largely due to external forces, possibly including the occupational therapist. If occupational therapists intend to take the profession into the twenty-first century, then therapists must acquire cultural competency skills to improve their ability to work with diverse clients such as the LGBT population.

Chapter III presents the methodology used in the development of the product.
CHAPTER III
METHODOLOGY

The process of developing a resource guideline to Gaining Cultural Competency for the Occupational Therapy Student & Clinician: On the Lesbian, Gay, Bisexual, & Transgender (LGBT) population began with personal interest in advocacy of human rights. The authors of this project identified a need to gain a better understanding of the spectrum of sexuality in order to feel competent when addressing the topic within the clinic. In addition, it was felt that building awareness of LGBT issues is a primary goal to ensure client-centered care is administered at all occupational therapy levels: students, educators, and clinicians.

An extensive review of literature that was conducted that span from 1967-2008. The information was then compiled into the following common areas: 1) the definitions and language used with the LGBT population; 2) the demographics of the LGBT community; 3) the healthcare disparities that exist for LGBT individuals; and 4) the role of occupational therapy when working with LGBT clients. The process of researching information involved numerous search engines such as OT Search, PubMed, Cinahl, and Google. Key terms used in the search included: sexual orientation, gender identity, lesbian, gay, bisexual, transgender, LGBT, health disparities, and occupational therapy.

The literature review relied on research from other health professions both in the U.S and abroad to assist in developing the resource guidelines. Best practice information
was examined for this cultural group in the professional fields of social work, nursing, psychology, occupational therapy, and medical professions. Current literature is predominantly present in fields of social work, nursing, psychology, and medical professions. Research in the field of occupational therapy is limited.

The American Journal of Occupational Therapy has few articles related to sexuality and occupation with the most current literature emerging in the British and Australian Journals of Occupational Therapy. The literature identified several contributing factors to why practices have not yet developed in the field of occupational therapy. Areas identified include a lack of education, lack of cultural competence, and the attached stigma to working with LGBT clients.

In addition to literature review, several conversations occurred with individuals who are knowledgeable in topics related to the LGBT community. In order to develop the product, rich narratives were taken into account from individuals who are considered experts in this area. The authors of this project felt these informal conversations would assist with determining the direction of the project.

Involvement and correspondence in organizations such as the Human Rights Campaign, the Gay and Lesbian Medical Association, PFLAG, and 10% society have assisted in acquiring a thorough understanding of what research and support is currently in place and how occupational therapy can contribute to working with this population. Additional information was gathered from the Child Welfare League of America, and various resource and textbooks which are listed in the reference list.

The resulting product provides students and clinicians with basic information that outlines areas to highlight when working with the LGBT population. The aim of the
resource is to guide students and practitioners through self-reflective and self-directed learning in order to gain cultural competency in regards to LGBT clients. Education on why discussions of sexuality should not be absent from any part of the treatment process is explained. A basic understanding of the LGBT population must be understood before one begins to explore and develop cultural competency skills.

It is important to consider the information provided in this resource as guidelines rather than best practices due to the evolving nature of discussion surrounding this diverse population. It is not intended to stand alone as a single guide for the development of cultural competency. Rather, the intention is to increase awareness and push for self-directed learning towards competency with this particular cultural group.
CHAPTER IV

PRODUCT

Occupational therapists demonstrate a lack of comfort when discussing sexuality both at the curricular and clinical levels. The scholarly project began with speculation on how to specifically address the needs of lesbian, gay, bisexual, and transgender clients. With little evidence of best practices in the professional literature, it was determined a resource that provides guidelines for the development of cultural competency of the LGBT population would be beneficial for students and clinicians. The authors of this project have a vested interest in advocating for this population, and determined a need for the profession to practice 'authentic occupational therapy' by learning what it means to be culturally sensitive to all clients.

Research began by finding out what other health professions have created in terms of Standards of Practice for the LGBT population. An extensive review of occupational therapy literature was completed to support the idea that discrimination continues to be evident in discussions, work setting, and society which is creating a barrier to providing quality care to LGBT clients. Demographics and the increased visibility of the LGBT culture provided enough evidence to support the assumption that occupational therapists inevitably will work with an LGBT client at some point in their career; therefore, a resource guideline to assist them throughout the therapeutic process is needed.
The purpose of the product, *Gaining Cultural Competency for the Occupational Therapy Student & Clinician: On the Lesbian, Gay, Bisexual, & Transgender (LGBT) Population*, is to outline specific guidelines to increase comfort levels when working with individuals who identify as LGBT. These resource guidelines were developed for occupational therapists; however, they can be used by other health professionals.

The design of this product takes into consideration the fact that occupational students and clinicians are adult learners who have been trained to self-reflect. In addition, the product has guided discussions about the LGBT culture in order to develop competency. This product will allow facilitate the exploration of sexual differences; exploring internal feelings of homophobia; becoming aware of specific health needs; and utilizing therapeutic use of self with all LGBT individuals. Recommendations to ensure that occupational therapists are providing comprehensive care through discussions, advocacy, and altering environments for which they practice is addressed throughout the product. Clarification of terms, and resources to assist in developing cultural competency for the LGBT population is included throughout the product.

It is important to consider the information provided in this resource as guidelines rather than best practices due to the evolving nature of discussion surrounding this diverse population. It is not intended to stand alone as a single guide for the development of cultural competency. Rather, the intention is to increase awareness and push for self-directed learning towards competency with this particular cultural group. The product: *Gaining Cultural Competency for the Occupational Therapy Student & Clinician: On the Lesbian, Gay, Bisexual, & Transgender (LGBT) Population* is presented in its entirety in
the section following this introduction. A general summary of the topics discussed in the product is listed as follow:

1. The **Demographics** section of the product summarizes population size and reasoning behind the limited data that is currently in the literature. Information was gathered from a variety of health fields, specifically through the American Medical Association and the Gay and Lesbian Medical Association. The authors feel it is important for occupational therapists to understand the prevalence of the LGBT population because it is likely that clinicians will work with a client from this culture at some point in their career.

2. The **Language and Basic Terminology** section identifies LGBT as a culture and highlights the importance for health professionals to use culturally sensitive vocabulary. Vocabulary was mainly gathered from Brown and Rounsley (1996) and Lev (2004). Using terminology that is meaningful to clients will assist in developing rapport and a trusting relationship to openly discuss sexuality.

3. The **Therapeutic Use of Self** section identifies how to develop therapeutic interventions through self-reflection and being mindful of one’s personal strengths and weaknesses. ACOTE Standards that are applicable to service delivery using therapeutic use of self when working with LGBT clients is outlined. Documents were researched from the AOTA website as well as the text written by Taylor (2008), titled *The Intentional Relationship: Occupational Therapy and Use of Self*. The authors wanted to connect the foundational framework for which occupational therapy is based and demonstrate how it is relevant to working with LGBT clients.
4. The **Gaining Cultural Competency for the OT Student and Clinician** section defines why it is important for therapists to gain cultural competency to effectively meet the needs of LGBT clients. Questions to guide practice and increase self-awareness as well as referral to additional resources are included. Publications primarily from the occupational therapy literature were used to develop this section. Highlighted authors include Muñoz, Jackson, Kingsley & Molineux, Harrison, and Yerxa. The authors of this project understand that gaining and maintaining cultural competency is a life-long process; therefore, it must be an active process that includes personal reflection and sensitivity, knowledge, skills, and advocacy.

5. The **Creating a Welcoming Clinical Environment for LGBT Clients** section outlines practical ways to demonstrate that a facility is open and inclusive to all clients. Some of these suggestions have been adapted from the *Guidelines: Creating a safe and welcoming environment for lesbian, gay, bisexual, transgender, and intersex (LGBTI) patients* with permission from the Gay and Lesbian Medical Association. The authors included topics related to staff training and connecting with LGBT organizations.

6. The **General Guidelines for Client-Provider Discussions** section outlines suggestions for initiating discussions related to sexual orientation and gender identity with clients. Because the research indicates that healthcare providers are not comfortable with discussions of this nature, this section provides suggestions to increase the clinician and students comfort level. Some of these suggestions have been adapted from the *Guidelines: Creating a safe and welcoming environment for*
lesbian, gay, bisexual, transgender, and intersex (LGBTI) patients with permission from the Gay and Lesbian Medical Association.

7. The **Specific Issues to Discuss with LGBT Clients** section was determined to be an important section due to the evidence of health disparities for this particular population. The authors gathered information from the Council on Scientific Affairs (1996), Dean et al. (2000), and various other sources to determine specific health needs of LGBT individuals.

8. The **Advocacy and Legislation** section provides a rationale for the importance of advocating for the LGBT population and suggestions to become an advocate. Part of eliminating health disparities is advocating for the needs of specific client populations. The authors of this project have joined advocacy groups such as the Gay and Lesbian Medical Association, Human Rights Campaign, and PFLAG.

9. The **Creating a Welcoming Clinical and Academic Environment** section provides additional suggestions related to work environments and school settings. Topics include becoming more aware of the heterosexual normalcy expressed in how people communicate, decorate, and behave. Evidence from Jackson (2000) article suggests that many occupational therapists fail to recognize that colleagues may identify as LGBT. The organizational staff must realize that all LGBT individuals deserve the same respect and safety within the work environment.

