

**CRITICAL ISSUES IN PRACTICE WITH
GAY, LESBIAN, BISEXUAL AND TWO-SPIRIT PEOPLE
EDUCATIONAL MODULE FOR PROFESSIONALS
IN THE FIELDS OF HEALTH AND ALLIED HEALTH**

Shari Brotman and Bill Ryan

McGill School of Social Work

March 2001

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Why Do We Need a Distinct Module on Gay, Lesbian, Bisexual and Two-Spirit (GLBT-S) People's Health?

It has been well documented in recent years that positive interactions between gay, lesbian, bisexual and Two-Spirit¹ (glbt-s) people and their health care providers are critical to supporting the development of appropriate health care utilization and to promoting health and well-being by these individuals and communities. Despite this, health care providers still know very little either about the global health and well-being of glbt-s people or about how best to develop appropriate and relevant affirmative² health services for them.

There are tremendous barriers to the development of positive health care encounters between health care providers and their glbt-s patients/clients. This is so for a variety of reasons. First, glbt-s health care has historically been marked by experiences of oppression and exclusion. Because glbt-s people have been socially defined within medical terms as mentally ill³, the health care system has been one of the primary arenas through which control over their lives was exerted. For glbt-s people, this has resulted in an uneasy relationship with and lack of trust of the health care system.

The legacy of this "ideology of pathology" is still evident in health systems, albeit often in a manner which is far less overt than in years past. At best, discriminatory practices and attitudes have been replaced by an environment of silence. What this means is that glbt-s patients/clients are frequently treated "just like everybody else", with no special attention placed on their particular needs or realities. In the experiences of glbt-s patients/clients, this inattention to sexual orientation can be equally harmful, particularly when environments continue to be marked by neglect, homophobia and heterosexism⁴. Under these circumstances, glbt-s patients/clients may feel forced to remain hidden in health care encounters, thus reducing the value of the interaction and eroding the process of building trust.

Second, there is little information available on the health issues facing glbt-s people. The absence of documentation on the global health needs of glbt-s people can be traced to the historic and current oppression they face within society generally and within health and social service institutions specifically. Historically, health research on glbt-s people, where it did exist, was used as a tool to support the efficacy and

¹ The definition of Two-Spirit people is provided on page 9.

² The term «affirmative» in the context of the current study refers to articulations of support to glbt-s people that range in degree from openness to solidarity.

³ This status was reinforced by the inclusion of homosexuality as a mental disorder in the Diagnostic and Statistics Manual of the American Psychiatric Association up until 1973.

⁴ The term "homophobia" was coined in 1973 by George Weinberg (*Society and the Healthy Homosexual*. Garden City, NY: Anchor). For him, homophobia is the irrational fear, hatred and intolerance of homosexuals. For Simkin (1993), heterosexism is the assumption that heterosexuality is the norm and that any other form of sexual expression is deviant (*Creating Openness and Receptiveness with Your Patients: Overcoming Heterosexual Assumptions*. The *Canadian Journal of Obstetric/Gynecology Women's Health Care*, 5(4), 485-489).

appropriateness of interventions designed to “heal” them from their so-called unhealthy same-sex attractions. This data is of little use to today’s health care practitioners who are interested in supporting their glbt-s patients/clients. Indeed, “conversion therapies” are now condemned by most professional mental health agencies.

In recent years, there has been a growing body of research on glbt-s health and health care undertaken by glbt-s health activists and their allies. Unfortunately, much of this research is not published in professional journals, rather it is housed in gay and lesbian health centres across North America. As a result, family physicians and other health care providers, unless attached to these centres, do not gain access to this information. Compounding this problem, is the fact that few educational or professional institutions make information on glbt-s health available to their students or members. There is a significant lack of content in academic programs related to sexual orientation. The de-pathologization of homosexuality in academic environments has largely meant that the «pathology of homosexuality» once taught in our university programs has been replaced by absolute silence. In this context, assumptions continue to be made based on old discourses – silence is also teaching something. The result of this reality is that, far too often, health care providers interested in developing affirmative practices are forced to work in a vacuum with respect to their glbt-s patients/clients. While most health care providers want to develop best-practice for all patients/clients, knowing what to do to achieve this goal is often out of reach.

This module is designed to enhance the development of professional expertise and practice excellence in the field of glbt-s health and health care. Participants will engage in a participatory learning process which incorporates the following questions or themes:

- Health and psycho-social issues faced by glbt-s people and how these are currently being addressed (with particular attention to the response of the health and allied health professions).
- Current met and unmet needs for services to glbt-s people.
- Service modalities which would best address these needs.
- Role of health and allied health professionals in addressing individual and community needs.
- The record of the health and allied health professions in the area of glbt-s services.
- Critique of traditional practice models in relation to the needs of glbt-s people.
- Field’s current understanding of “best practice” in regards to work with glbt-s people.

Participants will have the opportunity to engage with these themes through a review of relevant literature, in-class discussion and lectures. The goals of the course are to: increase awareness of the health and psycho-social issues of glbt-s people; identify ways in which practice can be transformed, and; suggest avenues for improving treatment options to these populations. By doing so, health care providers and systems can better meet the needs of glbt-s patients/clients, thereby improving the health and well-being of glbt-s people and communities.

Who is the GLBT-S Module For?

This module is designed for any health care provider interested in improving their practice with glbt-s people and communities. It includes anyone from health and allied health professions such as physicians, psychologists, sexologists, social workers, nurses, occupational therapists, physical therapists and support staff.

What Does the GLBT-S Module Cover?

This module covers key issues with respect to building knowledge about glbt-s communities, identifying barriers to care and improving practice. Areas covered include: defining concepts and populations; understanding the history of the treatment of homosexuality in society and by health systems and the impact of this treatment upon glbt-s people's relationship with health and social services; understanding the role of activism in the health and well-being of glbt-s people; gender and ethno-cultural diversity in glbt-s communities; the central role of coming out on glbt-s people's well-being and the impact of coming out to the health care encounter; life cycle issues; special health issues such as HIV, gay and lesbian health, addictions and substance abuse, mental health, depression and suicide, and; adapting practice.

What is the Format of the GLBT-S Module?

The GLBT-S Module is a series of 5, 3-hour sessions. The format of the sessions combine both lectures and group activities such as role plays, case studies and exercises in order to support the integration of material for practice. Sessions are designed to be didactic and participatory in nature, emphasizing a hands-on learning format. Sessions support building on the expertise of individuals in the group through discussion and sharing of information. People knowledgeable in the field teach all sessions.

Description of Sessions

Session 1: Introduction to Gay, Lesbian, Bisexual and Two-Spirit People and Communities

This session introduces participants to key concepts and ideas necessary to understanding current health issues facing glbt-s people. It provides the foundation for common understanding of issues and dilemmas faced by glbt-s people that will be covered in sessions 2-5. The session begins by defining terms and populations. Special attention is placed on recognizing and identifying diversity within glbt-s communities, particularly with respect to gender, ethnicity and race. The session also gives a short history of the social attitudes towards homosexuality in Canada and identifies institutional practices that contribute to discrimination against glbt-s people. The concepts of homophobia and heterosexism are defined and explored. Finally, the session ends by tracing glbt-s people's fight for human rights and recognition over the past three decades.

What We Need to Know:

Defining Concepts
History
Extent of the Problem
Defining Populations
Diversity within GLBT-S Communities
Who Are Two-Spirit People?

Practicing What We Have Learned:

Before Stonewall: The Movie
Identifying Our Sexual Orientation: Assumptions and Responses
Seeing the "Invisible" Privilege in Our Lives: Questions for Heterosexuals in a Heterosexist World

Session 2: The Impact of Coming Out on Health and Health Care Access

There is a direct relationship between the degree of affirmation of one's sexual orientation and health status; the more one is self-affirmed, the more likely one is to be physically and psychologically healthy. Affirmation is achieved through a process of personal and public disclosure called "coming out". In spite of its reported importance, however, coming out has been identified as the most problematic component in consulting a health care professional or gaining access to treatment. In fact, health care providers tend to underestimate the proportion of glbt-s people in their practice, because of patients'/clients' reluctance to disclose. This reluctance is often based upon the fear that disclosure will result in hostile or inappropriate treatment on the part of the service provider. Exposure to homophobic and heterosexist attitudes and practices both inside and outside health systems contributes to patients'/clients' perceived need to stay

hidden during interactions with their health care providers and often results in avoiding and delaying medical care and examinations. Patients/clients do often find the courage and/or safety to come out to their health care providers and the literature suggests that those who come out in affirmative environments report feeling more satisfied with treatment. Given the central importance of coming out to the experience of health, health care access, health care utilization and satisfaction with services, this session takes an in-depth look at the coming out process, models of coming out and the ways in which these relate to health.

What We Need to Know:

Benefits of Coming Out for Health
Strategies and Methods for Coming Out
Diversity in the Experience of Coming Out
Barriers to Coming Out

Practicing What We have Learned:

Models of Coming Out Exercise
Case Study: Coming Out to the Family

Session 3: Gay, Lesbian, Bisexual and Two-Spirit People Through the Life Cycle

There are as many ways of being gay, lesbian, bisexual and Two-Spirit as there are glbt-s individuals. The contexts in which glbt-s people live out their lives are unique and diverse. They are young and old, they live in couples and alone, in rural and urban settings, they have families, friends, children and grandchildren. But while each individual glbt-s person is unique, they share in common the experience of living with and managing oppression and exclusion. This has had a marked impact on their lives and their ability to self-affirm across the life span. Despite this, glbt-s people have survived, flourished and created individual, familial and community identities. It is important for all health care providers to understand the realities that glbt-s face, both those issues they share in common with heterosexual people and those which are unique to their experience as glbt-s. There is a growing body of research that documents the needs and experiences of glbt-s people throughout their lives. This session addresses glbt-s people across the life span, highlighting the ways in which they have coped with and adapted to life cycle stages and changes, while managing the added burden of discrimination. Such issues as identity formation among youth and young adults, couple concerns, creating families, having children, and growing old are discussed with an emphasis on improving understanding of glbt-s people in order to enhance health care practice.

What We Need to Know:

Youth and Young Adults
Aging

Relationships
Families

Practicing What We Have Learned:

Case Study: Dealing With Youth Who Disclose

Case Study: Parenting Annie

Case Study and Role Play: The Story of Carrie and Anne: Long-Term Care Crisis

Session 4: Special Issues in Health

The mental stress, lowered self-esteem and social isolation which result from hiding one's sexual orientation often lead to increased risks for physical and mental health problems, substance abuse and addictions, suicide and engagement in high risk behaviours. This session highlights some of the particular health issues facing glbt-s people. It identifies physical health concerns that providers should be aware of and addresses mental health issues facing glbt-s people and communities. Emphasis is placed on understanding the relationship between increased health risks and the stresses of living in homophobic and heterosexist environments.

