First, Do No Harm:

Reducing Disparities for
Lesbian, Gay, Bisexual, Transgender, Queer and Questioning
Populations in California

The California LGBTQ
Reducing Mental Health Disparities Population Report

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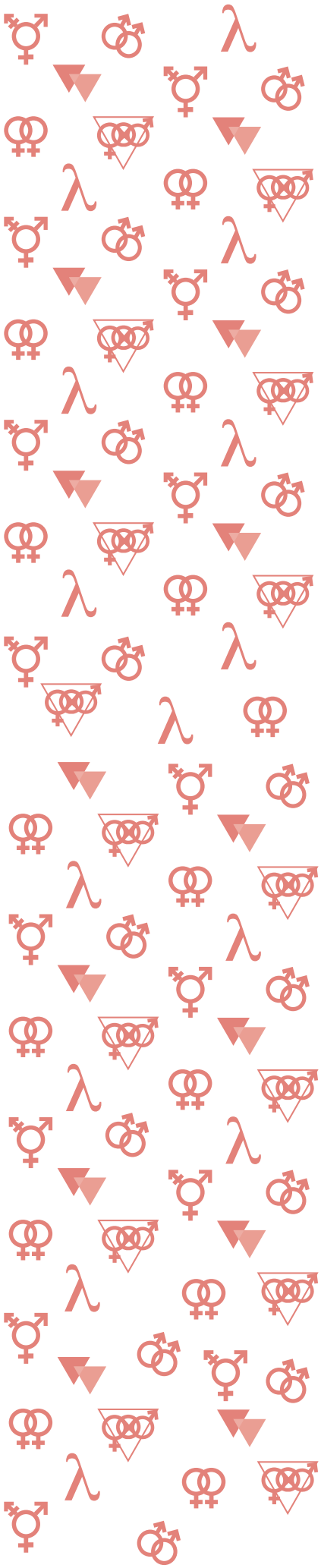

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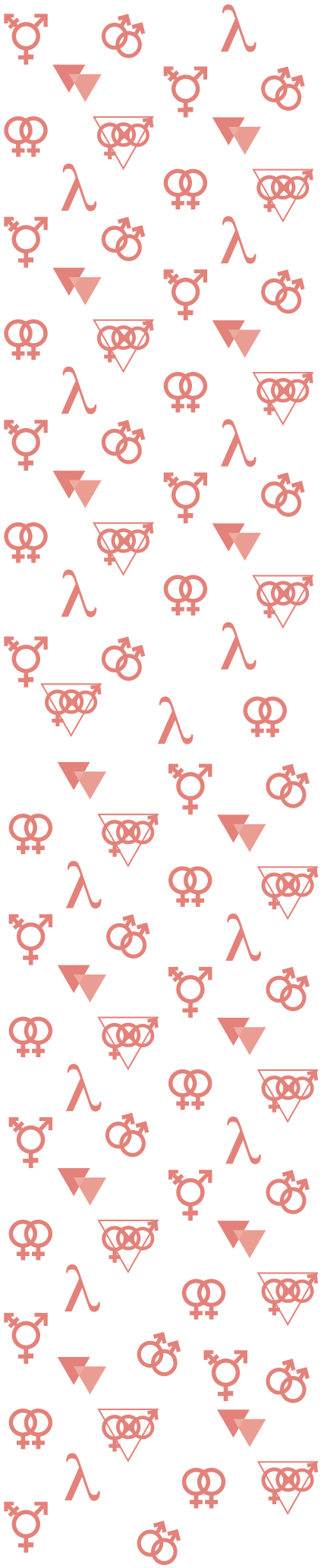

Special Thank You

We are grateful to Rachel Guerrero, members of the former Office of Multicultural Services (OMS), and all others who were involved in the creation of the California Reducing Disparities Project (CRDP)—as well as recognizing that LGBTQ communities need to be included when addressing mental health disparities.

We are extremely appreciative of all the support we have received from both the staff of the former OMS and staff from the Office of Health Equity (OHE), including Autumn Valerio, Claire Sallee, Kimberly Knifong and Shayn Anderson. We would particularly like to thank Marina Augusto for her leadership at the former OMS and during the transition to the OHE and California Department of Public Health.

We would like to thank the California LGBT Health and Human Services Network for their support in launching this project.

We would like to gratefully acknowledge the California MHSA Multicultural Coalition, the African American, Asian and Pacific Islander, Latino, and Native American Strategic Planning Workgroups for their support and contributions to the success of this project.

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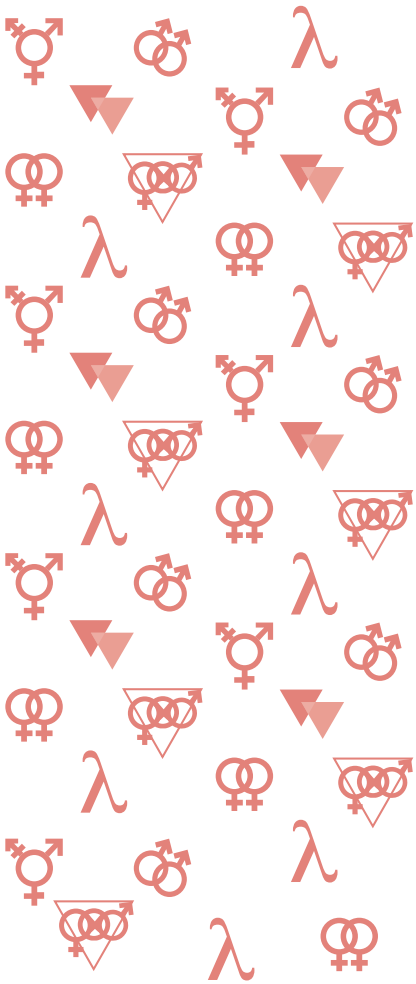
Finally, there is no way to truly express the gratitude we feel toward all the community members who supported this project in so many ways, including hosting community meetings, providing publicity, and helping with outreach efforts. Although already acknowledged as contributors to the report, we want to thank again all the subject-matter experts who so graciously gave of their time and added to the richness of the report. Most importantly, we want to thank every Community Dialogue and survey participant for their time and their voices. As this report will go on to state, we are multiple communities who identify ourselves in many different ways. We value, recognize and are indebted to all those who were willing to come together in order to help reduce disparities and increase mental wellness for all sexual orientations, gender identities and gender expressions in California.

Executive Summary

In collaboration with Equality California Institute and Mental Health America of Northern California, the Strategic Planning Workgroup (SPW) of the Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) Reducing Disparities Project was charged by the former California Department of Mental Health (DMH) to seek community-defined solutions for reducing LGBTQ mental health disparities across the state of California. The project is funded through the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA).

The LGBTQ Reducing Disparities Project was an enormous undertaking. Like the other underserved groups—African American, Asian and Pacific Islander, Latino, and Native American—targeted for assessment in the larger California Reducing Disparities Project, LGBTQ people exist in every geographic and economic range. Unlike the other groups, however, LBGTQ people are also found in every racial and ethnic group. Furthermore, each population represented by the acronym LGBTQ has its own needs as well as its own issues of diversity. Age, gender, sex assigned at birth, socioeconomic status, education, religious upbringing, and ethnic and racial backgrounds all play a role in how an individual experiences their sexual orientation and gender identity. For this reason, this report includes significant discussion of the literature that provides a necessary background to inform mental health professionals' understanding of LGBTQ lives.



There is a myth that LGBTQ is one community, once we get beyond the "gay" we still need to support one another—we are more than just labels. We are individuals.

Desert Valley Community Dialogue participant

Methodology

In accessing California's widespread and diverse population, the methodology used by the LGBTQ Reducing Disparities Project involved extensive engagement of community members and subject matter experts from across the state through Advisory Groups and a Strategic Planning Workgroup (SPW). Because of the wide diversity of the target population, and the difficulties inherent in achieving access to various subgroups within it, the project utilized a multi-method approach. Community Dialogue meetings were held in 12 communities, drawing over 400 people. The information gathered in these live sessions, along with extensive Advisory Group and SPW input, guided the development of the online LGBTQ Reducing Disparities Community Survey, which was the primary research tool used to gather quantitative information

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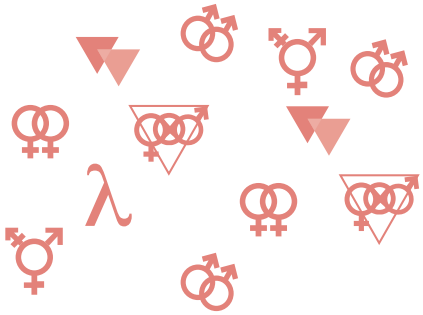
Desert Valley Community Dialogue participant



about LGBTQ-identified Californians. This method was chosen to complement the in-person outreach of the Community Dialogue meetings, as well as the continual input from Advisory Group and SPW members. The online survey provided an avenue for reaching populations traditionally hidden or invisible. Over 3,000 California residents ($N = 3,023$) who identify somewhere on the LGBTQ spectrum responded to the Community Survey (CS), surpassing the initial goal of 2,500 respondents.

One of the major concerns raised by using an online process as a survey tool is one of access. Those who may be facing the most severe disparities may also not have access to, or be reached by, a survey tool that is totally Internet-based. Many agencies and programs serving hard-to-reach LGBTQ populations promoted the CS and allowed clients access to computers so their voices could be heard. Every recommendation made in this report should be viewed with the diversity of the LGBTQ communities in mind.

Findings

This report's findings illuminate the diversity of the target population, and the difficulties its members experience with respect to accessing and receiving appropriate mental health care. For example, CS respondents were asked how much they agreed with the following statement: "I have experienced emotional difficulties such as stress, anxiety or depression which were directly related to my sexual orientation or gender identity/expression." Over 75% somewhat or strongly agreed that they had. The Trans Spectrum group reported the highest rate of agreement (89%). Queer-identified individuals, Native Americans, and youth also reported higher rates than other subgroups. Even though older adults had the lowest rate, almost two-thirds of the group still somewhat or strongly agreed.

Other important findings include:

- Overall, approximately three quarters (77%) of CS respondents indicated they had sought mental health services of some kind. Trans Spectrum individuals reported seeking services at an even higher rate (85%).
- CS participants were asked to indicate which mental health services they needed or wanted, but did not receive. Individual counseling/therapy, couples or family counseling, peer support

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Community Survey Findings

groups and non-Western medical intervention were ranked by all subgroups as 4 of the top 6 services they reported seeking, but not receiving. All subgroups (except youth) also ranked group counseling/therapy among the top six services they sought, but did not receive. For the general CS sample (all subgroups combined), Western medical intervention was ranked sixth of those services sought, but not received. Queer, youth, older adult, and people of color (POC) subgroups all indicated seeking but not receiving ethnic/community-specific services. Notably, Trans Spectrum respondents ranked "counseling/therapy or other services directly related to a gender transition" and Latino respondents ranked "suicide prevention hotline" as the number six service they sought but did not receive.

- CS respondents were provided a list of problem areas that was developed from Community Dialogue feedback and Advisory Group discussions. CS respondents were asked to indicate whether each area listed was a problem for them in the past 5 years. Concerns most frequently reported as a severe problem by all or most subgroups were:
    1. Did not know how to help me with my sexual orientation concerns—*all subgroups*.
    2. Did not know how to help me with my gender identity/ expression concerns—*all subgroups*.
    3. My sexual orientation or gender identity/expression became the focus of my mental health treatment, but that was not why I sought care—*all subgroups.*
    4. Made negative comments about my sexual orientation—*most subgroups*.
    5. Did not know how to help same-sex couples—*most subgroups*.
    6. Did not know how to help mixed-orientation couples (e.g., one partner straight/one partner gay or one partner lesbian/one partner bisexual)—*most subgroups*.
- It should be noted that "Made negative comments about my gender identity/expression" was also one of the most frequently reported severe problems by Trans Spectrum, Queer, youth, Asian Americans, Native Hawaiians & Pacific Islanders (AA & NHPI), Black, Latino and urban subgroup respondents. Trans Spectrum

Respondents who reported having only Medi-Cal had more difficulty accessing the services when they needed and wanted them than those who reported having private insurance, Medicare, another type of government insurance (e.g. VA, Tri-Care, Indian Health) and/or a combination of the above.

Community Survey findings

respondents were 4 times as likely ($P < .001$) to have this problem than non-Trans Spectrum respondents. In addition, they were 5 times more likely to have mental health providers who "did not know how to help me with my gender identity/expression concerns."

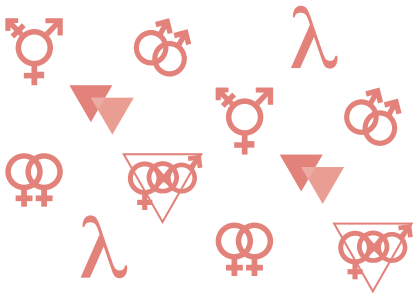
- CS participants were asked how satisfied they were, in general, with the mental health service(s) they had received in the past 5 years. Only 40% of LGBTQ respondents stated they were "*very* satisfied," although satisfaction rates differed among subgroups. Older adults reported the highest rate (60%) and youth the lowest (23%) for "very satisfied". Trans Spectrum (31%), Bisexual (32%), Queer (25%), AA & NHPI (24%), Latino (36%), Native American (29%) and rural (35%) subgroups all had even lower rates of "very satisfied" than the overall sample.
- Respondents who reported having only Medi-Cal had *more difficulty* accessing the services when they needed and wanted them than those who reported having private insurance, Medicare, another type of government insurance (e.g. VA, Tri-Care, Indian Health) and/or a combination of the above. Only 45% of Medi-Cal respondents were able to access couples or family counseling compared to 69% of those with private insurance. Only 40% were able to access Western medical interventions compared to 75% with private insurance and 84% with Medicare. Finally, only 37% were able to access peer support groups compared to 77% with private insurance, 71% with other governmental insurance, 91% with Medicare and 81% of those with some combination of the above.

Researchers also conducted the LGBTQ Reducing Disparities Provider Survey (PS) to complement the Community Survey. The PS allowed the Research Advisory Group to develop questions specifically intended to assess barriers providers may face in providing culturally appropriate, sensitive and competent care to membes of LGBTQ communities. In addition, the PS included questions to address the intersection of being both LGBTQ and a service provider.

The PS was made available to mental, behavioral and physical health care professionals, educators, administrators, office staff, support staff, and *anyone who comes in contact with clients, patients, students and/or family members, whether or not they provide services specifically for LGBTQ individuals*. Over 1,200 ($N = 1,247$) providers working

or volunteering in California completed the PS, including over 350 providers who also identified as LGBTQ.

Using an adaptation of the Gay Affirmative Practice (GAP) Scale developed by Catherine Crisp (2006), researchers were able to assess the extent to which the provider respondents engage in principles consistent with gay affirmative practice. The most significant finding here is that training matters; the higher the number of trainings specific to LGBTQ issues, the higher the GAP scores. In general, LGBTQ providers took more trainings than heterosexual providers, but sexual orientation does not predict greater competence. Regardless of sexual orientation, increased numbers of trainings attended resulted in more affirming providers.



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Provider Survey findings

Demographic information should be collected for LGBTQ people across the life span, and across all demographic variations (race, ethnicity, age, geography) at the State and County levels.

First, Do No Harm: Recommendations

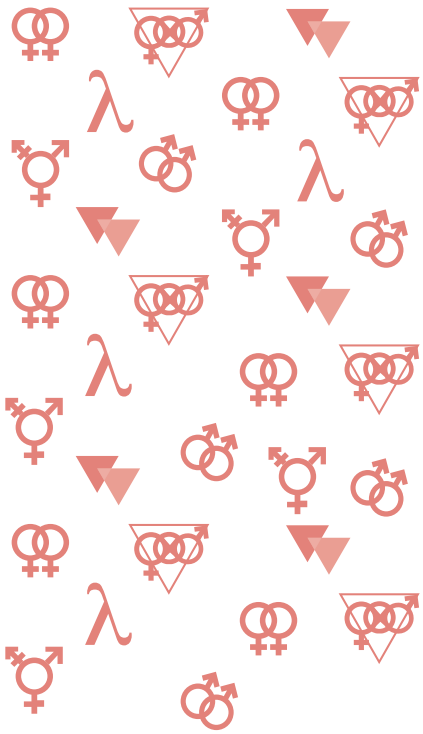
Statewide workforce training and technical assistance should be required in order to increase culturally competent mental, behavioral and physical health services.

First, Do No Harm: Recommendations

Recommendations

Two central concepts have come out of this research. LGBTQ people are being harmed daily by minority stressors such as stigma, discrimination, and lack of legal protection, prior to entering mental health services. Further, there is a profound lack of cultural competence, knowledge and sensitivity among providers who are expected to work with them once they access services. Among the recommendations contained in this report, some of the most important are:

- Demographic information should be collected for LGBTQ people across the life span, and across all demographic variations (race, ethnicity, age, geography) at the State and County levels. Standardization of sexual orientation and gender identity measures should be developed for demographic data collection and reporting at the State and County levels. Race, ethnicity, culture and age should be considered and the measures differentiated accordingly.
- Statewide workforce training and technical assistance should be required in order to increase culturally competent mental, behavioral and physical health services, including outreach and engagement, for all LGBTQ populations across the lifespan, racial and ethnic diversity, and geographic locations.
- Training of service providers in public mental/behavioral and physical health systems should focus on the distinctiveness of *each* sector of the LGBTQ community—lesbians, gay men, bisexual, transgender, queer and questioning—within an



overarching approach to mental health throughout the lifespan for the racial, ethnic and cultural diversity of LGBTQ communities. Cultural competency training, therefore, cannot only be a general training on LGBTQ as a whole, but also needs to include separate, subgroup-specific training sessions (e.g., older adult, youth, bisexual, transgender, Black, Latino, etc.).

- Development and implementation of *effective* anti-bullying *and* anti-harassment programs should be mandated for all California public schools at all age and grade levels and should include language addressing sexual orientation, perceived sexual orientation, gender, gender identity and gender expression issues. In addition, implementation of evidence-based, evaluated interventions that specifically address physical bullying and social bullying should be mandated for all California public schools at all age and grade levels.
- All locations where State or County funded mental/behavioral and physical health care services are offered should be required to be safe, welcoming and affirming of LGBTQ individuals and families across all races, ethnicities, cultures, and across the lifespan.
- State and County mental/behavioral health and physical health care departments should create an environment of safety and affirmation for their LGBTQ employees.

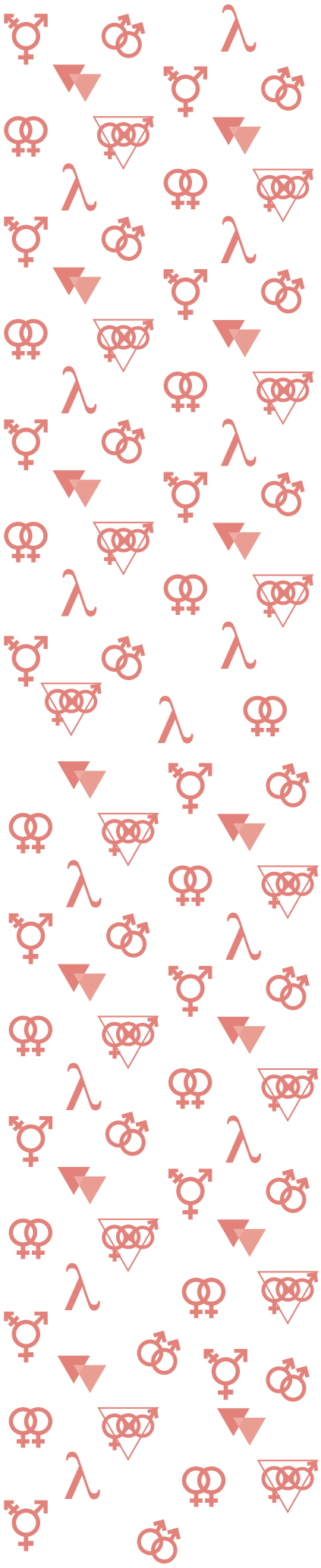
All locations where State or County funded mental/behavioral and physical health care services are offered should be required to be safe, welcoming and affirming of LGBTQ individuals and families across all races, ethnicities, cultures, and across the lifespan.

First, Do No Harm: Recommendations

Conclusion

The need for culturally competent mental health services is great, but greater still is the need to eliminate the multiple harms that contribute to negative mental health throughout LGBTQ communities. This report represents a snapshot in time of certain LGBTQ people living in California. Not everyone that could—or should—be included is in the picture. In many ways, LGBTQ cultural competency work is still in its infancy, with growth and changes occurring rapidly. This report, therefore, cannot and should not be the final word in reducing disparities for LGBTQ Californians. The work begun by the LGBTQ SPW, including community engagement, advocacy, data collection, and community-based recommendations, needs to be continued, and the LGBTQ Reducing Disparities Project should remain funded beyond the dissemination of this report. Nevertheless, the authors of this report are extremely proud of the accomplishment of the long list of contributors and volunteers who worked on this project and made this landmark

document possible, and they hope the entirety of the information it contains will educate and inspire its readers to continue working to eliminate the mental health disparities and harm LGBTQ populations continue to experience.



Part 1:
Introduction and Background Information

In response to the call for national action to reduce mental health disparities and seek solutions for historically underserved communities in California, the Department of Mental Health (DMH), in partnership with Mental Health Services Oversight and Accountability Commission (MHSOAC), and in coordination with California Mental Health Directors Association (CMHDA) and the California Mental Health Planning Council, have called for a key statewide policy initiative as a means to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities. (California Department of Mental Health [DMH], 2010, p. 1)

In collaboration with Equality California Institute and Mental Health America of Northern California, the Strategic Planning Workgroup (SPW) of the Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) Reducing Disparities Project was charged by the former California Department of Mental Health (DMH) to seek community-defined solutions for reducing LGBTQ mental health disparities. The SPW was asked to "move beyond defining disparities" and seek solutions which include "culturally appropriate strategies to improve access, services, outcomes and quality of care" (DMH, 2010, p. 1).

There is no doubt that LGBTQ communities are unserved, underserved and inappropriately served within the mental health care system, and the charge from the former DMH is warranted and valid. LGBTQ individuals seek mental health care at rates far beyond their heterosexual and/or gender conforming counterparts and deserve to be treated in an appropriate and culturally competent manner. However, simply seeking to correct disparities for LGBTQ individuals within the mental health care system is akin to treating a symptom without first examining the disease.

The LGBTQ Reducing Disparities Project is funded through the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA). First and foremost, therefore, *prevention* should be the operative term when discussing LGBTQ disparities and *first, do no harm* should be the credo. LGBTQ individuals are being harmed on a daily, weekly, monthly, yearly, and sometimes lifetime basis due to stigma, discrimination, prejudice, rejection and legal inequality.

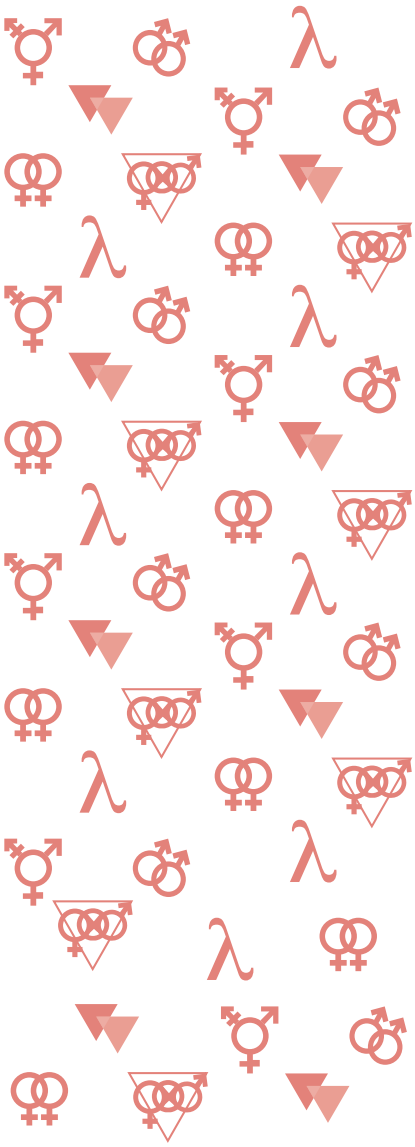
They represent essentially invisible populations whose existence is not accurately documented and rarely acknowledged in any form of official data gathering. For LGBTQ individuals who are also members of other disparity groups, such as Asian American, Black/African American, Latino, Native American and Native Hawaiian/Pacific Islander, the harm they experience is compounded on multiple levels.