10. The **Creating a Welcoming Academic Environment** section defines special considerations related to the school setting were adapted from a book written by Brill and Pepper (2008). Children must feel emotionally and physically safe in order to
learn effectively; therefore, occupational therapists must use their skills and knowledge to make appropriate adjustments to the school setting.

11. The Resource section provides users of the guide an avenue to connect with other organizations to further develop their cultural competency when working with LGBT clients. Websites, support groups, and recommended readings have been gathered throughout the completion of this scholarly project.

12. The Glossary section was adapted with permission from the Ohio University Lesbian, Gay, Bisexual, and Transgender (LGBT) Center. The authors feel it is important for therapists to have basic knowledge of the terminology used by the LGBT culture. Terminology is continually evolving; therefore, word usage may adjust over time and labels differ person to person.
Gaining Cultural Competency for the Occupational Therapy Student & Clinician

On the Lesbian, Gay, Bisexual, & Transgender (LGBT) Population

Lindsey Belzer MOTS & Jessa Hulteng MOTS
LaVonne Fox, OTR, PhD: Advisor
May 2009
Foreword

Everyone is in some way affected by issues surrounding the LGBT population. That is why I saw a need to increase awareness about LGBT issues in the profession of occupational therapy. I feel it is important for students and clinicians to have the education and resources to gain competency in this area of study. The University of North Dakota Occupational Therapy department provides an avenue for developing cultural competency through the multicultural curriculum. Self-reflection and guided discussions with classmates about various issues related to culture are foundational for developing cultural competency, but we must understand that this development is a lifelong process of learning about people different from ourselves. The world is constantly changing; cultures emerge, policies are amended, and rights are granted. The profession of occupational therapy must adjust to dynamic situations and have a better understanding of what our role is when working with LGBT clients. It is our ethical duty to prepare for these changes by becoming educated and unbiased when working with different populations. It is my hope that this project will provide my family, therapists, students, and society with a better understanding of how we must love and accept people for who they are regardless of race, gender, sexual orientation, disability, culture, or religion. The work of this project is dedicated to my brother KC, who reminds me to be open-minded and proud to be in a profession that has the potential to stand up for the rights of all people.

- Lindsey Belzer

Too often, health professionals do not take time to truly understand the clients they work with. In order to treat clients holistically, therapists must gain a full understanding of the clients they work with. LGBT clients have every right to receive holistic care, which may include discussions related to relationships and sexuality. In my experience, people tend to shy away from conversations regarding the LGBT population. I believe this is because people have not been provided with adequate knowledge about this population and it is my hope that these resource guidelines will increase comfort level of clinicians and students accessing this resource and spark a discussion on how to better serve the LGBT population. This work is dedicated to my son, Sam, he is my inspiration for all that I do. My hope is that he will grow up in a world that is more tolerant and accepting of everyone. This is also dedicated to my loved ones because without their love and support none of this would have been possible.

- Jessa Hulteng
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In 1995, the American Occupational Therapy Association (AOTA) adopted a policy of nondiscrimination to include sexual orientation. The policy states that all members of the occupational therapy profession have the "right to achieve a productive and satisfying professional and personal life without regard to age, race, disability, culture, sexual orientation, national origin, gender, religion, or employment status" (AOTA, 1995, p. 1009). The following year, AOTA incorporated a policy of full inclusion into the association stating:

All individuals, regardless of ethnicity, race, age, religion, gender, sexual orientation, or disability should be able to be a part of the naturally occurring activities of society. Full inclusion addresses the need for all individuals to have the same opportunities. It also recognizes the benefits to everyone of being with individuals who are different from themselves. By embracing an attitude of full inclusion, all individuals will benefit from the opportunities afforded by a diverse society (1996, p. 855).

AOTA recognizes that the concept of full inclusion incorporates "perceptions, values, attitudes, expectations, and behaviors for all persons, those with and without disabilities" (1996, p. 856). It is essential to recognize and accept differences in order to "promote human diversity and individual choice" (AOTA, 1996, p. 856).

One of the most controversial dimensions of diversity is sexual orientation. Based upon these positions of AOTA, the occupational therapy profession acknowledges the importance of addressing the needs of the lesbian, gay, bisexual, and transgender (LGBT) population, but has failed to support this diverse group in topics in the curriculum and in the clinic.

For many people, discussion about the LGBT community and sexuality is uncomfortable, or is often deemed private to avoid discussion. Therapists often state, "well, it's none of my business," but Harrison says that it is our job as health professionals to provide therapy settings that are safe for all individuals to openly express themselves (2001, p. 143).

Harrison (2001) suggests therapists must consider clients' sexual identity differences as a culture, and that it is our responsibility, as healthcare professionals, to provide therapy settings that are safe for all
individually to express themselves. Kingsley and Molineux (2000) state that “it is now a time that a broader and more thorough understanding of how sexual orientation can influence (how) occupation is developed, so that therapy can be more authentic with people who are gay, lesbian, or bisexual” (p. 207).

The challenge that arises is that there is a lack of resources for therapists to access in regards to working with LGBT clients. It is the belief of these authors that resources are needed to develop a greater understanding of sexual differences in order to be able to provide quality service to future clients of the LGBT community. When considering the large numbers of the LGBT cultural group in the United States, occupational therapy has minimal resources and research to assist therapists in gaining cultural awareness and removing the myths and stereotypes. These myths and stereotypes can negatively affect a professional’s beliefs and attitudes toward individuals in this group. Researchers have indicated that in order for occupational therapists to provide authentic care, it is critical that issues around homophobia be addressed (Harrison, 2001, p. 142).

It is important for the profession to understand the impact of making assumptions in relation to sexuality (Harrison, 2001, p. 143). Currently, there are no standards of practice to assist occupational therapists when working with LGBT clients. This resource provides guidelines that can be used to direct students and clinicians in developing LGBT cultural competency. It is important to consider the information provided in this resource as guidelines rather than best practices due to the evolving nature of discussion surrounding this diverse population. The authors of these resource guidelines welcome readers to adapt the content and add to the content to better fit their specific needs.

The Adult-learning Theory, also referred to as Andragogy, developed by Malcom Knowles, was used for the development of the resource guidelines. Andragogy is defined as the art and science of adult learning (Bastable, 2006, p. 124). Since this resource is intended to be used by occupational therapists, the therapists and students are the adult learners. The resource guidelines are organized to follow a natural progression of learning. It is important to gather information and then learn how to apply the information in a practical manner.
The following learning objectives were developed to be incorporated in the use of these guidelines:

Learning Objectives:

Students and Practitioners will

- Identify ways to create a safe work, school, and home environment;
- Engage in open, honest, and respectful discussions within the classroom and in the clinic;
- Model how to address intolerance and prejudice issues;
- Attend at least one LGBT event independently and annually;
- Know how to access additional services if clients express concerns outside of the occupational therapy scope of practice;
- Be aware of LGBT legal issues within the healthcare system at state and federal levels;
- Identify high risk behaviors related to the LGBT population;
- Write examples of non-discrimination policies to be implemented into any organization;
- Understand how to collect and manage confidential information;
- Be able to use the culturally sensitive language and terminology established by the LGBT community; and
- Self-reflect on personal bias in order to increase cultural competency.

Understanding how prevalent the LGBT population is in society will allow occupational therapists to realize the importance of learning the basic skills when working with LGBT clients. The resource guideline will define terminology to assist therapists throughout the treatment process and will serve as a quick reference to access when discussions related to sexual orientation and gender identity occur. Ideas for creating a welcoming therapeutic environment as well as suggested health issues that should be
addressed with this population are discussed. Advocacy and legislative issues are explored for the purpose of understanding additional roles occupational therapists hold as professionals. Highlights for creating change in the workplace and school setting provide general suggestions to promote inclusivity and safety for LGBT individuals. Additional resources are provided at the end of these resource guidelines to direct your learning in other areas in need of clarification.

The goal of this resource is to provide occupational therapists with guidelines to use when working with LGBT clients. The researchers of this project have taken material from a variety of resources within a variety of disciplines. The lack of OT literature suggests more research must be conducted to expand on the profession's role in terms of interventions, assessments, and therapeutic use of self.

Information provided in this guide is basic and promotes self-exploration of additional information to gain a better understanding of how to care for LGBT clients. OT's work in a variety of diverse settings, and must demonstrate cultural competency not only with the clients but also with their co-workers. Consequently, OT's need the skills and resources relevant to all populations they work with. The knowledge you will have gained from this resource will assist in developing competency when working with LGBT clients and will educate you on why discussions of sexuality should not be absent from any part of the treatment process.

Limitations of the Resource

Because of limited research in the field of occupational therapy, much of the information was drawn from other health disciplines and adapted to the OT profession. In addition, these resource guidelines provide a general overview of the LGBT population and suggestions for increasing the competence of therapist's working with individuals in this population. The broad scope of these resource guidelines made it difficult to go into extensive detail on specific areas, and for this reason users are encouraged to adapt the guidelines as needed.

In addition, occupation-based activities were not discussed in detail in the resource guidelines. This is due in part to the limited research in the occupational therapy profession. Without further research it is difficult to determine if how sexual orientation and gender identity can impact the therapists approach to occupation-based activities. Suggestions for working
with transgender clients have been included in the resource section on page 38.

**Future Plans**

The future plans are to continue to develop materials that enable occupational therapists to provide more comprehensive and respectful services to their clients who are LGBT. So, we would like to have your feedback on the information provided and suggestions on where and how to expand this resource.

