RAINBOW Health Initiative
Advancing Health Equity

Equity & Inclusion Education Program

Inclusive Practices Working with LGBTQ Communities

Last updated: February 2018

Resource Packet

Equity and Inclusion Education Program

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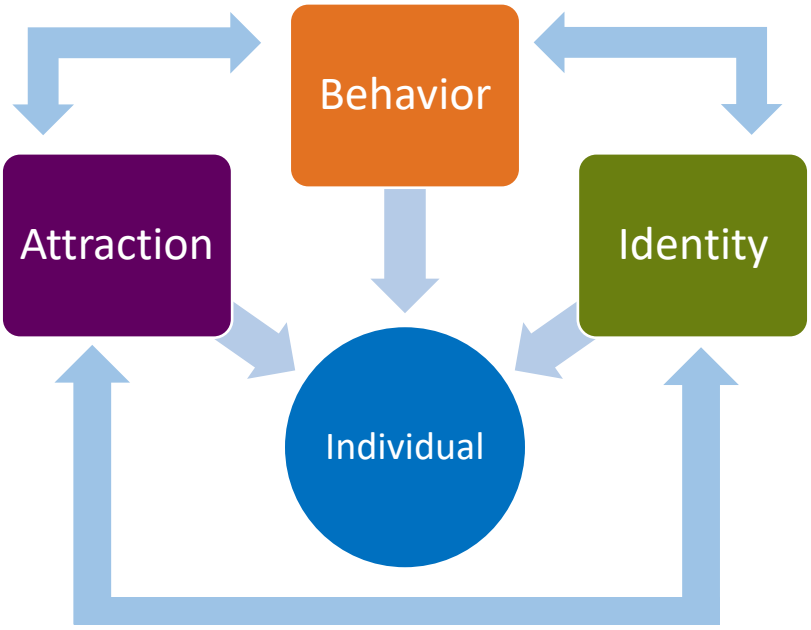
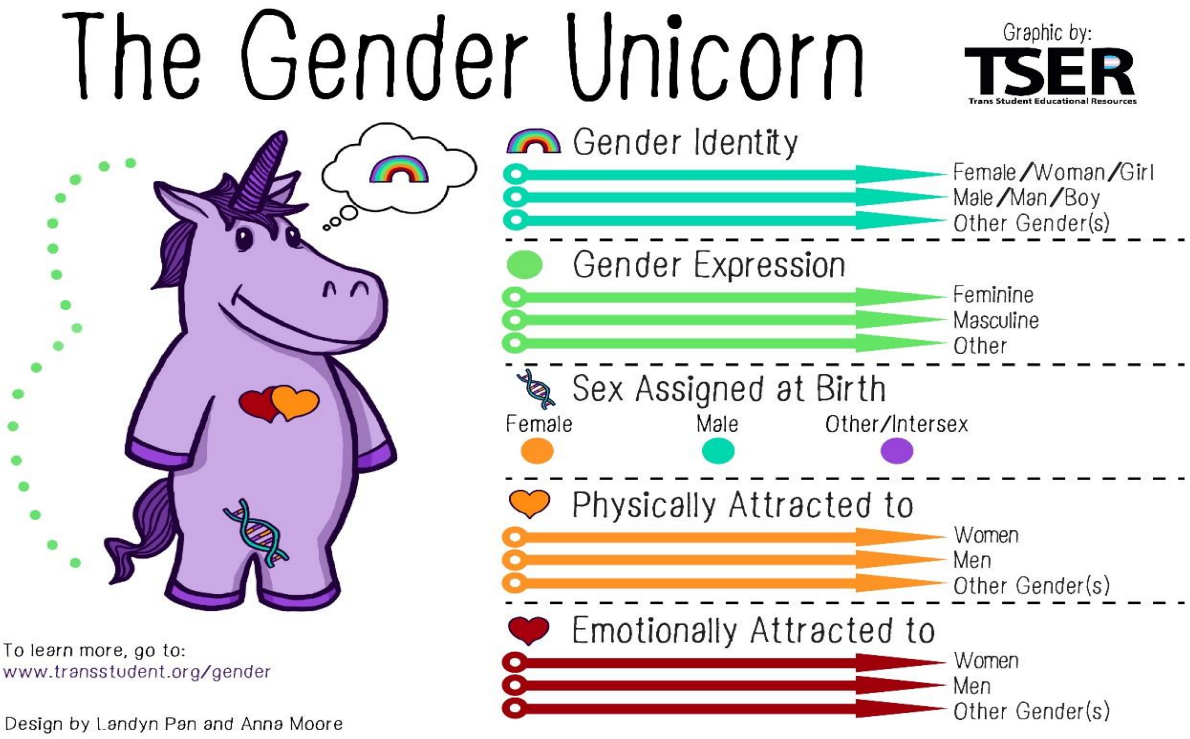
Sexual Orientation



Attraction refers to the desire to form sexual relationships with other people.
Behavior refers generally to an individual's actions.
Identity refers to how a person self-defines or labels their sexuality.
Asexual: An individual who, to varying degrees, does not experience sexual attraction to persons of any gender. Some may experience other types of attraction, including romantic, emotional, intellectual, or sensual, or they may not. Asexuality is not a choice (i.e. celibacy) and does not determine sexual behavior (i.e. they can engage in sexual behavior).
Bisexual: An individual who has the potential to be attracted – romantically and/or sexually – to people of more than one sex and/or gender, not necessarily at the same time, not necessarily in the same way, and not necessarily to the same degree.
Gay: An individual who identifies as a man and is romantically and/or sexually attracted to people who identify as men. This term is also used as an umbrella term to refer to a non-heterosexual person and/or to the entire LGBTQ community (e.g., gay rights, the gay community).
Lesbian: An individual who identifies as a woman, who is romantically and/or sexually attracted to people who identify as women.
Queer: An umbrella term that can refer to anyone who transgresses society's view of gender or sexuality. A queer person may be attracted to people of multiple genders and/or identify with any gender along the gender spectrum. Queer may also be used as a political identity that refers to a disruption of social norms.