To truly prevent mental health disparities and promote mental wellness the California Department of Public Health, the Office of Health Equity, the Department of Health Care Services, MHSOAC, CMHDA, the Californian Mental Health Planning Council, California legislators, school administrators, and service providers of all types must be committed to preventing the harm LGBTQ individuals are exposed to by society-at-large. The need for culturally competent mental health services is great, but greater still is the need to eliminate the multiple harms that contribute to negative mental health throughout LGBTQ communities.

Unraveling the Rainbow

Although often referred to as such, LGBTQ is not a homogeneous, monolithic entity. Each population represented by the acronym has its own needs as well as its own issues of diversity. Age, gender, sex assigned at birth, socioeconomic status, education, differences in abilities, religious upbringing, and ethnic and racial backgrounds all play a role in how an individual experiences their sexual orientation or gender identity (Wierzalis, Barret, Pope, & Rankins, 2006). LGBTQ is also not a single *community* but rather represents many diverse communities and populations. The New Oxford American Dictionary (2001) defines *community* as "a group of people having a religion, race, profession, or other particular characteristic in common" (p. 347). What LGBTQ individuals have in common is they are seen as living outside the norm of expected heterosexual and assigned gender behavior, and therefore may and do experience stigma, discrimination and oppression from government, health systems, school systems, religious institutions, employers, family members and society-at-large.

The acronym LGBTQ is used in this report for the sake of brevity and as an attempt to utilize somewhat commonly understood language. This usage, however, comes with the caveat that the LGBTQ acronym does *not* represent all individuals or populations whose sexual orientation, gender identity or gender expression is seen as outside society's expected



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Desert Valley Community Dialogue participant

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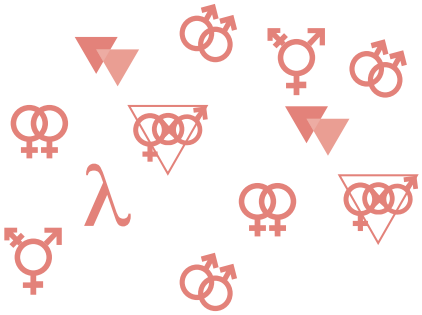


norms. The myriad of self-described identities, attractions and expression by individuals from all races, ethnicities, cultures, genders, ages, and background cannot begin to be covered by a simple acronym developed predominantly in a white, Western, comparatively affluent context.

The five populations identified by the former DMH for the California Reducing Disparities Project (API, African American, Latino, Native American, and LGBTQ) were each assigned the identifier for their respective project prior to the Request for Proposal (RFP) process. The former Office of Multicultural Services should be applauded for advocating to add the "Q" to the LGBT acronym. In the RFP and subsequent former DMH literature, the "Q" has been defined as *Questioning*. Many community members, including SPW and Advisory Group members, have voiced their desire for the "Q" to represent *Queer*. For the purposes of this report, and to honor both community desires as well as official state literature, the "Q" in LGBTQ represents both queer and questioning individuals.

What We Know, What We Don't Know, and What We Need to Know About LGBTQ

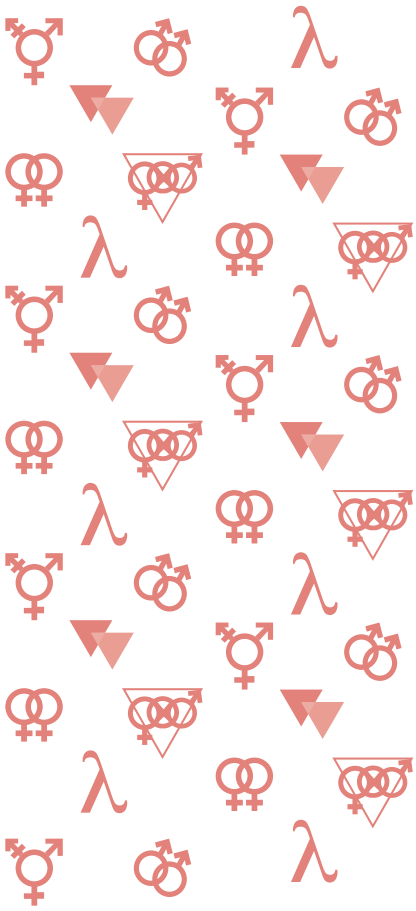
In general, many providers, administrators, policy makers and members of the general public do not have accurate information regarding LGBTQ individuals and communities. The following section contains material gathered from existing literature and subject-matter experts. The diversity of California LGBTQ communities is limited only by the diversity of the California population in general. Therefore, this section represents only a fraction of knowledge and does not cover all LGBTQ individuals and their myriad intersecting needs and identities. For those providers who aspire to cultural competence when working with LGBTQ individuals, for administrators and policy makers who wish to create a more LGBTQ-affirming environment, and for the general public who want to learn more—this is a beginning.

Research Issues: Who Counts, What Counts, How to Count

There are several issues that arise regarding research within LGBTQ populations. Sampling bias occurs for many reasons, including bias of the researcher (Cochran & Mays, 2006; Herek, 1998; Stacey & Biblarz, 2001), the often hidden nature of LGBTQ individuals, making them difficult to locate through random sampling methods (Cianciotto

& Cahill, 2003; Herek, Kimmel, Amaro, & Melton, 1991; Hughes & Eliason, 2002; S. T. Russel, 2006; Savin-Williams, 2001), as well as an historical lack of heterosexual control groups (Cochran & Mays, 2006). Comparatively little LGBTQ research is conducted or published, with the bulk of research focusing on HIV and AIDS. While HIV and AIDS research is extremely important, it should not be a replacement for or in competition with LGBTQ-specific research. For example, Boehmer (2002) states that the National Institutes of Health has funded $20 million dollars per year for HIV-focused research since 1982, compared to an average of $532,000 per year for LGB research which was *non*-HIV related. In their review of social work journals, Van Voorhis and Wagner (2002) found only 3.92% of articles published during a 10 year period addressed lesbian or gay male issues, and less than 35% of those articles were non-HIV related. Of the 77 articles published, only five focused on lesbian clients—mostly pertaining to lesbian families with children. There were "no articles…published about families headed by gay men… No articles addressed practice with elderly lesbian and gay clients" (p. 349). Studies which include bisexual individuals often do so by conflating them with lesbians and gay men, essentially eclipsing the unique needs and issues of bisexual individuals, while also providing possibly faulty statistics regarding mental health issues of lesbians and gay men (Miller, André, Ebin, & Bessonova, 2007).

How sexual orientation is defined is one of the major issues in LGBQ research, as there are no set standards to identify various sexual orientations. How a sexual orientation is defined can change the meaning of the data, as well as causing difficulty in comparing different studies (Savin-Williams & Ream, 2007). For example, Kinsey defined homosexuality through reported behavior. His estimation that 10% of the population is homosexual—an estimation which has been quoted extensively—referred only to white, adult, American males who reported essentially exclusive homosexual behavior for at least 3 years (Cahill, 2000). Sexual activity, sexual attraction, and sexual identity are not always synonymous. Studies find that people who engage in same-sex behavior often do not identify as LGBQ, while others may have same-sex attractions with or without accompanying sexual activity and/or LGBQ identification (Frankowski, et al., 2004; Hoburg, Konik, Williams, & Crawford, 2004; Savin-Williams & Ream, 2007). Another issue which arises if using sexual behavior or sexual attraction when defining sexual



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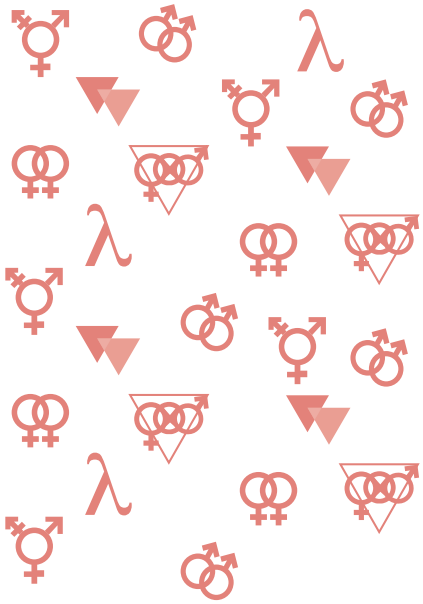

orientation is the cut-off point. In other words, how much same-sex attraction/sexual behavior defines a person as gay or bisexual or, for that matter, how much opposite-sex attraction/sexual behavior defines a person as heterosexual (Savin-Williams & Ream, 2007). As stated previously, relying on self-identification may also yield inaccurate results as many individual do not identify as LGBQ, although other definitions might categorize them as such.

There are specific and innumerable difficulties in researching transgender, transsexual, and trans-identified populations. First, the communities are not cohesive. While there may be pockets of trans-identified people visible in some cities or towns, or there may be known sites of congregation for some trans people, these visible groups are not usually representative of the full range of people who experience themselves as gender nonconforming, transgender or transsexual, or who have this experience as part of their history. Second, because of the risks and stigma of identifying publicly as any variety of trans person, it is reasonable to assume that many trans people avoid any type of association with other trans people. Third, even though the Internet has had a remarkable impact on increasing the availability of trans-related information and interpersonal networking, many trans people do not have access to computers due to economic disparities borne of prejudice against people who do not or cannot conform to gender norms, or who change their gender presentation or physical sexual characteristics. Fourth, there has been little concerted effort from agencies to reach trans or gender nonconforming people for reasons that might benefit these populations, so among community members there is no perceived value in cooperating with researchers.

The problem with capturing gender as a categorical term, means that it is being defined as two—we are saying it's this or this—so it is automatically going to leave out Trans because of the way the research is defined.

Transgender Advisory Group member

History—the Sexologists

Although same-sex sexuality has been documented throughout history, the concept of homosexuality as an identity and an inherent part of one's personality is relatively recent (Lev, 2004; Sullivan, 2003). The term *homosexual* was not published until 1869 (Kennedy, 1997; Sullivan, 2003) and was only one of many terms used. By the 1950s, it became the commonly used term to describe same-sex sexual behavior (Kennedy, 1997). Karl Maria Kertbeny originated the term as part of a larger classification of sexual types. In an effort to fight for the decriminalization of sexual behavior between men, he argued there are many inborn sexual

types (homosexuality being one of them). Kertbeny eventually replaced the term *normal sexuality* with *heterosexuality* (Wikholm, 1999). Karl Heinrich Ulrichs, a contemporary of Kertbeny, theorized that within the male homosexual there is a female psyche. He described this as a "third sex," arguing, also in the fight for civil rights, there is an inborn determinant for homosexuality (Kennedy, 1997). This concept still appeals to some transgender and transsexual people as they struggle to explain their experience.

The psychiatric view of homosexuality as pathological may have begun with Karl Westphal's 1869 article: "The Contrary Sexual Feeling: Symptom of a Neuropathic (Psychopathic) Condition" (Kennedy, 1997, p. 39). This theme was carried on by other sexologists, who characterized homosexuals or *inverts* as psychopathological degenerates (Gibson, 1997). Some argued that inverts also suffered from gender discordance, while others believed their attraction to the same-sex was delusional and fetishistic in nature (V. A. Rosario, 1997). The German sexologist Max Marcuse published a 1916 article on the "drive for sex transformation, in which he distinguished the request for sex-change surgery from more generalized sexual inversion or crossgender identification." (Meyerowitz, 2002, p. 18).

In their book, *Sexual Inversion*, Ellis and Symonds (1897) described sexuality as "comparatively undifferentiated in early life" (p. 39). They posited that permanent inversion in later life was caused by arrested development and a sign that the person was abnormal from birth. This portrayal of inversion as a predetermined congenital condition countered the more common view which equated homosexual behavior with degeneracy (Pettis, 2004). Ellis also argued against attempts to cure inverts of their abnormality. It was his belief "it is often not difficult to prematurely persuade an invert that his condition is changed…if he experiences some slight attraction to a person of the opposite sex he hastily assumes that a deep and permanent change has occurred" (Ellis & Symonds, 1897, p.145). Ellis believed that any change experienced was temporary and would not eradicate a man's instinctual inversion (Ellis & Symonds, 1897).

During the late 19th century, women's demands for education and equal rights also led to an increase in medical reports of female inversion, as well as "the creation of the 'mannish lesbian' (Gibson, 1997, p. 111). Normal females were considered to be asexual. Arguments that

female inverts were essentially masculine, and therefore not truly female, allowed for a continuing view that asexuality in women was normal, healthy and preferred. There was also a pronounced fear that female inversion was contagious, and that female inverts would increase their numbers through "encounters with 'experimenting' women" (Gibson, 1997, p.124).

In this same period, a growing number of scientists in Europe and the United States began to challenge the notion of separate and opposite sexes. In conjunction with the movement toward equality between the sexes, many social scientists of the period began to emphasize what men and women had in common. Other scientists focused on the physical body, arguing "that male and female were ideal types that did not actually exist in reality. All women and men . . . fell somewhere in between the two idealized poles" (Meyerowitz, 2002, p. 22). They conflated sex, gender, and sexuality, grounded these traits in what we now call biological sex, posed them all as signs of the physical condition, and framed physical bisexuality (having a mixture of masculine and feminine traits) as the default human condition. Earlier theories had proposed three categories of sex: male, female, and intermediate. This latter category often included "hermaphroditism and sometimes also homosexuality as unusual mixed-sex or intermediate conditions" (Meyerowitz, 2002, p. 24).

Freud's first writings on the subject of homosexuality were published in 1905. Although he has been portrayed as anti-homosexual, taken within historical context Freud can be described as supportive and affirming of homosexuality (Freud, 1951; Rothblum, 2000). In reality, it was Freud's successors who "were mainly responsible for characterizing homosexuality as a perversion, needing professional intervention" (Sullivan, 2003, p. 7). Psychoanalytic theory was used to justify conversion or reorientation therapies (Rothblum, 2000). The medical community also played a powerful role at this time in classifying homosexuals as mentally ill individuals who needed treatment. By the 1930s, and increasingly after World War II, sociological perspectives continued to bolster the belief that heterosexuality was required for healthy and normal psychosexual development—defining homosexuality as a perversion and a sign of mental impairment and defectiveness (Sullivan, 2003).

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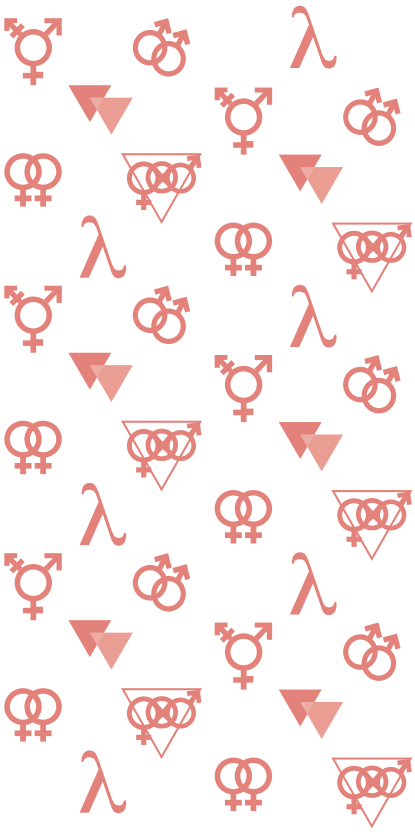
Although the primary view of homosexuality as pathological remained, there were those who began to challenge its validity. Kinsey's study of human sexuality beginning in the late 1930s found that homosexual behavior is common. Although he made no pronouncements as to what is "normal," his research indicated that gay men and lesbians are a significant percentage of the population (Kenen, 1997; Sullivan, 2003) and that the percentage of people whose sexual behavior is bisexual is greater than that percentage which is exclusively heterosexual or homosexual (H. B. Green, Payne, & J. Green, 2011). Prior to Evelyn Hooker's landmark study in the 1950s, mental health research had only been conducted on gay men in psychiatric settings (Cochran & Mays, 2006). Hooker, a psychologist, chose to conduct her research comparing "normal" gay men and their heterosexual counterparts. In 1956, Hooker presented her empirical data which found "that homosexual men were as well adjusted as heterosexuals" (Rothblum, 2000, p. 73) to the American Psychological Association.

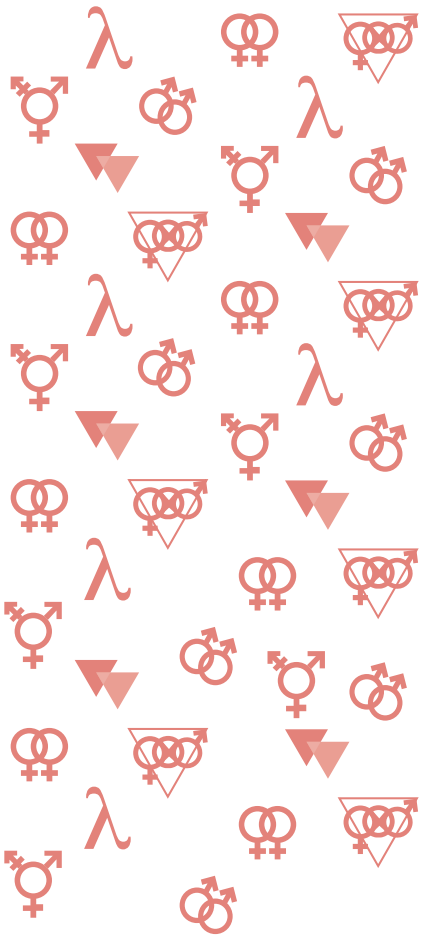


Prior to 1970, practically all clinical textbooks defined homosexuality in pathological terms.

(Hellman & Drescher, 2004)

The Diagnostic and Statistical Manual of Mental Disorders

Prior to 1970, practically all clinical textbooks defined homosexuality in pathological terms (Hellman & Drescher, 2004), and most still label much of transgender experience as disordered. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA) as a tool for clinical diagnosis, has included homosexuality in various ways. The DSM-I, first published in 1952, labeled homosexuality as a "sociopathic personality disturbance" (Lev, 2005, p. 40). The DSM-II, published in 1968, also included Homosexuality as a mental illness (Rothblum, 2000). It was listed as the first of 10 sexual deviations—which included necrophilia, pedophilia, and sexual sadism (Kutchins & Kirk, 1997). In the early 1970s, gay activists and their allies challenged the inclusion of Homosexuality in the DSM. Using the work of Hooker, Kinsey and others, gay activists and their allies argued that homosexuality did not fit the criteria for mental illness (Uldall & Palmer, 2004) and such inclusion was not scientifically correct (American Psychiatric Association [APA], 1973).



The common belief is that Homosexuality was removed from the DSM-II in 1973 (Kennedy, 1997; Lev, 2004; Sullivan, 2003; Uldall & Palmer, 2004). The diagnosis was actually replaced in the DSM-III with Ego-dystonic Homosexuality (Lev, 2005), "characterized by guilt,

shame, anxiety, and depression" (Sullivan, 2003, p. 6) regarding one's same-sex desires. According to the APA's (1973) position statement at the time, "this change should in no way interfere with or embarrass those dedicated psychiatrists and psychoanalysts who have devoted themselves to understanding and treating those homosexuals who have been unhappy with their lot" (p. 3). In addition, the writers of the position statement emphasized: "by no longer listing it [Homosexuality] as a psychiatric disorder we are not saying that it is 'normal' or as valuable as heterosexuality" (p. 2). Nor was the support for removing Homosexuality from the DSM overwhelming, as the recommendation was only ratified by 58% of the APA membership (Kennedy, 1997). Not long after the removal, a survey of 2,500 APA members revealed "that a majority considered homosexuality pathological and also perceived homosexuals to be less happy and less capable of mature and loving relationships than heterosexuals" (Rothblum, 2000, p. 74). The official stance, that lesbians, gay men and bisexual individuals were not mentally ill, did allow for the development of gay-affirmative counseling as well as bolstering the case for gay civil rights (Lev, 2005).

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(Lev, 2005)

Ego-dystonic Homosexuality was not included in the DSM-IV, leading to the common belief there is no longer a diagnostic category for homosexuality in the DSM (Alexander, 2002; Boysen, Vogel, Madon, & Wester, 2006). A more thorough examination reveals a reference under the category of Sexual Disorder Not Otherwise Specified (NOS) with the statement: "Examples include… Persistent and marked distress about sexual orientation" (APA, 2000a, p. 252). Although homosexuality is not specifically mentioned, clearly this is not intended for diagnosing and treating distressed heterosexuals (Lev, 2004). There are clinicians who continue to view homosexuality as pathological and in need of treatment (Lev, 2004; Logie, Bridge, & Bridge, 2007; National Association for Research & Therapy of Homosexuality [NARTH], 2012b; Nicolosi & Nicolosi, 2002; Stacey & Biblarz, 2001). If they are utilizing the DSM, Sexual Disorder NOS is one avenue of diagnosis and the other is Gender Identity Disorder (Bartlett, Vassey, & Bukowski, 2000; Langer & Martin, 2004; Lev, 2004, 2005; Nicolosi & Nicolosi, 2002). The conflation of gender variant behavior with homosexuality was a common theme among sexologists (Gibson, 1997; Kennedy, 1997; V. A. Rosario, 1997) and appears to continue to the present with the use of the Gender Identity

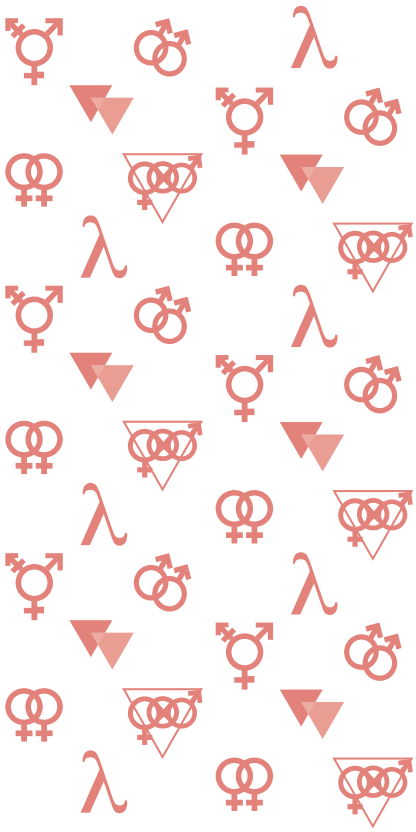
Disorder diagnosis (Bartlett, et al., 2000; Hill, Rozanski, & Carfagnini, 2005; Lev, 2005).

Gender Identity Disorder (GID)

Gender Identity Disorder (GID) is the current nomenclature in the American Psychiatric Association's Diagnostic and Statistical Manual, version IV-TR (2000) that describes the experience of strong identification with "the opposite sex." This nomenclature first appeared in DSM-IV (1994). Prior to that, DSM-III (1980) contained the category of Transsexualim, which included many of the features that were incorporated into the later GID diagnosis. It is anticipated that this nomenclature and diagnostic criteria will change again in DSM-V, which is scheduled to be released in May, 2013 (American Psychiatric Association [APA], 2011). Conflation of sex and gender categories, as well as binary and extreme views of sexual orientation and of the meanings of sexual behaviors as interpreted by psychiatrists and other mental health professionals have long contributed to the difficulties for transgender and transsexual people alike (J. Green, 2011). This is because transgender issues are different from transsexual issues, and both are different from issues faced by lesbian, gay, and bisexual people (J. Green, 2004).

A common misperception that ties LGB and T people together in the public mind is the notion that gay men want to be women and that lesbians want to be men. Ideas concerning same-sex sexual desire or sexual behavior often imply the belief that such sexual expression is indicative of a desire to replicate "normal, heterosexual" behavior, even to the extent of changing one's body. If this were true, the demand for surgical sex reassignment would likely be much higher than it is. The need for physical change is reflective of gender identity, not sexual orientation—that is, it is dependent on how one sees one's self, not on to whom one is attracted sexually (J. Green, 2004).

The first male-to-female sexual reassignment surgeries (SRS) were performed in Germany in the early 1920s by Dr. Levy-Lenz (Abraham, 1997). SRS were originally conceived as the creation of genitalia in as close a replication of the "opposite" sex as was technically possible, accompanied by sterilization. The modern definition takes individual needs into account. It is currently defined as: "Surgery to change the primary and/or secondary sex characteristics to affirm a



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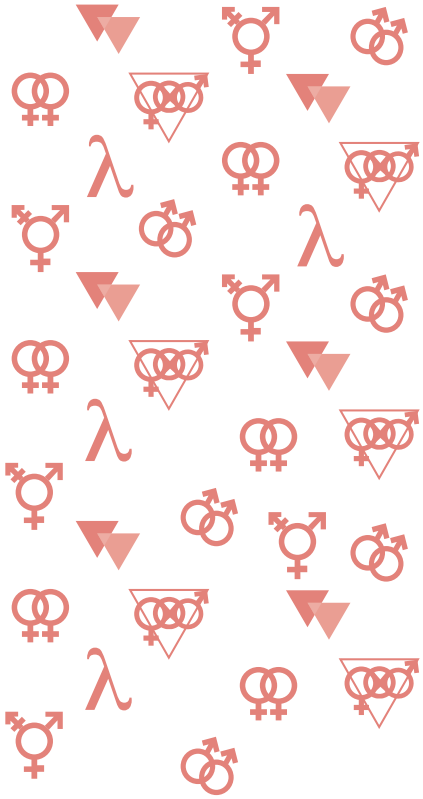

person's gender identity" (Coleman et al., 2011, p. 97). Sterilization is no longer required for legal change of sex in the United States and many other countries.