Future projects could include guidelines for specific areas of practice such as school, psychiatric, assisted living, and community-based settings. Furthermore, it would be beneficial to examine the role of occupation-based activities for working with LGBT clients. In addition, further research needs to be conducted in both areas of cultural competency and working with the LGBT population to increase support in the occupational therapy profession. This project has potential to increase collaboration within the field of occupational therapy for developing research, and to increase collaboration with organizations that are devoted to eliminating health disparities related to the LGBT population.
Introduction

Using the concepts of the Adult-learning Theory, it can be assumed that the user of this guide has a vested interest in gaining further knowledge to better address the needs of the LGBT population. It can be assumed that healthcare professionals will work with a client who identifies as LGBT at some point in their career (Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006). A basic understanding of the population must be understood before one begins to explore and develop cultural competency skills.

Population Size

Many components influence how individuals define themselves. This has an effect on the ability to determine the number of individuals in the U.S. that make up the LGBT population. Current research, focused on the number of LGBT people, is limited because of factors such as self-definition, stigma, and fear of discrimination (Dean et al., 2000). Most of the data collected does not include transgender, primarily representing individuals who identify as lesbian, gay, and bisexual. In addition, there is no clear-cut way to define or count people in this population because people define themselves differently (Lev, 2004; Dean et al., 2000). Despite these issues, some statistics exist that attempt to find a representative estimate of the LGBT population. Most of the statistics have been gathered through convenience sampling (GLMA & LGBT Health Experts, 2001).

Perhaps the most widely accepted estimate is that LGBT individuals make up 10% of the U.S. population; this figure came out of the 1948 Kinsey Survey, in which 10% of the male population and 5 to 6% of the female population identified as gay and lesbian (GLMA & LGBT Health Experts, 2001). More recent surveys find this estimate to be high (Council on Scientific Affairs, AMA, 1996). One study, completed in 1994 by The Social Organization of Sexuality, suggests that between 1.4% to 4.3% of women and 2.8% to 9.1% of men in the United States identify as lesbian, gay, or bisexual, though the researchers note these numbers may be low due to the difficulty of obtaining sensitive information (Dean et al., 2000). The 1990 U.S. Census data found that 1.63% of people 15 years of age and older reported themselves as an unmarried same-sex partner in the household (GLMA & LGBT Health Experts, 2001). In the 2000 U.S. census, data shows...
that "same-sex couples can be found in 99.3% of U.S. cities (More, Whitehead, & Gonthier, 2004).

An estimate of the number of people who are transgender is virtually non-existent due to factors such as how individuals define themselves, social stigma, and discrimination (Dean et al., 2000). One estimate is that people who identify as transgender comprise 2-3% of the LGBT population (Burdge, 2007). Healthy People 2010 indicates that 25,000 U.S. citizens have undergone sexual reassignment surgery and approximately 60,000 individuals consider themselves candidates for sexual reassignment surgery (GLMA & LGBT Health Experts, 2001).

Healthy People 2010 advocates that more must be done to gain a more accurate number of LGBT in the United States in order to better address and treat health concerns and issues related to this demographic group (GLMA & LGBT Health Experts, 2001). It is evident that LGBT people make up a strong portion of the U.S. population, and healthcare professionals must consider this when treating clients.
Language: Understand the Basic Terminology Used in the LGBT Community

LGBT is a term that is used to broadly group together individuals who self-identify as lesbian, gay, bisexual and transgender. It needs to be recognized that, while some similarities are shared among various members of this group, there are far more differences and unique health disparities that each member faces individually (Dean et al., 2000; GLMA & LGBT Health Experts, 2001). Research has indicated that the stigma placed upon them and the discrimination that results may be the only similarity held among this population (GLMA & LGBT Health Experts, 2001). People in the LGBT population are diverse in terms of “cultural background, ethnic or racial identity, age, education, income, and place of residence” (Dean et al., 2000, p. 102). Furthermore, the “degree to which sexual orientation or gender identity is central to one’s self-definition, the level of affiliation with other LGBT people, and the rejection or acceptance of societal stereotypes and prejudice vary greatly among individuals” (Dean et al., 2000, p. 102).

One construct used to describe the LGBT population is that they are a cultural group. This is fitting in that sexual orientation and gender identity are components of one’s identity, which is multi-faceted, similar to culture (Harrison, 2001). Culture is considered the “customs, beliefs, values, knowledge, and skills that guide people’s behaviors along shared paths” (GLMA & LGBT Health Experts, 2001, p. 21). Culture is intertwined with factors influencing health, but it should be noted that the use of the culture construct is not without debate (GLMA & LGBT Health Experts, 2001). Like using any label to describe a population, there can be negative consequences. Similar to other cultural groups, there are many complexities that influence and impact the dynamics within the population. It cannot be assumed that everyone fits into the same mold, which is the prevalent assumption of western healthcare ideals (Iwama, 2003). There are intricate subcultures within the LGBT population, and it can be difficult to determine where to begin when developing a greater cultural competency toward working with this population.

Though individuals of this population are broadly defined as LGBT, they may not use the terms lesbian, gay, bisexual, or transgender to define themselves (GLMA, 2002). This may be more evident with older clients who have same-sex partners, but have never ‘came out’ to family and friends.
In addition, individuals may choose not to use a label to define themselves. Regardless of how a person self-identifies, healthcare providers must have a basic understanding of the terminology used within the population in order to provide culturally competent care. In addition, therapists must also respect their clients’ choice of terminology and not make assumptions before clarifying with clients what terms they use to define themselves (GLMA, 2002).

Most often, lesbian, gay, and bisexual (LGB) people are defined based on their sexual orientation. Sexual orientation describes both sexual preference and emotional attraction, and can be directed toward members of the same sex, the opposite sex, both sexes, or neither sex (Lev, 2004). Additionally, sexual orientation is an individual’s self-perception of being gay, lesbian, bisexual, or heterosexual (Council on Scientific Affairs, AMA, 1996). Sexual orientation does not always coincide with sexual behavior, and these perceptions may vary over time (Council on Scientific Affairs, AMA, 1996). A generally accepted definition of a person who is LGB is someone with an “orientation toward people of the same gender in sexual behavior, affection, or attraction, and/or self-identity as gay/lesbian or bisexual” (Dean et al., 2000, p. 102).

The transgender population is commonly defined based on gender identity. Gender is a social construct used to determine whether one is male or female, and is dependent on culture, meaning that we learn to act appropriately in our assigned gender roles (Brown & Rounsley, 1996). This can differ from ones’ gender identity, which is defined as the “internal experience of gender” or a “person’s self-concept of his or her gender” (Lev, 2004, p. 81). For most people, gender identity is congruent with their assigned sex; however, for some, their gender identity does not match their biological sex (Lev, 2004). People whose gender identity differs from their biological sex are often referred to as transgender. Transgender is an umbrella term used to “describe the full range of individuals who have a conflict with or question about their gender” (Brown & Rounsley, 1996, p. 18). People included under the transgender umbrella may be transsexual, transvestite, gender-variant, drag queens or kings, gender benders, cross-dressers, or people who are experiencing gender confusion (Brown & Rounsley, 1996). This population may live part-time or full-time as members of the opposite gender (Lev, 2004). In other words, transgender individuals may choose to work or participate in certain community activities as the gender they were born or assigned with, while participating in other
activities as the gender which they identify themselves to be. In addition,
people may identify themselves based on their gender vector. Male-to-
female (MTF) are people who have been assigned a male gender at birth, but
who identify their gender as female; and female-to-male (FTM) are
individuals who are biologically assigned females, but identify with the male
gender (Lev, 2004). Not everyone with a gender variance considers
themselves under the transgender umbrella. It is the duty of the healthcare
provider to use the terminology that the individual prefers.

These definitions only skim the surface of the LGBT population, but
they can assist therapists to develop cultural competency in working with
the LGBT population. Refer to the glossary for further clarification of
terms. Understanding terminology provides therapists with a starting point
that will assist them in providing valuable therapeutic experiences to clients
who identify as LGBT. Therapists need to understand and appreciate how
clients identify themselves in order to provide holistic care. For example, a
therapist assuming that a client identifies as 'transgender' can lead to
negative treatment outcomes if the client prefers the term 'transsexual'. In
this instance, making an assumption would imply to the client that their
personal beliefs and preferences were not considered in the therapeutic
relationship. If clients are not respected for the language they choose to
use, then it is unlikely that therapists will be able to develop therapeutic
relationships with their clients.
Therapeutic Use of Self

In a 2007 study by Taylor, Lee, Kielhofner, & Ketkar, 80% of 568 US occupational therapy clinicians rated therapeutic use of self as the most important influence of the outcome of therapy, however, less than half felt equipped with the skills upon graduation (as cited in Taylor, 2008, p. 3). The foundation of therapeutic use of self occurs through self-reflection and being mindful of one’s strengths and weaknesses (Taylor, 2008). Development of this intuition is a lifelong endeavor and is difficult to teach.

The therapeutic use of self intervention is new to the practice framework (AOTA, 2002) but it has been widely used in practice for decades (Taylor, 2008). It has been argued as being so important in our profession yet few guided descriptions of how to practice the skills exist (Taylor, 2008). Even fewer descriptions of therapeutic use of self exist when working with specific populations such as LGBT clients.