Gender



Gender Identity: This term describes an individual's internal sense, and deeply held psychological identification of their gender. This could be female/woman/girl, male/man/boy, or other genders, such as agender. When we say their internal sense, and deeply-held psychological identification, we mean that they understand themselves as this or that particular gender.
Gender Expression is the physical manifestation of one's gender identity through clothing, hairstyle, voice, body shape, etc.
Sex assigned at birth: the assignment of an individual at birth as either male, female, or intersex by the care provider based on biological criteria.
Physically attracted to: refers to sexual attraction, and the desire to form sexual relationships.
Emotionally attracted to: a different type of attraction from physical/sexual, which refers to the desire to form emotional relationships with people.

To learn more and see other Trans educational resources please visit: www.transstudent.org/gender

Gender Identity – Personal Pronouns

Why are we asking for which pronouns you use to describe yourself?
Gender identity is an important aspect of who we are as individuals. While we know that there are several genders (transgender man, transgender woman, genderqueer, non-binary, gender non-conforming, two-spirit, cisgender woman, or cisgender man), we cannot assume we know a person's gender identity simply by observing them visually. Requesting your personal gender pronouns allows us to create an inclusive environment so that participants can know how you choose to self-identify. This allows all of us to affirm each other's gender identity.

I did not realize there so many pronouns!
The LGBTQ communities and allies use and create gender-inclusive pronouns, in addition to she/her and he/him, to include the variety of gender identities that exist. The following is an incomplete list of pronouns that individuals use.

Subject	Object	Possessive	Reflexive	Pronunciation
Ey	Em	Eir	Eirself	Ay (as in "way"/em (as in "Emma")/ear/ear-self
He	Him	His	Himself	
Per	Per	Pers	Perself	Pur/purz/pur-self
She	Her	Her	Herself	
They	Them	Their	Themself	
Ve	Ver	Vis	Verself	Vee/Vur/Viz/Vur-self
Ze/Zie	Hir	Hir	Hirself	Zee/Here/Heres/Here-self

What should I do if I make a mistake with someone's personal gender pronouns?
Acknowledge, apologize, and continue on with the conversation. As when learning something new, it is a process to incorporate the new pronouns into your vocabulary. With practice, it will be second-nature.

Respect personal boundaries
Asking for and learning someone's pronouns does not open the door to ask personal questions about their body, their sexual practices, what their "real" name is/was, or if they "are in transition."

These are not "preferred"
Some groups will ask for your preferred pronouns. While they are indeed asking for your personal gender pronouns you use to describe yourself, "preferred" also implies optional. Allowing individuals to self-identify is not a preference – it is a value of equity and inclusion practice.

Try them out!
Trans Student Educational Resources provides resources on personal gender pronouns at http://www.transstudent.org/pronouns101. You can also use the following interactive website to practice using gender pronouns that are new to you: http://www.practicewithpronouns.com

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Gender Identity – Personal Pronouns

Personal Gender Pronoun Exercise Sheet

Select a set of pronouns you would like to practice with and then practice trying them out in the paragraph below. If you are having difficulty, consider a pronoun set you are familiar with (she/her or he/him) and look at the corresponding column. To use this multiple times, make copies before completing the worksheet.

Subject	Object	Possessive	Possessive Pronoun	Reflexive
Ey	Em	Eir	Eir	Eirself
He	Him	His	His	Himself
Per	Per	Pers	Pers	Perself
She	Her	Her	Hers	Herself
They	Them	Their	Theirs	Themself
Ve	Ver	Vis	Vis	Verself
Ze/Zie	Hir	Hir	Hirs	Hirself

I think you will really enjoy working with _____. _____ started working here two years ago. You can find _____ office on the third floor, room 3297. _____ earned _____ degree at the University of St. Thomas. It is important to _____ that our organization develops intercultural competency working with LGBTQ communities. It took a lot of work, but did you know that _____ developed this program _____? _____ works with all _____ clients _____. I see that you went to the Opportunity Conference this past year. _____ went to the Opportunity Conference too and _____ said that _____ really enjoyed _____.

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Inclusive Language

Starting the conversation (Individuation)

Goals

- Build a rapport with client
- Establish you are someone they can trust
    - Whether they do or not is their choice
- Define your role
    - Your expertise is there to assist them with their health needs/goals

Tips

- Don't rush into the "work" of the appointment, have a conversation first.
- If possible, don't sit behind a desk or other barrier
- If possible, arrange for no distractions (no phone calls, no emails, no people walking in)
- Engage the client and anyone else with them (i.e. don't stare at your computer screen the entire time)

Potential Questions (With Follow Up Questions)

- So, tell me a little about yourself…
- What brought you to this clinic/college/organization?
    - That is an interesting job/college major, how did you choose it?
    - Have you always been interested in "…"?
    - What is your dream job after graduating?
    - What are you most looking forward to working on when you get that job?
    - How did you know you wanted to work for that company/in that field?
- How are your classes going this semester?
- What do you do for fun when you're not working/studying?
- What does healthy mean to you?
- What would be one or two of your health goals? What is your role in achieving them, and how do you see my role?

Challenges

If you get one-word replies and/or people who do not know what to say, this might be them coping and throwing up a defense mechanism. Trying sharing something about yourself (like why you chose medicine as a career, or what you like about living in the town/city you are in), something you feel comfortable sharing. Or re-frame the conversation with something to the effect of, "so many providers want to just get to the appointment, and I like to make the process a little more human, so we can get to know each other." If they are still defensive, focus on building the relationship through time, setup a relatively soon follow up appointment, and then lay out for them the strategy of how you going to provide service to them *over time*. When they start to see that you are in this with them and you are committing to them, they may begin to open and trust you moving forward.