In the United States, SRS first received widespread public attention in 1952, with the sex reassignment of Christen Jorgensen. The "sudden" possibility of SRS awakened an unforeseen interest in treatment across the United States, as documented by Dr. Harry Benjamin (1966). In the 1970s, many psychiatrists made an effort to prevent the condition of adult transsexualism from developing in children whom they deemed displayed unacceptable levels of cross-gender behavior (Bartlett, et al., 2000). Gender Identity Disorder of Childhood (GIDC) first appeared as a psychiatric diagnosis under the heading of *Psychosexual Disorders* in the DSM-III. It was later moved to the section titled *Disorders First Evident in Infancy, Childhood, or Adolescence* (Langer & Martin, 2004). Today, it resides in the DSM-IV-TR in the *Sexual and Gender Identity Disorders* section under the general heading of GID with a code to distinguish GID in children from that found in adolescents or adults (APA, 2000a). Aside from the shifting conceptualization of GIDC, there has also been some change in criteria. For example, in the DSM-III boys did not have to state a desire to be the opposite sex, although girls did (Langer & Martin, 2004). In the DSM-IV-TR, a "repeatedly stated desire to be, or insistence that he or she is, the other sex" (APA, 2000a, p. 581) is no longer required for a diagnosis of GIDC. Langer and Martin (2004) state that one concern regarding this change is this diagnosis may now be applicable to a greater number of children.

There is extensive criticism of the GID diagnosis (Bartlett, et al., 2000; Brownlie, 2006; Burgess, 1999; Haldeman, 2000; Hill, et al., 2005; Hughes & Eliason, 2002; Langer & Martin, 2004; Lev, 2005; Winters, 2005). The GID diagnosis labels transgender individuals as mentally ill. Hughes and Eliason (2002) argue there is no empirical evidence which supports such a label. The nomenclature of GID implies that there is a natural, normal, non-disordered way to express gender, and anyone who deviates from that expression can not only be considered deficient, but may be diagnosed as mentally ill (Lev, 2005). As part of their critique, Langer and Martin (2004) contend "there is little evidence of diagnostic reliability for GIDC among boys, and virtually none among girls" (p. 9).

Diagnosing gender nonconformity presumes there is a consensus on what is and is not gender appropriate. There is a lack of agreement

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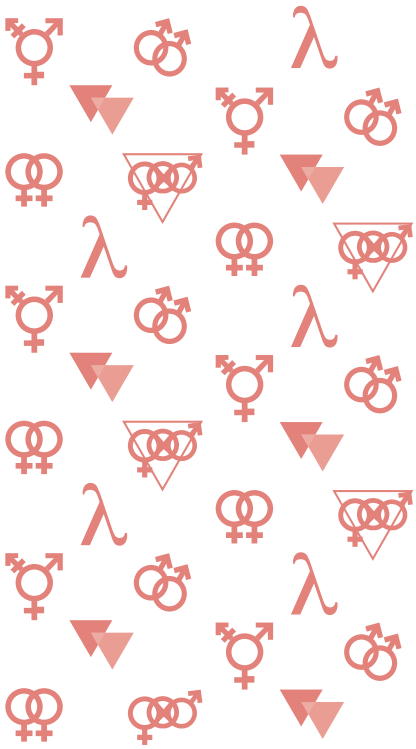
(Lev, 2005)

across cultures and over time, however, as to what is appropriately masculine and feminine, making gender roles and gender-appropriate behavior social constructs (Cahill, 2000; J. Green, 2000; Langer & Martin, 2004). Further, because our society values masculinity over femininity, family and peers view masculine behavior in girls as less troublesome than feminine behavior in boys. This is highlighted by reports that boys are brought in for GID treatment at 6 times the rate as girls. The demonstration that socially desirable, yet equally gender nonconforming, behavior in girls does not cause the same requests for treatment "serves to underscore the socially constructed nature of GID" (Haldeman, 2000, p. 194).

Comfort with one's biological sex is statistically the norm. Those with cross-gender identification deviate from the norm to varying degrees. Langer and Martin (2004) argue that the GID diagnosis assumes that deviation from the norm equals dysfunction. Evidence of people with cross-gender identification in historical accounts and in cultures around the world suggests this may simply be a normal variation of human behavior. Relying on deviation from the norm as the definer of dysfunction raises questions of how much gender conformity is enough and how much gender nonconformity is too much—and who will be the arbiters of normal versus pathological gender expression (Brownlie, 2006). Haldeman (2000) argues that a child who prefers play objects and activities which are considered gender nonconforming could be diagnosed with GID on this basis alone. Hill, et al. (2005) use as an example a girl who enjoys activities which are stereotypically male, is uncomfortable with personal expressions of typical femininity, and yet is very aware she is female with no desire to change her sex. They state that, according to the literature, this girl would be diagnosed with GID Not Otherwise Specified.

Supporters for treating GID in children state three principal objectives: 1) minimize social rejection; 2) treatment of latent psychopathology; and 3) protection against developing adult transsexualism (Haldeman, 2000). When a child is ostracized or bullied by their peers for other reasons, such as physical disabilities, racial discrimination or religious differences, the solution has not been to ask the child to change, but to find interventions which remedy the social oppression (Lev, 2005).



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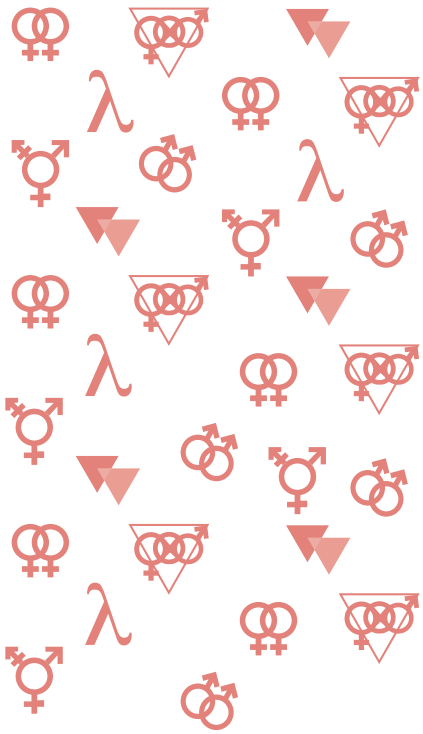


There is no evidence transsexualism is the result of underlying psychopathology or that gender-variant individuals are mentally ill.

(Hill, et al., 2005; Hughes & Eliason, 2002; Langer & Martin, 2004)

There is no evidence transsexualism is the result of underlying psychopathology or that gender-variant individuals are mentally ill (Hill, et al., 2005; Hughes & Eliason, 2002; Langer & Martin, 2004). Further, no direct link has been established between childhood gender nonconformity and adult transsexualism, nor has research shown that most children diagnosed with GID grow up to be transsexual (Haldeman, 2000; Hill, et al., 2005; Lev, 2005). Rather, research indicates the most likely outcome of a GID diagnosis in childhood is that the child will grow up to be LGB (Bartlett, et al., 2000; Lev, 2005). As there is not 100% concordance between gender variance and LGB orientation, a substantial number will grow up to identify as heterosexual (Haldeman, 2000). Very few of either group will identify as transsexual in adulthood (Lev, 2004; W. Meyer, et al., 2001). One of the dangers of GID, therefore, is the pathologizing of what may be normative pre-LGB childhood behavior. As LGB sexual orientation is no longer included as a mental illness in the DSM, the question becomes whether there is value in diagnosing pre-LGB children as gender-disordered (Bartlett, et al., 2000; Haldeman, 2000).

GID treatment protocols for children identify prevention of future homosexuality as a compelling factor (Langer & Martin, 2004; Lev, 2005). Some have argued that the GIDC diagnosis was created as a way to justifiably treat children suspected of homosexual tendencies, as the inclusion of the diagnosis in the DSM coincidentally occurred when homosexuality was removed. Further, psychiatry has long associated homosexuality with gender nonconforming behavior (Langer & Martin, 2004). Parents often bring their gender-variant child in for psychological treatment because of fear their child may be homosexual (Haldeman, 2000; Langer & Martin, 2004). In his book, *A Parent's Guide to Preventing Homosexuality*, under the section titled "Identifying Gender-Identity Disorder (GID)," Nicolosi states: "I believe in a reparative approach to gender-identity conflict. Something is lacking in the GID…child's sense of himself as truly male…The effeminate boy is an exaggerated case of the general syndrome of gender nonconformity that leads to homosexuality" (Nicolosi & Nicolosi, 2002, p. 44). Of possibly more concern is this additional rationale for diagnosis and treatment: "Many of the children we describe—in the course of their development toward homosexuality—fell short of the strict criteria for a clinical diagnosis of GID, but the warning signs of gender conflict and

homosexuality were there nonetheless" (Nicolosi & Nicolosi, p. 13). The GID diagnosis, therefore, can be used by mental health professionals who believe homosexuality represents treatable mental illness, essentially continuing the pathologizing of LGB youth by using this convenient alternative diagnostic category (Lev, 2004, 2005).

There are no empirical research findings indicating that transsexual-identity development or LGB-identity development can be altered through childhood therapeutic intervention (Haldeman, 2000). Further, Langer and Martin (2004) observe that treatment protocols for children diagnosed with GID are strikingly similar to those used in conversion or reparative therapies for homosexuality. Conversion and reparative therapies have been condemned by professional mental health organizations (American Psychological Association Council of Representatives, 1997; APA, 2000b; NASW National Committee on Lesbian, Gay, and Bisexual Issues, 2000; Pan American Health Organization [PAHO], 2012), in part because of potentially harmful consequences for the client (Langer & Martin, 2004). Studies indicate that pressure to conform to gender stereotypes can create stress, lower self-esteem and cause internalization of difficulties (Hill, et al., 2005). Haldeman (2000) expresses concern these therapies may communicate to the gender-variant child they are somehow damaged, intrinsically undesirable as who they are, and that they have only themselves to blame for the pain inflicted on them by a non-accepting society. The *Standards of Care (SOC) for The Health of Transsexual, Transgender, and Gender Nonconforming People (formerly the Standards of Care for Gender Identity Disorders)*, published by the World Professional Association for Transgender Health (WPATH), are internationally accepted as the professional guidelines for the treatment of GID. Hill, et al. (2005) highlight that reparative therapies for GID in children contravene the guidelines for psychological intervention listed in the SOC, and the latest version of the SOC specifically calls these therapies unethical (Coleman, et al., 2011, p. 16).

Proponents of the GID diagnosis state it affirms and validates transgender experiences, makes their issues valid mental health concerns, and creates a framework for mental health practitioners. However, as the revision process for DSM-V has progressed, it is starting to become clear that there are alternative, less pathologizing pathways to accomplish these goals (J. Green, personal communication, June 4, 2012).

Etiology: The "Choice" Debate.

With the concept of homosexuality as an identity came the speculation as to the cause. Historically, there have been three basic positions in this discussion: 1) the cause is biological; 2) the cause is environmental; and 3) both biological and environmental causes are the source (Ellis & Symonds, 1897; Gibson, 1997; Kennedy, 1997; Nicolosi & Nicolosi, 2002; Rothblum, 2000; Sullivan, 2003; Wikholm, 1999). What may be interesting to note is that this speculation does not include what causes heterosexuality, highlighting a presumption that heterosexuality is the normative and therefore natural sexual orientation (Long & Lindsey, 2004). In addition, there is the supposition that heterosexuality and homosexuality are opposites, rather than "variations on a single theme of human romantic attachments, sexual attraction, and the capacity for love" (R.-J. Green, 2004, p. xiv).

The etiology of any human sexual orientation or gender identity is unknown (Frankowski, et al, 2004; Institute of Medicine [IOM], 2011). No scientific evidence exists which indicates poor parenting, sexual abuse, or other traumatic or adverse life events influences the development of a non-heterosexual orientation (Frankowski, et al., 2004; Perrin, 2002). While many theories continue to exist, the debate over what causes a person to "become" non-heterosexual can be controversial and political—with influences over mental health providers and the quality of services they offer to LGBTQ individuals.

The pivotal issue in the question of etiology appears to be whether or not sexual orientation is a choice (Perrin, 2002). Studies indicate that those who have a negative view of homosexuality adhere to theories which conclude sexual orientation is a choice (Sullivan, 2003). These theories are the basis for reparative or conversion therapies. The belief that homosexuality is based in biological or genetic causes appears to promote a more accepting view (Sullivan, 2003), a finding replicated in a recent study of social work students (Swank & Raiz, 2007). According to Perrin (2002), there are basic flaws in this debate. One flaw is equating etiology with choice. Whatever the cause, there is extensive evidence demonstrating individuals cannot change their sexual orientation—which would indicate it is involuntary and not a choice. A second flaw is the viewpoint that a chosen orientation should have less validity, equal rights and protection than an involuntary orientation. Perrin cites that religion is neither inborn or involuntary, yet we value and protect the diversity

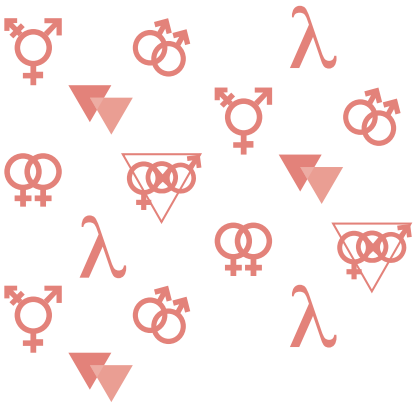
Whatever the cause, there is extensive evidence demonstrating individuals cannot change their sexual orientation—which would indicate it is involuntary and not a choice.

(Perrin, 2002)

of religious belief. She argues it would be ethically suspect to allow discrimination against "certain members of a society…based on whether they had *chosen* their particular way of being or it had been imposed on them" (p. 53). Some individuals view trans-ness (whether transsexual or transgender) as an extreme form of homosexuality, and therefore also a choice or a perversion, and consequently treatable through curative or punitive practices (Bailey, 2004; J. Green, 2011).

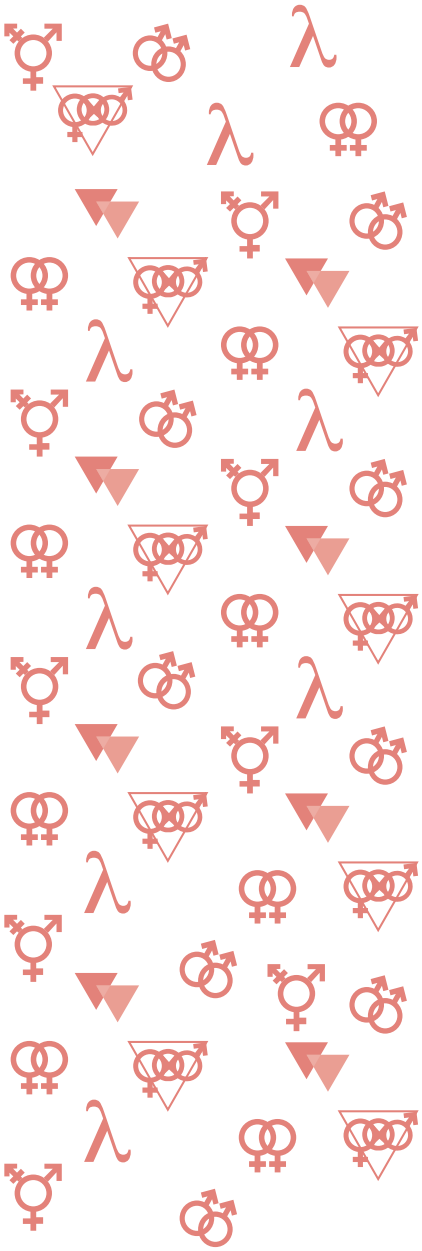
Heterosexism and homonegative bias within mental health care are expressed in the extreme through those practitioners who advocate and practice reparative or conversion therapies (Crisp, 2006; Jenkins & Johnston, 2004; Mallon, 2001). Conversion or reparative therapy—the attempt to change a person's sexual orientation to heterosexual—first emerged in the 1800s. At that time, common techniques used on homosexual men included: "visits to prostitutes, marriage… isolation with a woman for 2 weeks…electroshock…lobotomies, and castration" (Bieschke, et al., 2000, p. 311; for contemporary reflection on these patterns, particularly relating to gender nonconformity, see Burke, 1996). Today, conversion and reparative therapies have been condemned by major professional organizations (Crisp, 2006), including the American Psychological Association, APA, and NASW (American Psychological Association Council of Representatives, 1997; APA, 2000b; NASW National Committee on Lesbian, Gay, and Bisexual Issues, 2000). Despite this censure, there are those mental health practitioners who continue to practice reparative and conversion therapies, as well as advocate for their use (Jenkins & Johnston, 2004; Mallon, 2001; NARTH, 2012b; Nicolosi & Nicolosi, 2002).

The National Association for Research and Therapy of Homosexuality (NARTH), founded in 1992 (Zucker, 2003), is one of the major organizations of what is known as the ex-gay movement (Burack & Josephson, 2005). The ex-gay movement is made up of organizations that work to eliminate same-sex desires in people who have them—including encouraging them to enter into heterosexual relationships. NARTH has as its premise that sexual orientation is caused by environmental factors and therefore can be cured through reparative techniques (NARTH, 2012b). NARTH attracts professionals from all over the world and its current officers include three psychologists, a Licensed Marriage and Family Therapist, a psychotherapist, and a psychoanalyst who is also a former Clinical Professor of Psychiatry at the University of California, Davis (NARTH, 2012a). The ex-gay movement uses its own research



Reparative therapy negates bisexuality. It traumatizes people severely and has them cling to their identity and never even consider bisexuality. It is so ingrained that you are in the dichotomy [of sexual orientation].

Bisexual Advisory Group member



to substantiate their claims that homosexuality is curable. Burack and Josephson (2005) state: "This research continues to be generated by conservative Christian authors and academics who are committed to the conclusion that same-sex sexuality is dysfunctional and contrary to God's will" (p. 10). Joseph J. Nicolosi, PhD, psychologist and past-president of NARTH, has reacted to the American Psychological Association's opposition to NARTH's positions as an indication that the organization has been co-opted by gay activists (Burack & Josephson, 2005). In his book, *A Parent's Guide to Preventing Homosexuality*, Nicolosi states: "My premise is that all people are, by their nature, heterosexual; some people, however, have a homosexual *problem*. More accurately, I consider the word *homosexual* to be shorthand for 'a heterosexual person with a homosexual problem'" (Nicolosi & Nicolosi, 2002, p. 173).

The NARTH position on transgender children who express a gender identity different from their apparent biological sex, and on transsexual male-to-female adults (as published on the NARTH web site in articles that are often undated) is that both manifestations of gender variance result from attachment problems generated by a psychological disturbance in the mother (Nicolosi, 2009). One author, Sander Breiner, M.D. (a member of NARTH's Scientific Advisory Committee), in an article entitled *Transsexuality Explained*, states: "There are a significant number of male homosexuals who would like to become a female with a penis" (Breiner, 2010). This view of both homosexuality and transsexuality may apply to some individuals, but it is extremely offensive to most gay men and transsexual women (Smith, 2003).

There is no empirical research demonstrating that reparative or conversion therapies are effective in changing an individual's sexual orientation (Bieschke, McClanahan, Tozer, & Grzegorek, 2000; Burack & Josephson, 2005). While their external sexual behavior may appear heterosexual, the individual's "internal goodness of fit remains gay or lesbian" (Mallon, 2001, p. 64). Such therapeutic techniques can be harmful, causing shame, guilt, and the possibility of irreparable psychological and spiritual damage (Jenkins & Johnston, 2004). One of the most often cited articles in support of the possibility of changing one's sexual orientation was published in *Archives of Sexuality* (Spitzer, 2001), which made no claims for the success rate of reparative therapy, but concluded that for a highly select group of motivated individuals, it worked. However, in 2012, Dr. Robert Spitzer repudiated his own study,

saying he knew his study was flawed, his conclusions invalid, and he owed the gay community an apology for any harm he caused (Arana, 2012; Carey, 2012; Grindley, 2012).

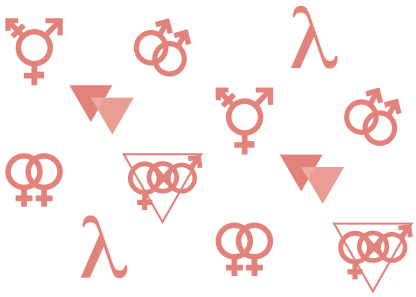
The Many Forms of Stigma

Mental health stigma. According to the U.S. Department of Health and Human Services (1999):

> Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders… It reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society. (p. 6)

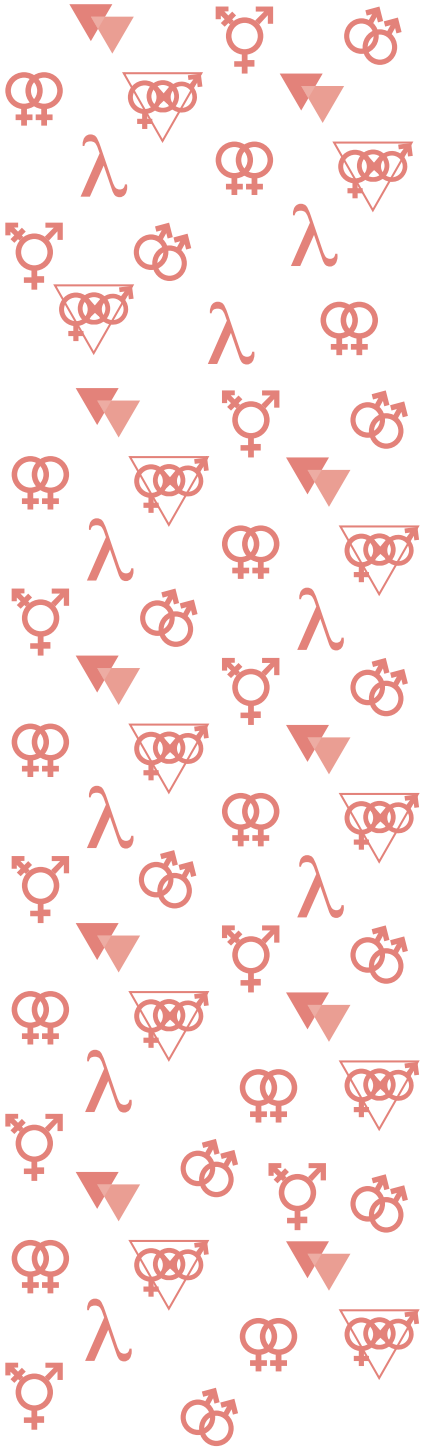
Mental health concerns have long been characterized by profound stigma and misunderstanding. Skepticism about psychoanalysis, psychiatry, psychology, talk therapy, and medications to control thoughts and behavior has been for lay persons the safest reaction to the topic, since public disapproval has been so common. Fear of "craziness" and shame about needing help for mental health concerns have long created effective barriers to care in many communities throughout California and the United States (DMH, 2008). A simple Google search reveals extensive literature documenting the effects of stigma in relationship to psychological issues and mental health.

Homophobia, transphobia and heterosexism. Stigma in relation to LGBTQ people is exacerbated by the existence of homophobia, transphobia, and heterosexism. The term *homophobia* was first coined by George Weinberg and popularized in his 1972 book *Society and the Healthy Homosexual* (Herek, 2000). Although it is indicated in the direct translation of the word, "*homophobia* seldom refers to a phobic or fearful response. Often, though, it is used to indicate *anti-homosexuality prejudice*" (Ritter & Terndrup, 2002, p. 12). Some argue, however, the term implies that anti-gay attitudes are merely a type of individual neurosis, instead of a societally reinforced prejudice (Herek,



LGBT elders grew up in a climate wherein seeking psychotherapy was seen as something for "crazy" people.

Older Adult Advisory Group member



Mental health professionals are always asking "why" we are this way (either trans or LGBQ). [We] need to teach therapists why this might be offending.

Transgender Advisory Group member

The belief that homosexuality is a choice is used to "blame the victim" and justify discrimination.