Enhancing client-practitioner relationships requires occupational therapists to be aware of personal tendencies towards inappropriate inferences and evaluate behaviors that challenge their own world views (Neslen & Neslen, 1996). Both Jackson (1995) and Harrison (2001) present the need for occupational therapists to gain greater knowledge to work with the LGBT population. The following ACOTE Standards outline areas applicable to service provision, using therapeutic use of self, when working with LGBT clients:

| B.2.9. | Express support for the quality of life, well-being, and occupation of the individual, group, or population to promote physical and mental health and prevention of injury and disease considering the context (e.g., cultural, physical, social, personal, spiritual, temporal, virtual). |
| B.5.6. | Provide therapeutic use of self, including one’s personality, insights, perceptions, and judgments as part of the therapeutic process in both individual and group interaction. |
| B.9.1 | Demonstrate a knowledge and understanding of the American Occupational Therapy Association (AOTA) Code of Ethics, Core Values and Attitudes of Occupational Therapy, and AOTA Standards of Practice and use them as a guide for ethical decision making in professional interaction, client treatment, and employment settings. |
| B.9.4. | Discuss strategies for ongoing professional development to ensure that practice is consistent with current and accepted standards. |
Therapeutic use of self is subjective when assessing its effectiveness in the clinic. Kirsh, Trentham, & Cole (2006), interviewed occupational therapy consumers, who identified themselves as minority group members, to gain a better understanding of their experience of the OT process. Five primary themes emerged from the data that could be linked to more thoroughly understanding how therapeutic use of self can be used when working with LGBT clients:

- **Theme 1**: describes the ability for a client to gain a sense of community with the therapist, for example, same sex, culture, or sexual orientation. Some participants were distinguished from this 'insider' phenomenon and were concerned with areas regarding privacy and confidentiality within their particular culture.
- **Theme 2**: conveyed the positive effects of having a therapist who could be understanding and considerate of other's culture regardless if it was different from their own.
- **Theme 3**: identifies looking at the client holistically and enabling them to share themselves fully free of judgment. Sexuality, physical aspects and orientation alike, were seen as primary areas of omission.
- **Theme 4**: participants felt they were 'locked in' to particular roles or expectations and identified their roles as constantly changing rather. The need to recognize sex as an occupation for persons with disabilities across cultures was also re-addressed.
- **Theme 5**: some participants felt discriminated against related to their minority status. Examples such as using unfamiliar language, excluding from the decision making process, and sexual orientation were all identified with these discriminatory behaviors.

Cultural and sexual identities influence occupational choices therefore have an impact on the therapeutic process. Practice models that outline how culturally constructed meanings of occupation guide treatment in an increasingly diverse practice environment must be developed (Kirsh et al., 2006). There is a need to examine how minorities, beyond ethno-cultural or

| B.9.6. | Discuss and evaluate personal and professional abilities and competencies as they relate to job responsibilities. |
| B.9.10. | Explain strategies for analyzing issues and making decisions to resolve personal and organizational ethical conflicts. |
race, connect their lives to occupation through their lived experiences and life narratives.

Occupational therapists are equipped to help people transform their lives through, "enabling them to do and to be through the process of becoming" (Wilcock, 1999). The profession of occupational therapy is applicable when working with this population because of the professions focus on peoples' occupations, which includes sexuality (Harrison, 2001). Occupational therapists must gain cultural competency related to the LGBT population, in order to be aware of personal biases and to provide client-centered care to individuals within this cultural group. Identifying best educational practices for teaching about gender and gender theory to develop cultural competence is paramount. Kingsley and Molineux (2000) provide two primary recommendations to build on within the OT profession:

1. Expand a knowledge base building cultural competency of gay, lesbian, and bisexuals. Including this topic within the curriculum will increase awareness and comfort levels when working with someone of a different sexual orientation.

2. Understanding the relationship between sexual orientation and occupation within the profession of OT. This involves conducting more research into the link between sexual orientation and occupation and its relevance to the profession.

It should be every occupational therapist's aim to provide what Yerxa (1967) calls 'authentic occupational therapy' or in other words, allowing a client, through the therapeutic process, to discover his or her own personal meaning (p. 8). Education must take place among practicing occupational therapists, occupational therapy educators, and occupational therapy students in order to develop greater knowledge and competency when working with this population.
Gaining Cultural Competency for the OT Student and Clinician

Introduction

Muñoz states that "culture is profoundly and inextricably tied to matters of health and healthcare" (2007, p. 256), which seems to be the consensus among other health professions (Sanchez, et al., 2006; Taylor, 1999; Burdge, 2007). If culture impacts the quality of healthcare that clients receive, then one can assume that healthcare service providers must gain cultural competency to treat clients more holistically. Cultural competency is defined in many ways; however, the following definitions were chosen for the purposes of this guide:

- Cultural competency is a journey rather than an end. It refers to the process of actively developing and utilizing appropriate, relevant, and sensitive strategies and skills in interacting with culturally different persons (AOTA, 1995 as cited in AOTA, 2005).
- It is a set of congruent behaviors, attitudes, and polices that come together in a system, agency, or among professionals to work effectively in cross-cultural situations (Cross et al., 1989 as cited in AOTA, 2005).
- Cultural competence entails "understanding the importance of social and cultural influences on clients' health beliefs and behaviors; considering how these factors interact at multiple levels of health care delivery system; and finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations" (Betacourt et al., 2003, p. 297 as cited in AOTA, 2005).

Furthermore, cultural competency is essential for occupational therapists to effectively meet the needs of clients (Kirsh et al., 2006; Muñoz, 2007). This is supported by the following:

1. A core premise, in OT, is to focus on people's occupations, which are defined as "daily activities that reflect cultural values, provide structure to living, and meaning to individuals; these activities meet human needs for self-care, enjoyment, and participation in society"
(Crepeau, Cohn, & Schell, 2003, p. 1031). Sexuality is also an occupation that needs to be taken into consideration.

2. Yerxa (1967) defines "authentic care" as: a therapeutic relationship between the client and therapist in which the therapist does not impose his or her personal values on the client, but rather learns about the client in order to provide client-centered care (p. 8).

3. Harrison (2001) states that it is our responsibility as healthcare professionals to provide therapy settings that are safe for all individuals to express themselves (p. 143).

There are many complexities to developing and maintaining cultural competency. According to the definitions of cultural competency on pg. 17, occupational therapists need to have knowledge and sensitivity of how culture influences the client's health care experience, and the necessary skills to implement unbiased, appropriate treatment interventions to diverse cultural groups. Kirsh et al. (2006) take this definition a step further and state that the concept of cultural competence has evolved beyond knowledge, sensitivity, and skills to include a "greater awareness of cultural biases, both individual and professional" (p. 303).

Based on these definitions, the key points to developing cultural competency are that it should be viewed as a life-long journey, and it must be an active process that includes personal reflection and sensitivity, knowledge, skills, and advocacy.

**Basic Components of Cultural Competency**

Therapists must consider all aspects of an individual's life when providing care. This is achieved by providing authentic occupational therapy to clients, and to do this occupational therapists must consider what is meaningful to the client and understand how meaning is played out in each person's life through occupational engagement (Jackson, 1995; Yerxa, 1967).

Sexuality and gender expression are occupational activities that merit the same priority as any other aspect of daily living (Couldrick, 1999). Therapists must consider clients' sexual identity differences as part of their culture (Harrison, 2001). Development of a broader, more thorough understanding of how sexual orientation can influence occupation must be prioritized so that occupational therapy can be more authentic with people who are gay, lesbian, or bisexual (Kingsley & Molineux, 2000).
Core texts, models of practice, assessment tools and the professional literature need to resonate with a professional belief that sexual activity is as much at the heart of occupational therapy as personal care, work, and leisure. Then the practitioner needs awareness, knowledge, skills, and support to put that into practice (Couldrick, 1999, p. 28).

Knowledge, skills, and attitudes are the three basic components of cultural competency. Attitudes are discussed first because one must first reflect on their own person beliefs and values before gaining knowledge and understanding of others beliefs and values. In addition, it is necessary to understand the potential impact stigma can have on therapeutic relationships.

**Attitudes**

Research in cultural competence suggests that an individual's attitudes and individual cultural beliefs have a direct impact on the services they provide (Kirsh et al., 2006). When working with clients, it is often assumed that our cultural values are similar to those we work with. These assumptions are the first mistake we can make when working with clients.

Personal biases affect the attitudes of therapists when working with clients (Muñoz, 2007). Biases are typically developed through societal relationships. For instance, growing up in a family that was intolerant of people in the LGBT community could create negative biases toward the LGBT community in future interactions. Another example could be that growing up in a rural area may have limited opportunities to engage with people of various cultural groups. Limited exposure to various cultural groups does not imply that, as a therapist, you cannot gain competence to work with diverse groups such as the LGBT population. It does imply that therapists must be aware their personal biases so that they do not interfere with providing culturally competent care.

**Knowledge**

Research has found that knowledge of various cultural groups equips therapists to use higher-level clinical reasoning when working with individuals from different groups. It is important to understand that knowledge of various cultural groups cannot be applied individually to clients. People within cultural groups are not static, meaning that they are individuals with unique
values and interests. Gaining knowledge of cultural groups provides therapists with a basis for opening communication. Knowledge of appropriate language to use, health disparities, and personal attitudes are a good starting point for any therapist.