Setting the stage for a sexual/social history

Some care providers have expressed to us being uncertain how to take an inclusive sexual/social history with their LGBTQ clients. It is really important to establish trust and set the stage for why you are asking the questions you are asking. Use this worksheet to craft an opening statement you can use before starting a social/sexual history. It should include the following:

- Rationale – in your own words – for why you ask the questions
- Remind them about client confidentiality and data protections (have hard copy to give them)
- Remind them about non-discrimination policy (have hard copy to give to client)
- Define your role as you interpret it
    - Your expertise is there to assist them with their health needs/goals
- Acknowledge client's potential fears/emotions are valid
    - This may be the first time they talk about these issues with someone in-person, or with an "authority" figure, or with someone besides their friend(s), or ever.
- Acknowledge trust is something you both earn and create together
    - You are the expert in the room, but that doesn't mean they trust you.
    - Do not be surprised by skepticism and doubt
- Remind them they do not need to answer all questions today, but can do so later with time.

Model questions for a primary care interview[1]

Generally, try to avoid yes/no questions. This allows the patient to use their own words to describe their lived experiences. Sometimes it is necessary to ask a yes/no question, if so, have an open-ended follow-up question ready. The following questions are not meant to be exhaustive. Some would be used in different situations than others.

Directly assessing identity

- How do you describe your gender?
- Which personal gender pronouns do you use?
- Do you feel sexually attracted to men, women, both, or neither?
- How do you describe your sexual orientation?

Taking a social history

- Who have you brought with you to the visit?
- Do you have a significant other?
- Are you in a relationship?
- Can you tell me about your partner or significant other?
- Tell me about who makes up the people you consider your family?
- Who are the people that you turn to for support?

Taking a sexual history

- Have you had any sexual contact with others in the last year (meaning, contact involving the mouth, vagina, penis, or anus)?
- When was the last time you were sexually active?
- How many partners do you have now?
- What kind of sexual activities are a part of your relationship?
- What kind of sexual activities are a part of your sex life with partners that you are not involved with romantically?
- Do you use sex toys or other items as part of your sex life?
- Do you have any concerns or questions about your sexuality, sexual orientation, or sexual desires?
- In what ways do you practice safer sex?

[1] Eckstrand, K.L. & Ehrenfeld, J.M. (Eds.). (2016). *Lesbian, gay, bisexual, and transgender healthcare*: *A clinical guide to preventive, primary, and specialist care*. New York, NY: Springer International Publishing, p. 27.

Be Prepared to Refer!

Have the following REFERRALS available:

- LGBTQ Patient Toolkit
  - Designed by LGBTQ people for LGBTQ people, RHI's Patient Toolkit is an interactive online and comprehensive in-print resource. Complete with information on receiving competent medical care, insurance access, tools for visiting providers, and the legal rights and support systems available throughout the state, this toolkit also provides information about self-care and how to apply for health insurance.
  - www.rainbowhealth.org/resources-for-you/patient-toolkit/
  - www.tinyurl.com/patienttoolkit
- LGBT Therapists
  - MN LGBT Therapists Network is a network of lesbian, gay, bisexual, transgender, queer, questioning, intersex, pansexual, two-spirit, and asexual affirming mental health and social service workers and their allies in Minnesota (MN).
  - www.lgbttherapists.org
- MN LGBTQ Provider Directory
  - The goal of this project is to create a comprehensive health and wellness provider directory for Lesbian, Gay, Bisexual, Transgender, and Queer people seeking health-related resources in Minnesota.
  - www.rainbowhealth.org/resources-for-you/provider-directory/
  - http://mnlgbtqdirectory.org/
- LGBTQ focused support groups, community organizations, and specialized professional mental health and health providers.
  - http://www.rainbowhealth.org/resources-for-you/patient-toolkit/patient-toolkit-welcome/lgbtq-resources
  - https://www.outfront.org/resources
- Minnesota Transgender Health Coalition
  - The Minnesota Transgender Health Coalition is committed to improving health care access and the quality of health care received by trans and gender non-conforming people through education, resources, and advocacy.
  - Services: Support Groups, Shot Clinic, Training Services, HIV Testing, Syringe Exchange
  - http://www.mntranshealth.com/
- Family Tree Clinic
  - Family Tree Clinic is a leading reproductive and sexual health care clinic. We strive to offer quality, respectful health care services at prices you can afford.
  - Services: Low-cost birth control without an exam, FREE Rapid HIV testing for uninsured patients (results in 20 minutes!), Comprehensive STI testing and treatment, Urinary and vaginal infection testing and treatment, Annual exams, Pap tests & colposcopy services, Birth control, including IUDs and Implanon, Emergency contraception, Breast/chest exams and mammogram referrals,

Menopause care, Preconception planning and referrals, Pregnancy testing and all-options counseling, Nutrition counseling.
    - Limited primary care services
    - Trans hormone care
    - http://www.familytreeclinic.org/
- University of Minnesota Physicians Smiley's Family Medicine Clinic
    - The team at University of Minnesota Physicians Smiley's Family Medicine Clinic provides a full range of services for your entire family. The specialty of family medicine treats people of all ages, from newborns to seniors. Family medicine also includes care of patients through pregnancy and childbirth and the treatment of women's health issues. We are a Certified Health Care Home and offer enhanced care coordination services.
- Park Nicollett – Blaisdell Dr. Deb Thorpe (leading expert in Minnesota on Transgender Healthcare)
- Minnesota LGBTQ-welcoming Places of Worship
    - There are many of them! Outfront Minnesota keeps a regional/county list:
    - https://www.outfront.org/resources/worship
    - The GALIP Foundation is a non profit 501(c)(3) organization dedicated to bringing the reconciling message of God's love and reconciliation to the gay, lesbian, bisexual and transgender community. They keep database of LGBT affirming churches:
    - http://www.gaychurch.org/
    - Father Shannon T.L. Kearns is a writer, speaker, and theologian based in the Twin Cities. He is the co-founder of Queer Theology and the founder of Uprising Theatre Company.
    - http://www.shannontlkearns.com/
- Know these local organizations and what they do: Outfront MN, Gender Justice, Minnesota GLBTA Campus Alliance, Reclaim!, Bisexual Organizing Project, Quatrefoil Library, Transforming families (http://transformingfamiliesmn.org/)
- Reading materials and web-based materials on LGBTQ health issues and supportive resources
    - PRIDE Institute - https://pride-institute.com/
    - National LGBT Health Education Center - http://www.lgbthealtheducation.org/
    - National Coalition for LGBT Health – www.healthhiv.org
    - Minnesota Aids Project - http://www.mnaidsproject.org/
    - LGBT Health - http://www.liebertpub.com/lgbt
    - Healthy People 2020 - https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health
    - Institute of Medicine The Health of Lesbian, Gay, Bisexual, and Transgender People (2011) - https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People/LGBT%20Health%202011%20Report%20Brief.pdf