(LaSala, 2006)

2000; Sullivan, 2003). The term *heterosexism* came into use in the early 1970s. Its ideology has been compared with sexism and racism (Herek, 2000; Krieglstein, 2003; Ritter & Terndrup, 2002), and may therefore be a more accurate term than homophobia (Ritter & Terndrup, 2002; Snively, Kreuger, Stretch, Watt, & Chadha, 2004). Heterosexism is defined by Herek (1990) "as an ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community. It operates principally by rendering homosexuality invisible and, when this fails, by trivializing, repressing, or stigmatizing it" (Herek, 1990, p. 316). The term *transphobia* appeared in the 1990s, evolving from the term homophobia, but meaning fear of transness or fear of apparently unstable sex or gender (Stryker, 2008). Both homophobia and transphobia are capable of manifesting as extreme violence toward the perceived homosexual, transgender or transsexual target, who then may be verbally, emotionally or physically assaulted, often ostensibly as punishment for the victim's transgression of expected "normal" appearance or behavior (Wilchins, 1997).

Heterosexism permeates our society, promoting and condoning prejudice and bigotry against LGBTQ individuals. The belief that homosexuality is a choice is used to "blame the victim" and justify discrimination (LaSala, 2006). One study indicated LGB individuals are twice as likely to experience a life event associated with prejudice than heterosexual individuals (I. H. Meyer, 2003). Individuals are empowered by the hegemony of heterosexism (Krieglstein, 2003) to express "anxiety, fear, disgust, anger, discomfort and aversion" (Snively, et al., 2004, p. 63) which may also manifest in hostile or violent actions against one or more LGBTQ individuals. A study on hate-crime victimization in the Sacramento area found approximately 20% of the women and 25% of the men had faced criminal victimization (including sexual and physical assault) related to their sexual orientation (Herek, et al., 1999).

A variety of beliefs and stereotypes regarding LGBTQ individuals fuel heterosexism and homophobia. Among them are:

- Heterosexual attraction is necessary for biological reproduction and is therefore the only natural state (Phillips, 2006).
- Same-sex relationships are only sexual in nature and cannot have the depth and quality of heterosexual relationships (Crisp, 2006), nor should same-sex couples be allowed the same legal status as male/female couples (ProtectMarriage, 2008).

- Same-sex sexual relationships are sinful and prohibited by the Bible (Crisp, 2006; Sullivan, 2003).
- Children are at risk of sexual abuse by gay men and lesbians (Boysen, et al., 2006; Crisp, 2006; Sullivan, 2003).
- Homosexuality, bisexuality and gender-variancy is a choice and can be changed or cured (Crisp, 2006; Nicolosi & Nicolosi, 2002; Sullivan, 2003).

Many of these beliefs are maintained even though there is substantial and continually mounting evidence to the contrary.

Internalized stigma. The absorption of society's anti-gay and anti-transgender messages into one's self-perception, known as *internalized homophobia*, *internalized transphobia*, or *internalized sexism* affects all LGBTQ individuals to varying degrees (DiPlacido, 1998; R.-J. Green, 2004; I. H. Meyer, 2003; Otis, Rostosky, Riggle, & Hamrin, 2006; Serano, 2007). Studies indicate internalized homophobia and transphobia can lead to psychological distress and mental health issues. Consequences can include lower self-esteem to overt self-hatred, guilt, depression, anxiety, substance abuse, and suicidal ideation (Boysen, et al., 2006; Connolly, 2004; DiPlacido, 1998; Holeman & Goldberg, 2006; Logie, et al., 2007; I. H. Meyer, 2003; Morrow, 2004; Otis, et al., 2006). High levels of internalized homophobia have been linked to limited success in both intimate relationships and career pursuits (Otis, et al., 2006). While supportive relationships with family members, friends, romantic partners and/or LGBTQ communities can help to mitigate negative consequences (DiPlacido, 1998), the absence of external validation serves to increase internalized homophobia (Connolly, 2004). Possibly the most insidious feature of internalized homophobia is that the LGBTQ individual is unlikely to be aware they are affected by it (Van Den Bergh & Crisp, 2004). Likewise, the specter of internalized sexism can have a profoundly negative effect on gender nonconforming, transgender, and transsexual people, resulting in miscommunicated gender signals, lack of ability to properly read social cues, and loss of self-esteem. Trans people are often berated for violating gender and sex norms, but also for trying to conform to them (Serano, 2007).

Possibly the most insidious feature of internalized homophobia is that the LGBTQ individual is unlikely to be aware they are affected by it.

(Van Den Bergh & Crisp, 2004)

Minority Stress

In its general form, stress theory posits that individuals may be exposed to external events or circumstances which overwhelm their

ability to effectively cope. This, in turn, can precipitate mental health difficulties or physical illness. Stress theory has been extended by some to include social stress factors, suggesting that negative mental and physical consequences can arise from exposure to a stressful social environment and not exclusively from personal events. Social stress theory posits an individual's experience of prejudice and discrimination may require personal adaptation which produces stress (I. H. Meyer, 2003). Minority stress theory further distinguishes the excessive and chronic stress experienced by individuals who are members of socially stigmatized minority groups (I. H. Meyer, 2003; Otis, et al., 2006). Brooks (1981) defines minority stress as "a state intervening between the sequential antecedent stressors of culturally sanctioned, categorically ascribed inferior status, social prejudice and discrimination, the impact of these environmental forces psychological well-being, and consequent readjustment or adaptation" (p. 107).

I. H. Meyer (2003) states three assumptions underlying the concept of minority stress:

1. Minority stress is unique and in addition to stressors faced by all people. Individuals experiencing minority stress are therefore required to make a greater adaptation effort than those who are not members of a stigmatized minority.
2. Minority stress is chronic.
3. Minority stress is socially based and "stems from social processes, institutions, and structures beyond the individual" (p. 676) and which the individual has minimal to no control over.

While minority stress theory has predominantly focused on the effects of stress on racial and ethnic minority members, this model has also been applied to LGBTQ individuals (Brooks, 1981; DiPlacido, 1998; I. H. Meyer, 2003; Otis, et al., 2006). These individuals are exposed to stigma, prejudice, discrimination, harassment, sexual abuse and physical violence as a result of their LGBTQ status (Badgett, 2000; Bradford, 2004; Cahill, 2000; Cianciotto & Cahill, 2003; D'Augelli, Grossman, & Starks, 2006; Dworkin, 2006; J. Green, 2000; Herek, Cogan, & Gillis, 1999; IOM, 2011; Juang, 2006; Kosciw, Diaz, & Gretak, 2008; Kuvalanka, Teper, & Morrison, 2006; LaSala, 2006; Lev, 2004; Monro, 2000; Valentine, 2007). Such exposure causes stress for LGBTQ individuals which is in addition to stressors experienced by all people, is pervasive in nature and essentially beyond their control. Therefore,

1. Minority stress is unique and in addition to stressors faced by all people. Individuals experiencing minority stress are therefore required to make a greater adaptation effort than those who are not members of a stigmatized minority.
2. Minority stress is chronic.
3. Minority stress is socially based and "stems from social processes, institutions, and structures beyond the individual" and which the individual has minimal to no control over.

(I. H. Meyer, 2003)

[The] focus of services needs to center around changing the levels of institutional oppression. Reducing institutional oppression would help me feel like my comments are valid and not going to get shoved in the drawer and forgotten.

East Bay Community Dialogue participant

the stress experienced by LGBTQ people fits the conceptualization of minority stress as described by I. H. Meyer (2003) as it is unique, chronic, and socially based. Otis, et al. (2006) include the psychological costs of remaining closeted and the internalization of anti-LGBTQ societal messages as additional sources of minority stress.

When exposed to a stressful event, individuals will develop behavior which is either adaptive or maladaptive. As the duration and intensity of the stress increases, so does the probability of maladaptive behavior (Brooks, 1981). Brooks (1981) argues: "on the basis of these findings…it would be reasonable to assume that minority-group members would evidence higher rates of dysfunction than majority-group members" (p. 80). Research "clearly demonstrates that LGB populations have higher prevalences of psychiatric disorders than heterosexuals" (I. H. Meyer, 2003). In addition, those working with the transgender population state symptoms such as low self-esteem, suicidal ideation, self-harming behavior, depression, anxiety, insomnia and eating disturbances are a reaction to and the result of societal discrimination, stigma and abuse (Carroll, Gilroy, & Ryan, 2002; Denny, 2004; Lev, 2004).

All LGBTQ people are exposed to unique and chronic socially-based stressors. Brooks (1981) states "the central factor in their varying responses is the availability of mediating resources" (p. 107). This would suggest that access to competent mental health services could help mitigate the negative effects of minority stress for LGBTQ individuals.

Majority Rules—Anti-LGBTQ Initiatives

In many areas of social life, significant gains are being made to protect the rights and livelihoods of LGBTQ people. A recent report by the Human Rights Campaign (2011) notes there have been advancements in marriage equality, anti-bullying legislation, and gender identity protections. Yet, anti-LGBTQ legislation is still prevalent and continues to be a source of minority stress for LGBTQ people (Human Rights Campaign [HRC], 2011). Though some of the more contested pieces of legislation surround relationship recognition, LGBTQ people also face anti-LGBTQ policies/legislation in employment, housing, child adoption, and hate crime laws. Transgender and gender nonconforming people face similar discriminatory practices and experience additional discriminatory policies in health insurance and identity recognition.

[We are] dealing with multiple forms of oppression on a regular basis, both externalized and internalized, such as racism, sexism, homophobia, transphobia, heterosexism, and classism, which can lead to trauma responses,…substance use issues, self-hatred/self-esteem issues, violence, and abuse, to name a few.

Black/African American Advisory Group member

Lack of legal protections have numerous consequences both emotionally and financially.

(HRC, 2011)

As mentioned elsewhere in this report, relationship recognition is not available for LGBTQ people in all states. According to the HRC (2011), 41 states have either a constitutional amendment or a state law restricting marriage to one man and one woman. In 18 of these states, the language of the amendment or law also prohibits or restricts other types of same-sex relationships such as civil unions and domestic partnerships. Even when relationship recognition is available, legal recognition is hampered by Federal restrictions. The Defense of Marriage Act (DOMA), signed into law in 1996, gave states the right to refuse recognition of same-sex couples married in other states, defined "marriage"—for Federal recognition—as only between one man and one woman, and defined "spouse" as an opposite sex husband or wife (HRC, 2011). Lack of legal protections have numerous consequences both emotionally and financially. For example, DOMA restricts same-sex married spouses in California (those marriages entered into prior to November 8th, 2012) from filing joint federal tax returns which can cause some to pay more federal taxes than their opposite sex counterparts (HRC, 2011).

Relationship recognition is not the only area where LGBTQ people lack legal protections. LGBTQ people are frequently faced with state and federal laws that do not protect them from discrimination or hate crimes. For example, only 15 states (including California) and the District of Columbia prohibit discrimination based on sexual orientation and gender identity and 5 additional states prohibit discrimination based on sexual orientation but not gender identity. Similarly, only 13 states have hate crimes laws covering both sexual orientation and gender identity with an additional 31 having hate crime legislation covering only sexual orientation. Other states have hate crimes laws that do not address sexual orientation or gender identity (HRC, 2011).

Parenting laws vary by state, as well. Second-parent adoptions are legal for same-sex couples in 16 states (including California) and the District of Columbia. Same-sex second-parent adoptions are prohibited in Mississippi and Utah. Other states have a variety of rules and regulations and may or may not allow for same-sex second-parent adoptions.

These laws are typically accompanied by anti-gay political campaigns. The negative effects of these campaigns have been the subject of recent research with LGBTQ populations. Yet, the breadth of

knowledge remains small and frequently has focused only on lesbians and gay men. A review of the literature shows there has been no research to assess the effects of these campaigns on transgender or bisexual people. But Levitt, et al. (2009) suggests that transgender and bisexuals individuals may experience similar effects because they may have same-sex relationships, because they are part of LGBTQ communities, and because they frequently face similar prejudices and discrimination. It is important to note that much of the research has also determined there are positive resilience outcomes related to anti-LGBTQ legislation (G. Russell, 2004; G. Russell, Bohan, McCarroll, & Smith, 2010; G. Russell & Richards, 2003). However, the evidence overwhelmingly suggests that LGBTQ people experience additional mental health stressors as a result of these anti-LGBTQ movements.

Research by G. Russell and Richards (2003) suggests there are five sources of stress for LGBQ people during anti-gay political campaigns. These include:

- Encountering homophobia
- Divisions within the LGBQ community
- Making sense of danger—LGBQ people in the face of anti-gay political campaigns experience a challenge to their sense of the world as a safe place which causes an increased sense of anger and awareness of anti-gay stigma (e.g. jokes, slurs), and a questioning of straight ally support
- The failure of family members to support LGBQ people
- Internalized homophobia

Anti-LGBTQ legislation campaigns promote a negative, misleading, demoralizing and dehumanizing rhetoric which reinforces already existing prejudice, stigma and discrimination against same-sex couples (Political Research Associates, 2006; G. Russell, 2004; G. Russell & Richards, 2003). Negative messaging is spread publically throughout the entire campaign making it difficult or even impossible for LGBTQ people, who are exposed to this negative messaging, not to absorb some of the messages resulting in increased levels of internalized homophobia (G. Russell, 2004). Participants in a retrospective study of Coloradoans following the passage of Amendment 2 (which denied LGB people legal recourse to address discrimination based on their sexual orientation) reported increases in levels of depression, anxiety and post-traumatic stress disorder (PTSD) (G. Russell, 2000). These participants also

We realized there were other gay people because of Proposition 8 and as a result advocacy groups began to emerge.

Inland Empire Community Dialogue participant

Straight allies are brave here. They take risks when it would be easier to walk away. When someone who is not living the experience stands up it means a lot because for every straight ally I see I have hope that someone is not being rejected by their family.

Humboldt County Community Dialogue participant

reported feeling shocked, angry, fearful, hopeless and alienated. The author suggests that people may question themselves, have increased negative thoughts about their sexual identities, and may have a reduced level of self-esteem as a result of these messages. Findings by Levitt, et al. (2009) show that participants reported "unrelenting distress caused by the recurrent messages that their humanity is not recognized" (p. 72).

Encountering homophobia forces LGBTQ people and their family members to acknowledge that it exists and is widespread, influential and can cause physical and psychological damage (Arm, Horne, & Levitt, 2009; Levitt et al., 2009; G. Russell, 2004). As G. Russell (2004) suggests, it may be especially painful for people who have convinced themselves that homophobia has disappeared from their lives or that they are not affected by it. These encounters can also lead to fear of physical assault, being outed, of rejection, of discrimination, and of isolation (Levitt et al., 2009; G. Russell, 2004). This frustration and anger stems from feeling unsafe, seeing negative images of LGB people, unfair treatment, feeling hated, and having one's life debated by the public (Levitt, et al., 2009; G. Russell, 2004; G. Russell & Richards, 2003).

While social supports have been shown to have a buffering effect on distress and negative mental health outcomes for LGBTQ people (Levitt et al., 2009; G. Russell, 2004; G. Russell & Richards, 2003), threats to these social supports can be highly stressful for LGBTQ people. For example, G. Russell and Richards (2003) suggest that existing divisions within LGBTQ communities can be a source of distress rather than support. As mentioned elsewhere in this report, LGBTQ people are not one community but many communities, each with their own unique needs and stressors. Anti-LGBTQ campaigns may highlight these differences, resulting in less community social support. Similarly, LGBTQ people may also experience an increase in stress and negative mental health outcomes such as depression, anxiety, fear and anger, if they do not receive support and validation from non-LGBTQ sources such as families of origin and heterosexual allies during anti-LGBTQ legislation campaigns (Levitt et al. 2009; G. Russell, 2004). The need for social support in times of an anti-LGBTQ political campaigns may be so great that participants may consider relocating to other areas with greater levels of support and protections for LGBTQ identities (Levitt et al., 2009). These findings are enlightening, despite the limitations of the study ($N = 13$), because they highlight mental health stressors (e.g

relocating) that are not typically considered when researching LGBTQ populations and the effects of anti-LGBTQ legislation.

Studies also show that anti-gay legislation campaigns force LGBTQ people to be more aware of the dangers surrounding their LGBTQ identity. G. Russell & Richards (2003) argue these campaigns challenge the belief systems of LGBQ people, resulting in anger, a greater awareness of anti-gay sentiment, and suspicion of heterosexual people's feelings toward LGBQ people (even when heterosexual people are supportive). The effects of negative public sentiment about LGBTQ identities creates fear for one's safety, for one's place in society, of a discontinuation of existing rights (i.e as parents), of showing affection for one's partner in public and of unexpected prejudice—LGBTQ people feel under siege and the targets of a culture war (Levitt et al., 2009; G. Russell, 2004).

Though the long term effects of anti-LGBTQ legislation and their negative media campaigns need further study, some authors have suggested that the negative effect of anti-LGBTQ political campaigns may be short-lived. Participants in Rostosky, Riggle, Horne and Miller (2009), reported higher levels of negative affect, stress and depressive symptoms in states where there was a recent passage of an anti-same sex marriage initiative than LGB participants in other states where there was no anti-same sex legislation or time had passed since the anti-LGBTQ legislation was approved by voters. Yet, in a qualitative study with 14 Coloradoans, participants reported experiencing negative consequences a full decade after the passage and reversal of Amendment 2 (G. Russell, et al., 2010). Several respondents indicated a high level of disempowerment and the authors suggest "political victories do not always compensate for feelings of personal victimization" (p. 17). It is clear that more research is needed on the long-term effects of anti-LGBTQ legislation.

Similarly, additional research is needed of the effects of anti-LGBTQ political campaigns on family members. In a small convenience study by Arm, et al. (2009), family members reported experiencing anger, frustration, pain, hurt, and isolation. They also reported questioning their belief systems, losing faith in their governments, and questioning their own ability to be effective in advocating for equal rights for LGBTQ people. Interestingly, heterosexual family members reported more physical reactions (e.g. anxiety, high blood pressure) to anti-gay stigma

than their LGBTQ family member. They also reported feeling guilty about not doing "more" for the advancement of LGBTQ rights or for their LGBTQ family member, and frustrated by the lack of involvement of other family members in LGBTQ rights advocacy. Arm, et al. (2009) suggest that negative effects of anti-LGBTQ movements on family members are influenced by how much the anti-LGBTQ movement impacts their family member. More research is needed to further explore these experiences.

Coming Out / Staying In

The term *coming out* refers to the process an individual experiences as they become aware of and begin to acknowledge their non-heterosexual and/or their non-gender-normative identity. Coming out generally takes place on two levels: a personal recognition to oneself and a more public acknowledgement to others. Coming out can be a difficult process, as it involves redefining one's sexual orientation away from society's accepted heterosexual norm to that of a stigmatized minority (Ford, 2003; Reynolds & Hanjorgiris, 2000). It is also a unique developmental stage in the formation of sexual identity which heterosexuals do not share. Likewise for trans people, the process of coming out can be quick or very slow, but is almost always complicated by the fact that once it starts it is a lifelong and continued process—because no one can come out all at once to everyone (J. Green, 2004). *Staying in the closet* is the antithesis of coming out and refers to an individual's attempt to hide their sexual orientation or gender identity from themselves or others (Ford, 2003).

In terms of mental health, coming out has come to be seen as "a necessary step toward a positive identity formation with respect to sexual orientation" (Ford, 2003, p. 94), along with other positive psychological benefits. In order to receive support for one's sexual orientation, it is necessary to come out to at least a minimal degree (Ford, 2003; Jordan & Deluty, 1998). Those who stay in the closet may be doing so out of shame and guilt (I. H. Meyer, 2003). Staying in the closet can contribute to psychological stress, including self-hatred, depression, shame, fear, anxiety and isolation (DiPlacido, 1998; Jordan & Deluty, 1998).

LGBTQ people must make continuous decisions about their level of outness with different people and different social contexts. Outness refers to the level disclosure of one's sexual orientation. Levels

[By being invisible] you are intentionally voiding out your life to make other people comfortable.

Inland Empire Community Dialogue participant

of outness vary by individual and can change throughout the lifespan. Coming out for many LGBTQ people is a not only a lifelong but selective process (Legate, R. Ryan, & Weinstein, 2003). No matter how self-accepting of their sexual orientation or gender identity an LGBTQ person is, they must constantly choose whether or not to come out to others. Each new social situation or encounter with someone they do not know creates an occasion of choice: "Should I come out, how should I come out, what will happen if I come out?" This can also occur when an LGBTQ individual sees a new therapist or comes into contact with any other type of mental health services, as there may be a fear of negative judgment if their sexual orientation or gender nonconforming identity is revealed (DiPlacido, 1998; J. Green, 2004; Guthrie, 2006).

There are numerous legitimate reasons for an LGBQ person to remain in the closet, whether fully or partially. For example, in many cases they could lose their job, lose custody of their children, be cut off from their family-of-origin, or make themselves vulnerable to verbal, physical or sexual abuse (DiPlacido, 1998; J. Green, 2004; R.-J. Green, LaSala, 2000; I. H. Meyer, 2003). Limiting self-disclosure, on the other hand, can also lead to negative consequences. The person must constantly monitor their behavior, appearance, speech or anything else which might make them vulnerable to possible discovery (I. H. Meyer, 2003). This vigilance can take a toll both emotionally and physically, including lowering one's immune system (DiPlacido, 1998). Many LGBQ people are placed in this no-win situation.

Women have to guard their information closely because they are often fearful of how it might affect their home situations, custody situations etc.

Women's Issues Advisory Group member

HIV and AIDS

HIV and AIDS continues to affect the gay male community. Older gay men who have lived through the beginning of the AIDS pandemic have lost an overwhelming number of their peers and what might have been their social support as they age. Survivor's guilt, as well as continuing grief, anger and depression, should not be overlooked among this cohort (Wierzalis, et al., 2006). Sexual behavior which heightens the risk of transmission or reception of HIV is a concern for gay men of all ages. Alcohol and other drug (AOD) use and abuse has been found to increase the likelihood a gay or bisexual male might participate in unprotected sexual activities (M. Rosario, Schrimshaw, & Hunter, 2006; Shoptaw & Reback, 2007).

Since the introduction of effective medications for HIV-positive

individuals, encouraging successes have been achieved in reducing the incidence of HIV and improving health outcomes for HIV-positive people. However, with over 70% of the 41,000 HIV cases (California Department of Public Health [DPH], 2011) in California from LGBTQ communities, additional work needs to be done to reduce disparities and improve quality health outcomes of this population.

Significant negative health outcomes for LGBTQ communities result from the combined influence of three primary factors: lack of cultural competency in the health care system, reduced access to employer-provided health insurance and/or lack of domestic partner benefits, and social stigma against LGBTQ persons. These factors are amplified among LGBTQ persons of color, increasing the likelihood of disparities and negative health outcomes (Krehely, 2009).

Mental health issues are also common among HIV-positive individuals. One California study examined the prevalence of three stress-related psychiatric diagnoses—depression, post-traumatic stress disorder (PTSD), and acute stress disorder (ASD)—among a population of HIV-positive persons attending two county-based HIV primary care clinics. High percentages of participants met screening criteria for depression (38%), PTSD (34%) and ASD (43%), while 38% screened positively for two or more disorders. Of the patients with at least one of these disorders, 43% reported receiving no concurrent mental health treatment (Israelski, et al., 2007). Results from other studies indicate that psychosocial health problems were independently related to a greater likelihood of high-risk behavior and of having HIV (Stall, et al., 2003).

Youth aged 15-24 have the lowest utilization of medical office visits of any age group. Stigma may lead individuals to avoid disclosing their sexual or gender identity to health care providers who, as a result, remain unaware of their LGBTQ patients' specific physical or mental health concerns. Among those aged 20-29, men have lower rates of utilization of ambulatory and preventive care compared to women. Moreover, for both males and females, African American and Hispanic youth have lower utilization rates than whites (Hightow-Weidman, Smith, Valera, Matthews, & Lyons, 2011). All of these disparities are compounded within LGBTQ communities.

Alcohol and Other Drugs (AOD)

Abuse and/or addiction to alcohol and drugs is a concern within LGBTQ communities. LGBTQ individuals struggling with AOD issues

not only share a common bond with all addicted clients, but also face experiences and circumstances which are unique to their situation. Separating which issues are related to their LGBTQ status and which are not is one of the important challenges for treating this population (Matthews & Selvidge, 2005). Unfortunately, due to research limitations, much of our knowledge regarding substance use within LGBTQ communities is restricted to self-identified white gay men and lesbians with higher levels of education (Hughes & Eliason, 2002).

Both historically and today, one of the most visible, accessible, and sometimes only entrance into LGBTQ communities was and is through gay and lesbian bars. The mixing of alcohol, drugs and social gathering can become a problem for some (D'Augelli, Grossman, Hershberger, & O'Connell, 2001; Matthews & Selvidge, 2005; Matthews, Lorah, & Fenton, 2006). Although recent findings suggest a possible decline in AOD use overall—at least among lesbians and gay men—several studies also indicate the rate of alcohol use declines much less with age when compared to heterosexuals.