Stigmatization

LGBT individuals often confront stigma, prejudice, and discrimination based on their sexual orientation or gender identity. Detrimental effects that can result from these negative attitudes and behaviors include feelings of low self-esteem, isolation, and hopelessness (Prince & Prince, 2002). Oppression from society places this minority group at higher risk for mental illness (NAMI, 2008). The consequence of this is that persons may experience dual stigma, and according to the National Alliance on Mental Illness (NAMI), dual stigma is especially harmful because the stigma of having a mental illness is combined with discrimination leaving individuals in a vulnerable position (NAMI, 2008; Scheffer, 2003). In other words, stigma is attached to sexual orientation or gender identity, and there is also stigma attached to mental illness. As a result, LGBT clients are at high risk for suicide, depression, poor body image, substance abuse, and self-mutilation (Dean et al., 2000). Discrimination and negative attitudes towards the LGBT minority groups are evident in healthcare; therefore, people are less likely to seek necessary services (Burdge, 2007). It is our job as health professionals to provide therapeutic settings that are safe for all individuals to openly express themselves (Harrison, 2001).

Research suggests that people in the LGBT population may choose not to "come out" to their therapist for fear that they will be discriminated against. Examples of social discrimination and violence include denying services, not allowing persons to crossdress, and acts of violence when external anatomy and expressed gender identity is different (Harrison, 2002). Fear of disclosing sexual orientation information and other aspects related to stigmatization may lead to increased depression, anxiety, and other mental health related issues (Council on Scientific Affairs, AMA, 1996). The first step to ensuring that clients are in a welcoming environment is for therapists to understand how their own personal biases and cultural values influence their feelings of discrimination. Some of the research indicates that self-reflection should be utilized by therapists so they can develop and provide unbiased clinical experiences to clients (Kirsh et al., 2006; Muñoz, 2007).
One way of monitoring personal bias and attitude is to reflect on personal feelings and experiences. Using self-reflection to adjust personal beliefs can be challenging for clinicians. The following suggestions will guide you in developing awareness of your own biases surrounding homophobia and gender related issues.

**Questions to consider in self-reflection**

1. Reflect on a time when you felt discriminated against. What were your feelings about this?
2. What are your personal views of sexuality, and how could these views impact the services you provide to clients?
3. What does your body language say when discussing topics related to gender and sexuality with clients?
4. Do you use questions that allow for clients to fully express themselves safely?
5. Think of an experience or discussion you had with someone in the LGBT community. Were there any assumptions you had made that you discovered were false? What did you learn from that experience?
6. How would you respond to a close friend or co-worker who disclosed to me that three years ago he or she had gone through sex reassignment surgery? Would this change your perceptions of the person?
7. Do you think individuals in the LGBT population should have equal rights, including the ability to marry? If not, what is your rationalization for this belief? What personal biases are influencing this choice? Are you familiar with the facts about LGBT equal rights or do you assume that you know?
8. Have you ever worked with someone who was gay? Did their sexual orientation affect their job performance? Were there assumptions I had made that I later discovered were not true?

**Culturally Sensitive Highlights**

1. Search your community for local events that highlight diverse cultural groups and make a commitment to attend once a month.
2. Be open to asking people about their cultures and have discussions on similarities and differences among cultures. Ask about values within their family structure and be sure to keep questions open-ended.
3. Realize you need to be open to discuss your culture as well. You will probably be asked about your thoughts and beliefs, which is only fair.
since you are asking about theirs...so watch a tendency to become defensive.

4. Use the internet as a tool to network outside of your local community but make sure it is a reputable site.

For additional resources, refer to the resource section of the guidelines on page 38.
Creating a Welcoming Clinical Environment for Lesbian, Gay, Bisexual, and Transgender (LGBT) Clients

Introduction

Studies show LGBT populations experience both health disparities and barriers related to sexual orientation, gender identity, and/or expression. Many individuals in the LGBT group avoid accessing necessary care or receive sub-optimal care for reasons related to homophobia and discrimination by health care providers (Jackson, 1995). One study found that medical students who had less knowledge of the LGBT population were more uncomfortable working with LGBT individuals (Sanchez, et al., 2006). Health professionals can take the necessary steps towards promoting health of their LGBT clients by self-reflecting on personal bias, becoming more educated regarding issues related to this population, adapting intake and assessment forms, displaying diverse informational booklets and décor, and ensuring that policies and behaviors within the organization are anti-discriminatory. These resource guidelines outline specific suggestions and techniques with which you can ensure your facility is sensitive to LGBT clients.

Making Changes to Your Facility

In order to ensure that your facility is prepared to work with LGBT clients, continued education regarding LGBT issues must occur. Challenges arise when managers of an organization do not know where to start, or when they themselves are not trained in this area. The goal of this resource is to guide your learning by focusing on areas to be aware of and how to gain competency when working with LGBT clients. Established organizations with aims to increase competency can come to your facility, community, or school to help you through this process. Contacts for these organizations are listed in the resources section of this manual on page 38.

Here are some general suggestions to create a welcoming clinical environment for LGBT clients:

1. Advertising that your organization promotes a safe, inclusive environment can be done through local LGBT organizations.
2. Accessing the PFLAG Chapter (Parents, Families and Friends, of Lesbians and Gays) in your area is an excellent resource and a way to inform the local LGBT community of your efforts to be inclusive and non-judgmental when providing therapy services. This simple gesture will allow clients to access clinics or hospitals that are sensitive to LGBT issues and put them at ease before they step foot into the facility. Materials can be picked up at the local PFLAG chapter and can include information regarding gender behaviors, “Questions and Answers for Parents of Gay, Lesbian, & Bisexual People,” and “Our Trans Children.”

3. Office brochures and other educational materials that include information relevant to LGBT clients should be visibly displayed.

4. Networking with the local 10% Society is another way to build rapport with the LGBT community as well as having personal resources to access when difficult questions arise. Use your preferred search engine to locate the nearest LGBT organizations and learn about meeting times.

5. Staff Education and Training: Listed below are the highlights of areas to consider when training and educating staff.
   - Training all administrative staff, nursing, and technicians is critical to creating and maintaining practice environments deemed safe for LGBT clients. These training sessions should occur consistently and periodically to keep up-to-date with changes.
   - Train all front-line staff on standards of respect toward transgender people, including using their chosen name, and using chosen pronouns. This will prevent ‘outing’ an individual in public areas and demonstrates to clients that you respect them and their confidentiality.
   - Designate an on-site LGBT resource person to answer any questions that arise. In addition, have a contact person in the community who is an active member in the 10% society or advocates for LGBT individuals.

6. Make practical changes to waiting area or office, including:
   - Posting a rainbow flag and unisex bathroom signs;
   - Displaying posters showing racially and ethnically diverse same-sex couples or transgender people;
• Using resources from the Human Rights Campaign website at www.hrc.org and click on the HRC shop icon;
• Creating multilingual brochures about LGBT health concerns, substance use, and STDs (refer to resource section and materials for waiting room);
• Posting a mission statement that outlines non-discrimination and promotes diversity policies;
• Acknowledging relevant days of observance such as World AIDS Day, LGBT Pride Day, and National Transgender Day of Remembrance; and
• Searching the local PFLAG website to gain access to a host of resources to provide to clients when questions arise.
http://gfpflag.tripod.com/pflag.html

Topics to include in staff training

1. Using appropriate language when addressing or referring to clients and/or their significant others;
2. Learning how to identify and challenge many internalized discriminatory beliefs about LGBT people;
3. Being familiar with LGBT health issues such as the impact of homophobia, violence, mental health and depression, substance abuse, and safe sex;
4. Knowing indications and mechanisms for referring to LGBT-friendly providers;
5. Developing a list of resources for client interactions; and reinforce
6. Emphasizing that all employees understand that discrimination is unethical and unacceptable and that it will not be tolerated.

Adapted from the Gay & Lesbian Medical Association

Some of these suggestions have been adapted from the Guidelines: Creating a safe and welcoming environment for lesbian, gay, bisexual, transgender, and intersex (LGBTI) patients with permission from the Gay and Lesbian Medical Association. Permission obtained February 29, 2009.


**General Guidelines for Client-Provider Discussions**

**Introduction**

Discussions of sexuality have been largely omitted in occupational therapy sessions due to decreased comfort levels surrounding the topic (Couldrick, 2005). In addition, some therapists believe the act of sex is considered an activity rather than an occupation; therefore, questions surrounding the topic, are left out (Harrison, 2001). Other research suggests that therapists are ill equipped to open the conversation about sex or feel that it is a private issue (Jones, Weerakoon, Pynor, 2005). The problem with these reasons of omission is that occupational therapists are not treating the client holistically; as a result, they are not providing authentic services to LGBT clients (Jackson, 1995). A devastating consequence of the lack of discussion is that the life histories of older LGBT people may not be shared to their fullest (Harrison, 2002). Issues surrounding homophobia must be addressed if therapy is to be client-centered and to better understand what is meaningful to each individual (Harrison, 2001).

**Open Discussion Suggestions**

All occupational therapists must follow the profession's standard of approaching all clients with empathy, open-mindedness, and without rendering judgment. In combination, LGBT friendly assessments and intake forms should be implemented throughout these discussions because they set the stage for how open clients will be when discussing personal issues.