What We Need to Know:

Gay Men's Health

Lesbian Health

Addictions and Substance Abuse

Mental Health

Practicing What We Have Learned:

Case Study and Role Play: Delaying Medical Care

Case Study and Role Play: Daniel in Detoxification

Case Study: Refusal to Treat

Session 5: Adapting Practice

The final session brings together all the information learned throughout the module and explores the means by which health care providers can adapt practice. It takes a focused look at the ways in which providers can increase knowledge, improve communication and environments, support patients/clients and their loved ones and advocate for change. The goal of the final session is to give participants tools and ideas for creating best-practice in their settings.

What We Need to Know:

Building Affirming Environments

Increasing Knowledge and Expertise

Building Better and More Open Communication
Improving Documenting and Recording
Improving Referral Practices
Supporting Partners, Family and Friends
Advocating for Patients, Clients, Colleagues and Communities
The Benefits and Risks of Improving Practice

Practicing What We Have Learned:

Video Role Play: Jane and the Gynecologist
Video Role Play: Jane and the Psychologist
Video Role Play: Gary and Michael and the Social Worker
Video Role Play: Peter and the Nurse

SESSION 1: INTRODUCTION TO GAY, LESBIAN, BISEXUAL AND TWO-SPIRIT PEOPLE AND COMMUNITIES

This session introduces participants to key concepts and ideas necessary to understanding current health issues facing glbt-s people. It provides the foundation for common understanding of issues and dilemmas faced by glbt-s people that will be covered in sessions 2-5. The session begins by defining terms and populations. Special attention is placed on recognizing and identifying diversity within glbt-s communities, particularly with respect to gender, ethnicity and race. The session also gives a short history of the social attitudes towards homosexuality in Canada and identifies institutional practices that contribute to discrimination against glbt-s people. The concepts of homophobia and heterosexism are defined and explored. Finally, the session ends by tracing glbt-s people's fight for human rights and recognition over the past three decades.

What We Need to Know:

Defining Concepts

(Based upon: Project Interaction (2001). Community Needs Assessment of Montreal's GLBT-S Communities. Montreal: QC: McGill School of Social Work)

Sexual orientation: A characteristic of an individual that describes the people he or she is drawn to for satisfying intimate affectional and sexual needs – people of the same sex, opposite sex or both sexes. Sexual orientation encompasses sexuality, emotionality and social functioning.

Sexual preference: This relates to “doing” – sexual activities, attraction, desire, romance and intimacy, regardless of sexual orientation.

Gender identity: An individual's subjective sense of self as male or female.

Transgender: An umbrella term encompassing the diversity of gender expression, including drag queens and kings, bigenders, crossdressers, transgenderists, and transsexuals. Those who identify as transgender find their gender identity to be in conflict with their anatomical gender.

Gay: Males who have (almost exclusive or exclusive) feelings of affection and attraction, both emotionally and physically, for other males. Gay is also an inclusive term used by many people to describe anyone who is not heterosexual.

Lesbian: Females who have (almost exclusive or exclusive) feelings of affection and attraction, both emotionally and physically, for other females.

Bisexual: Those who have feelings of affection and attraction, both emotionally and physically, for both males and females.

Two-Spirit: Much evidence indicates that Native people, prior to colonization and contact with European cultures, believed in the existence of three genders: the male, the female and the male-female. The term Two-spirited or Two-Spirit was derived from interpretations of Native languages used to describe people who displayed both characteristics of male and female. Being given the gift of two-spirits meant that this individual had the ability to see the world from two perspectives at the same time. This greater vision was a gift to be shared with all, and as such, Two-spirited beings were revered as leaders, mediators, teachers, artists, seers, and spiritual guides. The arrival of the Europeans was marked by the imposition of foreign views and values on Native spirituality, family life and traditions. Two-spirited people were often beaten, killed or driven out of their homes and communities by European colonizers. Colonization fundamentally shifted the place and perception of Two-spirited people within their own communities, often resulting in isolation and shame. In order to survive, Two-spirited people, their identities and culture increasingly moved underground. This term of ancient usage is being reclaimed by many gay, lesbian, bisexual, and transgendered aboriginal people today to invoke remembrance of a time before colonialism and the exploitative contact with Europeans when Two-spirited people were honoured (Meyer, F., Goodleaf, S., Labelle, D. (2000) Project Interaction Website. Montreal, QC: McGill School of Social Work).

Queer: A new and fluid identity label, queer incorporates ambiguity into definitions of gender identity and sexual orientation. It is a re-appropriation of a traditional “put-down” and explores new combinations of identities and pluralistic forms of sexual expression. At the same time, the term queer is meant to gather resistance to all forms of heterosexist oppression.

Coming Out: To be “out” refers to telling yourself and/or others about your gay, lesbian, bisexual or Two-Spirit orientation. Coming out is a process which continues to take place over time.

Homophobia: The irrational fear, hatred and intolerance of homosexuals.

Heterosexism: The presumption that heterosexuality is the norm and that any other form of sexual expression is deviant.

History:

(Based upon: Kinsman, G. (1984) *The Regulation of Desire: Sexuality in Canada*. Montreal, QC: Black Rose Books)

While the entire history of the existence and treatment of glbt-s people is too long to document here, several concepts are important to understand the context of glbt-s people’s lives. In modern times, glbt-s people were characterized through the following four lenses:

UNNATURAL: This claim was made to underpin the notion that homosexuality was a sinful act, denying the existence of homosexual behaviour within the animal kingdom (except in unnatural situations like farms, zoos, cages and laboratories). Only in the last few decades norms for animal studies require observing animals in natural

environments. In their natural environments most animal species show heterosexual, homosexual and bisexual behaviours.

MORTAL SIN: In different periods of Christian history, and indeed in more liberal churches today, homosexuality was tolerated and even celebrated. In the Middle Ages, for various reasons including the Bubonic Plagues and the Protestant Reformation, all sexual activity that was not procreative (homosexuality, oral sex, masturbation and contraception) was outlawed.

MENTAL ILLNESS: In the late 19th century as the power of the Church over universities and their teaching waned, independent sciences were born. The new sciences of psychology, psychiatry, sexology, etc., who could not use a theological term like “sin” to characterize homosexuality, determined that homosexuality was a mental disorder. Indeed the term “homosexual” itself was coined in this period, long before the term “heterosexual”. In 1973 the American Psychological Association removed homosexuality from the Diagnostic and Statistical Manual, and in 1992 the World Health Organization removed homosexuality from its list of mental disorders. In 1998 the American Psychiatric Association decreed that it was unethical for any professional to attempt to treat homosexuality as a pathology.

CRIME: In Canada until 1855 homosexuality was punishable by death, and until 1955 was treated as a serious crime with prison sentences imposed. In 1969 the Canadian Parliament decriminalized all sexual activity between consenting adults in private, including homosexual sexual activity.

While the source of these claims vary, they are rooted to the location of power within various societies over the past few hundred years. Describing homosexuality in these ways exemplifies the various roles of Church, Medical Systems and the State in social and population control.

Glb-t-s people have been organizing against these claims for decades. The first public organizations for homosexuals in North America date back to the 1940's. Gay liberation gained momentum in the early 1970's alongside black power and feminist movements. Gay liberation activists focussed on human rights issues such as recognition, equity and access.

Important Dates:

1940's-1950's:

- Men and women returning from the war effort (in theatres of war or in factories in Canada) to their towns and cities were encouraged to readopt traditional roles in society. Many gay men and lesbians, who had discovered that there were others like themselves began small underground movements across the country.

1969:

- In Canada homosexuality was decriminalized by the Omnibus Bill passed by Parliament. In the United States, due to patrons at a gay bar fighting arrest and oppression, the Stonewall Riots as they came to be known, galvanized the divergent gay and lesbian groups into a movement – the Gay Liberation Movement. Stonewall is observed worldwide as a defining moment in modern gay and lesbian history.

1976:

- Before the arrival of athletes and tourists for the Montreal Olympic Games, Mayor Drapeau asked the Montreal Police to clean up the undesirables of Montreal. Included were sex trade workers, street people and homosexuals. Hundreds of men were arrested in raids on gay bars. The resultant protests, complaints, and activism led to the Quebec government introducing sexual orientation as a prohibited grounds of discrimination in 1977 – the first in Canada and the second jurisdiction in the world to do so.

1977-1998 :

- During this period all provinces, territories and the federal government prohibit discrimination on the basis of sexual orientation, some of their own volition, some due to a decree of the Supreme Court of Canada which stated that:

“Gays, lesbians and bisexuals, as individuals or as couples, form an identifiable minority, which is still today victim to serious social, political and economic inequities.” (Egan vs. Canada (1995 2 R.C.S. 513)

1999:

- The Supreme Court of Canada declares that any provincial law recognizing common law relationships that does not extend equality to same-sex couples is unconstitutional.

The Continuum of Attitudes Towards Homosexuality

(Based upon: Ryan, B. (1999). Course notes: Critical Issues in Social Work with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

Attitudes towards homosexuality range on a scale from the most overt forms of hatred to alliances based upon recognition and respect. The continuum presented here addresses this range of attitudes which are made manifest in individual beliefs, institutional practices and government policies.

Homophobia Heterosexism Indifference Tolerance Solidarity

Defining the Population

Using the Kinsey Scale... how many people are homosexual?

Kinsey was the first sociologist to study homosexuality in the population from a non-pathological/deviance perspective. His studies in the 1950's on the incidence of male homosexuality in the general population led to the widespread view that approximately 10% of all people have a homosexual orientation. Many researchers have repeated or adapted Kinsey's scale to document the incidence of homosexuality since that time. However, it is impossible to validate various estimates of the percentage of gay men, lesbians and bisexuals among the general population, because of both the methods employed in research and the high risk of stigmatization experienced by this minority, which is an important inhibitor of their self-identification as gay, lesbian or bisexual.

Kinsey Scale- The data below is an example of more recent applications of the scale in research on prevalence. (Based upon: Klein, F., Sepekoff, B., Wolf, T. (1985). Sexual Orientation: A Multi-Variable Dynamic Process. Journal of Homosexuality 11(1/2), pp. 35-49)

0: Exclusively other-sex oriented in behaviour and psychological response	50%
1: Incidental same-sex behaviour	15%
2: More than incidental same sex behaviour	12%
3: About equal amounts of same-sex and other-sex behaviour	9%
4: More than incidental other-sex behaviour	6%
5: Incidental other-sex behaviour	4%
6: Exclusively same-sex oriented in behaviour and psychological response	4%

Diversity Within GLBT-S Communities

(Based upon: Ryan, B., Brotman, S., Rowe, B. (2000). Access to Care: Exploring the Health and Well-Being of Gay, Lesbian, Bisexual and Two-Spirit People in Canada. Montreal, QC: McGill Centre for Applied Family Studies)

Gay, lesbian, bisexual and Two-Spirit people and communities are as diverse as the general population. We highlight the current North American research on three specific communities to exemplify this diversity: rural gay, lesbian and bisexual people; gay, lesbian and bisexual people from ethno-cultural minority communities; and, gay, lesbian and bisexual people with disabilities. Since this published research on diverse communities has not taken Two-Spirit people into consideration, we also provide a separate section on Two-Spirit people to highlight what is known about this particular population.