LGBTQ individuals experiencing external stigma, internalized homophobia, isolation and/or family rejection may use alcohol or drugs as a coping mechanism (D'Augelli, et al., 2001; Matthews & Selvidge, 2005; Matthews, et al., 2006). Participants in a study of gay men and lesbians in recovery "reported that conflict related to sexual orientation was a major contributing factor to their alcoholism" (Matthews, et al., 2006, p. 112). In addition, AOD usage may allow an individual to act on their tabooed desires, as well as coping with the aftermath of such actions. Recovery from AOD addiction is also linked to the individual accepting their sexual orientation. Support in the form of gay and lesbian-specific recovery programs or meetings, as well as connection with sober gay and lesbian social activities, has been found to facilitate recovery (Matthews, et al., 2006).

Domestic Violence

Domestic violence (also known as intimate partner violence) in heterosexual and LGBTQ populations consists of a pattern of coercive and abusive behaviors used by an individual to gain power and control over his/her intimate partner. It occurs in LGBTQ communities with the same frequency and severity as in the heterosexual population yet information about, and resources and legislation dedicated to addressing

In rural areas, especially for those who have been in the same place for generations, there is this mentality of doing without, and dealing with issues through denial and drugs because this is better than dealing with mental illness.

Rural Advisory Group member

You don't only talk about your AOD issues but also your life—because almost everyone in the room is like me … you can be more open about yourself—in "straight" organizations you can't talk about certain things.

San Francisco Community Dialogue participant

this epidemic are decades behind the mainstream battered women's movement.

LGBTQ domestic violence is a reality that, despite epidemic proportions, has remained relatively invisible. There is no government source that systematically tracks or reports LGBTQ domestic violence and statistics (Senate Health Committee Analysis, AB 2006). While there is not sufficient data on which to draw firm conclusions, it appears that the prevalence of domestic violence in gay and lesbian relationships is comparable to the prevalence in heterosexual relationships (Merrill & Wolfe, 2000; Senate Health Committee Analysis, 2006). While it is believed that most of the violence in opposite sex couples is committed by men against women, it appears that about half of the abuse in the gay and lesbian community occurs in lesbian relationships and about half in gay relationships (Senate Health Committee Analysis, 2006). When the definition of aggression was broadened to include psychological and sexual abuse in addition to physical violence and all forms of aggression were considered, more respondents reported victimization (Lie, Schilit, Bush, Montagne, & Reyes, 1991).

Although the literature suggests that the frequency and severity of LGBTQ battering is, in fact, comparable to that in the heterosexual population (Burke & Follingstad, 1999; Coleman, 1991, 1994; GLBT Domestic Violence Coalition and Jane Doe, 2005; Mitchell-Brody & Ritchie, 2010; Waldner-Haugrud, Gratch, & Magruder, 1997), the *true* extent of LGBTQ domestic violence still remains unknown (American Psychological Association, 1996). Nevertheless, a number of prevalence studies which that have been conducted since the mid-1980's suggest relative consistency over time and reflect an approximate rate of 25% to 33% (Fountain, Mitchell-Brody, Jones, & Nicols, 2009). The majority of empirical studies on same-gender violence have primarily surveyed young, white, educated, middle-class female respondents who were members of lesbian organizations (Lie, et al., 1991; Schilit, Lie, Bush, Montagne, & Reyes, 1991) or were "out" individuals attending social events that attracted large groups of lesbians (Lie & Gentlewarrior, 1991; Loulan, 1987; Perry, 1995). Nevertheless, researchers (Farley, 1992; Island & Letellier, 1992; Bologna, 1987; Greenwood, Relf, Huang, Pollack, Canchola, & Catania, 2002) have estimated high numbers of gay men affected by domestic violence and some researchers (Gentlewarrior, 2009) have concluded that transgender people may experience a higher

level of both intimate partner violence and sexual assault. A 1998 survey found that as many as 50% of transgender individuals indicated that they had been raped or assaulted by an intimate partner (Courvant & Cook-Daniels, 1998; Office of Victim Services, 2009). There is essentially no research which has attempted to study bisexual domestic violence. In fact, bisexual victims are likely to be undercounted, or not counted at all, if the agency where they seek services assumes the sexual orientation of the victim based solely on the gender of the abusive partner (Fountain & Skolnik, 2007). Transgender domestic violence has also received very little research attention. From what has been studied, some researchers have concluded transgender people may experience higher levels of both intimate partner violence and sexual assault (Grant, et al., 2010).

No one—regardless of race, ethnicity, nationality, culture, class, age, level of education, income, political affiliation, spirituality, religion, size, ability, strength, gender identity, or sexual orientation—is safe from domestic violence (Fountain, et al., 2009). Batterers can be male or female, "butch or "femme," large or small. So can victims. Intimate partner violence is one of the largest health problems in LGBTQ populations (Island & Letellier, 1991) and has serious physical health, mental health, and social consequences for its victims, their families, LGBTQ communities, and society-at-large. While it shares some similarities with domestic violence in the heterosexual community, there are numerous and complex differences that complicate intervention with LGBTQ individuals as well as their safety and well-being (Fountain, et al., 2009; National Resource Center for Domestic Violence [NRCDV], 2007; Peterman & Dixon, 2003). Without an understanding of these differences, intervention is potentially damaging, oftentimes dangerous, and can increase risk for serious injury and/or death (S. Holt, personal communication, May 11, 2012).

Only a handful of books have focused specifically on violence in same-gender relationships compared to the hundreds of books and articles that have examined heterosexual domestic violence (Amezcua, et al., 2012; Dixon, Frazer, Mitchell-Brody, Mirzayi, & Slopen, 2011). Further, LGBTQ communities have been reluctant to address battering in part because many LGBTQ people fear that acknowledgement of domestic violence will invite additional prejudice (NRCDV, 2007). In 2008, with the passage of Proposition 8, a ballot referendum that eliminated the approved right of same-sex marriage in the State of California, a

Intimate partner violence is one of the largest health problems in LGBTQ populations.

(Island & Letellier, 1991)

new barrier to help seeking and reporting LGBTQ domestic violence was established. With LGBTQ people fighting desperately to prove the validity of their relationships, few are apt to acknowledge intimate partner violence out of fear that negative representations of same-sex unions could influence the public and increase anti-LGBTQ bias and discrimination (S. Holt, personal communication, May 11, 2012; Los Angeles Gay and Lesbian Center [LAGLC], 2005).

Attempts to control and gain/maintain power over one's intimate partner is accomplished by using various abusive and violent tactics and behaviors which can be verbal, emotional, psychological, physical, sexual, and/or financial in nature (Amezcua, et al., 2012; Dixon, et al., 2011; Peterman & Dixon, 2003; Saltzman, Fanslow, McMahon, & Shelley, 2002). Unlike heterosexual battering, however, LGBTQ domestic violence always occurs within the context of societal anti-LGBTQ bias (homophobia, biphobia, transphobia)—all very powerful and effective weapons of control. This bias can be found in all societal institutions and service delivery systems the abused LGBTQ person comes into contact with from law enforcement, social welfare organizations, the legal system, mental health providers, domestic violence organizations, etc. and frequently exacerbates and provides the abuser with unique and highly effective tactics (threats to out the victim; child custody problems, etc.). Furthermore, anti-LGBTQ bias and societal ignorance fuel the numerous myths and misconceptions that exist about intimate partner violence (men aren't victims, women don't batter, LGBTQ domestic violence is mutual, etc.) (NRCDV, 2007). These misconceptions are underscored by predominant domestic violence theories that are generally dependent on traditional gender-based analyses which tend to exclude the possibility of LGBTQ battering. Subsequently, LGBTQ domestic violence is frequently invisible, minimized, or not likely to be identified (Friess, 1997; Island & Letellier, 1991; NRCDV, 2007).

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Barriers to accessing domestic violence services or taking preventive steps are many, varied, and complex regardless of the victim's gender identity or sexual orientation (Wilson, 2006). However, while battered heterosexual women often receive support from family, friends, and/or religious communities, many battered LGBTQ persons (because of their sexual orientation or gender identity) have been rejected by and ostracized from these same supports and receive the majority, if not all, of

their support from their abusive partners (Fountain, et al., 2009; Island & Letellier, 1991; Peterman & Dixon, 2003). In addition, because domestic violence is commonly defined and discussed within a heterosexual context, members of LGBTQ communities don't always recognize that what they are experiencing is violent and abusive, even when the battering is severe. As indicated previously, numerous myths and misconceptions about LGBTQ domestic violence mask the reality of it and exacerbate its invisibility. In fact, it is common for battered LGBTQ victims to see their sexual orientation or gender identity as the problem rather than the violence itself. Nevertheless, even when recognized, one of the largest problems facing LGBTQ individuals who are experiencing intimate partner violence is the lack of culturally competent resources and services. The vast majority of mainstream systems, shelters, and services responsible for addressing domestic violence are at best ignorant of, and, at worst, indifferent to LGBTQ victims and ill-trained to work effectively with them. LGBTQ-specific domestic violence programs are rare. Two of the largest programs in California—the Los Angeles Gay & Lesbian Center's STOP DV Program (STOP DV) in Southern California and Community United Against Violence (CUAV) in San Francisco—are located in major urban centers approximately 500 miles apart (Holt, 2011). The majority of LGBTQ-specific organizations and programs that do exist, including STOP DV and CUAV, are often under-staffed and under-funded. Services for men and transgender males are even more difficult to locate (Friess, 1997). Male victims are generally sent to homeless shelters where they are likely to face more danger. Homeless shelter locations are not confidential and their staff is rarely trained to work with LGBTQ victims of domestic violence, nor are they necessarily trained in recognizing or addressing domestic violence in general. This frequently results in the victim's decision to return to the abuser or stay at home, rather than face hostility in an unfamiliar setting (S. Holt, personal communication, May 11, 2012).

Although intimate partner violence is generally not thought to be a mental health issue by the mainstream domestic violence movement, mental health providers commonly see large numbers of individuals, couples and families experiencing domestic violence. Research by Claire Renzetti (1992), as well as surveys conducted by LAGLC STOP DV (Holt, 2011), consistently reflect, however, that LGBTQ persons are *most likely* to seek the help of mental health professionals, rather than domestic

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(Holt, 2011)

violence service providers, when domestic violence is present. Mental health professionals and interns in California are now required by the Healing Arts: Training in Spousal or Partner Abuse Act (2002) to receive training in domestic violence, including training in same-gender domestic violence. Yet, information about LGBTQ domestic violence is rarely included in the trainings, despite the fact that same-gender domestic violence is required to be part of the curriculum. If included at all, it is usually limited to brief comments regarding prevalence rates (S. Holt, personal communication, May 11, 2012).

Suicide

As mentioned previously, LGBTQ individuals may suffer from the manifestations of internalized homophobia, including from lower self-esteem to overt self-hatred, guilt, depression, anxiety, substance abuse, and suicidal ideation (Boysen, et al., 2006; Connolly, 2004; DiPlacido, 1998; Logie, et al., 2007; I. H. Meyer, 2003; Otis, et al., 2006). Although most attention on suicidality has focused on youth, there is also a strong relationship between same-sex attraction and suicidality in adult men and women (de Graaf, Sandfort, & ten Have, 2006). A study of young adults found the greater the degree of same-sex attraction, the greater the risk of self-harming behaviors (Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003). One study of male-male twin pairs found that men reporting same-sex sexual behavior after age 18 are 6.5 times as likely as their co-twins to have attempted suicide (Herrell, et. al, 1999).

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(de Graaf, Sandfort, & ten Have, 2006)

Witten (2012) notes:

> Very little has been written about palliative care and end-of-life challenges for the LGBT population . . .Transgender elders express great concern about how they will be treated, [and] whether they will be respected or abused. Many, when asked about their later life care plans, responded with very disturbing statements: "I plan on committing suicide at 60 or earlier" [and] "If I become incapacitated, I plan to end my life." (pp. 21-22)

A further discussion of suicide risk for youth is included in the youth section of this report.

Resiliency

While all LGBTQ individuals are exposed to heterosexism, homophobia and prejudice, a majority do not experience major mental health problems (Cochran & Mays, 2006; DiPlacido, 1998; IOM, 2011).

Social support can mitigate the psychological stress of stigmatization (D'Augelli, et al., 2001; R.-J. Green, 2000). Affiliation with LGBTQ communities can provide individuals with a stigma free environment, as well as support for negative experiences perpetrated by a heterosexist society. LGBTQ communities may also mirror a positive reflection to the individual, allowing them to compare themselves to peer group members rather than to members of the heterosexual majority (I. H. Meyer, 2003). Early treatment models for trans people discouraged group affiliation, but this view has now changed. Peer support organizations can provide model coping strategies and help to build a network of supportive friends, which can bolster resiliency (Denny, Green, & Cole, 2007).

All people exposed to psychologically stressful circumstances cope with them differently, and LGBTQ individuals are no exception. Some are able to develop successful coping mechanisms, while others may experience more difficulty (DiPlacido, 1998). It is important to note there is a critical difference between personal resources and resources derived at a group level. LGBTQ individuals with otherwise excellent personal coping skills may find themselves vulnerable when deprived of group-level support (I. H. Meyer, 2003).

There is a dilemma between focusing attention on the resilient LGBTQ individual and highlighting their status as a victim. I. H. Meyer (2003) warns:

> The peril lies in that the weight of responsibility for social oppression can shift from society to the individual. Viewing the minority person as a resilient actor may come to imply that effective coping is to be expected from most, if not all, of those who are in stressful or adverse social conditions. Failure to cope, failure of resilience, can therefore be judged as a personal, rather than societal, failing. (p. 691)

Through the Center I became involved in a women's focus group—it has expanded my social life, people I know, and creates shared experiences.

Orange County Community Dialogue participant

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(Meyer, 2003)

Mental Health Services: The Good, the Bad, and the Harmful

A number of studies indicate gay men and lesbians access mental health services at a higher rate than heterosexuals (Bieschke, et al., 2000; Cochran & Mays, 2006; Cochran, Sullivan, & Mays, 2003; Ritter & Terndrup, 2002; Twist, Murphy, Green, & Palmanteer, 2006). Approximately 25% to 80% of gay men and lesbians seek counseling (Alexander, 1998; Hughes & Eliason, 2002; Sullivan, 2003; Twist, et al., 2006), percentages two to four times greater when compared with heterosexuals (Twist, et al., 2006). Lesbians appear to utilize therapy at a higher rate than gay men (Alexander, 1998; Hughes & Eliason, 2002). Bisexual men and women are usually classified with gay men and lesbians in research studies, (Hughes & Eliason, 2002; Miller, et al., 2007), which therefore limits knowledge about usage rates for bisexual individuals (Bieschke, et al., 2000). According to the California Health Interview Survey (CHIS) (2009), bisexual respondents reported higher rates (33%) for accessing mental or behavioral health services than heterosexual participants (11%) in the past year, and slightly higher rates than their lesbian and gay counterparts (33% vs. 27%). Studies regarding the transgender population are few, and focus primarily on male-to-female transsexuals seeking hormones and/or surgery (Hughes & Eliason, 2002).

LGBTQ persons seeking therapy or other mental health services often do so with fear and trepidation. As stated previously, many LGBTQ individuals experience heterosexism and homophobia from society, family or friends. This experience informs the expectation that their sexual orientation or gender identity may result in negative scrutiny by the therapist or other mental health provider (Alexander, 1998). Their concerns may be justified. The former California Department of Mental Health identified LGBTQ among the populations that are "unserved, underserved or inappropriately served in the mental health system" (DMH, 2010, p. 1). Studies also indicate mental health care for LGBTQ individuals may often be inadequate and/or inappropriate, with clients offering mixed reviews of their mental health care providers (Cochran & Mays, 2006; Page, 2004; Ritter & Terndrup, 2002). Therapists who are themselves LGBTQ tend to receive higher satisfaction scores from LGBTQ clients, but sexual orientation or gender identity status in no way guarantees the therapist will offer quality mental health care (Hunter & Hickerson, 2003).

LGBTQ clients can potentially be harmed by heterosexism within the mental health care system (Berkman & Zinberg, 1997; Crisp, 2006; Logie, et al., 2007; Long & Bonomo, 2006; Morrow, 2000; Van Den Bergh & Crisp, 2004). Heterosexism in clinical practice can have negative affects on "every aspect of the practice process including referral, history taking and assessment, and the intervention process" (Hunter & Hickerson, 2003, p. 219). As members of the society at large, mental health care providers can be strongly affected by heterosexist attitudes and bias against LGBTQ populations (Connolly, 2004; Logie, et al., 2007; Morrow, 2000; Snively, et al., 2004; Twist, et al., 2006; Van Voorhis & Wagner, 2002), despite the official stance of many professional organizations (American Academy of Pediatrics, 2004; American Psychological Association, 2008; APA, 1992; Morrow, 2000; NASW, 1999). Long and Bonomo (2006) have found evidence of heterosexism in mental health care in beliefs such as: (a) only heterosexuality is healthy or normal; (b) heterosexually-based research and theories are relevant for and can be generalized to LGBTQ individuals; and (c) normative heterosexuality must be used as the comparison standard in order to understand LGBTQ individuals.

While homosexuality has essentially been removed from the DSM for many years, there are practitioners who continue to think of LGBQ clients as abnormal, sick, sinful and immoral, and who believe trying to change a client's sexual orientation is warranted (Crisp, 2006; Hunter, 2005; Hunter & Hickerson, 2003; NARTH, 2012b; Nicolosi & Nicolosi, 2002; Van Den Bergh & Crisp, 2004). Hunter (2005) observes less extreme, yet still harmful manifestations of practitioners' heterosexist attitudes:

- *Pity:* Practitioners view heterosexuality as preferable to any other sexual orientation. Persons who cannot change their lesbian, gay or bisexual orientation or seem to be born that way should be pitied.
- *Tolerance:* Practitioners tolerate same-sex or bisexual orientations as just a phase of adolescent development that eventually will be outgrown. These practitioners treat those who do not outgrow this "phase" or are "immature" in their development with the protectiveness and indulgence one might apply to a young child.
- *Acceptance:* Practitioners say they accept LGB persons.

Thinking that they have to accept them, however, implies that these clients have a "problem."

- *Liberal:* Practitioners are friendly with LGB persons but have not thought beyond this to how they are still biased. They display heterosexist bias, for example, when they take for granted the privilege associated with heterosexual status. (Hunter, 2005, pp. 137-138).

While objecting to blatant discrimination, even practitioners who embrace the liberal level of heterosexism feel disquieted by public displays of affection between same-sex individuals, and are uncomfortable with the non-binary status of those clients who identify as bisexual or transgender. They may question the necessity of LGBTQ persons labeling themselves, using the viewpoint that there are no meaningful differences between sexual orientations or the experiences of LGBTQ individuals. All clients, therefore, will receive treatment as if they are heterosexual and nontransgender. This type of practitioner may believe that they are tolerant and accepting, but their bias essentially serves to make LGBTQ clients invisible and their unique needs unmet (Brown, 1996; Hunter & Hickerson, 2003; Morrow, 2000). Equally egregious is over-focusing on the client's sexual orientation or gender identity, or exaggerating its importance in terms of the presenting problem. Practitioners who do so may also encourage clients to come out to others without honoring the potential negative consequences of doing so (Hunter & Hickerson, 2003; Safren & Rogers, 2001; Van Den Bergh & Crisp, 2004). One significant consequence of practitioner heterosexism "is a lower quality of service that may actually harm the recipients" (Van Den Bergh & Crisp, 2004, p. 228).

It's not enough to be compassionate…most folks who say they are compassionate end up being patronizing.

Long Beach Community Dialogue participant

Acceptance: Practitioners say they accept LGB persons. Thinking that they have to accept them, however, implies that these clients have a "problem."

(Hunter, 2005)

Even if the therapist is caring and understanding I am still having to educate and explain things.

Transgender Advisory Group member

One significant consequence of practitioner heterosexism "is a lower quality of service that may actually harm the recipients."

(Van Den Bergh & Crisp, 2004)

First, Do No Harm

Therapists, counselors and other mental health providers working with LGBTQ clients should have as their first priority not to harm those who have come to them for care—as would be the case for any mental health client. Unfortunately, harm may be caused through well-meaning albeit detrimental actions, due to lack of education, lack of adequate supervision, heterosexist ideology, firmly held religious beliefs, or a combination of any of the above (Crisp, 2006; R.-J. Green, 2000, 2004; Guthrie, 2006; Hunter & Hickerson, 2003; Morrow, 2000; Twist, et al., 2006; Van Den Bergh & Crisp, 2004; Van Voorhis & Wagner, 2002).

Harm may occur in varying degrees, from the client receiving no help to irreparable psychological and spiritual damage (Jenkins & Johnston, 2004).

As stated previously, societal heterosexism, homophobia and religious beliefs all contribute to negative attitudes toward LGBTQ individuals. Mental health providers are not immune to the homonegative messages permeating our culture. Crisp (2006) states that adhering to any of the following beliefs renders a practitioner incapable of affirmative practice with LGBQ individuals:

> Homosexuality is sinful or against God's wishes; homosexuality is sick, unnatural, or perverted; homosexuality is inferior to heterosexuality; monogamy is the only healthy way to have a relationship; gay and lesbian relationships can only be short-term, sexual, or lacking in depth; gay men and lesbians are more likely to sexually abuse children; gay and lesbian parents are inferior to heterosexual parents; and bisexual individuals can decide to be gay or lesbian or heterosexual. (p. 117)

Transgender and transsexual people are subject to similar prejudices and challenges when engaging with mental health providers (J. Green, 2011).

Morrow (2000) voices concern that religiously conservative practitioners may contribute to an LGBQ client's internalized sense of shame and guilt. She questions a practitioner's ability to adhere to religious ideology which demeans LGBQ people, while also professing they are providing unbiased therapy to such clients. Twist, et al. (2006) questions how mental health providers who do not support human rights for LGBQ individuals can ethically work with this population. There is a consensus among these authors that those practitioners who are unable or unwilling to change their negative attitudes toward LGBQ individuals, or who cannot firmly separate their religious beliefs from their mental health practices, should refrain from working with this population.

As stated previously, heterosexism and homonegative bias within mental health care are expressed in the extreme through those practitioners who advocate and practice reparative or conversion therapies (Crisp, 2006; Jenkins & Johnston, 2004; Mallon, 2001). The Pan American Health Organization (PAHO) recently released a position statement denouncing reparative or conversion therapies, stating in their press release these practices signify "a serious threat to the health and well-being—even the lives—of affected people" (PAHO, 2012a). The

People hide behind religion and culture to explain homophobia–agencies do not know how to deal with that because they want to respect people's religious beliefs and support Queer people at the same time.

Butte County Community Dialogue participant

position statement, *"Cures" for an Illness That Does Not Exist*, refers to findings from a 2009 American Psychological Association review of individuals who had undergone treatments to change their sexual orientation.

> Not only was it impossible to demonstrate changes in subjects' sexual orientation, in addition the study found that the intention to change sexual orientation was linked to depression, anxiety, insomnia, feelings of guilt and shame, and even suicidal ideation and behaviors. In light of this evidence, suggesting to patients that they suffer from a "defect" and that they ought to change constitutes a violation of the first principle of medical ethics: "first, do no harm." (PAHO, 2012b, p. 2)

Lack of Training

[We need to] require cultural competency training to work with the Queer population. Being nice is nice, but it's not enough.

Coachella Valley Community Dialogue participant

Mental health service providers do not receive adequate, if any, education or training regarding the needs of LGBTQ individuals (Hunter, 2005; Long, Bonomo, Andrews, & Brown, 2006; Matthews, et al., 2006; Morrow, 2000; Ritter & Terndrup, 2002). In addition, "most therapists are not aware of homonegative and heterosexist bias inherent in many personality theories, therapy approaches, and assessment and diagnostic techniques" (Morrow, 2000, p. 139), nor are they aware of their own biased views influenced by societal heterosexism and homophobia. Along with the requirement to include sexual orientation content in social work curriculum (Council on Social Work Education [CSWE], 1994) came the perception that this would adequately address "the 'problem' of heterosexism among social workers" (Krieglstein, 2003, p. 76). Studies indicate, however, that at least some heterosexist attitudes are harbored by a majority of social workers (Berkman & Zinberg, 1997; Krieglstein, 2003), with 5.5% to 10% of social workers reporting beliefs labeled as homophobic (Berkman & Zinberg, 1997; B. S. Newman, Dannenfelser & Benishek, 2002). Krieglstein (2003) found that social workers who had earned either a BSW or MSW degree reported receiving very little education regarding gay men and lesbians, with 39% of the MSWs reporting they had received no education in this subject during their graduate studies. In this study, "hours of education was negatively correlated with heterosexism" (Krieglstein, 2003, p. 82).