Here are general suggestions for client-provider discussions:

1. Develop rapport with the client before asking probing questions. Occupational therapists understand the importance of developing a relationship with clients in order to gain a better understanding of who they are people using therapeutic use of self.
2. Ask about the language your client identifies with. Find out how they would like to be addressed, what pronouns, or what label they prefer, if any. Clients who are transgender may ask you to address them by their chosen name rather than what is listed on their chart. In addition you will need to determine what pronouns the chosen name
corresponds to and when to use them; i.e. 'he, or him' in the office or out in public. It is empowering for oppressed groups to control the language representing them and honors the personal meaning of clients' chosen words (Burdge, 2007). For a sample form that has been modified, access the GLMA Guidelines for Care of LGBT clients (2002, p. 15).

Form modifications in the GLMA guidelines include:

a. Use “relationship status” in place of “marital status”;

b. Use “partner” or “significant other(s)” instead of “husband/wife”;

c. Add “transgender” to the binary “male/female” checkboxes and add an “other” option.

3. Ask the client to clarify any terms or behaviors with which you are unfamiliar, and repeat these terms back to the client to ensure there is no miscommunication.

4. Be aware of additional barriers caused by differences in socioeconomic status, cultural norms, age, physical ability, and geography. Do not make assumptions about literacy, and comfort with direct communication.

5. When assessing the sexual history of people who are transgender, do not make assumptions based on their presentation. Many people do not define themselves through a sexual orientation label even though they may have sex with people of the same sex or with more than one sex. For example, men who have sex with men may identify as heterosexual and have both female and male partners. Some individuals may present themselves differently from how they feel on the inside because of discrimination, desired approval from society, or a lack of confidence and support in expressing who they truly are.

6. Understand that discussions surrounding sexual orientation and gender identity can be stressful and very sensitive. Individuals who have not ‘come out’ or simply do not understand themselves and what their identity is may be uncomfortable with this topic because of their own lack of education or ability. Barriers to coming out in society such as the lack of national legal protection, inadequate state laws, and insufficient training on the unique health issues faced by the LGBT community perpetuate the problem and inhibit the ability to express gender identity and sexual orientation openly (Human Rights Campaign, 2009). In addition, these individuals may fear ridicule and
rejection from family, friends, their workplaces and their healthcare providers; therefore, do not fully disclose this private information.

7. Ask transgender people if they have had any gender confirmation surgeries to assess for risks. This should only be done to improve the effectiveness of your services. It should not be done just out of curiosity. Explaining why you need information and how it is relevant to treatment can help avoid the perception of intrusion. For example, say “To help assess your health risks, can you tell me about any history you have had with hormone use?” It is important to be knowledgeable about what risk factors may be related to sex re-assignment. Check out “The Transgender Child” written by Brill and Pepper (2008) or online at http://unityms.org for additional guidance.

8. Do not be afraid to tell clients about your inexperience. Clients themselves may be questioning the idea of being LGBT and are working through their own understanding of self. Support them through their journey with validation, open discussions, and connecting them to people who have gone through similar circumstances. This is where networking with the local 10% society can come into play as well as knowing how to access a variety of resources identified at the end of this guide. They will respect your openness and your honesty and it will promote a healthy therapeutic relationship.

Some of these suggestions have been adapted from the Guidelines: Creating a safe and welcoming environment for lesbian, gay, bisexual, transgender, and intersex (LGBTI) patients with permission from the Gay and Lesbian Medical Association. Permission obtained February 29, 2009.
Specific Issues to Discuss with LGBT Clients

Due to the limited access of inclusive healthcare provided to LGBT clients, health disparities for this population are evident. Stress and anxiety, in addition to oppression from society, places LGBT clients at high risk for depression and mental health issues. Disconnection with the healthcare system directly impacts how educated this population is on safe sex practices, annual check ups, and preventative care.

Specific areas clinicians should pay attention to include:

1. Find out the level of disclosure clients have with family, friends, employers, and within the community at large to ensure that you are providing confidential services.
2. Understand LGBT clients' vulnerability to social stresses and its impact on tobacco and substance use.
3. Discuss safe sex techniques and be prepared to answer questions related to Sexually Transmitted Diseases (STDs) and HIV/AIDS transmission. Annual STD screenings for males who have sex with males are recommended by the Center for Disease Control: rates of syphilis, gonorrhea, Chlamydia, HIV, and hepatitis A and B are on the rise. It may be more appropriate to refer to someone who is trained and more qualified in this area.
4. If a female client identifies as a lesbian, do not assume she has never had a male sexual partner, has no children, or has never been pregnant.
5. If a male client has a male sex partner, do not assume he has never had a female sex partner or does not have children.
6. Do not make assumptions about past, current, and future sexual behavior.
7. Be aware that transgender people can be subject to extreme levels of social exclusion creating instability in their lives. Risks to watch out for include changing employment frequently (creating cycling healthcare coverage), avoiding medical care, pursuing alternate gender confirmation therapies like injecting silicone or taking street drugs, engaging in survival sex, and extreme poverty.
8. If a client reports a history of having physical, mental, or sexual abuse, evaluate for PTSD or other mental illnesses related to the trauma or refer to those more qualified.

Some of these suggestions have been adapted from the *Guidelines: Creating a safe and welcoming environment for lesbian, gay, bisexual, transgender, and intersex (LGBTI) patients* with permission from the Gay and Lesbian Medical Association. Permission obtained February 29, 2009.
Advocacy and Legislation

People of the LGBT population are becoming increasingly visible in American society through advocacy, media attention, and people’s comfort levels with those outwardly identifying as LGBT (Hobbs, 2004; Dean et al., 2000). A survey completed by CIRCLE, the Center for Information & Research on Civic Learning & Engagement, found that young Americans are the most tolerant age group and are becoming more tolerant over time (Olander, Hoban Kirby, & Schmitt, 2005, p. 1). Of those surveyed, 85% of people between 15 and 25 years of age felt that gay and lesbian people should have equal protection in housing and employment, and from hate crimes (Olander et al., 2005, p. 2). In addition, data from the survey found that 50-63% of younger adults were in support of civil unions, legal marriages, and the ability to adopt children for people who are gay or lesbian (Olander et al., 2005, p. 2). Overall, this survey found that the majority of people surveyed were supportive of gay rights, though people 38 years old and over were less supportive (Olander et al., 2005, p. 2). These statistics suggest that the views of American society are shifting toward providing all citizens with equal rights, which must be taken into consideration in the healthcare system as well.

Despite the increase in visibility and an apparent increase in tolerance in the US, there is continued opposition to providing this population with rights that are congruent with the heterosexual majority (Hobbs, 2004). Society perpetuates heterosexism through its major institutions such as law, policy, religion, and the economy (Kingsley & Molineux, 2000). Barriers to quality care result from a lack of national protection, inadequate state laws, and insufficient education within the healthcare system (The Human Rights Campaign, 2008). Currently, states are not required to have anti-discrimination laws regarding sexual orientation and gender identity, or laws on hate crimes related to sexual or gender identity. This population must be better served by the healthcare system, and in order to do that, knowledge of specific healthcare needs must be gained by healthcare providers.

Lack of research and limited discussion surrounding LGBT issues reinforces the cycle of invisibility (Harrison, 2002). Fear often overpowers discussion and the need for addressing advocacy, policy, networking, home support, and legal issues is missed (Harrison, 2002). Advocacy for LGBT people is essential in healthcare because all individuals deserve to be given the best possible care. Some of the medical issues that LGBT people may
encounter are the female to male perspective of menopause, osteoporosis, breast and ovarian cancer, as well as the male to female perspective of prostate cancer (Harrison, 2002). Issues such as these indicate that there is a strong need for research and advocacy (Harrison, 2002). In addition, examples of social discrimination and violence include denying services, not allowing persons to crossdress, and causing physical violence when external anatomy and expressed gender identity are different (Harrison, 2002).

Healthcare professionals can take a number of steps to advocate for client rights. People have the freedom of choosing an active advocacy role or taking a more passive role in the process. Note that by taking a passive role you must ensure that you are not continuing the cycle of oppression. By this, we mean that, when you hear derogatory comments you should address them. Here are a few suggestions to get started in advocacy areas:

1. Join organizations such as the Gay and Lesbian Medical Association to support the rights of the LGBT population. By doing this you will stay up-to-date with current issues and will have the opportunity to donate to advocacy issues that you find meaningful.

2. Participate in special interest groups in your facility to advocate for equal rights for LGBT and all clients. This could be a group that focuses on ending health disparities or increasing cultural awareness in your facility.

3. Get involved with local and state legislation issues by contacting your state representatives. It is easy to contact your legislators and voice your opinion. Do not hesitate to voice your opinion regarding LGBT issues. Starting the discussion of LGBT health is the first step in creating change.

4. Write to your local newspaper to comment on legislative issues.

For contact information of advocacy organizations refer to page 38 of the resource section.
Creating a Welcoming Clinical Environment for Lesbian, Gay, Bisexual, and Transgender (LGBT) Colleagues

General Guidelines for Workplace Discussions

Having dialogue free of discrimination goes beyond clinician to client. AOTA has emphasized the need for OT professionals to understand the concept of full inclusion and how it applies to our interactions with one another (1995, p. 1009). Members of the LGBT community are practicing within the field of OT, and sensitive language should always be used with colleagues as well as clients. Research has shown how heterosexist occupational therapy work climates are maintained through language, assumptions, and stereotypes (Jackson, 2000). Society in general is bombarded with messages that say heterosexuality is the only framework for which people think and behave (Jackson, 2000).