Rural dwellers

- ✓ Gay, lesbian and bisexual (glb) people living in rural areas tend to be invisible and are facing a hostile, homophobic environment that inhibits the development of their identity.

- ✓ Remaining unknown and invisible in rural areas appears to be a survival tactic for glb people, or a means of coping with non-acceptance, discrimination, oppression, and at times, physical and psychological violence.
- ✓ Glb people living in rural areas suffer from social and geographical isolation.
- ✓ In rural areas, the concept of a gay community is non-existent, whereas the concept of community ties is very pervasive.

People from ethno-cultural minority communities

- ✓ Knowledge of glbt-s people from ethno-cultural minority communities is very limited.
- ✓ Glb people from ethno-cultural minority communities appear to be struggling against heterosexism, homophobia and racism.
- ✓ Glb people from ethno-cultural minority communities suffer from isolation due to rejection by their communities of origin but also by glb communities.
- ✓ Glb people from ethno-cultural minority communities are underrepresented in samples.
- ✓ Studies of glb people from ethno-cultural minority communities are mainly US-based and not very representative of Canadian realities.
- ✓ Glb people from ethno-cultural minority communities are also coping with the coming out process, but in a context of acculturation and racism.
- ✓ There is little or no knowledge of health issues affecting glb people from ethno-cultural minority communities, and little or no information is available on their interactions with the health care and services system.

People with disabilities

- ✓ Glb people with disabilities face discrimination within the general population, within disability communities and within glb communities.
- ✓ Idealized notions of the body make it difficult for glb people with disabilities to find support and acceptance in glb communities.
- ✓ Glb people with disabilities face multiple oppression in health care encounters which make it more complex for them to come out in health care settings.
- ✓ Glb people with disabilities face a lack of recognition of their sexuality.
- ✓ Glb people with disabilities experience significant powerlessness, both societal and institutional.
- ✓ Few community spaces are accessible to glb people with disabilities.
- ✓ Glb people with disabilities have a long history of creating pride and identity through disability culture and political organizing.

Two-Spirit people

- ✓ Little research has been done on Two-Spirit people.
- ✓ Information on Two-Spirit people derives mainly from oral tradition, newspaper and magazine articles, poems, essays and novels.
- ✓ It appears that the majority of Aboriginal languages have a term to designate individuals considered to be neither men nor women.

- ✓ The terms “Two-Spirit” or “Two-Spirit people” appear to be more acceptable to many Aboriginals than the terms “berdache,” “amazon” or “gay/lesbian/bisexual.”
- ✓ Colonization and Christianity appear to be responsible for the exclusion of Two-Spirit people from certain Aboriginal communities.
- ✓ Two-Spirit people appear to be struggling against discrimination, homophobia, stigmatization and rejection by their own communities but also by the gay and lesbian community.
- ✓ As Two-Spirit people, it appears to be difficult to live on one’s reserve, but life in urban areas presents its own difficulties.
- ✓ There are few or no services and resources available for Two-Spirit people living in urban areas or on reserves.

Practicing What We Have Learned:

(1) Before Stonewall: The Movie

Sections of the film Before Stonewall, which describes life for gay and lesbian people in the United States prior to the modern day gay liberation movement, will be shown. The Stonewall Inn, a gay bar in New York, was the location of an act of unified public resistance by gay men and lesbians in the United States against the oppression of the police. On the night of June 28, 1969, during a routine police raid on the bar, gay men and lesbians stood up and fought back. This act became a spark for continued action and community organizing for glbt-s rights in the United States and around the world. Discussion after the film will centre on the issues facing glbt-s people prior to the development of public action and advocacy for human rights.

(2) Identifying Our Sexual Orientation: Assumptions and Responses

(Based upon: Ryan, B. (1999) Course notes: Critical Issues in Social Work with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

In this exercise, participants are asked to take on a particular sexual orientation that is assigned to them and then reflect on their personal reactions, both with respect to themselves and towards others around the room.

(3) Seeing the “Invisible” Privilege in Our Lives: Questions for Heterosexuals in a Heterosexist World

(Based upon: Lesbian, Gay, Bisexual Caucus, Maritime School of Social Work. Halifax, Nova Scotia)

This exercise highlights the ways in which privilege is assigned to heterosexual sexual orientation in visible and invisible ways. Participants will discuss items on a questionnaire with respect to themselves and their practice.

- If I wish I can put a picture of my partner on my desk, bulleting board, locker etc., at work without fear of harassment, exclusion or firing.
- I can easily buy posters, paintings, greeting cards, music, books, videos, magazines and children’s toys depicting people of my sexual orientation.

- I have never received a death threat because people in my community knew of my sexual orientation.
- People do not assume that I may sexually abuse children when they learn of my sexual orientation.
- I do not have to change my words when I talk about my partner so that other people won't know that he/she is my partner.
- If members of my family do not like my partner, I know that it isn't because of our sexual orientation.
- If I fall in love with someone who is not Canadian, I can apply to sponsor that person's move to Canada.
- As a child, I was shown positive images and role models of people of my sexual orientation, including single people, couples, families with children and extended families.
- I fit into one of the categories provided on most forms (single, married, widowed, divorced).
- The last time I began a new intimate, romantic relationship, I could discuss it with friends and family without considerable discomfort, silencing or outright rejection on their part.
- If I have or plan to have children, I can be reasonably sure my sexual orientation would not be a factor in a court decision on child custody.
- I can be reasonably sure that my children will not be treated poorly because of my sexual orientation.
- I can be oblivious to the existence, customs, culture and problems of lesbian and gay people without suffering any penalty for such oblivion.
- I have never feared or experienced being cut off by my family because of my sexual orientation.
- I am never asked to speak or represent all people of my sexual orientation.
- I can obtain the services of a physician, lawyer, family counselor, etc. who is of my sexual orientation, or who I know will be comfortable with, and knowledgeable about my sexual orientation.
- I can obtain housing where I will not be harassed, threatened, or evicted if neighbours and/or the landlords find out about my sexual orientation.

Articles Used for This Session:

Appleby, G., Anastas, J. (1998). Homophobia and Heterosexism: Understanding the Context of Gay, Lesbian and Bisexual Lives. (pp. 3-43). In *Not Just a Passing Phase: Social Work with Gay, Lesbian and Bisexual People*. New York, NY: Columbia University Press.

Brotman, S., Ryan, B., Jalbert, Y., Rowe, B. (2002). Reclaiming Space-Regaining Health: The Health Care Experiences of Two-Spirit People in Canada. *Journal of Gay and Lesbian Social Services*, 14 (in print).

SESSION 2: THE IMPACT OF COMING OUT ON HEALTH AND HEALTH CARE ACCESS

There is a direct relationship between the degree of affirmation of one's sexual orientation and health status; the more one is self-affirmed, the more likely one is to be physically and psychologically healthy. Affirmation is achieved through a process of personal and public disclosure called "coming out". In spite of its reported importance, however, coming out has been identified as the most problematic component in consulting a health care professional or gaining access to treatment. In fact, health care providers tend to underestimate the proportion of glbt-s people in their practice, because of patients'/clients' reluctance to disclose. This reluctance is often based upon the fear that disclosure will result in hostile or inappropriate treatment on the part of the service provider. Exposure to homophobic and heterosexist attitudes and practices both inside and outside health systems contributes to patients'/clients' perceived need to stay hidden during interactions with their health care providers and often results in avoiding and delaying medical care and examinations. Patients/clients do often find the courage and/or safety to come out to their health care providers and the literature suggests that those who come out in affirmative environments report feeling more satisfied with treatment. Given the central importance of coming out to the experience of health, health care access, health care utilization and satisfaction with services, this session takes an in-depth look at the coming out process, models of coming out and the ways in which these relate to health.

What We Need to Know:

(Based upon: Brotman, S. (1999) Course notes: Critical Issues in Social Work with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

- To be "out" refers to telling yourself and/or others about your gay, lesbian, bisexual or Two-Spirit orientation. Coming out is an ongoing process which continues to take place over time and which is adapted for various contexts.
- One is never fully out in all contexts. Since society assumes heterosexuality (heterosexist norm), glbt-s people have to consciously decide in each and every new encounter if and when they should disclose their sexual orientation. Decision to disclose is often based on one's ability to identify the level of acceptance/tolerance/solidarity towards homosexuality of individuals, institutions and communities. This process of constant assessment has been described by glbt-s people as exhausting and fraught with conflict.
- The risks of coming out in hostile or intolerant environments, thereby being exposed to homophobia and heterosexism, causes significant stress on glbt-s people and often forces them to focus more on assessing the safety of environments rather than on developmental achievements (such as education, employment, family, social networks, etc.). This contributes to lower life satisfaction and self-esteem among glbt-s people.

- Youth are particularly at risk for a variety of reasons. Adolescence is a time in which the exploration of personal and sexual identity is a part of normal development. It is crucial for youth to receive positive role modeling, support and guidance during this period of identity-formation. When youth are forced to deal with identity issues in a context of discrimination, isolation and non-acceptance, then the potential risks of developing damaging self-concepts and behaviour increases. Documentation shows that glbt-s youth are at a much higher risk for suicide, school drop-out and substance abuse than their heterosexual peers.
- The process of coming out for ethno-cultural minority and Two-Spirit people is seen as more complex because of the risk of marginalization and discrimination within one's own community as well as the risk of facing racism from gay and lesbian communities.
- Research indicates that women generally come out later than men, on average. Men tend to come out in their late teens or early twenties, while women tend to come out in their mid to late twenties.
- People who come out as elders face tremendous discrimination in health and social services and elder care institutions. Many older people have stayed hidden throughout most of their adult lives in response to environments of extreme hostility common prior to the development of the gay liberation movement.