Strategies to reduce implicit bias

Re-structure decision-making processes[2]

This is a primary strategy and focuses on analyzing/changing decision-making processes to ensure implicit biases are minimized. For example, to address implicit bias against professional female musicians, orchestras created a "blind" audition process where musicians play on-stage behind a screen and cannot be seen, only heard by a hiring committee. This is also called "blind hiring" in other sectors, where names are taken off resumes and cover letters. The rationale is that hiring committees will not be able to use a candidate's name to judge their gender, national origin, or ethnic/racial community.

Stereotype replacement[3]

This strategy involves replacing stereotypical responses for non-stereotypical responses. This involves recognizing that a response is based on stereotypes, labeling the response as stereotypical, and reflecting on why the response occurred. Next one considers how the biased response could be avoided in the future and replaces it with an unbiased response.

Counter-stereotypic imaging[4]

This strategy involves getting to know individuals who are counter-stereotypic of their community. The strategy makes positive exemplars salient and accessible when challenging a stereotype's validity.

Individuation[5]

This strategy relies on preventing stereotypic inferences by getting to know an individual based on their personal, rather than group-based, attributes.

Perspective taking[6]

This strategy involves taking the perspective in the first person of a member of a stereotyped group. Perspective taking increases psychological closeness to the stigmatized group.

Increasing opportunities for contact[7]

This strategy involves seeking opportunities to encounter and engage in positive interactions with out-group members. Increased contact can ameliorate implicit bias through a wide variety of mechanisms, including altering the cognitive representations of the group or by directly improving evaluations of the group.

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[2] Goldin, C. & Rouse, C., "Orchestrating Impartiality: The Impact of "Blind" Auditions on Female Musicians," The Am. Econ. Rev. 90(4) (2000).

[3] Devine, P.G., Forscher, P.S., Austin, A.J., & Cox, W.T.L. (2013). Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. Journal of Experimental Social Psychology, 48(6), 1267-1278. Retrieved from http://doi.org/10.1016/j.jesp.2012.06.003

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Ibid.

LGBTQ Health Disparities

Rainbow Health Initiative. (2017). ***Voices of health: A survey of LGBTQ health in Minnesota.*** **Minneapolis, MN.**

32% of LGBTQ respondents said that were homeless at least once in their lifetimes. At the time of the survey, 3% reported being currently homeless.

24% of LGBTQ respondents said in the past year, they were hungry but didn't eat because there wasn't enough money for food.

61% reported being diagnosed with depression.

45% reported a PTSD diagnosis.

36% reported some of anxiety diagnosis.

58% of respondents reported that they had experienced unwanted sexual contact during their lifetime.

43% are not out to their doctors about their LGBTQ identity.

51% reported that cost was a barrier to accessing health care, even if they had insurance.

2% had a provider refuse to treat them because they are LGBTQ.

10% postponed or didn't get preventative medical care when sick or injured because of disrespect or discrimination from providers.

Rainbow Health Initiative. (2015). ***Invisible Youth: The Health of Lesbian, Gay, Bisexual, and Questioning Adolescents in Minnesota*****. Minneapolis, MN.**

A greater percentage of LGBQ students reported:

- Physical abuse in their household (1.5 to 2.5 times higher than straight youth)
- Being sexually abused by relatives (5.5 to 9 times higher than straight youth)
- Running away from home (2 to 3.5 times higher than straight youth)
- Being homeless without a relative or guardian (3 to 5 times higher than straight youth)
- Being physically assaulted at school (1.5 to 2 times higher than straight students).

LGBQ youth reported lower educational aspirations. More reported planning on getting a job rather than continuing to a 2 or 4 year educational institution after graduation. Significantly more LGBQ youth (between 1 and 7 percent) reported that they were not finishing high school compared to their straight peers (between 0.12 and 0.34 percent).

Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. ***American journal of public health*****,** ***91*****(6), 915.**

A survey conducted in San Francisco showed that of the over 500 respondents, rates of depression were 55% for Transgender men and 66% for Transgender women.

Centers for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12—Youth Risk Behavior Surveillance, selected sites, United States, 2001-2009. ***MMWR*****. 2011.**

The Youth Risk Behavior Surveys found that in 2001-2009, 12% - 28% of LGB students were threatened or injured with a weapon at school. Upwards of a third of LGB students experienced dating violence. Between 14%-32% of LGB students disclosed they were forced to have sex at least once.

Park, H., Mykhyalyshyn, I. June 16, 2016. "L.G.B.T. People Are More Likely to Be Targets of Hate Crimes Than Any Other Minority Group." ***New York Times*****.** **http://www.nytimes.com/interactive/2016/06/16/us/hate-crimes-against-lgbt.html (June 30, 2016).**

At the time of publication (June 2016), and according to data analysis by the Federal Bureau of Investigation (FBI), LGBT persons are most likely the victims of a hate crime in the United States.

The Williams Institute. (2016). ***Evidence of Employment Discrimination Based on Sexual Orientation and Gender Identity: An Analysis of Complaints Filed with State Enforcement Agencies, 2008-2014*****. Los Angeles, CA.** **http://williamsinstitute.law.ucla.edu/wp-content/uploads/Employment-Discrimination-Complaints-2008-2014.pdf**

An aggregation of all available state-level data shows that sexual orientation and gender identity employment non-discrimination laws are used by LGBT people at a similar rate to the use of race nondiscrimination laws by people of color and sex discrimination laws by women.