Throughout the workday there are numerous opportunities for colleagues to talk about matters that are not related to work, and often these other matters have a heterosexual tone about them (Jackson, 2000). It is often an unspoken assumption that when discussing children, the parents are male and female, or when discussing an upcoming date, the significant other is of the opposite sex. Jackson (2000) discusses many of the assumptions that are made in clinical settings and how these assumptions affect LGBT individuals. The impact of this is that these therapists often will altogether avoid workplace discussions, which also omits them from the discussions colleagues have with one another regarding clients and what approaches would work best with specific issues (Jackson, 2000). As professionals it is our duty to provide respectful and safe environments to both clients and colleagues.

Specific ideas of how to ensure equality within the workplace

1. Eliminate homophobic jokes or references;
2. Caution against stereotyping about sexual orientation and gender identity;
3. Caution assuming that all clients and practitioners are heterosexual; and
4. Use open ended questions when discussing significant others, children, roles, marriage, or other topics relevant to heterosexuals.
Creating a Welcoming Educational Environment for Lesbian, Gay, Bisexual and Transgender Students

Introduction

LGBT students are also disproportionately targeted for harassment and discrimination in schools (National Center for Lesbian Rights, 2002). Children spend the majority of their time in schools alongside peers and teachers. The experiences gained from this social avenue can significantly enhance or undermine their sense of self (Brill & Pepper, 2008). Children must feel emotionally and physically safe in order to learn effectively (Brill & Pepper, 2008). Schools must develop and stand-by their anti-discrimination and zero-tolerance policies in order to promote a safe learning environment. Even schools with these set standards will still need training on how to effectively implement these standards.

Occupational Therapists educate parents and staff in ways to accommodate specific needs for each child. The same is true for a child who deviates from the pervasive norms pertaining to gender or sexual orientation. Do not assume the teachers, principals, counselors, or other school faculty will do the necessary work to self-educate and step in when bullying and teasing surface in the school setting (Brill & Pepper, 2008).

Brill and Pepper (2008) outline a step-by-step guide on how schools can support gender-variant and transgender students. The Gender Spectrum is an organization that can send you these additional materials (refer to the organizations section in the resource section on page 38). The same guidelines are applicable for any diverse population and can lay the groundwork for any professional making these changes within the school system. A summary of the guidelines are as follows (p. 153-182):

Guidelines for creating supportive schools

1. Create a Supportive Organizational Structure: Each and every staff person within a school system must know and understand the school’s commitment to treating people with respect, valuing and affirming differences, and not tolerating harassment or discrimination of any kind. This means that not only are they aware of it, but that they are trained to practice it. Knowing does not necessarily mean doing.

2. Adopt Zero Tolerance for Discrimination: Policies that prohibit discrimination must be presented in a clear, easy to understand format, and implemented in every classroom. Copies of these policies should be
distributed to each staff member, parent, and student. Training needs to occur consistently and periodically. Consequences of not adhering to these polices must be outlined and implemented.

3. **Update Policies and Forms:** Using gender-inclusive language in application forms, surveys, announcements, etc. will communicate to everyone an accepting, welcoming environment.

4. **Honor Preferred Names:** It is the responsibility of the school to honor each child’s preferred name and pronoun. These identifications are determined solely by the student and are based on their asserted gender identity.

5. **Develop Guidelines for Transgender Students:** Policies and procedures for a variety of circumstances will arise, and it is important to plan accordingly. For example, problems may arise with school identification cards, locker-rooms, bathrooms, athletic teams, sex-segregated classes or activities, and maintaining confidentiality. For examples of schools that have developed these policies go to [www.gpac.or/genius/2007.pdf](http://www.gpac.or/genius/2007.pdf).

6. **Staff Training:** Both initial and on-going training should exist within the school and be implemented by a trained professional. This step is a crucial part of cultural change and reinforces the school’s commitment to creating an inclusive environment.

7. **Provide Parent Education:** This can be done through newsletters, parent-teacher conferences, or in-services. Providing parents with additional resources so they can locate information is also useful.

8. **Provide Student Education:** Every student should understand what anti-discrimination is and why it is important. Increasing the safety for LGBT students is reinforced when a strong anti-teasing, strong self-esteem and ally-building curriculum is implemented.

9. **Bathroom Safety:** Children have the right to have their basic needs met. Gender-variant children experience a great deal of stress when it comes to choosing a bathroom. Non-conforming individuals have been harassed for entering the “wrong” bathroom, so creating an all inclusive space for people to go to the bathroom is advised. Recommendations include establishing single-occupant bathrooms, or family bathrooms.

10. **Document Harassment of Gender-variant Students:** A school must be able to respond quickly and refer to their set standards of zero-tolerance.
11. Provide Resources and Support for Families with Gender-variant Children: Know how to access resources for LGBT individuals in areas within the community, internet, and within the school.

12. Conduct a Gender Sensitivity Inventory of the School: Development of a committee that evaluates how well a school is adhering to gender-inclusiveness and sexuality with respect to diversity will ensure safety and inclusivity for all students.
Conclusion

Occupational Therapists have limited resources in terms of standards of practice for LGBT clients. This resource provides a general summary of best practices found within counseling and social work literature. The goal is to provide students and clinicians with basic information that outlines areas to highlight when working with the LGBT population. It is not intended to stand alone as a single guide for the development of cultural competency. Rather, the intention is to increase awareness and push for self-directed learning towards competency with this particular cultural group.

The profession of occupational therapy promotes an all-inclusive environment, which must include and support individuals in diverse groups. It is the responsibility of the therapist to examine how occupational roles impact one’s life, and the research indicates that sexual orientation and gender identity may impact an individual’s role performance. If occupational therapists intend to take the profession into the twenty-first century, then therapists must acquire cultural competency skills to better work with diverse clients such as the LGBT population.
Resources

Book Resources


Organizations

- Gender Spectrum Education and Training
  http://www.genderspectrum.org

- Parents and Families of Lesbians and Gays (PFLAG)
  http://www.pflag.org

- Site for trans youth and parents
  http://transproud.org

- The Trevor Project: The Nation's only 24/7 crisis helpline for LGBT and questioning youth
  1-866-4-U-Trevor (1-866-488-7386)

- LGBT Aging Issues Network
  http://www.asaging.org

- The Human Right's Campaign
  http://www.hrc.org

- The Gay and Lesbian Medical Association
  http://www.glma.org

- The Gay, Lesbian and Straight Education Network
  http://www.glsen.org

Resources for Waiting Room

American Cancer Society

- Cancer Facts for Gay and Bisexual Men
- Cancer Facts for Lesbians and Bisexual Women
- Tobacco and the LGBT community

Place order for free brochures by phone: 800-ACS-2345

American College Health Association
- Man to Man: Three Steps to Health for Gay, Bisexual, or Any Men Who Have Sex with Men
- Woman to Woman: Three Steps to Health for Lesbian, Bisexual, or Any Women Who Have Sex with Women

Periodicals
- The Networker
- Advocate
- Curve
- Girlfriends
- Instinct
- Out
- Renaissance News
- Your local LGBT newspaper

Resources for Advertising and Gaining Referrals
- www.glma.org
- www.gayhealth.com
- The Networker

Resources for Employers/Managers for training staff
- Debra Davis & the Gender Education Center
  www.debradavis.org
  P.O. Box 1861, Maple Grove, MN 55311
  763/424-5445
  email: info at debradavis.org
- Gender Spectrum Education and Training
  http://www.genderspectrum.org

Occupation-Based Activities to consider for transgender clients

Adapted from Benjamin 2005.
- Biological Males
a. Cross-dressing: unobtrusively with undergarments, unisexually, or in a feminine fashion
b. Changing external appearances: hair removal, education on minor plastic cosmetic surgical procedures
c. Grooming, wardrobe, vocal expression skills (referral to Speech Language Pathology).

• Biological Females
  a. Cross-dressing: unobtrusively with undergarments, unisexually, or in a masculine fashion
  b. Changing external appearance: breast binding, weight lifting, applying facial hair
  c. Padding underpants or wearing penile prosthesis
  d. Education and assistance with toileting tasks using adaptive equipment

• Both Genders
  a. Connecting clients with support groups and gender networks, communicating with peers on the internet, education on literatures about legal rights pertaining to work, relationships, and public cross-dressing
  b. Involvement in recreational activities of the desired gender
  c. Etiquette: Bathrooms, public locations, education of preferred gender norms

• Mental Processes
  a. Acceptance of personal homosexual or bisexual fantasies and behaviors as distinct from gender identity and gender role aspirations.
  b. Acceptance of the need to maintain vocation, provide for family or significant other
  c. Integration of male and female gender awareness into daily living
  d. Identification of the triggers for increased cross-gender tendencies, development of self-protecting and assertiveness skills.
Glossary

Terms reproduced with permission from the Ohio University Lesbian, Gay, Bisexual, and Transgender (LGBT) Center on April 9, 2009, and can be accessed online at: http://www.ohio.edu/lgbt/resources/educate_def.cfm

Advocate:
A person who actively works to end intolerance, educates others, and supports LGBT issues, concerns, equal rights legislation, etc.

Ally:
A heterosexual or LGBT person who supports LGBT people.