Benefits of Coming Out for Health

(Based upon: Brotman, S. (1999) Course notes: Critical Issues in Social Work with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

- ✓ Improved self-esteem, self-acceptance, self-affirmation
- ✓ Reduced risk of physical and mental health problems, substance abuse and addictions, suicide and engagement in high risk behaviours
- ✓ Building of relationships based on honesty
- ✓ Increased likelihood of finding friends, community, belonging
- ✓ Increased personal advocacy for adapted treatment, demand to have needs met
- ✓ Appropriate and timely use of health services

Strategies and Methods for Coming Out

(Based upon: Tiemann, K. A., Kennedy, S. A., Haga, M. P. (1998). Rural lesbians' strategies for coming out to health care professionals, In *Gateways to improving lesbian health and health care – Opening doors*, Christy M. Ponticelli (Ed.), Harrington Park Press, New York, pp. 61-75)

- ✓ Screening, or the selection of individuals (friends, health care providers, etc.) sensitive to glbt-s issues
- ✓ Unplanned disclosure caused by a situation or an impromptu event that encourages or forces the glbt-s person to discuss his or her sexual orientation
- ✓ Planned disclosure used by individuals who think that it is necessary or desirable to be out
- ✓ Non-disclosure

The Steps to Self-Acceptance

(Based upon: Ryan, B. (1999) Course notes: Critical Issues in Social Work with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

- ✓ Questioning your feelings
- ✓ Acknowledging your feelings
- ✓ Exploring your feelings
- ✓ Accepting your feelings
- ✓ Feeling good about your feelings
- ✓ Integrating your feelings

Questioning Your Feelings: Am I? I can't be!

- ✓ Feelings of being marginalized
- ✓ Labeling and self-labeling
- ✓ Testing of peoples' attitudes
- ✓ Seeking information in secret

Acknowledging Your Feelings: I think I might be!

- ✓ Conflict between perceived self and social self
- ✓ Confronted by heterosexism and homophobia
- ✓ Evaluates possibility of being gay or lesbian

Exploring Your Feelings: I likely am!

- ✓ Exploration of social and sexual situations
- ✓ Differentiates from heterosexual youth
- ✓ Considers divulcation (who, when, how)

WATCH: Isolation, suicidal tendencies, self-destructive behaviours, vocabulary.

PROVIDE: Accompany don't diagnose, furnish information, clarify feelings

Accepting Your Feelings: I accept that I am!

- ✓ More interest in social/sexual exploration
- ✓ Coping strategies developed regarding duality
- ✓ Adoption of an ideology of legitimacy

WATCH: socialization, withdrawal from family, grieving process, vocabulary

PROVIDE: models, couple info, safe sex info

Feeling Good About Your Feelings: I am proud to be!

- ✓ Abandonment of absolute clandestinity
- ✓ Exaggeration of gay identity and pride
- ✓ «Us» and «them»

WATCH: sexual activity, over-investment in the community, ostracism

PROVIDE: affirmation of gay identity, critique of segregationism, holistic approach to components of personality

Integrating Your Feelings: I am at ease with myself, I am at ease with others.

- ✓ Consolidation of gay identity
- ✓ Establishment of relationships
- ✓ I am more than my sexual orientation

WATCH: coming out process, systemic discrimination, «gay adolescence», safe sex

Components of a Non-Heterosexist Approach

(Based upon: Ryan, B. (1999) Course notes: Critical Issues in Social Work with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

- ✓ Validate all relationship models
- ✓ Don't assume sexual orientation
- ✓ Be inclusive with all youth
- ✓ Heterosexuality does not guarantee happiness, homosexuality does not guarantee sadness
- ✓ Find the real problem, don't assume it is homosexuality
- ✓ Don't brush off homophobia (It is not a problem for me!)
- ✓ One homosexual experience doesn't make a homosexual and one heterosexual, a heterosexual.
- ✓ Accompany, don't diagnose.
- ✓ Tolerance or acceptance??

Practicing What We have Learned:

(1) Small Group Exercise: Models of Coming Out

(Based upon: Ryan, B. (2000) Course notes: Critical Issues in Practice with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

This exercise is designed to help participants integrate the information presented with the development of affirmative practice in health.

In Groups of 4 or 5, develop a model of coming out which would support the health and well-being of people. The model should be designed from the perspective of your particular profession. Consider your coming out model from a life-course perspective, examining how your model would need to be adapted for the following age groups: youth (adolescents), adults and/or elders.

Divide up into groups concentrating on the following:

Gay men or Lesbians
Gay men and Lesbians
Bisexuals

(2) Case Study: Coming Out to the Family

(Based upon: Ministère de la Santé et des Services sociaux (1993). Pour une nouvelle vision de l'homosexualité. Québec, QC: Gouvernement du Québec)

This exercise is designed to enable participants to articulate personal and professional values.

The success of this case study is not based on finding the correct answer. Allow yourselves to react spontaneously and honestly to the situations outlined below. The process we ask you to follow is one where you look at your emotional responses, your comfort and discomfort working with the client or situation, and your personal and professional values.

Your only son, 19 years of age, is studying in Ontario, away from home. Matthew is a young man who was always popular as a date with the young women of his high school, but he never really went steady with any particular girl. You consider it to be just part of his growing up and you are glad that he did not seem to want to settle down with one girl just yet. He has come home for the weekend. During supper he announces that he has something difficult and important he needs to discuss with you. Your immediate reaction is that you fear he wants to quit school. Instead he tells you that Christopher, his roommate, is also his boyfriend. He is in love and he wants you to know. He doesn't want to live in secret anymore. In fact he wants Christopher to spend Christmas with you and your relatives in a few months.

What would your initial reaction be?

How would you react as a parent?

How do you think the rest of the family would react?

How would you react to his wish to be open with his family about his relationship?

Articles Used for This Session:

Brotman, S., Ryan, B., Jalbert, Y., Rowe, B. (2002). The Impact of Coming Out on Health and Health Care Access: The Experiences of Gay, Lesbian, Bisexual and Two-Spirit People. *Journal of Health and Social Policy*, forthcoming.

Smith, A. (1997). Cultural Diversity and the Coming-Out Process: Implications for Clinical Practice (pp. 279-301). In Greene, B. (ed.) *Ethnic and Cultural Diversity Among Lesbian and Gay Men*. Thousand Oaks, CA: Sage.

Frappier, JY, Girard, M., Meilleur, D., Ryan, B. (1998). L'orientation sexuelle et l'homosexualité. In Michaud, PA, Alvin, P. (eds.). *La santé des adolescents: Approches, soins, prévention*. (pp. 314-323). Montréal, QC: Les Presses de l'Université de Montréal.

SESSION 3: GAY, LESBIAN, BISEXUAL AND TWO-SPIRIT PEOPLE THROUGH THE LIFE CYCLE

There are as many ways of being gay, lesbian, bisexual and Two-Spirit as there are glbt-s individuals. The contexts in which glbt-s people live out their lives are unique and diverse. They are young and old, they live in couples and alone, in rural and urban settings, they have families, friends, children and grandchildren. But while each individual glbt-s person is unique, they share in common the experience of living with and managing oppression and exclusion. This has had a marked impact on their lives and their ability to self-affirm across the life span. Despite this, glbt-s people have survived, flourished and created individual, familial and community identities. It is important for all health care providers to understand the realities that glbt-s face, both those issues they share in common with heterosexual people and those which are unique to their experience as glbt-s. There is a growing body of research that documents the needs and experiences of glbt-s people throughout their lives. This session addresses glbt-s people across the life span, highlighting the ways in which they have coped with and adapted to life cycle stages and changes, while managing the added burden of discrimination. Such issues as identity formation among youth and young adults, couple concerns, creating families, having children, and growing old are discussed with an emphasis on improving understanding of glbt-s people in order to enhance health care practice.

What We Need to Know:

Youth

(Based upon: Ryan, B., Brotman, S., Rowe, B. (2000). Access to Care: Exploring the Health and Well-Being of Gay, Lesbian, Bisexual and Two-Spirit People in Canada. Montreal, QC: McGill Centre for Applied Family Studies)

- ✓ It appears that the term “gay, lesbian, bisexual and Two-Spirit youth” may apply to different age groups and may be used to refer to people aged 14–30.
- ✓ Glbt-s people under 30 and glbt-s adolescents do not appear to be target clienteles of research on glbt-s people.
- ✓ Young gays and lesbians appear to be invisible and ignored by society, the public health system and research.
- ✓ The social and health problems of young glbt-s people appear to be intrinsically related to the coming out process and their acceptance of their own sexual orientation.
- ✓ Young glbt-s people appear to have more emotional, social and physical health problems than their heterosexual peers because of homophobia, heterosexism and the coming out process.
- ✓ Compared to older people, young glbt-s people have more difficulty negotiating the isolation and stigma associated with a homosexual identity.
- ✓ Suicide is a significant issue in the lives of young glbt-s people going through the coming out process.
- ✓ School does not seem to offer a safe environment for young glbt-s people.

- ✓ The primary and predominant sources of information on homosexuality for young glbt-s people are television and hearsay.
- ✓ Young glbt-s people appear to attach special importance to the confidentiality of the information they confide to their health care providers.
- ✓ Health care providers do not habitually inform young people of their right to confidentiality, which appears to inhibit young glbt-s people from disclosing their sexual orientation.
- ✓ Barriers to health care accessibility reported by glbt-s people include inappropriate language used by health care providers, absence or presence of questions on socio-sexual history, absence of educational and preventive literature directed at young gays, lesbians and bisexuals in health care establishments, the responses of health care providers, the failure to respect confidentiality, the ignorance of homosexuality among adolescents and the presence of heterosexism.
- ✓ Young glbt-s people apparently prefer to consult a health care provider with the same sexual orientation (apparently also preferring health care providers of gender and ethnicity that correspond to their realities).

Gay and lesbian parenting

(Based upon: Ryan, B., Brotman, S., Rowe, B. (2000). Access to Care: Exploring the Health and Well-Being of Gay, Lesbian, Bisexual and Two-Spirit People in Canada. Montreal, QC: McGill Centre for Applied Family Studies)

- ✓ Gay and lesbian families are invisible in US and Canadian national statistics.
- ✓ The most common means by which glbt-s people become parents are through previous heterosexual relationships.
- ✓ US and Canadian laws generally prevent or hinder adoption by gay and lesbian couples and individuals. Where laws are more open, attitudes of adoption workers often result in glbt-s people being discouraged from adoption.
- ✓ Many lesbians want to have children and artificial insemination appears to be the most frequently employed method.
- ✓ Discrimination apparently occurs in prenatal classes, medical follow-up care, fertility clinics, interactions with heterosexual couples, the gay and lesbian community, the family, society at large and so forth.
- ✓ Lesbians appear to be more satisfied with the services of midwives than physicians.
- ✓ Gay men wishing to become biological fathers face unique barriers and often create alternative arrangements such as co-parenting.

Dispelling Myths of GLBT-S Couples and Families

(Based upon: Ryan, B. (1999) Course Notes: Adolescent Psychiatry, McGill. Montreal, QC: McGill University)

Mental health of glbt-s Individuals

- ✓ GLBT-S people do not exhibit higher levels of psychopathology than heterosexuals.
- ✓ There is no evidence to suggest that glbt-s people are less healthy psychologically than heterosexuals.

Stability of glbt-s relationships

- ✓ There is no evidence to suggest that glbt-s people have unstable or dysfunctional relationships.
- ✓ GLBT-S Couple relationships are similar to those of heterosexual couples.
- ✓ Children raised by glbt-s parents will not be more frequently subject to loss.