Nationally, on average, approximately 4.6 complaints of sexual orientation and gender identity discrimination are filed for every 10,000 LGBT workers each year, compared to approximately 4.9 complaints of race discrimination filed for every 10,000 workers of color, and 3.7 complaints of sex discrimination filed for every 10,000 female workers.

Complaint rates for Minnesota (per 10,000) 2008-2014
Race: 2.4
Sex: 0.8
Sexual Orientation & Gender Identity: 1.6

Egan, P. J., Edelman, M. S., & Sherrill, K. (2008). Finding from the Hunter College poll of lesbians, gays, and bisexuals: New discoveries about identity, political attitudes, and civic engagement. Retrieved from Human Rights Campaign website:http://www.hrc.org//documents/Hunter_college_report.pdf

While LGBT persons tend to have more education on average than the general population, evidence suggests that they make less money than their heterosexual and cisgender counterparts (Factor and Rothblum, 2007; Fassinger, 2007; Egan, Edelman, & Sherrill, 2008). Studies on income differences for LGBT persons indicate that:

- Gay men earn up to 32 percent less than similarly qualified heterosexual men.
- Up to 64 percent of transgender people report incomes below $25,000.
- While 5.9% of the general population makes less than $10,000, 14% of LGBT individuals are within this income bracket.

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LGBTQ Intercultural Competency

What do we mean by culture?

Intercultural Development Inventory Definition

Patterns of interpretations (values, beliefs, perceptions) and behavior learned from one's group that guides individual and group activity.

Here is a useful breakdown of how to think about culture[1]:

- The lens through which a group of people view the world
- Values that tend to be shared by a group of people
- Values that persist over time, even if not uniformly practiced by a group of people
- Group patterns and thought to promote group survival

Are cultural differences just about racial or ethnic cultures?

No, there are LGBTQ cultures. There are cultures based on ability (e.g. Deaf culture). There are cultures based on socio-economic difference (e.g. middle class culture, working class culture, the 1%, etc.) There are cultures based on faith tradition (Baha'i, Muslim, Armenian Apostolic, Methodist, and Baptist).

[1]Source: Garcia, S., Guerra, P. (2006). Conceptualizing culture in education: Implications for schooling in a culturally diverse society. In J.R. Baldwin, S.L. Faulkner, M.L Hecht, & S.L. Lindsley (Eds.), *Redefining culture: Perspectives across the disciplines* (103-162). Mahwah, New Jersey: Lawrence Erlbaum Associates, Inc. Publishers

How do I develop intercultural competence?

As you interact and/or immerse yourself within your own culture and another culture, it is important to have a structured self-reflection process. This process reveals the knowledge/skills you are learning. Your Intercultural Development Plan has several recommendations on actions and self-reflection questions to guide your development based on your customized IDI profile. However, here are some general self-reflective questions:

Regarding the cultural activity you are participating in:

- What words, phrases, gestures, colors, pictures, symbols, and objects were used?
  - Why were these valuable from their perspective?
  - Are there variations in how these items are used or considered valuable?
- Why is the activity/action valuable to its culture? What values does it perpetuate, from their perspective?
- How was the activity/action organized? Who had what organizing role and how were those roles assigned?
- What were considered positive/respectful behaviors? What were negative/stigmatized/rude behaviors?
  - Who took on the role of policing these behaviors?
- Who held positions of respect and/or authority? How did they receive these roles? What actions did they perform?

Build relationships first!

You may have a friend or co-worker who is Queer, or Trans, or Black, or Dakota, or Armenian, or Deaf, or Muslim. Their purpose in life is not to teach you about their people or identity. Be a friend first. Once you establish trust, then you can take them out to lunch and politely ask about their experiences which are unique to them.

If someone declines to talk to you about "what it means to be Queer" or "what it means to be Black" don't take it personally.

- What key words or phrases were repeated? What is the history of these words/phrases? Who gets to them say them, to whom, and why?

SKILL	WHAT IT LOOKS LIKE
Self-awareness	"I can describe how my culture influences my perspectives and actions to promote my culture's position or survival."
	"I can describe how my culture is influencing organizations I work and volunteer with to promote my culture's position or survival."
	"I regularly participate in my own culture's activities and can describe why they are considered valuable to my culture."
Perspective-shifting	"I can describe another culture's perspectives/actions in ways that the other culture considers accurate and authentic."
	"I understand that another culture's definition of the concepts 'engagement,' 'participation,' and 'professional' can be different than my own. I can describe those differences accurately, respectfully, and authentically."
Relationship-building	"I can make cross-cultural relationships (e.g. friendships, business relationships, etc.) that affirms the values of both their culture and my own."
	"I do not use my cross-cultural relationships to stereotype their culture."
Cultural Humility	"I do not expect people from another culture to stop practicing their own culture when they interact with me, my organization, or my culture."
	"I know how to decenter my culture's perspective/behaviors and participate in an intercultural dialogue to develop polices, programs and activities."
	"If another culture critiques my own, I can analyze how and why they feel that way from their perspective, even if I do not agree with their critique."
Adaptation	"I can participate in another culture's activities and community events in a way that they feel is appropriate, authentic, and respectful."
	"I regularly participate in another culture's activities."
Language	"I can describe terms and phrases from another culture and why it is valuable to that culture – from their perspective. If I use those terms and phrases, that culture feels my usage is appropriate, authentic, and accurate."
	"I learned and can speak the language of another culture in a way that native speakers of that language find appropriate, authentic, and accurate."
Conflict Transformation	"I can describe power imbalances between cultures from the perspective of another culture and my own culture."
	"I can describe power structures that lead to dominance/sub ordinance between cultures from the perspective of another culture and my own culture."
	"I can describe and practice my culture's approach to conflict resolution."
	"I can describe another culture's approach to conflict resolution in such a way that that culture feels is accurate and authentic."
	"I can participate in intercultural conflict resolution by shifting my perspectives and behaviors to meet the needs of each participant."
	"I can contribute to a conflict resolution process that affirms each participating culture."