The paucity of education and training results in many implications and consequences regarding the mental health care of LGBTQ clients.

These can include, but are not limited to: failing to assess the impact of internalized homophobia for each LGBTQ client (LaSala, 2006); misdiagnosing coming out behaviors as indicators of Narcissistic or Borderline Personality Disorder (Ritter & Terndrup, 2002); assuming sexual behavior defines sexual orientation, thus arbitrarily defining a client's sexual orientation for them rather than encouraging a client's own self-identification; displaying clinical behaviors which perpetuate internalized homophobia or transphobia within the LGBTQ client (Crisp, 2006; Mizock & Fleming, 2011); pathologizing a client's sexual attractions or gender-variant behavior (Logie, et al., 2007); and minimizing or overemphasizing a client's LGBTQ status (Berkman & Zinberg, 1997).

Lack of education for mental health practitioners also leads to inferior treatment for specific populations within LGBTQ communities. For example, those suffering from major mental illness may find their sexual orientation or gender identity attributed to their mental illness, rather than a legitimate part of their identity (Page, 2004). Therapists working with LGBTQ-parented families may provide inappropriate or inadequate treatment due to well-meaning but ignorant assumptions (Long & Bonomo, 2006; Martin, 1998). The majority of substance abuse counselors are not prepared to address the unique recovery issues often experienced by LGBTQ individuals struggling with addiction (Hughes & Eliason, 2002; Matthews & Selvidge, 2005). Buxton (2006) estimates that approximately 2 million LGB individuals (and an unknown number of those identifying as transgender) have come out within the context of a heterosexual marriage. Yet these couples and families remain invisible, as very little has been written or taught regarding their distinctive needs. In addition, for those couples who choose to remain in a mixed-orientation married, adequate professional support is almost non-existent (Buxton, 2006). Transgender individuals who seek medical intervention for physical confirmation of their gender identity may be required to obtain mental health services prior to accessing medical treatments (hormones or surgery). Ironically, they may need to seek these services from providers who are not trained to assess readiness for medical treatments, and who may therefore turn these clients away (Denny, Green, & Cole, 2007).

Institutional heterosexism also exists in the non-development of LGBTQ-affirmative programs within mental health agencies. Agency

Providers need to not just go to culturally competent training but need to be assessed in their cultural competency. …Providers need to have conversations with each other about how they are treating their clients.

Oakland/East Bay Community Dialogue participant

I think that when you are seeking services…providers need to not expect us to educate them about our gender identity and sexual orientation.

Bisexual Advisory Group member

Provide resources, tools and funding for existing organizations to include LGBTQ issues, folks and needs.

Oakland/East Bay Community Dialogue participant

My daughter was turned away from the Mental Health Department because no one could help her with an issue related to her Queer identity. There was no one there trained to help her.

Long Beach Community Dialogue participant

[Supervisors] are asking staff a "yes or no" question about their LGBT competence, but there is no definition of what LGBT competence is. Many who say "yes" often do so simply because they know "gay" people exist.

County Staff Advisory Group member

Self-awareness of one's internal heterosexism or homophobia is the critical first step toward cultural competence.

(Van Den Bergh and Crisp, 2004)

practice often does not include assessment for sexual orientation or gender identification, rendering LGBTQ clients essentially invisible to agency staff. Many administrators fail to recognize the specific needs of LGBTQ clients, believing that these needs can be met by existing agency services—services that focus on and have been developed for heterosexual and nontransgender clients (Hunter, 2005; Hunter & Hickerson, 2003; Van Voorhis & Wagner, 2002).

Seeking Cultural Competence

Despite the affirming stance of many professional organizations (American Academy of Pediatrics, 2004; American Psychological Association, 2008; APA, 1992; Morrow, 2000; NASW, 1999), many mental health care providers continue to be strongly affected by heterosexist attitudes and bias against LGBTQ populations (Connolly, 2004; Logie, et al., 2007; Morrow, 2000; Snively, et al., 2004; Twist, et al., 2006; Van Voorhis & Wagner, 2002). These negative perspectives can inhibit proficient practice with LGBTQ individuals, including the possibility of causing harm (Berkman & Zinberg, 1997; Crisp, 2006; Logie, et al., 2007; Long & Bonomo, 2006; Morrow, 2000; Van Den Bergh & Crisp, 2004). Van Den Bergh and Crisp (2004) state that self-awareness of one's internal heterosexism or homophobia "is the critical first step toward cultural competence" (p. 234). With respect to transgender communities, sexism is also at work (J. Green, 2004; Serano, 2007). In order to work effectively with LGBTQ clients, practitioners must assess, understand and continually be aware of their internal barriers and biases regarding LGBTQ populations and individuals—with the goal that negative or harmful attitudes be exchanged for a more affirmative approach (Bettinger, 2004; Hunter & Hickerson, 2003; Kulkin, Chauvin, & Percle, 2000; Morrow, 2000; Reynolds & Hanjorgiris, 2000; Twist, et al., 2006).

Self-awareness of internal heterosexism or heterocentric bias is essential and may be the first, but certainly not the only, step toward effective work with LGBTQ clients. Achieving competency includes acquiring accurate and scientifically valid knowledge regarding the unique needs, challenges, and issues of LGBTQ communities and individual members (Bieschke, et al., 2000; Hunter & Hickerson, 2003; Reynolds & Hanjorgiris, 2000). Practitioners must also educate themselves regarding the stigma, discrimination and oppression these populations endure (Kulkin, et al., 2000). All of these factors and

others contribute to the heightened incidence of mental health issues among LGBTQ persons. Novices in the field need to seek supervision or consultation on a regular basis from those professionals who have the necessary knowledge and experience working with LGBTQ clients, and who are able to perceive subtle indications of bias (Hunter & Hickerson, 2003). Those professionals who provide such supervision or consultation should ensure they have the needed skills, knowledge base and experience before they do so (Bettinger, 2004). Practitioners should also honor the experiences of each individual LGBTQ client, learning that every person also has their own unique story to tell (Hunter & Hickerson, 2003). This does not mean, however, that professionals should rely on their LGBTQ clients to provide them with the education needed for culturally competent practice (Morrow, 2000).

When working with LGBTQ individuals, mental health providers should not overly attribute a client's issues to their LGBTQ status, nor should their LGBTQ identity be dismissed or ignored (Matthews & Selvidge, 2005; Morrow, 2000; Van Den Bergh & Crisp, 2004). Treating LGBQ clients as if they were the same as heterosexual clients is an insidious manifestation of heterosexism (Van Voorhis & Wagner, 2002). Practitioners should assess for sexual orientation rather than assuming all clients are heterosexual. This assessment should include gender-neutral and open-ended questions. Asking questions in a manner that presumes heterosexuality or different-sex attraction can be interpreted as heterosexist, potentially alienate LGBQ clients and/or cause them to be fearful of revealing their LGBQ status (Hunter & Hickerson, 2003; Morrow, 2000; Van Den Bergh & Crisp, 2004). In addition, mental health providers should not assume they know a client's sexual orientation based on the client's sexual behavior or vice versa. There are many people who participate in same-sex behavior who do not identify as LGBQ. Conversely, individuals displaying heterosexual behavior (or no sexual behavior) may be harboring same-sex attractions they are reluctant to reveal (Miller, et al., 2007). It is also important to recognize that a client's gender identity may differ from their presentation. Practitioners should avoid assuming all clients are gender-normative or gender-conforming based on their appearance (Lev, 2004).

Another common assumption in the mental health field is that LGBTQ practitioners are culturally competent to work with LGBTQ clients merely because they share the same sexual orientation or

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>
> *Oakland/East Bay Community Dialogue participant*

> I think that when you are seeking services…providers need to not expect us to educate them about our gender identity and sexual orientation.
>
> *Bisexual Advisory Group member*

Being LGBTQ doesn't *make* you a good counselor for LGBTQ youth.

School-Based Issues Advisory Group member

I was frustrated by having to list myself as "father" [on my child's form] when I am not...it's degrading.

Tulare County Community Dialogue participant

transgender status. While there may be advantages to such a pairing, LGBTQ status on the part of the practitioner does not ensure quality mental health care for the LGBTQ client (Hunter & Hickerson, 2003). In addition, an LGBTQ therapist's competency with one sexual orientation or transgender identity does not automatically indicate competency with all sexual orientations or transgender identities (Morrow, 2000). For example, a gay male therapist may not have the experience necessary to work with a male-to-female transsexual. LGBTQ practitioners also need to be comfortable with their own sexual orientation (Hunter & Hickerson, 2003). Morrow (2000) warns "therapists struggling with their own sexual orientation (even unexamined heterosexuality) should not attempt to work with clients who are also in struggle" (p. 142). In addition, therapists should be comfortable with their own gender identity (Lev, 2004).

Many LGBTQ people have received negative treatment by family, friends, schoolmates, coworkers and strangers. Practitioners should therefore expect their LGBTQ clients may feel fear and trepidation when accessing mental health services or beginning with a new therapist (Alexander, 1998). An affirmative environment in the waiting room, such as the display of LGBTQ symbols, informational pamphlets or reading material, can help clients feel they are in a safe and welcoming location. Client forms which offer nonheterosexual and gender neutral options allow for a feeling of inclusion and freedom to self-disclose (Hunter & Hickerson, 2003).

Alexander (1998) recommends therapists disclose to their LGBTQ clients their professional experience working with other LGBTQ clients. This is often a concern for these clients, even though they may not ask. Because victimization is so pervasive in their lives, Alexander also states LGBTQ "clients require assurance from the therapist that he or she will not harm them, ridicule them, violate their personal boundaries, or subject them to harm" (p. 100).

Clients who are questioning their sexual orientation or gender identity, or who have recently come out, may be particularly vulnerable in the therapeutic process. It is important for therapists to understand that the coming out process is a unique experience for LGBTQ individuals not shared by the heterosexual and gender normative populations (Ford, 2003; Coleman, et al., 2011). While there can be positive psychological benefits to publicly disclosing one's sexual orientation or gender identity, there can also be very real negative consequences. R.-J. Green (2000)

warns that therapists who adhere to the theory that family secrets are detrimental to a client's mental health may ignorantly extrapolate this knowledge to the LGBTQ experience, thus encouraging their LGBTQ client to come out to their family-of-origin. Unknowingly for the therapist, this can expose their client to very real rejection by their family members. R.-J. Green emphasizes that therapists should not generalize the importance of family support, or lack thereof, for all LGBTQ clients. Each client should, instead, be encouraged to explore the benefits and consequences of coming out to their family and others without the therapist second-guessing which course of action would be best (Erwin, 2006; R.-J. Green, 2000; Martin, 1998).

Van Den Bergh and Crisp (2004) suggest using the gay affirmative practice (GAP) model as one source for garnering cultural competency standards. They have placed the six major themes of the GAP model into the following framework:

Attitudes

1. Same gender sexual desires and behaviors are viewed as a normal variation in human sexuality.
2. The adoption of a GLBT [*sic*] identity is a positive outcome of any process in which an individual is developing a sexual identity.

Knowledge

3. Service providers should not automatically assume that a client is heterosexual.
4. It is important to understand the coming out process and its variations.

Skills

5. Practitioners need to be able to deal with their own heterosexual bias and homophobia.
6. When assessing a client, practitioners should not automatically assume that the individual is heterosexual. (p. 226)

The core of this model spotlights a fundamental social work theme: "unconditional positive regard and acceptance of a client that affirms a client's sense of dignity and worth" (Van Den Bergh & Crisp, 2004, p. 226).

In 2010, the WPATH Board of Directors issued a statement noting that "the expression of gender characteristics, including identities, that

are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative" (Coleman, et al., 2011, p. 9). Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria (Coleman, et al., 2011).

Reynolds and Hanjorgiris (2000) also emphasize an affirmative approach in order to confront the homonegative and heterosexist assumptions all LGBTQ individuals are exposed to. Merely creating an accepting therapeutic environment is often not enough to counteract the effects of internalized homophobia or transphobia. The therapist needs to take a proactive, affirmative role in which they challenge their client's internalized negative messages, as well as encouraging them to explore and embrace their sense of themselves as LGBTQ.

Intersecting Identities

LGBTQ individuals come from all cultural, ethnic and racial backgrounds. They participate in multiple religions, occupations and political parties. They come in all ages and can come out at any age. They are as diverse as the heterosexual population, and their identity expression, appearance, behavior and manner of dress are as diverse as well. Therefore, mental health professionals should absolutely refrain from stereotyping their LGBTQ clients (Van Den Bergh & Crisp, 2004). Because LGBTQ individuals are so diverse, it is important practitioners recognize the influence and impact of multiple identities and multiple oppressions. This is particularly true for those working with LGBTQ people of color. Focusing on only one identity can cause the therapist to neglect the struggles and challenges of those who have multiple and intersecting identities (Fukuyama & Ferguson, 2000).

There is never a discussion about the intersection of identity within LGBTQ populations and it is not embedded in [our] trainings.

County Staff Advisory Group member

Lesbians

Lesbians are doubly exposed to minority stressors, due to their sexual orientation and their gender. They are therefore subjected to heterosexism, homophobia and sexism (DiPlacido, 1998). One study comparing lesbians and bisexual women to heterosexual women found that the lesbian and bisexual women experienced greater rates of discrimination (Koh & Ross, 2006). Lesbians of ethnic or racial

minorities face a triple exposure to minority stressors (DiPlacido, 1998). LaSala (2006) explains: "an African American lesbian…could experience racism, homophobia, and sexism in the general society, racism in the lesbian community, and homophobia and sexism in segments of the African American community" (p. 188). Lesbians face discrimination both in the law and in the workforce. They are currently allowed civil marriage in only six states and the District of Columbia (CNN Wire Staff, 2012) and are denied legal recognition of their relationships on a federal level (Kuvalanka, et al., 2006). Their lesbian status has also been used to deny custody or visitation with their children (Frederiksen-Goldsen & Erera, 2003). In addition, female same-sex couples earn 18% to 20% less on average compared to their married different-sex counterparts (Badgett, 2000). They may also face discrimination within the mental health profession. One study of social work and counseling students found 17% surveyed believed lesbianism is a sin, and 16% felt that job discrimination might be justifiable in certain situations (B. S. Newman, et al., 2002).

Lesbians utilize mental health services at a higher rate than heterosexual women (Cochran, et al., 2003; Koh & Ross, 2006; Razzano, Cook, Hamilton, Hughes, & Matthews, 2006; Ritter & Terndrup, 2002). Usage rates for therapy and counseling have been found to be as high as 80% (Hughes & Eliason, 2002). One study comparing lesbians and heterosexual women indicated a usage rate of 75% versus 29% respectively (Ritter & Terndrup, 2002). Razzano, et al. (2006) found lesbians reported use of mental health services at 3.5 times the rate of heterosexual women. In their research, Cochran, et al. (2003) also found higher usage rates within the past year by lesbians and bisexual women when compared to heterosexual women. Koh and Ross (2006) found lesbians were 56% more likely than heterosexual women and 82% more likely than bisexual women to have received treatment for depression. The effects of heterosexism, discrimination, stigma, and exposure to bias-related victimization have all been offered as explanations why lesbians seek out mental health services at such high rates (Koh & Ross, 2006; Razzano, et al., 2006; Ritter & Terndrup, 2002).

Depression is the most common reason lesbians give for seeking psychotherapy. Depression can be related to several issues lesbians are confronted with, including the need to lead a double life (for those who are partially or wholly in the closet), unresolved orientation issues,

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(LaSala, 2006)

rejection by family, and distress related to coming out (Razzano, et al., 2006). Lesbians are also subject to varying degrees of internalized homophobia. Wells and Hansen (2003) found that although their "sample had high levels of lesbian identity integration and was educationally and occupationally successful" (p. 104), they continued to suffer from high levels of internalized shame.

Lesbians are at greater risk for AOD issues and dependency when compared to heterosexual women (Cochran & Mays, 2006; Corliss, Grella, Mays, & Cochran, 2006). Bostwick, Hughes, and Johnson (2005) found the risk of alcohol dependence for lesbians almost doubled in the presence of lifetime depression. Furthermore, lesbians are at higher risk for suicide attempts. In their study comparing lesbian, bisexual and heterosexual women, Koh and Ross (2006) found that 16.7% of lesbian respondents reported attempting suicide compared to 10.2% of heterosexual women respondents. Lesbians who had not disclosed their sexual orientation to others were 90% more likely than heterosexual women to have attempted suicide.

Much attention has been paid to the process of sexual identity development for lesbians, gay men and bisexuals. Diamond's (2006) longitudinal study of lesbian and bisexual women suggests traditional sexual identity models may be too simplistic. As a result of her findings, Diamond lists three mistakes regarding sexual identity for lesbian and bisexual women: "Mistake 1: Most sexual-minority women are exclusively attracted to women" (p. 78). Studies indicate that nonexclusive attraction is normative among LGBTQ individuals, particularly women. This does not suggest lesbian and bisexual women are equally attracted to both sexes, but it does have the important implication that women who identify as lesbian may also have other-sex attraction. In a binary, either/or view of sexual orientation, the acknowledgment and acceptance of other-sex attraction may play an important role in lesbian sexual identity development. "Mistake 2: Sexual questioning ends once you identify as lesbian, gay or bisexual" (p. 80). Diamond found the women in her study continued to examine their sexual identity after coming out, and 70% of them changed how they labeled that identity at least once. "Mistake 3: It's better to have a sexual identity label than not to" (p. 82). Conventional sexual identity models assume that a clearly delineated identity as lesbian or bisexual is essential for a sexual minority woman's healthy development. The

Mistake 1: Most sexual-minority women are exclusively attracted to women.

Mistake 2: Sexual questioning ends once you identify as lesbian, gay or bisexual.

Mistake 3: It's better to have a sexual identity label than not to.

(Diamond, 2006)

women in Diamond's study challenge this notion, because the more comfortable they became with their sexual attractions, the less need they had for labels. Savin-Williams and Ream (2007) comment that it is the labels, and not the inherent sexual and romantic attractions that appear to change, suggesting a fluidity of labeling rather than a fluidity of sexuality.

In addition to recommendations regarding LGBTQ mental health care, practitioners working with lesbians should be unreservedly comfortable discussing issues regarding lesbian sexuality (Erwin, 2006; Robinson & Parks, 2003). The heterosexual definition of sex as male-to-female penile penetration creates a vacuum for understanding female same-sex sexuality. When lesbians were allowed to define sex for themselves, 90% of the sample studied "included hugging, cuddling, and kissing as sexual activities" (Garnets & Peplau, 2006, p. 72). Heterosexual standards of sexual frequency are also held up as the norm and standard for a couple's healthy sex life. Garnets and Peplau (2006) question whether lower sexual frequency for lesbian couples should be considered a problem. Counselors working with women who partner with women need to be aware of the impact heterocentric and heterosexist definitions of sex, including what is considered good and bad sex, may have on their clients (Erwin, 2006). In addition, practitioners should be prepared to address any internalized shame regarding lesbian sexuality their clients may be struggling with (Robinson & Parks, 2003).

Partner abuse within lesbian or female same-sex relationships is a hidden problem and may be occurring in greater numbers than the lesbian or therapeutic communities are aware of (McLaughlin & Rozee, 2001). Heteronormative views and feminist constructs of domestic violence hinder both victim and practitioner from recognizing and responding to same-sex partner abuse (Ristock, 2001). Most important to note for the safety of the battered lesbian or bisexual woman is that violence within a lesbian or female same-sex relationship should not be considered less dangerous than violence within a heterosexual relationship (McLaughlin & Rozee, 2001).

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(McLaughlin & Rozee, 2001).

Gay Men

As with all LGBTQ individuals, gay men face discrimination and prejudice fueled by societal heterosexism and homophobia. Many gay men, especially those perceived to be effeminate, have been victims of anti-gay abuse since childhood—often long before they identified as

gay (LaSala, 2006). Gay men "violate normative gender roles and that violation comes with severe consequences" (Phillips, 2006, p. 407). Gay men have been characterized as perverted, lonely, and dangerous to children (Boysen, et al., 2006). Gay men are also quite often stereotyped as feminine—essentially conveying the message they are not real or normal men (Phillips, 2006). Gay men face discrimination in the work force, with earnings as much as 27% less than their heterosexual counterparts (Badgett, 2000). In addition, research suggests gay men may still be considered sexually deviant by some members in the mental health field (Boysen, et al., 2006). The consequences of violence, discrimination and stigma, as well as the internalization of societal homophobia, may all serve to jeopardize the mental health of gay men (LaSala, 2006).

Gay and bisexual men seek out mental health care services more than their heterosexual counterparts, as well as disproportionately suffering from depression, anxiety, substance abuse and panic disorder (Boysen, et al., 2006; Cochran, et al., 2003; Mills, et al., 2004), and having a greater risk for suicide (Cochran and Mays, 2006; de Graaf, et al., 2006; Paul, et al., 2002; Skegg, et al., 2003). In addition, C. J. Russel and Keel (2002) found gay and bisexual men at greater risk for eating disorders. When compared to heterosexual men, Cochran, et al. (2003) found gay and bisexual men were "3.0 times more likely to meet criteria for major depression and 4.7 times more likely to meet criteria for a panic disorder" (p. 55). Mills, et al. (2004) found men who have sex with men (MSM), when compared to the general population, have rates of current depression which are 2.6 times higher. The general population sample used included women, who overall have higher rates of depression, making the statistic regarding MSM that much more noteworthy. Studies of suicidal risk report that up to 48.8% of gay men have death ideation (de Graaf, et al., 2006), 21.3% have made a suicide plan at some point, and 11.9% to 14.6% have either made a suicide attempt and/or deliberately harmed themselves (de Graaf, et al., 2006; Paul, et al., 2002). Cochran and Mays (2006) observed gay men were likely to report attempting suicide at 5 times the rate of men identified as heterosexual. Skegg, et al. (2003) found that men with even minor same-sex attraction were subject to greater risk of self-harm and self-induced injury than men who reported only opposite-sex attraction.

Gay men often cope with stigma in ways that are not transparent,

As you age you lose social support and access to services. There is little understanding of what it means to be a younger gay man by older gay men and vice versa. The gay male community needs more education around ageism. In addition, there is a lot of stigma around older men working with younger men which hinders adult-youth partnerships.

West Hollywood/Los Angeles Community Dialogue participant

offering a unique challenge to therapists who work with this population. LaSala (2006) advises not to oversimplify the relationship between gay-related stigma and the problems initially presented by a gay male client. Men, including gay men, are socialized to avoid appearing weak or vulnerable, and therefore a gay client may remain silent about or even repress stigmatizing experiences. Because society tends to ignore or minimize the effects of oppression, gay male clients may generalize this behavior to the therapist—believing the therapist does not want to listen to their client's feelings of persecution. LaSala therefore recommends "that therapists assess the role of stigma in their gay clients' presenting problems, no matter what complaints they articulate" (p. 188), as well as building a strong therapeutic rapport where gay male clients can feel comfortable exposing all their feelings.

In order to create an identity, couples need some type of support from their community. Gay male couples are not allowed the same level of legal and social status as heterosexually married couples. Practitioners working with male couples need to be open to the varying ways gay men may define their relationship (Tunnell & Greenan, 2004). Ossana (2000) adds, competent work with same-sex couples includes leaving "assumptions about what constitutes 'normal' sexual behavior at the office door" (p. 290). Because gay men are first and foremost men, they have been socialized as men to have a strong emphasis on their sexuality. In addition, gay male couples are made up of men and, therefore, do not have a female member limiting or influencing their male sexual perspective. This leads to one of the largest cultural differences for gay male relationships: they often do not practice sexual exclusivity as a couple (Bettinger, 2004). In the heterocentric arena of family therapy, the default presumption is that monogamy is an essential ingredient for a healthy relationship. However, studies indicate relationship quality is not significantly different when comparing monogamous and openly nonmonogamous gay male couples (Bettinger, 2004, LaSala, 2000).

Fidelity in a relationship is usually inextricably linked to sexual exclusivity. In actuality, these are two separate concepts. Many gay male couples who practice nonmonogamy openly discuss their rules and boundaries, defining for themselves what constitutes fidelity, faithfulness and commitment to the relationship (Bettinger, 2004). LaSala (2004) cautions that norms which connect sexual monogamy with intimacy may be heterosexist in nature and should not be applied to all gay may

People don't believe I am HIV-negative. Just because you are a gay man doesn't mean you are HIV-positive. People who are not [HIV] positive need support to stay [HIV] negative.

San Francisco Community Dialogue participant

couples. Instead, relationship problems for sexually nonexclusive male couples may require the therapist to help negotiate boundaries around outside sexual activity so it is not a threat to the primacy of the relationship. Ossana (2000) and LaSala both emphasize it is equally important for the therapist to support gay male couples who choose sexually monogamous relationships, as there are also gay men who "perceive sex, commitment, and intimacy as inseparable" (LaSala, 2004, p. 22).