Gender development, sexual orientation and general psychological adjustment of children of glbt-s parents

- ✓ Children of glbt-s parents develop gender roles within normal range.
- ✓ The great majority of children of glbt-s people are heterosexual as within society at large.
- ✓ Children show normal psychological development on various measures.

The effects of social stigma on children of glbt-s parents

- ✓ There is no indication that stigma is any worse than with other minority family situations.

Elderly people

(Based upon: Ryan, B., Brotman, S., Rowe, B. (2000). Access to Care: Exploring the Health and Well-Being of Gay, Lesbian, Bisexual and Two-Spirit People in Canada. Montreal, QC: McGill Centre for Applied Family Studies)

- ✓ Demographic studies on elderly people do not distinguish between gay men, lesbians and bisexuals.
- ✓ Elderly glbt-s people seem to be invisible not only in society and the media but also in the gay community.
- ✓ Rural and urban environments do not offer the necessary support networks, and this may affect the lives of elderly glbt-s people.
- ✓ Elderly glbt-s people appear to be in a better position than their heterosexual peers in regard to the stigma of aging since they have already lived through the stigma associated with their sexual orientation. In fact, it has been documented that elderly glbt-s people have a greater sense of independence, larger social support networks and a greater ability to advocate for appropriate services.
- ✓ Elderly glbt-s people do not appear to identify themselves in the same terms as younger people.
- ✓ Elderly glbt-s people appear to receive little support from glbt-s communities.
- ✓ Out elderly glbt-s people experience aging differently from their closeted peers.
- ✓ Menopause appears to be infrequently addressed in studies on lesbians.
- ✓ Elderly glbt-s people appear to be struggling against various myths and stereotypes.
- ✓ The cohort of gay men aged 40 to 50 today is perhaps smaller than past or future cohorts due to the AIDS epidemic.
- ✓ Elderly glbt-s people appear to be struggling against ageism and rejection on the part of younger glbt-s people.
- ✓ Contact with the gay community appears to favour the psychosocial adaptation of elderly glbt-s people to the aging process.
- ✓ Elderly glbt-s people have often coped with homophobic environments by remaining closeted. This was particularly necessary as they grew up in the era before gay

liberation. Practitioners should be careful not to force glbt-s elders to come out if this has been a mechanism of survival throughout their adult life.

Practicing What We Have Learned:

(1) Case Study: Dealing With Youth Who Disclose

This exercise is designed to enable participants to articulate personal and professional values.

The success of this activity is not based on finding the correct answer. Allow yourself to react spontaneously and honestly to the situation outlined below. The process we ask you to follow is one where you look at your emotional responses, your comfort or discomfort working with the client or situation, and your personal or professional values.

You work in a pediatric setting. At a multidisciplinary meeting, one of your nursing colleagues tells you that her patient, a 15 year old boy, has disclosed to her that he is interested in a boy at his school. She understood by his body language and expression that this interest was sexual in nature, although he didn't explicitly say so. She tells the team that she felt that it was important to address the issue directly with the teenager, to which your colleagues agree. She then states that she told the young man that it is quite normal at his age to have "crushes" on other boys but that he shouldn't confuse this with a sexual interest or that he is gay. In fact, she tells him that he should really try dating girls first because this is more accepted by society and that it's much easier to be heterosexual than homosexual. She assures him that he will like exploring sexual activity with members of the opposite sex and not to worry about his feelings for his male friend at school. She then gives him information on rates of suicide and depression among gay youth, which she says he has the right to know about. She hopes that this will discourage him from exploring his same-sex attractions. Your colleagues are silent.

Do you agree or disagree with the actions of your colleague?
How do you respond to her intervention?

(2) Case Study: Parenting Annie

(Based upon: Ministère de la Santé et des Services sociaux (1993). Pour une nouvelle vision de l'homosexualité. Québec, QC: Gouvernement du Québec)

This exercise is designed to enable participants to articulate personal and professional values.

The success of this activity is not based on finding the correct answer. Allow yourself to react spontaneously and honestly to the situation outlined below. The process we ask you to follow is one where you look at your emotional responses, your comfort or discomfort working with the client or situation, and your personal or professional values.

Elaine and Jane have been a couple for 10 years when they decide to adopt a little girl. They had to face many obstacles and due to the fact that their relationship has no legal status, the infant could only be legally adopted by one of them. For this reason, Elaine is the legal parent. Their little girl, Annie is now 5 years old. She has always called the two women Mommie (Elaine) and Mom (Jane). You work in a CLSC and among other things you are posted to the local elementary school. The principal of the school asks you to intervene with the two women because when they enrolled Annie at school, they both insisted that they be recognized as parents of the child. The principal says that this situation goes against the values preached by a Christian school and he would like you to clear up this problem.

As a worker, what is your first reaction to their situation?
How do you feel about the principal's request and comments?
What would you do? What is possible to do in this situation?
How could you ensure Annie is well integrated into school life?

(3) Case Study and Role Play: The Story of Carrie and Anne: Long-Term Care Crisis
(Based upon: Quam (1997). Social Services for Senior Gay Men and Lesbians. New York, NY: Harrington Park Press, pp. 97-99)

This exercise is designed to enable participants to articulate personal and professional values.

The success of this activity is not based on finding the correct answer. Allow yourself to react spontaneously and honestly to the situation outlined below. The process we ask you to follow is one where you look at your emotional responses, your comfort or discomfort working with the client or situation, and your personal or professional values.

Anne was a school teacher who began living with Carrie in 1951. Carrie was a nurse. She met Anne through mutual friends who thought that the two women had common interests. They got along so well that they decided to buy a house together. They found just the right house in the same neighbourhood where Carrie's sister and brother-in-law lived. Carrie and Anne never discussed the nature of their relationship with any family members and were very closeted in the ways in which they lived their lives. Anne described how, other than attending family gatherings, the two women socialized very little. They did have friends "of the same ilk" and they occasionally had "house parties" which were very private gatherings.

Two years ago, Anne fell and broke her hip and her arm, requiring considerable caretaking from Carrie. The hip did not heal well and Anne never fully recovered from the fall despite several surgeries. Anne agreed to go in for a hip replacement. But while Anne was hospitalized, Carrie had a stroke and became disabled. Meanwhile, Anne was ready to return home but since there was no-one to care for her she was sent to a nursing home.

Anne was distraught over her fear about what was happening to Carrie. A social worker was called in to talk to Anne about her depression. The worker contacted Carrie's family because she wanted to arrange a visit between Carrie and Anne and determine if it was possible for them to maintain a household again in the future.

Carrie's sister and brother-in-law refused to allow the visit saying that Anne was always upsetting Carrie. In fact, they had already decided that Carrie was unable to ever return home and were selling Carrie's house and all of the belongings.

As the worker, what is your first reaction to this situation?
What would you do? What is possible to do in this situation?

Now pick a partner and role play either a discussion between yourself and Anne at the nursing home or a meeting between yourself and Carrie's brother-in-law.

Articles Used for This Session:

Baum, M. (1996). Gays and Lesbians Choosing to be Parents (pp. 115-126). In Alexander, C. (ed.) *Gay and Lesbian Mental Health: A Sourcebook for Practitioners*. Binghamton, NY: Harrington Park Press.

Ryan, C., Futterman, D. (1998). Lesbian and Gay Adolescents: Experiences, Vulnerabilities and Risks (pp. 20-32). In *Lesbian and Gay Youth: Care and Counselling*. New York, NY: Columbia University Press.

Ramirez Barranti, C., Cohen, H. (2000). Lesbian and Gay Elders: An Invisible Minority (pp. 343-367). In Schneider, R., Kropf, N. & Kisor, A. (eds.). *Gerontological Social Work: Knowledge, Service Settings, and Special Populations* 2nd edition. Belmont, CA: Brooks/Cole.

SESSION 4: SPECIAL ISSUES IN HEALTH

The mental stress, lowered self-esteem and social isolation which result from hiding one's sexual orientation often lead to increased risks for physical and mental health problems, substance abuse and addictions, suicide and engagement in high risk behaviours. This session highlights some of the particular health issues facing glbt-s people. It identifies physical health concerns that providers should be aware of and addresses mental health issues facing glbt-s communities. Emphasis is placed on understanding the relationship between increased health risks and the stresses of living in homophobic and heterosexist environments.

What We Need to Know:

(Based upon: Ryan, B., Brotman, S., Rowe, B. (2000). Access to Care: Exploring the Health and Well-Being of Gay, Lesbian, Bisexual and Two-Spirit People in Canada. Montreal, QC: McGill Centre for Applied Family Studies)

Gay men's health

- ✓ Various diseases seem to affect gay men more often than heterosexual men, especially certain sexually transmitted diseases and HIV/AIDS.
- ✓ Research on gay male health appears to focus primarily on the problem of HIV/AIDS.
- ✓ Gay men, within the epidemiological category «men who have sex with men», have consistently been the group most affected by HIV infection since the beginning, in Canada. Epidemiological trends indicate that for the foreseeable future, gay men will continue to be, by far the group most affected by HIV and AIDS.
- ✓ HIV prevention priorities, programs and budgets at governmental and community levels have not been proportionate to the impact of HIV disease on gay men.
- ✓ Most strategies for HIV prevention in Canada have identified their targets as men who have sex with men (MSM), wishing to include gay men as an implicit subgroup within the broader MSM definition. In its implementation, a great deal of attention has been directed toward non-gay identified MSM on the presumption that gay men would take care of themselves, or be subsumed into the MSM category. The consequence of this exclusion of gay men has been the neglect of factors that account for HIV transmission among the population group that is most vulnerable to HIV infection.
- ✓ The development and availability of new and more efficient HIV treatments has led to a higher quality of life and has allowed many gay men living with HIV to continue or return to employment and active and visible roles within the gay and the wider community, as well as to active sex lives.
- ✓ Providers must acknowledge that most gay men feel well informed about the «facts» of HIV transmission but that effective risk reduction must take into account the societal, social, cultural and psychological contexts in which safer-sex decision making occurs.
- ✓ Research grants seem to be earmarked for gay sexual health issues, leaving aside other aspects of gay life.

- ✓ The most commonly reported social and health problems in gay men appear to be associated with the coming out and “pre-coming out” stages of self-acceptance.
- ✓ There are few studies on the incidence and prevalence of social and health problems among gay men.
- ✓ Knowledge of gay health issues after coming out appears to be limited to the aging process.
- ✓ There is a glaring absence of comparative studies on gay and heterosexual male health.
- ✓ Research has documented the health issues facing gay men include: isolation, depression, low self-esteem, suicidal ideation, substance abuse, HIV, STD infection, hepatitis A, B and C, gastro-intestinal infections, Hodgkin’s disease, anal and colon cancers, lung cancer and heart conditions.