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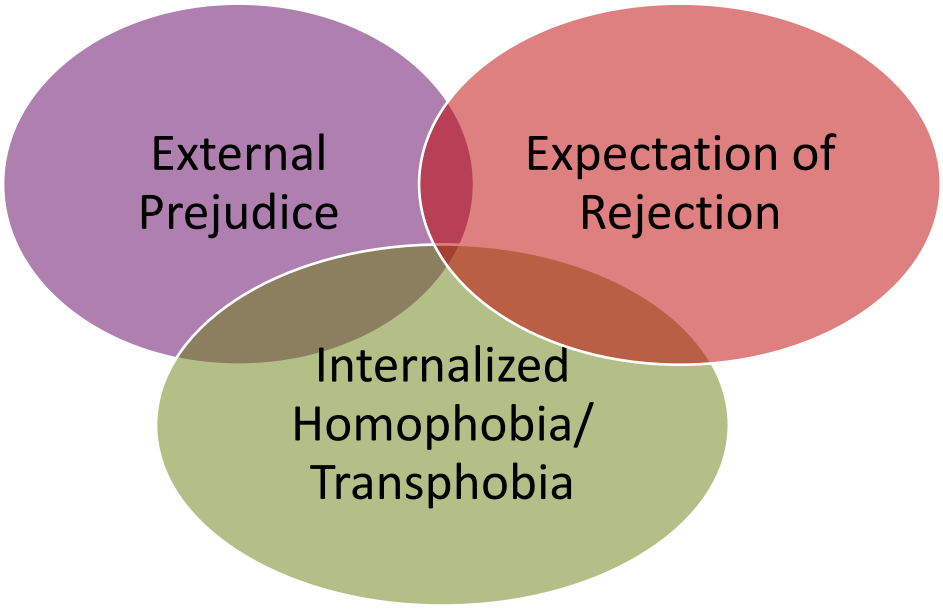
Don’t be fooled by these red herrings of cultural competency

Our organization has too many cultures to learn	•This is not about having total expertise in a particular culture. This is about understanding how your own culture shapes you; then, how you perceive, assess, and interact with cultural difference.
I already went to a conference or workshop about this	•Cultural competence, like medicine, teaching, or music is a practice. If you never practice, you do not have the skill-set. If you stop practicing, you lose the skill-set.
I am a minority. Therefore, I am interculturally competent	•Due to internalized oppression (e.g. internalized homophobia, internalized racism, internalized sexism) one cannot assume that they are interculturally competent. •Due to structural oppression it is important to delineate the difference between the skills needed to navigate forces of assimilation and intercultural competency skills.
We have diverse clients	•The presence of diverse patients, students, or clients does not necessarily indicate intercultural competence. There are a number of reasons (e.g. geographical proximity, cost constraints, etc.) to explain why your organization has diversity, but is not interculturally competent.
Self-reflection seems too basic and not clear enough on how to become competent	•Research has found that even if one moves to and lives in a foreign country, that does not guarantee one will learn intercultural competency. •Research has found this skill set is learned through interaction/immersion in both one's own and another culture, through a structured learning environment based on self-reflection.
This is just special treatment for a particular culture. If we give in to what they want, where will it end?	•This implies cultural supremacy: that your culture is in control of or owns the organization. Therefore, the "other" culture has to do what you say when interacting with your organization. •This is not a zero-sum game, where one culture gets "special" treatment at the expense of your culture. The point is to find the policy, program, and/or resolution that values, affirms, and meets the needs of both cultures.

Minority Stress Theory

Minority Stress Theory Concepts and LGBTQ health disparities

Currently, MST is considered the most prominent conceptual model.[8] The Institute of Medicine in 2011 listed MST as one of four core perspectives related to the study of LGBTQ health disparities



- External prejudice refers to perceived or actual experiences of prejudice/discrimination by an individual. This can be inter-personal prejudice, structural, and/or indirect[9].
- Expectation of rejection refers to an individual's perception, or lived experience, that they will be rejected on some level due to their LGBTQ identity.
- Internalized homophobia/biphobia/transphobia refers to an individual's internalized sense that their LGBTQ identity is negative and therefore justifies discriminatory behavior they receive.

[8] Meyer, I.H. (2016). Does an improved social environment for sexual and gender minorities have implications for a new minority stress research agenda? *Psychology of Sexualities Review*, *7(1)*, 81-90.

[9] Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of health and social behavior*, 38-56.

Implications of Minority Stress Theory

Cannot assume clients/patients trust you or organization (due to experiences of prejudice; expectations of rejection)

Strategies to address this:

- Build rapport and trust first. What are the client's goals? How does the client define/understand their needs? How does the client describe the resources they currently have to succeed?
- Mirror their language. If the client uses specific terms to describe their lived experience, like "GNC" for "gender non-conforming" or "Ace" for "asexual," mirror that language when speaking with them.
- Promote Shared-Decision Making (SDM) with the client. This promotes their resiliency; they have a say and agency in the decision-making process with you.

Cannot assume clients/patients have positive self-image (internalized homophobia/transphobia)

Strategies to address this (for clinical providers):

- Screen for Minority Stress. RESOURCE: Association for American Medical Colleges Clinical Vignette, including 5 minute video demonstrating how-to.
    - https://www.aamc.org/initiatives/diversity/450456/minority-stress.html

Strategies to address this (for non-profits, educational institutions):

- Display and tell stories of positive exemplars (i.e. LGBTQ people in leadership positions in your institutions; success stories of LGBTQ clients available on website/publications)
- For LGBTQ employees, have an employee resource group for employees to create solidarity with each other and recommend policies/programs to the organization.
- Be able to refer LGBTQ clients to LGBTQ culturally-responsive resources in your community.