Bisexual:
A person who is emotionally, physically, spiritually, and sexually attracted to members of more than one gender. Also can be referred to as omnisexual and pansexual.

Biological Sex:
A binary system (male/female) set by the medical establishment, usually based on reproductive organs. See Intersexed.

Closeted:
One who has not "come out of the closet" or who has come out to only a few people. One who may not be comfortable enough with their own sexuality to share it with others.

Coming Out:
The life-long process of discovering, defining, and proclaiming ones (non-heterosexual) sexuality.

Cross Dressing:
The act of wearing the clothing of the "opposite" sex for performance, sexual encounters, or comfort. Generally, the term cross dresser is preferred to transvestite. See Transvestite.

Drag:
Queen, a person who consciously performs femininity, sometimes in an exaggerated/theatrical manner, usually in a show or theatre setting; King, a person who consciously performs masculinity, sometimes in an exaggerated/theatrical manner, usually in a show or theatre setting.

Dyke:
Derogatory slang terms used to identify lesbians. This term has been embraced and reinvented as a positive, proud, political identifier when used by lesbians among and about themselves. See: faggot, queer.
Faggot:
Derogatory slang used to identify gay men, which has been embraced and reclaimed as a positive, proud, political identifier when used by gay men among and about themselves. See dyke, queer.

Gay:
Usually, but not always, refers to homosexual men. Also used as an umbrella term for the LGBT community.

Gender Identity:
How a person perceives and what they call themselves; may or may not agree with societal gender roles outlines for their sex; typically masculine/feminine. Coincides with what doctors and/or society have prescribed for that person or can also refer to a multitude of expression like femme, boy, faggot, leather, androgyous, leather, etc.

Genderqueer:
Any LGBT person whose gender presentation is an intentional mixture of gender signifiers, usually a political identity in support of transgender persons and against the binary gender system.

Gender Role:
The societal and cultural expects of people based upon their biological sex.

Hate Motivated Offenses:
Assault, rape, arson, and murder are crimes under any circumstance, but when a victim of such a crime was targeted simply because of their affiliation (or perceived affiliation) with a minority group, the FBI considers the crime a 'hate crime.' In some states, hate crimes carry an additional penalty beyond the standard penalty for assault, murder, etc. Also known as "gay-bashing", acts of intolerance, or hate crimes.

Heterosexual:
A person who has emotional, physical, spiritual, and sexual attractions to persons of the "opposite sex". The sexuality that dominant discourse prescribes.

Heterosexual Privilege:
Advantages that come with heterosexuality in this society and culture; i.e.:> Marriage and all the benefits that go along with it, acceptance from family, safety, and acceptance in their chosen career field.

Heterosexism:
The belief that all people are heterosexual, the assumption and/or belief that heterosexual relationships and behavior are superior, and the actions based on this assumption.

Homosexual:
A person who has emotional, physical, spiritual, and sexual attraction to persons of the "same
"sex". More of a medical term, it is considered an outdated term when referring to gay people or communities.

**Homophobia:**
Fear, anger, discomfort, intolerance, or lack of acceptance toward LGBT people, or experiencing these feelings about one's own non-heterosexual preference.

**Human Sexual Response:**
Behaviors, thoughts, dreams, fantasies; not just behavior.

**Intersexed:**
People born with "unexpected" genitals. Formerly referred to hermaphrodites, intersexed people are not easily categorized as male or female because of ambiguous genitals. Most intersexed people do not possess "both" sets of genitals, rather a blending or a different appearance that is medically unacceptable to most doctors. Intersexuality is fairly common. Many who identify as intersexed believe that early childhood surgical intervention is not only unnecessary but cruel and advocate counseling and support for children and families.

**Lavender:**
This association goes back into ancient times and has been strengthened by the fact that lavender, or purple, is the combination of red (pink) and blue, the traditional gender-identified colors.

**Lesbian:**
A woman who has emotional, physical, spiritual, and sexual attractions to other women.

**Lifestyle:**
How a person chooses to live and behave. Being LGBT is not a choice, and therefore is not considered a lifestyle (ie: yuppie, vegan, hobbies, rural/urban, etc.).

**Normal:**
Can refer to what is statistically more common, but is often confused by heterosexuals to refer to whatever it is that they condone morally. Only the individual can decide what is normal for them and it need not be what is normal to others.

**Outing:**
To declare a person's identity publicly; people can out themselves, or someone can out them either with or without their permission.

**Pride:**
Not being ashamed of oneself and/or showing your pride to others by coming out, marching, etc. Being honest and comfortable.

**Rainbow Flag:**
In 1978, San Francisco artist Gilbert Baker designed a flag for the city's Gay Freedom
celebration and LGBT movements worldwide have since adopted it as a symbol of gay identity and pride. It has six stripes in the traditional form, but can be seen as streamers, etc., which run in the order of red, orange, yellow, green, blue, purple. The flag also symbolizes diversity within unity.

Questioning:
The process of exploring one’s on sexual identity, including but not limited to one’s upbringing, expectations from others (family, friends, church, etc.), and inner motivation.

Queer:
Derogatory slang terms used to identify LGBT people. This term has been embraced and reinvented as a positive, proud, political identifier when used by LGBT people among and about themselves. See dyke, faggot.

Sexual Orientation:
To whom a person is erotically attracted. Not to be confused with sexual preference: What a person likes to do sexually.

Stonewall:
On June 28, 1969, NYC police attempted a routine raid on the Stonewall Inn, a working class gay and lesbian bar in Greenwich Village. Unexpectedly, the patrons resisted, and the incident escalated into a riot that continued for several days. Most people look to this event as the beginning of the American Gay Liberation movement and all subsequent LGBT movements.

Transgender:
An umbrella term for people who transgress society’s view of gender and biological sex as necessarily fixed, unchanging, and following from one’s biological sex. They view gender on a spectrum, rather than a polarized, either/or construct. This can range from identification to cross dressing, to undergoing hormone therapy, to sex reassignment surgery and/or to other forms of dress/presentation. Transgender people can include transsexuals, cross-dressers, drag kings/queens, masculine women, feminine men, and all those who defy what society tells them is appropriate for their “gender”. Political trans activists seek to create more space around gender, and to create a space and a society where the choice of gender expression/presentation is safe, sane, and consensual.

Transsexual:
A person whose core gender identity is “opposite” their assigned sex. Transsexuals may live as the opposite sex, undergo hormone therapy, and/or have sex reassignment surgery to “match” their bodies with their gender identity.

Transvestite:
A person who cross-dresses for erotic pleasure or relaxation.
References


CHAPTER V

SUMMARY

The purpose of this scholarly project was to examine if there was a need to provide clinicians and students with resource guidelines for working with the LGBT population. A need was determined based on the literature review. It was noted that clinicians, within the research studies presented in Chapter II, felt that they were unprepared to address issues regarding sexual orientation and gender identity. The *Occupational Therapy Cultural Competency Resource* was created to provide clinicians and students with an accessible tool that may facilitate increased comfort level of clinicians working with LGBT clients.

**Proposal for Implementation**

The product of this scholarly project is intended for multiple uses but the primary focus is on being a resource for students and clinicians to assist in developing cultural competency for working with the LGBT population. The resource guidelines can also be applied in academic courses to initiate the discussion of sexual orientation and gender identity and methods for providing client-centered care. Lastly, the product is intended to be adapted by clinicians and students in order to fit their appropriate settings and needs. It is important to note, this is only a starting point.
Project Outcomes

The plan is to distribute the resource guidelines to health professionals who are knowledgeable in the area of LGBT health. The purpose is to obtain feedback and recommendations for upcoming projects. In addition, research should be conducted to determine the efficacy of the resource guidelines. The resource guidelines provide occupational therapists an opportunity to begin gaining cultural competency when working with LGBT clients through guided self-reflection. Additional resources to access, if the student or clinician needs assistance, are readily available at the end of the product.

Limitations

A primary limitation was the limited research and general literature in occupational therapy. Research that currently exists in the field of occupational therapy indicated that students and clinicians feel that they are not prepared to address sexual orientation and gender identity with clients as presented prior.

Conclusions

In conclusion, this scholarly project is based on a large literature review and informal conversations from various experts throughout the country. The authors hope to continually update and modify the resource guidelines to meet the needs specifically addressed by the LGBT community. In addition, the authors plan to educate the occupational therapy profession on developing greater cultural competence to work with this population by submitting proposals to present at the national conference as well as state conferences. The journey that this project has taken these authors through has instilled the importance of continued education and advocacy.
Recommendations for Future Action

The authors of this project intend to continue researching the role of occupational therapy with the LGBT population and plan to submit the resource guidelines for publishing to the Gay and Lesbian Medical Association. Future projects could include guidelines for specific areas of practice such as school, psychiatric, assisted living, and community-based settings. In addition, further research needs to be conducted in both areas of cultural competency and working with the LGBT population to increase support in the occupational therapy profession. This project has the potential to increase collaboration within the field of occupational therapy for developing research, and to increase collaboration with organizations that are devoted to eliminating health disparities related to the LGBT population. Other recommendations are for ACOTE standards to include cultural competency in academic education, and for AOTA to utilize the Networker as a source for increasing awareness and knowledge of LGBT issues in the occupational therapy profession. It is the duty of the profession of occupational therapy to implement a broader concept of sexuality into the curriculum. Additionally, education should take place globally with continued education regarding the LGBT population for practicing occupational therapists.
REFERENCES