Lesbian health

- ✓ In terms of gynecological problems, there do not appear to be any significant differences between lesbians and heterosexual women.
- ✓ Lesbians appear to suffer more frequently from vaginitis and irregular menstruation than heterosexual women.
- ✓ Many lesbians have had heterosexual relations in the past without the use of contraceptives or condoms.
- ✓ Screening for sexually transmitted diseases, breast cancer and cervical cancer appear to be often neglected by lesbians or their health care providers.
- ✓ Lesbians appear to be at lower risk of contracting HIV than heterosexual women.
- ✓ Lesbians appear to be more open to alternative medicine.
- ✓ Lesbians are still often considered to be at high risk for contracting HIV due to their association with gay men, but this belief is not borne out by epidemiological studies.
- ✓ HIV-positive lesbians were almost always infected either by unprotected sexual relations with men or by exchanges of contaminated needles.
- ✓ Woman-to-woman HIV transmission appears to be unlikely and only four cases have been reported in the US.

Substance abuse and addictions

- ✓ Studies which conclude that glbt-s people have higher rates of substance abuse and addictions must be read with caution because of problems in study design, sampling bias and inconsistent definition of terms.
- ✓ Substance abuse and addictions among glbt-s people may be linked to homophobia, depression and the coming out process.
- ✓ Alcohol and drug abuse appear to be factors linked to domestic violence among gays and lesbians.
- ✓ Drug consumption appears to decline with age.
- ✓ Glbt-s people are not well served by mainstream drug and alcohol programs.

Mental health

- ✓ Gblt-s people appear to engage in certain high-risk behaviours such as smoking, alcohol and drug abuse and unsafe sex.
- ✓ Gblt-s people appear to be at greater risk for depression and suicidal ideation. In a recent study over one third of gay men and lesbians identified depression as their top health concern. In a study on youth suicide, it was identified that 70% of gblt-s youth consider suicide and 30% make at least one serious suicide attempt.
- ✓ These mental health problems are directly related to the stigma and shame associated with living in a homophobic society.

Practicing What We Have Learned:

(1) Case Study and Role Play: Delaying Medical Care

(Based upon: Brotman, S. (2000) Course notes: Critical Issues in Practice with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

This exercise is designed to enable participants to articulate personal and professional values.

The success of this activity is not based on finding the correct answer. Allow yourself to react spontaneously and honestly to the situation outlined below. The process we ask you to follow is one where you look at your emotional responses, your comfort or discomfort working with the client or situation, and your personal or professional values.

Andrea, a 45-year old Two-Spirit woman, discovered a lump in her breast several months ago. She explains that she put off going to the doctor for as long as possible because of a particularly bad experience many years ago with her family doctor. She had revealed her sexual orientation to her family doctor, who asked her when she had stopped having “normal” relationships, and made a joke that made Andrea feel very uncomfortable. She had not been to see a doctor since that encounter. Last week, Andrea finally visited a clinic in her neighbourhood, and the doctor determined that she had advanced stages of breast cancer. Andrea is in a state of shock.

As a worker, what is your first impression regarding this situation?

What do we know/not know about Andrea? What do we need to know?

What approach would you use to help Andrea? What would you say and do?

What might you have done if you had met with Andrea six months ago?

What responsibilities do physicians have to their gblt-s clients? What responsibilities do gblt-s clients have?

Now pick a partner and role play the scenario between Andrea and her doctor. Focus on ways in which you can support Andrea in this time of crisis.

(2) Case Study: Daniel in Detoxification

(Based upon: Brotman, S. (2000) Course notes: Critical Issues in Practice with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

This exercise is designed to enable participants to articulate personal and professional values.

The success of this activity is not based on finding the correct answer. Allow yourself to react spontaneously and honestly to the situation outlined below. The process we ask you to follow is one where you look at your emotional responses, your comfort or discomfort working with the client or situation, and your personal or professional values.

Daniel is a 26-year old gay man who grew up in Montreal. Last week he overdosed on heroin and was taken to Emergency in an ambulance. The doctor at the hospital transferred him to a detox facility. He is required to spend his mornings in a therapy group. The group facilitator spends a great deal of time on the issue of the impact of addiction on family relationships. People are encouraged to talk about their relationships with their husbands or wives. Everyone is required to share their experiences but Daniel feels there is no space or openness in which to talk about his partner David. Daniel does not want to stay there. He explains that he wants to get clean, but that he is very uncomfortable in that particular facility. He tells you that he will leave the detox tomorrow if nothing changes, and he asks for your help.

As a worker, what is your first impression regarding this situation?

Do you think it is realistic to move Daniel somewhere else?

What do we know/not know about Daniel? What do we need to know?

What approach would you use to help Daniel? What would you say and do?

How might this crisis have been avoided?

What responsibilities do service providers have to their glbt-s clients? What responsibilities do glbt-s clients have?

Now pick a partner and role play this situation.

(3) Case Study: Refusal to Treat

This exercise is designed to enable participants to articulate personal and professional values.

The success of this activity is not based on finding the correct answer. Allow yourself to react spontaneously and honestly to the situation outlined below. The process we ask you to follow is one where you look at your emotional responses, your comfort or discomfort working with the client or situation, and your personal or professional values.

Martin is HIV-positive. He lives in a small community in rural Nova Scotia. He is afraid of people finding out about his HIV status because he does not want to be stigmatized by

his neighbours, community or professionals in the health care system. He travels to Halifax to see a doctor who treats him for HIV and only uses a local doctor for minor health issues, such as colds. He is in good health. Martin has an accident bike riding and is cut and bruised. Although the injuries are not life-threatening, Martin needs to go to the emergency room at the local hospital to get treatment. He feels that it is only ethical to tell the emergency room attendants of his HIV status. He is immediately asked to wait in a separate room for a doctor to see him, rather than in the waiting room amongst the other patients. He waits for a long time but no-one comes to see him, nor can he seem to get anyone to answer his questions. The attendant has placed a note on the door warning health care providers to use precautions when entering. Martin fears that, because of this sign, everyone in the community will soon know about his HIV status. He is scared and furious.

How do you feel about Martin's disclosure? Should he have told the staff about his HIV-positive status?

What do you think about the response of the staff?

Is this situation realistic, in your opinion?

How can rural areas be made safer with respect to confidentiality?

Articles Used for This Session:

Anderson, S. (1996). Substance Abuse and Dependency in Gay Men and Lesbians. *Journal of Gay and Lesbian Social Services*, 59-76.

Ball, S. (1996). HIV Negative Gay Men: Individual and Community Social Service Needs (pp. 7-24). In Shernoff, M. (ed.). *Human Services for Gay People: Clinical and Community Practice*. Binghamton, NY: Harrington Park Press.

Daley, A. (1998). Lesbian Invisibility in Health Care Services: Heterosexual Hegemony and Strategies for Change. *Canadian Social Work Review* 15(1), 57-71.

Greene, B. (1997). Ethnic Minority Lesbians and Gay Men: Mental Health and Treatment Issues (pp. 216-239). In Greene, B. (ed.). *Ethnic and Cultural Diversity Among Lesbian and Gay Men*. Thousand Oaks, CA: Sage.

SESSION 5: ADAPTING PRACTICE

The final session brings together all the information learned throughout the module and explores the means by which health care providers can adapt practice. It takes a focused look at the ways in which providers can increase knowledge, improve communication and environments, support loved ones and advocate for change. The goal of the final session is to give participants tools and ideas for creating best-practice in their settings.

What We Need to Know:

(Based upon: Brotman, S., Ryan, B., Rowe, B. (2001). Equity in Health Service Delivery to Gay and Lesbian Patients in the Context of Family Medicine. Montreal, QC: McGill School of Social Work)

What stops glbt-s people from using the health care system?

- ✓ Homophobia and heterosexism experienced by glbt-s patients/clients, both in the past and present, make them mistrustful of health care providers and systems and results in the avoidance or delay of seeking medical attention.
- ✓ When glbt-s people do use the health care system, they often avoid coming out in order to protect themselves from the homophobic and/or heterosexist attitudes of health care providers. This has a significant negative impact upon their health and well-being.

What makes glbt-s people more satisfied with care?

- ✓ Being able to come out to one's health care provider in an atmosphere of safety and trust significantly improves health care interactions between glbt-s patients/clients and their health care providers as well as increasing satisfaction with care.
- ✓ Other factors that improve satisfaction with care include; support, openness, knowledge about glbt-s health and respect for confidentiality.

Improving practice through education and training

- ✓ Health care providers who hold homophobic or heterosexist attitudes towards glbt-s people need to understand the impact of these attitudes upon glbt-s patients/clients and be held accountable.
- ✓ Those who consciously believe that glbt-s people are "sick, delayed developmentally, sinful or immoral" will not willingly change their beliefs or practices. While it is recognized that these people represent a small minority of today's health care providers, it is important to address overt discrimination in the system through educational programs in schools and professional associations. Those who can not or will not unlearn negative beliefs or attitudes, should be encouraged to refer their glbt-s patients/clients elsewhere. This means making available, in every community, the names of health care providers who are able and willing to provide affirmative services.
- ✓ Providers can be discriminatory without intent. What counts most in identifying discriminatory practices is how these practices are perceived by the glbt-s

patient/client. If comments, attitudes or policies are felt to be discriminatory by the glbt-s patient/client, then they must be addressed as such, regardless of the presence or absence of intent to harm.

- ✓ Glbt-s patients/clients are health care providers' best teachers with respect to identifying discrimination against them. Creating an atmosphere of openness in which patients/clients are encouraged to tell practitioners when they are experiencing harm can do much to bring awareness to practice. Unsurprisingly, it is very difficult for patients/clients to tell their practitioners when they are experiencing oppression. This requires them to expose themselves to potential emotional, psychological and physical danger. Because of this, educational institutions, professional associations and health care providers themselves are the bodies who must take responsibility for creating change.
- ✓ It is important for health care providers to understand that glbt-s patients/clients may come into their office already mistrustful and unsure about the provider, even if it is a first encounter. Previous negative experiences will mark every encounter, both present and future ones. Health care providers must show patience and support when working with glbt-s patients/clients.
- ✓ Part of helping to improve perceptions of interactions with the health care system, means acknowledging the ways in which the medical establishment has discriminated against glbt-s people and acting as an advocate of the patient/client to ensure that future interactions do not reproduce oppression.
- ✓ The existence of homophobia and heterosexism in educational and professional environments continues to make it difficult for practitioners to develop explicitly affirmative practice or for glbt-s practitioners to come out. Research has shown that glbt-s health care providers are often targeted and discriminated against in professional environments. Professional associations and educational institutions must address this head-on. Providing safety for glbt-s practitioners and their allies is a necessary first step in order to send a clear message that both glbt-s people and work on glbt-s issues are legitimate and will be supported. This will ensure, for those people who want to be treated by a gay, lesbian or bisexual health care provider, that they have increased opportunities to do so.
- ✓ Education is the first and most crucial tool of change. Inclusion of glbt-s health curriculum, providing professional training, encouraging presentations and workshops at conferences, supporting and promoting research, encouraging publication and distribution of resource material, developing educational campaigns in the media, and doing outreach are all central recommendations of studies in the area of health care access.