Screening for Trauma

Are all LGBTQ clients suffering from some form of trauma?
No, it is inappropriate to assume that any person identifying as LGBTQ is currently experiencing (or previously experienced) symptoms related to trauma. While LGBTQ communities are at elevated risk of trauma, assuming/inferring a medical condition based on a client's sexual orientation and gender identity is not appropriate.

How should I screen for trauma then?
Depending on the number and types of populations you serve, it might make sense to have all new patients complete a screening for trauma. You can then contextualize it as a screening conducted with all new patients. Such a policy will not work for all clinics/providers. Another pathway forward is to code your EHR to flag LGBTQ clients for a trauma screening; however, then allow the care provider to first develop trust, rapport, a sense of safety, and autonomy with the client. Based on what the client then chooses to disclose, the provider can make an informed judgement if a trauma screening is appropriate.

Where is it appropriate to screen for trauma?
Primary care visits, behavior health visits, emergency room settings, and tertiary care settings.

SCREENING TOOLS	ASSESSMENT TOOLS
Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)	PTSD Checklist
Short Form of the PTSD Checklist	PTSD Symptom Scale – Interview for DSM-5
Short Screen Scale for PTSD	Clinician-Administered Posttraumatic Stress Disorder (PTSD) Scale (CAPS)
Startle, Physiological Arousal, Anger and Numbness (SPAN)	LGBT POC (People of Color) Microaggressions Scale
Screen Tool for Early Predictors of PTSD (STEPP)	The BTQ (Brief Trauma Questionnaire)
	ACE (Adverse Childhood Events)

What if the patient discloses stressors due to their identity, but they are unclear, or reluctant, to name it trauma?
Clients may disclose, if they feel comfortable and trusting in the care provider, instances of bullying, harassment, discrimination, chronic stress due to their identity, strained relationships due to their identity, and/or covering/hiding their identity (and related stress regarding that behavior). Hurly et al. (2017)[10] provide a series of clinical questions about minority stress and resilience you can use with your client to determine if a trauma screening is appropriate.

[10] Hurley, B., Lin, K., Niranjan Jani, S., and Kapila, K. (2017). "Screening and assessment of trauma in clinical populations" in *Trauma, Resilience, and Health Promotion in LGBT Patients*. (Kristen L. Eckstrand and Jennifer Potter, Eds.). Cham, Switerland: Springer International Publishing.

Screening for Minority Stress/Trauma/Resilience

Clinical questions/minority stress

- In what environments are you out about your sexual orientation/gender identity? In what settings are you not out?
- How comfortable are you with others knowing about your sexual orientation/gender identity status? At home? At work?
- What, if any, discrimination or unfair events have happened to you as a result of your sexual orientation, gender identity, or gender expression?
- How worried are you that others might treat you differently or discriminate against you as a result of your sexual orientation/gender identity?
- In what ways, if any, are you bothered or concerned by your sexual orientation/gender identity?
- Do you ever feel, of have you ever felt, depressed, anxious, sad, or stressed about your sexual orientation/gender identity?
- Do you ever feel you have to say or do things you don't want to in order to fit in with other LGBT individuals?
- In what ways, if any, do you feel you struggle with your sexual orientation/gender identity?

Clinical questions/resilience

- How have your feelings regarding your sexual orientation/gender identity changed over time?
- Who are the supportive individuals in your life? How supported do you feel by these people regarding your sexual orientation/gender identity?
- How supportive is your family regarding your sexual orientation/gender identity?
- Describe your social support network; how comfortable are you with this network?
- When you have a stressful life experience, how do you handle it?
- When you are in a situation that makes you feel unsafe, how do you handle it?
- How do you cope with depression, anxiety, or other challenging emotions?
- What ways, if any, do you feel you could be more supported regarding your sexual orientation/gender identity?

Culture as a Health Resource

The culture, or cultures, that a patient/client primarily identifies with can be used as a pathway, or resource, towards improving their healthcare. Always contextualize this conversation by affirming confidentiality and privacy. Remember that if they choose not to disclose now, that is their right, but they may choose to in the future.

Assess

Which culture(s) does your patient/client primarily identify with?

> *Sample question:* Culture is really important to some of my clients. As we design a care plan and help you achieve your health goals, it can be helpful to provide resources that are culturally specific. And I want to be mindful that some of my patients have two or three cultures that they primarily identify with. For example, they may feel very connected to the LGBTQ community and being Armenian. Or, they may feel very connected to living in Minneapolis and being Muslim. For you, which culture, or cultures, do you primarily identify with?

Follow up question: Thank you for sharing! What about your culture(s) should I know that would help me provide the best healthcare for you?

If they seem unsure what to say, provide the following examples:

- For some patients/clients, in their culture it is really important that family members have a say in the decision-making process.
- For others, they may have culturally specific dietary requirements they practice that I should know about when helping design a care plan.
- For others, their families of choice are really important to helping them adhere to care plans. And so it is important to consider how their families of choice fit into the care plan.

Culturally specific questions:

- Do you have dietary restrictions I should know about?
- In your culture, what do you call your condition? In your culture, what causes this condition and how is it treated?
- Do you consult with traditional healers regarding your condition or health in general?
- Do you have a specific religious custom that could support/impact your care plan?

Refer

Compile with your colleagues and staff health resources that are culturally specific for referrals and general knowledge (e.g. LGBTQ treatment programs, or programs that serve particular ethnic communities, etc.)

Intersectionality

Intersectionality is rooted in Black Feminist thought, going back to the 1800s with Sojourner Truth. Scholars and writers such as Kimberlé Crenshaw, Patricia Hill Collins, Audre Lorde, and bell hooks have advanced the field over the past forty years.