HIV and AIDS continue to be an issue for the gay male community. Older gay men who have lived through the beginning of the AIDS pandemic have lost an overwhelming number of their peers and what might have been their social support as they age. Survivor's guilt, as well as continuing grief, anger and depression, should not be overlooked among this cohort (Wierzalis, et al., 2006). Sexual behavior which heightens the risk of transmission or reception of HIV is a concern for gay men of all ages. AOD use and abuse has been found to increase the likelihood a gay or bisexual male might participate in unprotected sexual activities (M. Rosario, Schrimshaw, & Hunter, 2006; Shoptaw & Reback, 2007).

Bisexual Individuals

Historically, bisexuality has been ignored or conflated with homosexuality in research, theories, and sexual identity development models. Although there was a heightened research focus on bisexual orientation in the early 1990s, bisexuality as a unique orientation continues to be excluded from many sexual orientation studies. Lesbians and gay men also continue to be the exclusive subject of most sexual identity development models. The omission of bisexuality compounds the widespread assumption that non-exclusive attraction is the exception, while single-sex attraction is the norm (Diamond, 2006).

As stated previously, a major issue which affects understanding and knowledge of bisexual mental health needs is how sexual orientation is defined in LGBTQ research, as there are no set standards for how to identify various sexual orientations. Sexual activity, sexual/romantic attraction, and sexual orientation identity are not always synonymous. Studies find that people who engage in same-sex behavior often do not identify as LGBQ, while others may have same-sex attractions with or without accompanying sexual activity and/or LGBQ identification

We talk about gay parenting but bisexual parents often feel isolated and that they don't belong in those groups.

Bisexual Advisory Group member

When I have gone to a group [at a gay and lesbian center], I have had to walk through the "gay doors" to get to the "bisexual door"—it is really difficult to walk into places like that.

Bisexual Advisory Group member

(Frankowski, et al., 2004; Hoburg, et al., 2004; Savin-Williams & Ream, 2007). Hoburg, et al. (2004) found the majority of their respondents did not act on their same-sex attractions, suggesting that research which has used bisexual behavior as an indicator has underestimated rates of bisexual orientation. Relying on self-identification may also yield inaccurate results as many individuals do not identify as bisexual, although other definitions might categorize them as such.

Because studies which include bisexual men and women usually classify them with gay men and lesbians (Hughes & Eliason, 2002; Miller, et al., 2007), usage rates of mental health services for bisexual individuals are not known (Bieschke, et al., 2000). Research suggests, however, bisexual individuals are at greater risk for psychological distress and mental health challenges than gay men, lesbians or heterosexual individuals (Miller, et al., 2007; Page, 2004). Miller, et al. (2007) stress the following:

> Bisexual women's issues are not always the same as lesbian issues, even for bisexual women who only have sex with partners of the same gender or for lesbian-identified women who have sex with men as well as women. Bisexual men's issues are not always the same as gay male issues, even for bisexual men who only have sex with partners of the same gender or for gay-identified men who have sex with women as well as men. Likewise, heterosexuals' issues are different from those of bisexuals. (p. 31)

Bisexual individuals face unique oppressive conditions in the form of biphobia and bi-invisibility. One study indicated heterosexuals rated bisexuals less favorably than a number of other stigmatized groups, including lesbians and people with AIDS (Miller, et al., 2007). Bisexual individuals face stigmatization in both the heterosexual and lesbian/gay communities (Bradford, 2004; Dworkin, 2006). Both communities have stereotyped bisexual individuals as promiscuous, untrustworthy, unable to commit, obsessed with sex, deceptive, indecisive, cowardly, and transmitters of HIV (Bradford, 2004; Hostetler & Herdt, 1998; Israel & Mobr, 2004; McLean, 2004; Miller, et al., 2007). Bisexual individuals are also viewed as either in denial about their homosexuality, or too afraid or confused to choose a legitimate orientation (Hostetler & Herdt, 1998).

Biphobia intersects with homophobia at the point where heterosexism delegitimizes and denigrates same-sex romantic and sexual attractions. Heterosexism positions heterosexuality as normal,

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(Miller, et al., 2007)

with homosexuality as the deviant opposite. This viewpoint essentially makes bisexuality invisible (Miller, et al., 2007). In addition, bisexuality is viewed as a more deviant sexuality than homosexuality. Biphobia and bi-invisibility are also powered by a belief that sexual orientation is dichotomous. Even those who may accept heterosexual and homosexual orientations as equally legitimate may be disconcerted over the ambiguity of bisexuality. Within lesbian and gay male communities, biphobia is fed by fears that bisexual individuals will leave a lesbian or gay male partner for someone of the opposite sex and the ensuing heterosexual status and privilege. For some, there is a fear bisexual individuals are not committed to the gay and lesbian community. They perceive a bisexual identity as an unwillingness to unite with gay men and lesbians, while still benefiting from hard won civil rights. In addition, there is a perception and resentment that bisexual individuals are able to participate in the gay and lesbian community without foregoing their heterosexual privilege (Israel & Mobr, 2004).

Bisexual individuals also face stigmatization from the mental health profession. Mental health providers have been exposed to and affected by both societal and professional biphobia and bi-invisibility. The shift that occurred in the mental health field which encouraged affirmative therapeutic approaches for gay men and lesbians did not generally include the same for bisexual individuals. Psychological theories, and practitioners' training and practice historically have had embedded in them the same stereotypes and misconceptions stated previously, including the belief bisexual orientation does not exist (Fox, 2006). Israel and Mobr (2004) found therapists with biphobic attitudes, distinct from the presence or absence of homophobic attitudes, were more likely to have a negative reaction to bisexual clients and to judge a bisexual client as suffering from intimacy problems. Logie, et al. (2007) found MSW students had higher rates of phobia toward bisexual individuals than toward lesbians and gay men. In addition, individuals suffering from major mental illness have often been exposed to clinicians who view the client's bisexuality as a psychopathological symptom (Page, 2004).

Bisexual individuals exposed to stigma, biphobia and bi-invisibility often suffer from *internalized biphobia*. Internalized biphobia, similar to internalized homophobia, is the absorption of anti-bisexual societal and cultural messages. Miller, et al. (2007) list an array

When you have a diagnosis and they find you are LGBTQ it becomes part of your diagnosis.

Consumers/Clients Advisory Group member

of negative feelings bisexual individuals may struggle with as a result of internalized biphobia:

- We do not exist; we are invisible; bisexuality is not real.
- We are supporting the patriarchy; we are deserting feminism.
- We are responsible for the spread of AIDS.
- We are "on the fence," incapable of commitment.
- We do not know who we are; we're just "in a phase."
- We are hypersexual, "on the prowl" at all times. (p. 24)

Exposure to stigma, discrimination, bi-invisibility, and external and internalized biphobia produces psychological stress for bisexual individuals. Koh and Ross (2006) found bisexual women "were significantly more closeted and experienced significantly more emotional stressors than lesbians and heterosexual women" (p. 55). Bisexual women who were out to a majority of people were twice as likely as heterosexual women to have had an eating disorder. They were also twice as likely to report some degree of suicidal ideation compared to heterosexual women. In contrast, those bisexual women who remained closeted were 3 times more likely than heterosexual women to have attempted suicide (Koh & Ross, 2006). Men who have sex with men (whether or not they identify as gay or bisexual) were found to currently suffer from depression at rates 2.6 times higher when compared to lifetime rates of depression in the general population (Mills, et al., 2004). Skegg, et al. (2003) found that men with even minor same-sex attraction were subject to greater risk of self-harm and self-induced injury than men who reported only opposite-sex attraction.

Most individuals who choose to identify as bisexual do so because they have romantic and sexual attractions to both men and women (Miller, et al., 2007). Defining bisexuality specifically as an *equal* attraction to both men and women, however, would be inaccurate. Adhering to such a definition contributes to the belief bisexuality does not exist (Israel & Mobr, 2004). A sexual orientation label does not denote behavior and not all bisexual individuals act on their dual attractions. For example, a bisexual woman could spend her life in a monogamous relationship with a man or a monogamous relationship with a woman and still claim a bisexual identity. Relationship status also does not identify a person's sexual orientation. A couple comprised of a man and a woman could contain two heterosexual members, two bisexual members, one heterosexual and one bisexual member, one heterosexual and one gay or

Bisexual women were significantly more closeted and experienced significantly more emotional stressors than lesbians and heterosexual women.

(Koh and Ross, 2006)

You aren't [viewed as] bisexual any more once you have been in a long-term relationship with one sex.

Bisexual Advisory Group member

Relationship status also does not identify a person's sexual orientation. A couple comprised of a man and a woman could contain two heterosexual members, two bisexual members, one heterosexual and one bisexual member, one heterosexual and one gay or lesbian member or one gay or lesbian and one bisexual member.

(Miller, et al., 2007)

There is a lot of disapproval from my husband's family [about LGBTQ people]. I could never be out to them. I really have to hide myself from them. I feel like I would be accused of being sneaky or flakey. I have to keep it quiet for his benefit.

Bisexual Advisory Group member

lesbian member or one gay or lesbian and one bisexual member. Mental health practitioners should not assume, therefore, they know a client's sexual orientation status by the gender of their partner or spouse (Miller, et al., 2007).

Current research suggests bisexual identity development may be more complicated than sexual identity development for gay men or lesbians (Dworkin, 2006). Weinberg, Williams, and Pryor (1994) suggest there may be more commonalities shared between homosexuals and heterosexuals than either share with bisexual individuals. While the personal coming out stories of gay men and lesbians often include identifying as bisexual for a time, this should not be taken as evidence that bisexual identity is a transitional stage of sexual identity development (Israel & Mobr, 2004). In their study of midlife bisexual individuals, Weinberg, Williams, and Pryor (2001) found most participants continued to have a stable bisexual identity, and for some that identity had become stronger with age.

The stigma, phobia and invisibility surrounding a bisexual identity makes it difficult to estimate how many individuals have a bisexual orientation. Multiple studies indicate self-identity may greatly underestimate the number of bisexual individuals. One study found 1.8% of the men and 2.8% of the women identified as bisexual, as compared to 5.9% of the men and 12.9% of the women who reported attraction to both sexes. Another study of males residing in New York City found 10% who identified as heterosexual had sex with at least one man during the past 12 months. In addition, 73% of the men who reported having sex with men identified as heterosexual (Miller, et al., 2007). In their study of self-identified heterosexual college students, Hoburg, et al. (2004) found 12% to 19% of the men and 29% to 32% of the women reported preferences or sexual feelings for people of both sexes. Because socially undesirable behaviors are not always acknowledged, Hoburg et al. believe their findings likely underestimate bisexuality in this population.

Coming out and identifying as bisexual may be difficult for a variety of reasons. A lack of understanding of what bisexual orientation is can make it confusing to properly identify one's feelings, while lack of a visible community provides no role models, mentors or accessible support (Bradford, 2006). Biphobia and stigma prevent some from openly identifying as bisexual (Miller, et al., 2007). Bisexual individuals may also feel pressured to choose between the lesbian/gay community

and the heterosexual community (Bradford, 2004), or they may feel it is simply safer and easier to identify as gay, lesbian or heterosexual (Dworkin, 2006). This challenges the notion that bisexual individuals are really gay or lesbian, and suggests the possibility that many self-identified gay men and lesbians may in reality be bisexual (Lev, 2004)—as may many self-identified heterosexuals (Hoburg, et al., 2004; Miller, et al., 2007).

Once a bisexual individual has established a sexual identity for themselves—finding a label which feels relevant—they may face continual challenges in maintaining that identity. This is where sexual identity formation for gay men and lesbians differs from that of bisexual individuals. Once a gay or lesbian identity has been established, it tends to be confirmed within the lesbian/gay community, by the choice of a same-sex partner, and coming out to friends, co-workers and/or family. For bisexual individuals, establishing a bisexual identity is a life-long process. Due to bi-invisibility and lack of an active bisexual community, the bisexual individual often does not receive confirmation from other bisexual individuals. Internalized biphobia may also cause bisexual individuals to question the legitimacy of their orientation. The longer a bisexual individual is in a monogamous relationship, the more they tend to be identified as lesbian/gay or heterosexual—even when they have come out to others as bisexual—thus rendering their bisexual orientation invisible (Bradford, 2004, 2006). "This invisibility is one of the most challenging aspects of being an out bisexual" (Miller, et al., 2007, p. 27).

When a bisexual individual enters into a relationship, the very first issue they must grapple with is at what point they should disclose their bisexual orientation. Should they disclose before or after the first date? Before or after sexual attraction or sexual intimacy? Or not until there appears to be a possibility of long-term commitment? Both early and delayed self-disclosure bring their own risks of a possible negative reaction. Lesbians and gay men generally do not need to be concerned with coming out to a potential same-sex partner, as their orientation is assumed. Therapists may need to work with their bisexual clients to help them determine when and how much to self-disclose when entering into a romantic relationship (Bradford, 2006).

Dual attraction to both men and women manifests itself differently for different bisexual individuals. They may or may not feel the need to act on their attraction to both men and women. Just as some lesbians,

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(Bradford, 2004, 2006).

gay men, and heterosexuals are nonmonogamous, so are some bisexual individuals. The attraction to both men and women, however, does not automatically necessitate that attraction be acted on in order for bisexual individuals to feel contented. Contrary to the stereotypes, many self-identified bisexual individuals maintain long-term monogamous relationships (Miller, et al., 2007). Reconciling their dual attraction with wanting a committed relationship also leads many bisexual individuals to explore some type of nonmonogamy. As stated previously, fidelity in a relationship is usually inextricably linked to sexual exclusivity. While these are actually two separate concepts, bisexual individuals who are openly participating in non-sexually exclusive relationships are often accused of cheating, having an affair or being unfaithful. McLean (2004) argues "the powerful Western cultural ideal of monogamy… is rarely questioned by the media or society. Effectively, this means that relationships falling outside of the (hetero)normative 'coupled' arrangement are rendered invisible, and…delegitimised" (p. 85). Therapy with couples where one or both members are bisexual may need to include issues of polyamory and the negotiation of consensual nonmonogamy. Mixed-orientation couples which contain only one bisexual member may find therapy one of the only places where their relationship is validated and affirmed. It is vital, therefore, for therapists working with such couples to communicate validation and affirmation of the relationship, whether the partners have chosen monogamy or some variation of nonmonogamy (Bradford, 2004; Ossana, 2000).

In her research, Page (2004) found bisexual clients rated their mental health experiences lower than gay men and lesbians in comparable studies. Mental health professionals working with bisexual clients need to examine their own biphobic attitudes and perceptions, particularly the perspective that sexual orientation is dichotomous. Practitioners should also explore their client's sense of bisexual identity, rather than rely on their own assumed definition (Bradford, 2006). Participants in Page's study stressed the need for mental health providers to have up-to-date knowledge regarding bisexuality, as well as the skills to help clients with issues related to their bisexual orientation. Practitioners may have to pursue their own education in bisexual matters, however. Keppel (2006) suggests graduate programs in psychology, psychiatry, social work, and marriage and family therapy do not offer education in bisexual orientation—even when they offer competent training around lesbian and

When I went to the therapist, I was terrified to come out to her as a bisexual...when I did I felt like she saw my sexuality as a joke.

Bisexual Advisory Group member

gay male issues. Finally, therapists should be aware that their positive and supportive approach is counteracted on a daily basis by external stigma and lack of validation (Goetstouwers, 2006). Participants in Page's study emphasized their desire for a more active clinical approach. As is recommended for all LGBTQ clients, the therapist needs to take a proactive, affirmative role. A therapist's silence on the subject of bisexuality may be interpreted by the client as the therapist agreeing with societal bias.

Transgender Individuals

Transgender is an umbrella term which encompasses all individuals who are gender-variant. Carroll, et al. (2002) define transgender as a "range of behaviors, expressions, and identifications that challenge the pervasive bipolar gender system in a given culture" (p. 139). Lev (2004) stresses, however, that normative gender behavior is not necessarily a healthier or more functional form of gender expression. Transgender individuals encompass a wide range on the gender spectrum, and though grouped together under one term, should not be assumed to identify or express their gender in any uniform manner. Transsexual individuals strongly feel their gender identity does not fit with their biological sex. Transsexual individuals may or may not use medical intervention in order to live as their experienced gender. They also may or may not consider themselves transgender. It is important to note that transgender and transsexual are not equivalent identities. In other words, someone who is transgender is not necessarily transsexual (Lev, 2004). For multiple reasons, how many people are or identify as transgender is unknown (Burgess, 1999; Hughes & Eliason, 2002; Witten, 2003).

Transgender individuals emphasize there can be a difference between a person's sex and their gender. A person's sex refers to the biological and anatomical factors that identify someone as male or female. Gender refers to the set of attributes society associates with masculine or feminine. Gender roles are "culturally determined behaviors expected of men and women" (Lev, 2004, p. 84) which are dictated and reinforced by society. The term gender identity describes a person's internal sense of themselves on the gender continuum. A person may identify as male, female, a combination of male and female, somewhere in between, or they may have a gender identity which cannot be accurately verbalized. Gender expression, in contrast, refers to how

Transgender individuals encompass a wide range on the gender spectrum, and though grouped together under one term, should not be assumed to identify or express their gender in any uniform manner.

(Lev, 2004)

A lot of my community doesn't realize the level of education in the trans community. They have this idea that we are all sex workers.

Transgender Advisory Group member

Higher education [for trans people] doesn't necessarily lead to economic self sufficiency or permanent employment for the trans community.

Transgender Advisory Group member

I didn't want to be labeled as having a mental health diagnosis when I didn't feel that I had one.

Transgender Advisory Group member

Emergency rooms have no conception of transgender or intersex or body differences.

Orange County Community Dialogue participant

a person externally expresses their gender to others. A person's gender identity may or may not be congruent with their biological sex, society's perception of their gender, their assigned gender role, or their gender expression (J. Green, 2000).

Transgender individuals are often socially ostracized. As a group, the transgender community is one of the most oppressed and stigmatized in our society, both culturally and institutionally (Monro, 2000). Members of the transgender community are frequently denied employment or fired from their jobs if their transgender status becomes known, denied housing, and refused service in restaurants, bars or hotels. Transgender individuals are also greatly at risk for abuse and violence (Cahill, 2000; J. Green, 2000; Lev, 2004; Witten, 2003). One study found a history of rape or forced sex reported by 59% of their gender-variant participants (Lev, 2004). In the United States, at least 60% of the transgender population has been a victim of a hate crime, and an average of one transgender individual is murdered each month (Cahill, 2000). Those who commit violence against transgender individuals tend to be particularly brutal. When looking at statistics for all reported anti-LGBTQ murders, one study found approximately 20% of those murdered were transgender. In addition, transgender individuals were the victims of approximately 40% of all police-initiated violence. Almost all reported anti-transgender violence (98%) was directed at male-to-female (MTF) transgender individuals (J. Green, 2000).

The transgender population faces stigmatization and discrimination from the mental health and medical professions (Cook-Daniels, 2006; J. Green, 2000; Lev, 2004; Logie, et al., 2007; Winters, 2005; Witten, 2003). As discussed in the section on GID, gender nonconforming behavior or identity is pathologized and considered a psychological disorder in the DSM, as well as by many mental health professionals. When discussing the clinical needs of transgender individuals, almost every professional article or book uses the terms:

> "illness," "pathology," "disorder," "condition," and "problem" and identify clients as demanding, manipulative, controlling, coercive, and paranoid. Gender-variant people are identified as impulsive, depressed, isolated, withdrawn, anxious, thought-disordered, and suffering from narcissistic, schizoid, and borderline personality features. They are perceived as immature and egocentric with profound dependency conflicts, although natal males are almost

always seen as more disturbed than natal females. (Lev, 2004, p. 189)

As an additional example, Logie, et al. (2007) found MSW students had higher rates of phobia toward transgender individuals than toward lesbians and gay men. When seeking medical care, transgender individuals often face scrutiny if, when disrobed, their bodies are not congruent with their perceived or expressed gender. A well known case of medical discrimination is that of Robert Eads, a female-to-male (FTM) transsexual who died of ovarian cancer after being refused medical care from at least 20 doctors (Davis, 2011). Many gender-variant individuals avoid accessing medical care out of fear or experience of ridicule and mistreatment (Cook-Daniels, 2006; Witten, 2003).

Evidence of gender-variant people exists throughout history and across cultures. Individuals with cross-gender expression appear to be a stable minority among the human population—suggesting gender variance may be a natural part of human diversity (Lev, 2004). While Western society has very proscribed and delineated rules regarding acceptable gender expression and gender role behavior, there are other cultures which allow nonconforming gender behavior, non-binary gender identity and/or gender transformation as an accepted way of being (Lev, 2005; L. K. Newman, 2002; Young, 2000).

Most individuals feel congruent with the gender label assigned to them. Even though they may resent or disagree with society's gender role restrictions, and may challenge those restrictions with gender nonconforming behavior, (e.g., husbands who stay home to parent their children while their wives pursue careers), they feel comfortable that their biological sex fits with their personal gender identity. Transgender individuals, on the other hand, often feel a discordance with their assigned gender designation and their personal gender identity. For some, their biological body is in such direct conflict with their inner sense of gender they may choose to alter their appearance by taking cross-gender hormones and/or having surgery. Cross-gender behavior and identity is frequently present from a very young age. This differs from someone who may have a delusional belief their body does or does not have certain physiological characteristics. Transgender and transsexual individuals do not feel their physical body accurately describes their gender, while at the same time they are very aware of their actual physiology (Lev, 2004).

Transgender individuals must go through a coming-out process

It's not fair to transgender people to choose between male or female.

San Francisco Community Dialogue participant

A lot of us get damaged by the stereotypes about gender… most people think I am in a gay relationship, but both of us are Bi and are assumed to be male but this is just our gender expression. When we don't fit into these gender/sex binaries we are punished.

Older Adult Advisory Group member

similar to LGBQ individuals, with one major difference: in order to live out their gender identity, many gender-variant individuals need to make changes to their appearance which are often obvious to everyone who knows them. This is particularly true for those individuals who choose to outwardly express their inner gender on a full-time basis, as well as for those who alter their physical appearance through the use of cross-gender hormones and/or surgery. Living in the closet either partially or fully, therefore, may not be a viable option (Cook-Daniels, 2006). In a society which steadfastly acknowledges the only gender possibilities as male and female, with gender based on the biological appearance of the body, most transgender individuals struggle with and question their gender identity to some degree. Finding how to acknowledge and express one's gender identity in a way which is ego syntonic, while coping with whatever challenges and negative consequences this may bring, is the task many transgender individuals bring with them into the therapist's office (Lev, 2005).

Transgender individuals identify in many ways and use a variety of terms, such as "mixed gendered, dual gendered, gender-blended, or gender queer" (Lev, 2005, p. 46). Some gender-variant people experience their gender as stable and consistent (though at odds with their body), while some feel their gender is more fluid and changeable. There are many transgender people who experience their gender as somewhere in the middle of the gender continuum (neither male nor female in the most concrete sense of those terms). While the ability to access medical assistance is a vital issue for the transgender community, many gender-variant individuals express their gender without the use of hormones or surgery (Denny, 2004; Lev, 2004).

Traditionally, there has been a frequent assumption that those who violate normative gender roles are also homosexual (Lev, 2004). In today's society, there remains a belief that a person's sexual orientation is often revealed through the expression of their gender identity. In reality, a person's gender identity and their sexual orientation are separate aspects of who they are. Transgender people may be heterosexual, gay, lesbian, bisexual and/or asexual (Frankowski, et al., 2004; J. Green, 2000). Some transgender individuals identify as pansexual rather than bisexual, as bisexual presumes two genders (Monro, 2000). Lev (2004) points out our current views of sexual orientation are based on a bipolar gender system. Same-sex attraction can only exist if mirrored against opposite-

sex attraction. Sexual orientation becomes more complicated in the face of gender-variance. For example, if a natal female is predominantly attracted to other natal females, she would be identified as lesbian. But if that same natal female identifies her gender as male, then would her attraction to women be considered heterosexual? And would this be the case only if she physically changed her body to match her internal gender? In other words, is it the person's gender identity or their physical body (including surgical alterations thereto) which determines how to identify their sexual orientation (Denny & Green, 1996). This is why some people choose not to label themselves—our binary view and our language just do not adequately describe their personal experience (Lev, 2004).