Improving the environment: letting your patients/clients know you are affirmative

- ✓ Advertise in glbt-s media.
- ✓ Put posters and pamphlets about glbt-s issues in offices or institutions.
- ✓ Identify and advertise resources which are glbt-s friendly, including those in the glbt-s community.
- ✓ Do not begin publicly identifying as affirmative until you are prepared to provide affirmative services. This means increasing one's knowledge about glbt-s health

issues, building a resource and referral base in and among gay community organizations and with other affirmative practitioners, developing open communication strategies to encourage discussion with glbt-s patients/clients about sexual orientation and other issues important to them, training staff and creating office or institutional policies supportive of glbt-s patients/clients.

Improving practice through increased knowledge and expertise

- ✓ Read articles and books on glbt-s health care in both the professional and lay press.
- ✓ Surf the net (www.gayhealth.com is a good place to start).
- ✓ Talk to knowledgeable colleagues.
- ✓ Request and attend conference presentations and workshops.
- ✓ Encourage your professional association/university to provide more training.
- ✓ Make contacts with glbt-s community organizations inside or outside your community.
- ✓ Ask patients/clients to tell you about their experience or provide information that they have available on specific health concerns.
- ✓ Contact local gay, lesbian and bisexual physician groups for referral sources and for mentoring/guest speaker availability.

Improving practice through better and more open communication

- ✓ Open communication in an atmosphere of safety is key.
- ✓ Improve sexual history-taking for all patients/clients.
- ✓ Use gender-neutral language or inquire about both genders. Ask about someone's partner, not their husband or wife. Ask a patient/client if they have a romantic friend instead of simply assuming they are heterosexual.
- ✓ Identify your interests in developing "best-practices" for a variety of patients/clients; men and women, people of colour, gays and lesbians, etc. When you use those words first, you send the message that you are open to discussing sexual orientation.
- ✓ Allow patients/clients to take the lead. Let them tell you if they think that their sexual orientation is important to the issue at hand.
- ✓ Ask questions and admit if you don't know the answer to something. Glbt-s patients/clients want to work as partners in the health care encounter.
- ✓ Always keep information confidential. This is a major concern of glbt-s patients/clients.
- ✓ Remember that sexual orientation may change over time so that using categories or labels may sometimes be inappropriate or premature. Keep lines of communication open with patients/clients so that addressing sexual orientation and sexual behaviour is seen as part of an ongoing dialogue between patients/clients and health care providers.

Improving practice through better documenting and recording

- ✓ Because homophobia and heterosexism continue to operate in health care systems, marking sexual orientation in a patient's/client's chart/file can increase their risk of exposure to discrimination. A common example is the refusal of private medical insurance to gay-identified males because of their perceived or assumed risk for HIV infection, which would necessitate costly treatment.
- ✓ Give the patient/client a choice as to whether or not their sexual orientation is indicated in their chart/file. Put this information down in code so that only the health care provider or other key people in the office can identify this information but that outsiders (such as insurance companies, other hospital departments) cannot.

Improving practice through better referral

- ✓ Work to identify other health care practitioners who are sensitive to the needs of glbt-s patients/clients.
- ✓ You can be supported in this endeavour by professional associations and by glbt-s community organizations in your area.
- ✓ Finding affirming referral sources is much easier to do in large urban centres. However, those practicing in rural settings can talk with people in urban centres that are closest to their communities. Often, glbt-s organizations have contacts with individuals in nearby small communities that could be accessed or they can share documented information. There may be circumstances in which glbt-s patients/clients may chose to travel to larger centres in order to find an affirmative health care provider or specialist for particular needs. Advocating for increased education of health care professionals in urban and rural areas is one way to broaden the number of potential future referral sources.

Improving practice through support of partners, significant family and friends

- ✓ Glbt-s people need to include partners, significant friends and family in their health care interactions, decision-making and hospital visiting arrangements. These people need to be respected and supported.
- ✓ Making this possible in one's own practice and encouraging the development of institutional policies which ensure that these people are included are central to adapting practice.

Improving practice through advocacy

- ✓ Many of the changes necessary to improve and develop affirmative practice require systemic restructuring; more resources and focus on education and training, outreach, information, adapted policy, etc. These will only happen if individual providers request these changes of their educational institutions and professional associations.
- ✓ Engage with allied health professionals on improving practice in your area through workshops and the sharing of materials and resources.

- ✓ Talk with glbt-s patients/clients and communities about what they think needs to be done and support the organization of strategies.

The benefits and the risks of improving practice

- ✓ The benefits of improving practice for glbt-s patients/clients are enormous: better health, better satisfaction with care, increased self-esteem, reduced stress... the list is long.
- ✓ For health care providers who develop affirmative strategies in their practices, there is the satisfaction of providing appropriate and relevant service to their patients/clients and improving patient/client trust of health care providers and of the system generally.
- ✓ Learning about strategies to improve communication with patients/clients, particularly around sexual orientation and sexual activity helps improve the lives of all patients/clients.
- ✓ Connecting individual practice with the larger goals of community advocacy can support positive change and social solidarity for all glbt-s people and their families.
- ✓ Becoming a health ally also presents some risks. In an environment in which homophobia and heterosexism are still present, not everyone will be encouraging of making changes to support glbt-s health and well-being. It is important for health care providers to be prepared to deal with negative reactions from colleagues, staff, other patients/clients and communities including hostility and ignorance. Becoming publicly affirmative requires practitioners to be prepared to act as educators.

Practicing What We Have Learned: How It Is and How It Should Be

(Based upon: Bastien, S., Brotman, S. (2000) Course notes: Critical Issues in Practice with Gay, Lesbian, Bisexual and Two-Spirit People. Montreal, QC: McGill School of Social Work)

These video role plays are designed to identify current realities faced by glbt-s people during health care interventions. Participants will view interactions between glbt-s patients/clients and their health care providers, after which they will be asked to identify the range of attitudes exhibited by the practitioners in different settings. The second part of the exercise consists of a re-play of each interaction in which the provider instead uses affirmative models of intervention. Participants will then be asked to document and discuss the differences between traditional/affirmative models in order to highlight best-practice interventions and their potential impact upon glbt-s patient/client care.

(1) Video Role Play: Jane and the Gynecologist

Jane is a 22 year old bisexual woman. She is currently dating a man and goes to the gynecologist to get a prescription for the pill. Jane discloses her bisexual identity.

Scenario 1

Jane enters the doctor's office and sits down.

Dr. Smith: Please sit down. What can I do for you today?

Jane: Well, I came to see you for a prescription for the pill...

Dr. Smith: Is this your first time seeing a gynecologist?

Jane: Yes.

Dr. Smith: How old are you?

Jane: 22

Dr. Smith: Are you in good health?

Jane: Yes.

Dr. Smith: Any allergies?

Jane: No. Not that I know of.

Dr. Smith: Ok. Have you had any previous sexual relationships?

Jane: Yes, I have.

Dr. Smith: What have you used for contraception up to now?

Jane: Nothing really.

Dr. Smith: Nothing? Oh... well, have you ever been pregnant?

Jane: No.

Dr. Smith: You're very lucky. Have you been tested for sexually transmitted disease?

Jane: No.

Dr. Smith: Well, how many partners have you had?

Jane: About three.

Dr. Smith: Three? Well, I shouldn't have to tell you that having unprotected sexual intercourse puts you and your boyfriend at risk of getting STD's, including HIV transmission. And also, you could get pregnant. How come you are not using birth control?

Jane: Well... uh... uhm... my previous partners have all been women, actually. This is the first time I'm with a guy. We haven't had sex yet but I thought I'd be prepared.

Dr. Smith: Oh, I see. (silence)... well... OK. So how are you doing at school?

Jane: Fine, I guess.

Dr. Smith: And your family? Do you live at home?

Jane: Yes, I live with my parents and my little sister.

Dr. Smith: Any problems at home?

Jane: No, not really.

Dr. Smith (pause). Well OK then. Let's go through this list of questions about you and your family's medical history and then I'll do an exam. Ok? I'll call the nurse in now.

-after the exam, Dr. Smith and Jane sit down in the office again-

Dr. Smith: Jane, everything seems to be fine. I'll write the prescription for you but I am also going to suggest that you see a psychologist colleague of mine. She's very nice and has a lot of experience working with young people. I think she could help you.

Jane: Uh... help me?

Dr. Smith: Yes, with your confusion.

Jane: Oh... uh... OK...

Scenario 2

Jane enters the doctor's office and sits down.

Dr. Smith: Please sit down. What can I do for you today?

Jane: Well, I came to see you for a prescription for the pill...

Dr. Smith: Is this your first time seeing a gynecologist?

Jane: Yes.

Dr. Smith: How old are you?

Jane: 22

Dr. Smith: Are you in good health?

Jane: Yes.

Dr. Smith: Any allergies?

Jane: No. Not that I know of.

Dr. Smith: Ok. Have you had any previous sexual relationships?

Jane: Yes, I have.

Dr. Smith: Were they male or female partners... or both?

Jane: Oh... uh... female actually. One was a serious girlfriend. We just broke up six months ago.

Dr. Smith: How are you doing?

Jane: A bit sad still, but I'm ok. I just met this guy I'm seeing now after Chloe and I broke up. He's been real sweet... it's made things easier. We haven't had sex yet but I want to be prepared.

Dr. Smith: And why have you chosen the pill?

Jane: I dunno. It's easy I guess.

Dr. Smith: The pill is an excellent birth control device but it won't protect you from STD and AIDS.

Jane: Oh... I guess.

Dr. Smith: Well, let's talk about your options and then I'll perform an exam. I'll call the nurse in now.

Jane: OK.

(2) Video Role Play: Jane and the Psychologist

Jane goes to see a psychologist because her doctor strongly suggested she do this when prescribing birth control for her. She comes out to the psychologist as a bisexual woman.

Scenario 1

Dr. Field: Hi Jane. Come and sit down.

Jane: Thanks.

Dr. Field: So how can I help you today?

Jane: Well, I dunno. Dr. Smith suggested I see you. I'm not sure...

Dr. Field: Yes, I received a call from him about you. He said that you're experiencing some issues with respect to boyfriends and girlfriends?

Jane: Oh.

Dr. Field: Well, how do you see things?

Jane: Well, I broke up with my girlfriend six months ago and I feel pretty bad about it still.

Dr. Field: Yes?

Jane: And now there's this guy in my life. So I went to Dr. Smith for some information on contraception. I've never been with a guy before so I thought I should be prepared.

Dr. Field: (nods) never been with a guy before?

Jane: No.

Dr. Field: And why do you think that is?

Jane: I dunno. I've been with... had been with Chloe for three years and before that well... I guess it's just who I met. I'm bisexual.