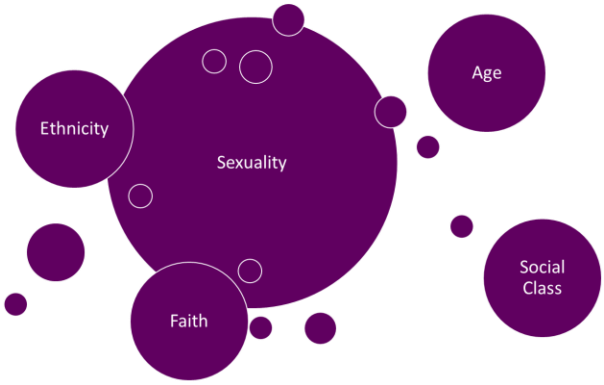
The Institute of Medicine cites Intersectionality as one of four approaches to understand why there are LGBTQ health disparities in the United States[11].

Intersectionality "examines an individual's multiple identities and the ways in which they interact."[12]

Hankivsky (2012) includes the following as the central tenets of Intersectionality[13]:

- Human lives cannot be reduced to a single characteristic
- Human experience(s) cannot be understood by prioritizing any one single characteristic
- Social categories are socially constructed, fluid, and flexible
- Social locations are shaped by cultural processes, power, time and place

Intersectionality can be visualized through items like the identity wheel (on the left), where a variety of identities come together to make up an individual's experiences, but also it can be visualized like the graphic on the right, where depending on time and place, certain identities take precedence and shape other aspects of a person more influentially.



[11] Institute of Medicine. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: National Academy of Sciences. Retrieved from http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People/LGBT%20Health%202011%20Report%20Brief.pdf

[12] Ibid.

[13] Hankivsky, O. (Ed.). (2012). *An Intersectionality-Based Policy Analysis Framework*. Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University.

Creating Intersectional Policies

According to the African American Policy Forum, "Intersectionality is a tool for analysis, advocacy and policy development that addresses multiple discriminations and helps us understand how different sets of identities impact on access to rights and opportunities."[14] The Institute for Intersectionality Research and Policy at Simon Fraser University, led by Olena Hankivsky, created the Intersectionality-Based Policy Analysis Framework (IBPA) to guide policymakers.[15] Here is an outline of the two components:

GUIDING PRINCIPLES	12 POLICY QUESTIONS
Intersecting Categories: Human lives cannot be reduced to singular categories (e.g. gender, race, age)	1. What knowledge, values, and experiences do you bring to this area of policy analysis?
Multi-level analysis: inequities are sustained macro (national), meso (state), and micro (campus) levels of policy making.	2. What is the policy problem under consideration? 3. How have representations of the 'problem' come about?
Power: An individual can experience power and oppression simultaneously depending on context and time.	4. How are groups differentially affected by this representation of the problem? 5. What are the current policy responses to the problem?
Reflexivity: requires folks to ongoing dialogue of implicit, explicit, personal, professional, and organizational knowledge and how it influences policy.	6. What inequities exist in relation to the problem? 7. Where and how can interventions be made to improve the problem?
Time and Space: Knowledge is situated in particular times and spaces.	8. What are feasible short, medium, and long-term solutions?
Diverse Knowledges: examining the relationship between power and who creates knowledge about the issue.	9. How will proposed policy responses reduce inequities? 10. How will implementation and uptake be assured?
Social Justice: while diverse in its approaches, social justice is concerned with transforming social structures.	11. How will you know if inequities have been reduced?
Equity: not to be confused with equality, equity exists when systems are designed to balance outcomes between more and less advantaged groups.	12. How has the process of engaging in an intersectionality-based policy analysis transformed the following: • Your thinking about relations and structures of power and inequity

[14] African American Policy Forum. 2013. A primer on Intersectionality. Retrieved from: http://www.aapf.org/publications/

[15] Hankivsky, O. (Ed.). (2012). An Intersectionality-Based Policy Analysis Framework. Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University. Retrieved from: file:///C:/Users/jparkerderbaghassian/Downloads/Intersectionality_Hankivsky_Intersectionality-BasedPolicyAnalysis%20(3).pdf

	• The ways in which you and others engage in policy development • Broader conceptualizations of power asymmetry

There are sub-questions to assist folks as they delve into a policy issue to ensure they are creating an intersectional understanding, both of the issue, as well as any solutions created to address the issue. It is not necessary to address all questions when using the IBPA framework. Some questions will be more pressing than others. The first question is considered required for all.

ADDITIONAL GUIDES

African American Policy Forum's *A Primer on Intersectionality*
http://www.aapf.org/publications/

European Project SOPHIE's *Incorporating Intersectionality in Evaluation of Policy Impacts on Health Equity*
http://www.sophie-project.eu/pdf/Guide_intersectionality_SOPHIE.pdf

An Open, Digital Classroom on Gender, Intersectionality, & Black Women's Rhetorics's *Intersectionality 101*
http://www.blackwomenrhetproject.com/intersectionality-101.html

CASE STUDIES

The Institute for Intersectionality Research and Policy has the following policy case studies available through their website: http://www.sfu.ca/iirp/ibpa.html

- An Intersectional Critical Discourse Analysis of Maternity Care Policy Recommendations in British Columbia
- Intersectionality and the 'Place' of Palliative Care Policy in British Columbia, Canada
- A Call for a Policy Paradigm Shift: An Intersectionality Based Analysis of FASD Policy
- Decolonizing Policy Processes: An Intersectionality-Based Policy Analysis of Policy Processes Surrounding the Kelowna Accord
- Perseverance, Determination and Resistance: An Indigenous Intersectional-Based Policy Analysis of Violence in the Lives of Indigenous Girls
- Reconceiving the 'Problem' in HIV Prevention: HIV Testing Technologies and the Criminalization of HIV Non-Disclosure
- Are There Enough Gay Dollars? An Intersectionality-Based Policy Analysis of HIV Prevention Funding for Gay Men in British Columbia, Canada

Prefatory: Informing Higher Education Policy and Practice Through Intersectionality, Journal of Progressive Policy & Practice, Volume 2, Issue 3, Fall 2014. http://caarpweb.org/wp-content/uploads/2014/12/Mitchell-Sawyer-2014.pdf

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