Dr. Field: Hmm (silence) And when did you start having these feelings?

Jane: I don't know. I've always had crushes on girls and guys. But I really knew when I was 14 and I met this girl at summer camp. We really hit it off.

Dr. Field: Yes, adolescence is a very confusing and exciting time.... Tell me about yourself a bit. Your family. What was it like for you growing up?

Jane: It was ok, I guess. I have a little sister. She's a bit of a pain. And my folks divorced when I was ten. That was kind of hard...

Dr. Field: Well, tell me about that. What was it like for you?

-they continue discussing this-

Dr. Field: Well, Jane, I'm glad you came in today. Let me tell you that I think that you have nothing to worry about. In my experience young people who are confused about their sexual identity eventually work things out and therapy can help you do this. The majority of people are either heterosexual or homosexual. (laughs) Of course only a small minority of people are homosexual! This can be triggered by many things... there is a biological link of course, but for young people stress and trauma can also delay a young person's development. In your case, it seems like your parents' divorce was very hard on you. In my work, I have helped many young people figure out who they are. I think that I can be helpful to you, especially since you now seem open to dating men. This is a good sign. So how about it? Do you think we can work together?

Scenario 2

Dr. Field: Hi Jane. Come and sit down.

Jane: Thanks.

Dr. Field: So how can I help you today?

Jane: Well, I dunno. Dr. Smith suggested I see you. I'm not sure...

Dr. Field: Yes, I received a call from him about you. He said that you're experiencing some issues with respect to boyfriends and girlfriends?

Jane: Oh.

Dr. Field: Well, how do you see things?

Jane: Well, I broke up with my girlfriend six months ago and I feel pretty bad about it still.

Dr. Field: Yes?

Jane: And now there's this guy in my life. So I went to Dr. Smith for some information on contraception. I've never been with a guy before so I thought I should be prepared.

Dr. Field: That sounds like a good idea. Are you thinking about exploring a sexual relationship with him?

Jane: Yah. We've talked about it a bit. I've only been with women up to now, but I feel very attracted to him and we are getting very close.

Dr. Field: And how do you feel about being with a man?

Jane: Fine...good... I'm bisexual. As far back as I can remember I've been attracted to both girls and guys.

Dr. Field: Do you have any difficulties about being bisexual?

Jane: Do you mean how do I feel about myself?

Dr. Field: That's a good place to start.

Jane: No. I'm fine. I used to be worried... I freaked out when I first realized I was attracted to women. But I got help back then. I'm ok about it.

Dr. Field: How about your friends and family?

Jane: Oh, everybody's cool.

Dr. Field: Who did you get help from when you first came out?

Jane: My friend Bertha and my school counselor. She was great. We even started a queer-straight alliance at my high school.

Dr. Field: Wow! That is great!

Jane: Yah.

Dr. Field: So, why are you here?

Jane: I'm not sure...

Dr. Field: Do you feel a need to talk about anything?

Jane: Not really.

Dr. Field: Is there something you spoke about with Dr. Smith that he might have been concerned about?

Jane: Don't think so...

Dr. Field: Well, thanks for coming in. Perhaps, if you don't mind, I'd like to get back to Dr. Smith to clarify what his concerns were.

Jane: Sure, ok... actually, now that you mention it, he was a bit of a jerk...

Dr. Field: Oh?

(3) Video Role Play: Gary and Michael and the Social Worker

Gary and Michael are having couple difficulties and seek out a family therapist in a local Family Mediation Institute. The origin of their difficulties is Gary's parents' lack of acceptance of them as a couple.

Scenario 1

Mary: Hi. Please sit down. How can I help you?

Gary: Well, Michael and I have been together for ten years now and we are having some difficulties we want to work through and we are looking for someone who can help us do this.

Mary: Yes. Please go on.

Gary: Yes, well, we are hoping to find someone who will be understanding and respectful of us as a gay couple.

Mary: Well, let me reassure you right from the start that you being gay does not matter to me at all! All couples, whether gay or straight, experience problems. I speak for both myself and the Institute when I say that we do not condone any kind of discrimination. (silence). So, that's settled, so let me tell you how I work. I usually begin with a general assessment of the couple, your current situation and history, ok?

Gary and Michael: Sure...

Mary: You have been together ten years? Tell me how you met.

Michael: We met through mutual friends at a dinner party. The only two people in the room that didn't know we were being set up was us.

Gary: And we've been together ever since!

Mary: How long have you been living together?

Gary: Close to 9 years.

Mary: Where do you live?

Gary: We live downtown.

Mary: And what do the two of you do for a living?

-the social worker continues the assessment-

Mary: So, when we meet next week, we can begin by discussing the problem that brings you here. See you next week.

Scenario 2

Mary: Hi. Please sit down. How can I help you?

Gary: Well, Michael and I have been together for ten years now and we are having some difficulties we want to work through and we are looking for someone who can help us do this.

Mary: Yes. Please go on.

Gary: Yes, well, we are hoping to find someone who will be understanding and respectful of us as a gay couple.

Mary: Let me tell you how I proceed. From my own experience and what I have read in the literature, all couples, regardless of sexual orientation, face many similar problems in negotiating their lives as couples. However, there are many differences and realities that gay and lesbian couples face, particularly because of having to live in often hostile environments. This can put a fair amount of stress on the couple. So my assessment and the questions that I ask will sometimes focus on this second point. Like what kind of support do you have of your couple and what is the impact of discrimination on your lives. Does this seem ok to you?

Gary: (sighs) Yes, it seems great.

Mary: When I am off track... like if I assume that your sexual orientation matters to a problem when it doesn't... or if it does matter and I don't make the connections, please let me know.

Gary: OK.

Mary: This is a working partnership so I hope we can develop a relationship in which you feel comfortable to re-direct me if I am off-track.

Gary: Sure.

Michael: Actually, what you said about support... that's why we're here. We've been together for ten years and Gary's family has never accepted me. And now, Gary's dad is sick and we are spending a lot of time with the family and I just can't take it anymore. It's causing a real strain on us.

Mary: Please tell me more... what is happening?

(4) Video Role Play: Peter and the Nurse

Peter is a gay man of 78 years living in a nursing home. The nurse on his floor notices the frequent and tender visits of an elderly gentleman and deduces that Peter is gay. Although she asks him directly about the nature of his relationship to this visitor, Peter states only that it is a close friend. After several weeks, Peter discloses to the nurse that he and his friend have lived together for over 35 years.

Scenario 1

Joan: How are you today Peter?

Peter: I'm ok... my hip is acting up a bit.

Joan: Do you need to see the doctor?

Peter: No... it's the usual stuff. The doctor is coming next week so if it's still bugging me, I'll talk to him then. Getting' old, that's all...

Joan: Oh yah... Peter... I wanted to ask you a question. I noticed that you have lots of visits from a very nice gentleman.

Peter: (tensing up)... yes...

Joan: Is it your brother?

Peter: No... uh... he's a friend of mine... John.

Joan: He is very nice. Always passes by the nursing station with a smile and a kind word. I really like him. John, you say?

Peter: Yes.

Joan: How long have you known him?

Peter: Over 40 years.

Joan: Wow. He must be a really good friend.

Peter: Yes, he is.

-A week passes. On several occasions, Joan drops in to say hi to Peter while John is visiting.-

Joan: Hi Peter!

Peter: Good morning.

Joan: John not here today?

Peter: No, he is in New York visiting with his daughter.

Joan: Oh, how nice. Are you close with his children?

Peter: Uh... (acting nervous)...

Joan: Peter, you don't have to be nervous telling me anything. I really like you and John. Are you... "together"?

Peter: Well, we lived together for 35 years.

Joan: I knew it! I just knew it! I told Kathy I thought you were a couple. I knew you were gay!

Peter: I'm not gay. We just lived together.

Joan: Oh, Peter... you shouldn't worry. We are all supportive here. There is nothing wrong with being gay. If you don't tell us, how can we support you? I think it's best to document this in your file so that you get the recognition and respect you deserve. It's not the same world you grew up in. Things are much better now. Besides... if anyone is mean to you I will let them have it!

Scenario 2

Joan: How are you today Peter?

Peter: I'm ok... my hip is acting up a bit.

Joan: Do you need to see the doctor?

Peter: No... it's the usual stuff. The doctor is coming next week so if it's still bugging me, I'll talk to him then. Getting' old, that's all...

Joan: Oh yah... Peter... I wanted to ask you a question. I noticed that you have lots of visits from a very nice gentleman.

Peter: (tensing up)... yes...

Joan: Is it your brother?

Peter: No... uh... he's a friend of mine... John.

Joan: He is very nice. Always passes by the nursing station with a smile and a kind word. I really like him. John, you say?

Peter: Yes.

Joan: How long have you known him?

Peter: Over 40 years.

Joan: Wow. He must be a really good friend.

Peter: Yes, he is.

-A week passes. On several occasions, Joan drops in to say hi to Peter while John is visiting.-

Joan: Hi Peter!

Peter: Good morning.

Joan: John not here today?

Peter: No, he is in New York visiting with his daughter.

Joan: Oh, how nice. Are you close with his children?

Peter: Uh... (acting nervous)...

Joan: Peter, you don't have to be nervous telling me anything. I really like you and John. Are you... "together"?

Peter: Well, we lived together for 35 years.

Joan: So you are a couple. I thought so. I can see how much you love each other. He seems like a good man.

Peter: He is.

Joan: You must miss not living together after 35 years.

Peter: Yes, it's very hard.

Joan: Is it ok for you here in the nursing home? I mean is it comfortable for the two of you?

Peter: Oh, it's terrible! After 35 years I am afraid to hold his hand again... in case anyone sees. We never did that sort of thing in public, not like these young kids do, it was impossible when we were young... but at least in our own home... well now there never seems to be any privacy. I miss holding his hand.

Joan: That must be awful! I don't know what can be done about it without somehow revealing your situation.

Peter: No! I don't want that.

Joan: Please don't worry, Peter. I promise to keep everything we discuss to myself. It's just between you and me. So tell me, where did you two meet?

Questions for discussion:

What kind of attitudes/beliefs do the professionals project in Scenario 1?

How are these attitudes/beliefs made manifest? Identify statements made and what they imply?

What kind of reactions do the patients/clients have to these attitudes/beliefs?

What are the differences between interactions in Scenario 1 and Scenario 2?

How do the responses of patients/clients differ in these scenarios?

Identify practices which hinder/improve communication/treatment with patients/clients.

Articles Used for This Session:

Ryan, B. (2000) La honte d'être. *Vis à Vie: La revue de l'association québécoise de suicidologie*, (10)2, 9-11.

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Simkin, R. (1993). Creating Openness and Receptiveness With Your Patients: Overcoming Heterosexual Assumptions. *The Canadian Journal of Ob/Gyn & Women's Health Care*, 485-489.