Gender dysphoria is a term used to describe the psychological discomfort a person experiences when their inner sense of gender does not align with their physical body and corresponding gender expectations. Gender dysphoria also refers to the "presence of clinical symptomatology associated with emotional difficulties" (Lev, 2004, p. 10). Lev (2004) lists a series of reactive symptoms transgender clients might present with due to their struggle with gender incongruence, including suicidal ideation, self-harming behavior, depression, anxiety, AOD issues, insomnia, and eating disturbances, as well as educational difficulties and chronic unemployment. The transgender model, as discussed by Denny (2004), maintains these and other symptoms are the result of societal discrimination and abuse, and not associative symptoms caused by the presence of gender incongruence—in essence, changing the locus of pathology from the individual to society. In addition, Lev suggests that much of the symptomatology seen in transgender clients is very similar to that of Post Traumatic Stress Disorder (PTSD), and is the possible reaction to the abuse and violence frequently inflicted upon transgender individuals. Carroll, et al. (2002) emphasize that due to the severe stigma associated with gender variance, transgender clients may experience particularly acute feelings of depression and low self-esteem.

Most mental health practitioners have not received adequate, if any, training or education regarding transgender experience and are not competently prepared to work with clients on issues related to gender identity (Carroll, et al., 2002; Lev, 2004). This lack of knowledge and training can have dire consequences for the gender-variant client. Lev (2004) warns that clinicians who are ignorant of transgender needs "often

Much of the symptomatology seen in transgender clients is very similar to that of Post Traumatic Stress Disorder (PTSD), and is the possible reaction to the abuse and violence frequently inflicted upon transgender individuals.

(Lev, 2004)

There are hundreds of transgender people, most of whom are hiding—there are no psych services, or physician services to help. We have a whole group of people going to Mexico, using the black market. There is a lack of services and information on what is safe and sane.

Inland Empire Community Dialogue participant

We actually make good workers…and didn't forget everything we've learned in the last 30 years.

Inland Empire Community Dialogue participant

I was treating a Female to Male who wanted to kill herself…I don't have enough time to deal with them being gay/ transgender, which may be why they want to kill themselves.

Desert Valley Community Dialogue provider participant

reflect back to their clients the same anxiety, depression, isolation, shame, and terror…their clients present to them.…Clinical experience yields frightening narratives of clients who have been misdiagnosed, mistreated, and misguided by uninformed clinicians" (p. 19).

Mental health practitioners need to understand the many challenges their transgender and transsexual clients may face. If their client desires medical interventions to alleviate their feelings of gender incongruence, the cost of those interventions are generally not covered by medical insurance. The cost of hormones and/or surgery may be prohibitive, thus denying the client access to the care they seek. Unless the transgender individual is financially well off, the cost of treatment is frequently prohibitive and can create an oppressive burden of debt and expense. Most antidiscrimination laws do not cover transgender individuals, including those for housing and employment. One study found 42% unemployment among the transgender population surveyed. Other challenges faced by transgender clients include: legal issues such as child custody, marriage rights, and legal recognition of their gender identity; fear of loss or actual loss of family and friends; access to schooling which is free of harassment and bullying; and loss of religious affiliation (J. Green, 2000; Witten, 2003). As with LGBQ, transgender individuals internalize societal phobia, stigma and rejecting messages—often without realizing the degree to which this internalization impacts their lives (Lev, 2004).

Mental health professionals working with transgender individuals need to have both an understanding of the latest version of the WPATH Standards Of Care (SOC) and the mental health needs of their clients. According to SOC guidelines, while access to cross-gender hormone therapy is less restricted, clients desiring SRS need to have a psychological assessment and receive letters of approval before gaining access to genital reconstruction. This, in essence, places the clinician in the role of gatekeeper. This role potentially creates difficulties within the therapeutic relationship for both the therapist and the transsexual client. The therapist's power to provide or withhold access to desired medical intervention may produce fear or resentment on the part of the client—resulting in behavior which may alienate the therapist. Transgender clients who are seeking hormone therapy or surgery, but who do not fit the DSM criteria for GID, are caught between revealing the truth of their cross-gender experience and gaining access to desired medical treatment.

A gatekeeping relationship between therapist and client encourages these clients to present a false self. Instead, using an advocacy-based model which allows alternative narratives of gender experience may provide both the therapist and the client an opportunity to build a supportive therapeutic relationship (Lev, 2004, 2005; WPATH, 2011).

There is historical transphobia expressed toward trans people from within the lesbian and gay communities, as well as homophobia expressed by some trans people. "Homosexual orientation does not automatically render a person able to understand transgender issues or experience. Nor does inclusion in GLB [*sic*] contexts mean that all transgender or transsexual welcome that inclusion or make use of it" (J. Green, 2004, p. 81). Because of mainstream confusion about sex and gender, and common assumptions that "gay men want to be women," some physicians in the mid-20th century actually proposed that "sex change" could be a useful tool for normalizing homosexual urges. It is not reasonable to assume that a gay man, even if he has some feminine characteristics, wants to be a woman, or even will be able to survive as one. And many trans people have had no experience whatsoever with transvestite performance or any other aspect of gay or lesbian communities. Female-to-Male trans people are often assumed to be lesbians because they have had female lovers, but if their identity is not connected to lesbian culture, they will not have any intrinsic connection to it, regardless of how it looks from the outside. (J. Green, personal communication, May 24, 2012.)

People of Color Who Are LGBTQ

Very little research regarding LGBTQ individuals has focused on or acknowledged ethnic or racial issues as they relate to sexual identity development, sexual orientation, gender identity or mental health issues (Boehmer, 2002; Cianciotto & Cahill, 2003; Collins, 2004). The limited research conducted with LGBTQ individuals of racial or ethnic minorities indicates they experience greater stress due to their multiple minority status (DiPlacido, 1998). Members of racial or ethnic minorities generally share their minority status with members of their family. They grow up in an environment which allows at least some protection against stigma and discrimination. This is not true for LGBTQ individuals, who are often the only one in their family or social group with an LGBTQ status (Cianciotto & Cahill, 2003; Guthrie, 2006; Safren & Rogers, 2001).

American perceptions of what it means to be LGBTQ may affect treatment of LGBTQ clients of color and those with other cultures.

West Hollywood/Los Angeles Community Dialogue participant

Having community spaces for LGBTQ folks of color helps queer folks of color create a better sense of identity.

Orange County Community Dialogue participant

In the Vietnamese culture, there is no language to describe mental or emotional issues; they speak mostly through physical pain.

AA & NHPI Advisory Group member

Coming out as LGBTQ for individuals who are also members of a racial or ethnic minority may require them to choose between the safety of their family and cultural environment and their LGBTQ identity. Unfortunately, they may also meet with prejudice and discrimination within LGBTQ communities. Their unique needs and status are often rendered invisible, whichever community they choose to associate with—and too often they find themselves having to choose (Fukuyama & Ferguson, 2000). In addition, they may be faced with a tricultural challenge, facing "homophobia from their respective racial or ethnic group, racism from within a predominantly white LGBTQ community, and combination of the two from society at large" (Cianciotto & Cahill, 2003, p. 17).

Asian American, Native Hawaiians and Pacific Islanders

Asian Americans, Native Hawaiians and Pacific Islanders (AA & NHPI) encompass many distinct and unique ethnic groups residing in the United States with ancestral ties from countries as geographically and culturally diverse as India, Bangladesh, Pakistan, Sri Lanka, Vietnam, Thailand, Cambodia, China, Japan, Korea, the Philippines, Indonesia, Samoa, Guam and Hawaii. AA & NHPI are diverse and comprised of heterogeneous groups with their own cultures, ethnic make-up, histories, languages, migration patterns, religions, acculturation patterns, financial resources, average social economic status, and other characteristics.

California is the state with the largest AA & NHPI population (Hoeffel, Rastogi, Kim, & Shahid, 2012; UCLA Asian American Studies Center, 2012). In 2010 AA & NHPI Americans made up 15% of the California population. California also has the largest population of AA & NHPI who identify as LGBTQ (Gates & Ramos, 2008; Wilkinson, 2010).

Immigration and marriage equality. Among bi-national same-sex couples (couples where at least one partner is not a U.S. citizen) in the United States, 45% of the *non*-citizen partners are AA & NHPI and 7% of the citizen partners are AA & NHPI. California has the largest number of bi-national same-sex couples (Konnoth & Gates, 2011).

United States immigration laws do not allow citizens to apply for permanent residence status for their non-citizen same sex partners (even if legally married) as it does for opposite sex spouses (Konnoth & Gates, 2011). For bi-national same-sex couples in the United States, these laws create an ongoing threat of deportation that perpetuates fears of loss and

significant disruption of family life. Because 32% of these couples raise children (Konnoth & Gates, 2011) the potential for destruction of the family extends to children as well.

Relationship status. Although the 2010 U.S. Census counted 22% of AA & NHPI LGBTQ as being part of a same-sex couple, a nationwide survey found 40% as being in a committed relationship or domestic partnership (Dang & Vianney, 2007; Gates & Ramos, 2008). Of AA & NHPI in same-sex couples, 21% of the men, and 31% of the women are raising their own children (Gates & Ramos, 2008). With an average income that is nearly one quarter less than their heterosexual counterparts, AA & NHPI same-sex parents have fewer financial resources to support their children and are less likely to own their own home, despite being more likely to have a college degree (Gates & Ramos, 2008).

Discrimination, violence, and harassment. As discussed earlier in this report, on a daily basis LGBTQ individuals of color face the implications of a multiple minority status. The 2007 National Gay and Lesbian Task Force (NGLTF) survey *Living in the Margins: A National Survey of Lesbian, Gay, Bisexual and Transgender Asian and Pacific Islander Americans* found the most important issue facing respondents were hate violence and harassment (Dang & Vianney, 2007). AA & NHPI individuals experience discrimination and harassment based on both their sexual orientation/gender identity as well as on their race/ethnicity. In the wake of the terrorist attacks of September 11, 2001, the societal harassment, discrimination, scrutiny, targeting, profiling, detentions, and deportations of South Asians have increased notably (Dang & Hu, 2005).

The 2007 NGLTF survey further found that the great majority of respondents (98%) had experienced discrimination or harassment in their lives, with 75% having experienced discrimination and/or harassment based on their sexual orientation and 85% having experienced discrimination and/or harassment based on their race or ethnicity (Dang & Vianney, 2007).

AA & NHPI LGBTQ are faced with the dual stressors of racism within the predominately white LGBTQ communities and heterosexism within AA & NHPI communities. In the 2007 NGLTF survey, the overwhelming majority of respondents reported experiencing verbal harassment for both their LGBTQ and AA & NHPI membership. Nearly

20% experienced physical harassment for being AA & NHPI (Dang & Vianney, 2007). This is particularly alarming because verbal harassment and physical violence towards LGBTQ individuals have been associated with several health disparities including lower self-esteem and higher rates of suicidal ideation (Gates & Konnoth, 2011; Huebner, Rebchook, & Kegles, 2004).

The 2007 NGLTF survey found that after hate violence/harassment, the four most important issues facing the LGBTQ AA & NHPI Americans were media representation, marriage equality, immigration, and job discrimination/harassment (Dang & Vianney, 2007). Similarly, a 2004 survey of AA & NHPI LGBTQ found that the top five concerns were immigration, hate violence/harassment, media representation, HIV/AIDS, and marriage/domestic partnership (Dang & Hu, 2005).

API families work as a very cohesive unit. LGBTQ individuals want the family to remain peaceful.

AA & NHPI Advisory Group member

Fear of rejection and other family-related stressors. AA & NHPI cultures traditionally have been described as prioritizing the relationship with the collective-family community over the needs of the individual. Therefore, AA & NHPI LGBTQ individuals may face heightened fears of rejection when contemplating coming out (or of being outed) to their immediate and extended family, as well as to their larger AA & NHPI community. Researchers and scholars have found that "the intensity of heterosexism is much stronger in Asian and Asian American cultures than in the dominant United States culture because homosexuality violates many traditional Asian values … that promote heterosexuality as the only viable form of intimate and/or sexual relationships" (Szymanski & Sung, 2010, p. 850). This perhaps explains why "many Asian American LGBTQ persons view the Asian American community as conservative and intolerant of homosexuality and describe feeling a lack of support from the Asian heterosexual community for their LGBTQ identities" (Syzmanski & Sung, 2010, p. 850).

Although modern AA & NHPI cultures are usually viewed as embracing heterosexism, there is evidence that pre-modern AA & NHPI traditions embraced and even revered individuals who today we would view as lesbian, gay, bisexual or transgender (Park & Manzon-Santos, 2000; Wilkinson, 2010). Park and Manzon-Santos (2000) explain that European Colonialism eventually destroyed most of these AA & NHPI cultures' traditions. Heterosexism ultimately replaced the diverse expression of gender identity and sexual orientation that were woven into the fabric of pre-modern AA & NHPI cultures.

Health disparities. Studies of AA & NHPI LGBTQ document a variety of health disparities, including increased incidences of substance abuse, high-risk sexual behavior, depression, anxiety, PTSD, and suicidality (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Gee, Jorge, & Takeuchi, 2007; Gee, Spencer, Chen, & Takeuchi, 2007; Konnoth & Gates, 2011; Lee & Mokuau, 2004; Mossakowski, 2003; Nemoto, Operario, Keatley, Han, & Soma, 2004; Wilkinson, 2010). A 2007 study of Latino and Asian American individuals found that suicide attempt rates for LGB individuals from these ethnic groups were 4 times (women) to 8 times (men) that of heterosexuals (Gee, Spencer, et al., 2007). Increased rates were also found for depression, anxiety, substance abuse, and eating disorders for Latino and Asian lesbian and bisexual women (Cochran, et al., 2007). For AA & NHPI LGBTQ, these health disparities are associated with higher rates of discrimination, harassment, abuse and hate violence (both for LGBTQ and AA & NHPI status); limited English-speaking capacity and the resultant lower income; and immigration and refugee issues associated with multiple losses, job disruption, trauma, and an inability to return to one's homeland (Cochran, et al., 2007; Gee, Jorge, et al., 2007; Gee, Spencer, et al., 2007; Lee & Mokuau, 2002; Mossakowski, 2003; Nemoto, Operario, Keatley, Han, & Soma, 2004; Wilkinson, 2010).

Mental health care—stigma & shame. Within AA & NHPI cultures, there is often shame and stigma associated with accessing mental health services. Barriers include a lack of bilingual mental health providers, a fear of opening up to strangers, an unwillingness to talk about emotions, and negative experiences in their home country where an admission to needing mental health care may result in being labeled as "crazy" and placed in long term institutionalization (Chung, 2002). In Chu and Sue's (2011) review of the literature, they found that Asian Americans have greater personal stigma associated with mental health issues and access health care from 2 to 5 times less than Caucasians independent of geographic location, age, gender, education, or Asian sub-group.

In the API community, the "straight" people don't realize the LGBTQ member of the family can go through mental health issues just like anyone else. They think we are immune to suffering related to mental health—it's your choice because you wanted to be like that.

AA & NHPI Advisory Group member

API individuals may delay seeking treatment due to a want and need to "save the family"—creating further damage.

AA & NHPI Advisory Group member

Black/African American/African descent

The most recent decennial U.S. Census indicates that Black/African Americans make up 6.6% of the California population (U.S. Census Bureau, 2010). Reaching members of the relatively small-sized

LGBTQ of color folks have support groups within the larger organizations. There are several different events for African American women that branch up and down the state. These allow me choices and it makes me feel good.

Oakland/East Bay Community Dialogue participant

I don't go to San Francisco, I just suffer. There are no services that exist here where I am comfortable.

Oakland/East Bay Community Dialogue participant

Our culture is different and we need different services for our mental health needs.

Black/African American Advisory Group member

Black LGBTQ community in California is challenging, as they are often hidden. Black LGBTQ individuals and families are among people who belong to historically marginalized communities which have experienced poor quality of care and may not want to risk further discrimination by coming out as LGBTQ individuals (Harper, et al., 2004; Malenbranche, et al., 2004; Battle & Crum, 2007; Wilson & Yoshikawa, 2007). In addition, this community has not been effectively included in the limited studies undertaken about the mental health needs of LGBTQ individuals and families (Zea, 2010).

LGBTQ communities in California include individuals whose racial and/or ethnic identity is Black, African American or another ethnic identity involving persons of African descent. Some Black LGBTQ people feel included as members of predominately white, urban LGBTQ communities such as the Castro district in San Francisco or West Hollywood in the Los Angeles area. However, many Black LGBTQ individuals and families do not feel part of or welcome in predominantly white LGBTQ communities. In addition, many do not identify with the term LGBTQ and would prefer to be identified as Same Gender Loving or SGL.

The issue of terminology (Fieland, Walters, & Simoni, 2007; Savin-Williams, 2005; Malenbranche, et al., 2004) exemplifies the need for providers to have an in-depth understanding of LGBTQ diversity along the lines of race, ethnicity and culture. Proper terminology is one of many factors that signal to Black LGBTQ consumers their provider is aware of and sensitive to these differences, as well as interested in being inclusive and welcoming to this segment of the LGBTQ community. It is important for a provider to know the particular LGBTQ communities they work with, because the terminology of the community and the issues of disclosure about sexuality may differ depending on underlying cultural differences. Through their use of language and through design and delivery of services, providers can indicate they are competent to meet the culturally specific needs of Black LGBTQ people.

Black LGBTQ individuals have also found it necessary to carve out safe space in both LGBTQ communities and in the Black community. In a society where overt and institutionalized racism transcends sexual orientation and gender identity, providers need to understand that Black LGBTQ people are *Black*. Examples of efforts in the 1990s to carve out safe space for Black LGBTQ in the Black community include the

establishment of faith-based communities in Los Angeles and in the Bay Area, such as Unity Fellowship Church Movement, and Arc of Refuge. Historical examples of carving out safe space in predominantly white-led LGBTQ communities include Black LGB-led efforts in the 1980s to pass legislation in major California cities against anti-discriminatory carding practices conducted by gay bars which dissuaded and limited Black LGBTQ patronage. During that period, Black LGBTQ people also made efforts to try to meaningfully participate in the governance of emerging, white-led LGBTQ political organizations. Efforts at Black LGBTQ self-empowerment were both welcomed and resisted by many white-led LGBTQ organizations which desired to address the problems, but lacked the capacity to do so. Inevitably, the Black LGBTQ and white-led LGBTQ communities were pitted against each other for scarce resources to address issues like health care. Today, there are organizations and programs around the state that have developed or adapted evidence-based behavioral interventions, such as evidence-based HIV prevention models that are designed specifically to target and serve Black men who have sex with men. Health disparities, including issues of access to mental health services, are clearly evident in the Black LGBTQ community and focused efforts should be undertaken to better understand and address these disparities in California (G. Gerald, personal communication, June 29, 2012).

Black individuals, families, communities and institutions draw strength and create unity in confronting racism together—protecting members from a persistent, insidious discriminatory force. Therefore, it makes sense that Black LGBTQ and other LGBTQ people of color have no interest in jeopardizing the support they receive from their own community by leaving that community for LGBTQ services (Harper, et al., 2004; Rosario, Schrimshaw, & Hunter, 2004). One solution to this conundrum is not only for organizations with a mission to serve LGBTQ communities work to increase their capacity to provide Black-specific LGBTQ services, but for organizations largely serving the Black community to build capacity to serve Black LGBTQ individuals and families.

Understanding the need for capacity-building in both LGBTQ communities and in the Black community has historical roots. Prior to the rise of LGBTQ political organizing in the 1950s and 1960s, there had been and continue to be hidden networks and social organizations for

Create resources from within and not look outside the community (not look at white models)—building capacity within individual groups to help themselves.

Oakland/East Bay Community Dialogue participant

Mental Health services are often seen a "white thing"—often African American clients aren't aware that there are African American therapists out there.

Black/African American Advisory Group member

Black LGBTQ individuals within the context of the Black community as a whole. During the 1990s, Black LGBTQ people also found it necessary to establish separate organizations addressing HIV/AIDS because many Black LGBTQ individuals felt strongly that white-led organizations were failing to address the epidemic in the Black community. The Minority AIDS Project in Los Angeles and the Black Coalition on AIDS in San Francisco are but two examples of this effort (G. Gerald, personal communication, June 29, 2012).

Due to the impact of HIV among Black men who have sex with men (MSM), relatively more needs assessments and studies have documented community need through the lens of HIV-related services. One feasibility study in the San Francisco Bay Area looked at developing a regional approach to disease prevention targeting Black MSM. This study found a number of similar needs and conditions across the region, including: isolation and barriers that are rooted in stigma associated with race, sex between persons of the same gender, and disease; the relatively smaller number of Black MSM in the region and the fact that many are hidden and hard to reach; the geographic distribution of the target population, widely dispersed in the region and also concentrated in urban neighborhoods; the psychosocial and culturally based needs of many which must be addressed as part of services; and the need for leadership development and capacity building within the Black MSM community and in the organizations, programs, and services that serve, or could potentially serve this group (Gil Gerald & Associates, Inc., 2009). Yet another study found that "Black lesbians are less likely to seek out traditional professional mental health help than are their white counterparts," and that "there is a pattern of higher suicide rates among Black lesbians" (Zuna Institute, 2010, p. 7). Because little attention is generally paid to women's issues, it is not surprising that the risks and stressors affecting Black lesbians are not well understood within the mental health arena.

Black transgender women in California are particularly at risk for social and economic marginalization, and while race and ethnicity are not risk factors for HIV in and of themselves, they are markers for other factors that put people at higher risk for HIV, including limited economic resources and unequal access to health care (Sevelius, Keatley, Rouse, Iniguez, & Reyes, 2008). In California, transwomen who are clients of publicly-funded STI counseling and testing sites have higher rates of HIV

diagnosis (6%) than all other risk categories, and Black transwomen have diagnosis rates as high as 29%, substantially higher than all other racial or ethnic groups of transwomen. (Sevelius, et al., 2008). Programs that treat transwomen as if they were MSM create barriers to the care these women need, and contribute to negative mental health among transwomen due to the blatant negation of their identities that such classification represents.

Another recent ethnographic study done in San Francisco on transgender people of color found that "HIV was a major concern… particularly in the African American transgender community" (Bith-Melander, et al., 2010, p. 215), especially for those transgender people engaged in survival sex work. The study subjects also expressed, however, a sense of community as they struggled to find mentors and social support while negotiating their transitions and establishing their identities. This report concludes:

> Despite social vulnerability,…transgender people of color in general show remarkable creativity, resilience, and social support to help each other define their identities and transition to their preferred gender expression… Resources for harm reduction and mental health are much needed to help these individuals live full and healthy lives. (Bith-Melander, et al., 2010, p. 218)

Managing diversity in sexual orientation or gender identity is not a simple matter within tightly-knit communities that rely on all their members for survival against racial prejudice and economic disadvantage. In her ethnographic study of Black lesbians and gay men in Los Angeles, Mignon Moore (2010) found:

> the relationships the Black LGBT informants in [the] study had with their religious and racial communities cannot be explained in a linear, uniform way… Some in the community were becoming more supportive of gay sexuality as an identity status that could exist alongside a strong racial group affinity. Others were holding fast to religious and cultural ideologies that reduced gay sexuality to an immoral behavior and thus not a valid identity status. Some LGBT people responded to the inconsistencies and occasional rejection by physically distancing themselves from the racial community. Others exited a "gay" life and retreated to a primary heterosexual identity while continuing to have same-sex intimate relationships in secret… The black Angelinos in [this] study remained in their racial communities, despite the conflicts over

Understand that even though the APA has removed homosexuality from its list of psychopathologies, this is not the case in the African American community. Therefore, a certain level of support for African Americans who are sexual minorities who choose to come out, is essential in order to minimize the trauma of this process within the social context of the African American community. Clients are now forced to decide whether they are Black or gay. This is an untenable and self-defeating choice.

Black/African American Advisory Group member

Spanish monolingual LGBTQ women may not have any services because of a language barrier.

Women's Issues Advisory Group member

> acceptance of their sexuality, because those conflicts were part and parcel of the sense of community and belonging. (Moore, 2010, pp. 208-209)

Latino/Hispanic/Mexican American/Chicano

Disparities in mental health care for Latinos are well documented and associated with several barriers impacting access to care (Aguilar-Gaxiola, et al., 2012; Guarnero & Flaskerud, 2008; Mustanski, Garofalo, & Emerson, 2010). There are a number of factors that can contribute to mental health disparities in the Latino LGBTQ community. Stigma, the continued need for LGBTQ-competent services and providers, and limited educational and community resources are among several of the barriers that separate Latinos from the receipt of culturally competent mental health services. While these barriers are extensive and difficult to overcome, additional barriers further complicate access to services for Latino LGBTQ.

Double stigma. As a minority group within the Latino community, Latino LGBTQ face stigma that can isolate them from family, classmates, and the Latino community but also from the receipt of mental health services. Stigmatized stereotypes and labels of LGBTQ communities all too often increase public hatred, homophobia, and fear towards them. Hence, for Latino LGBTQ the decision to disclose their sexual orientation may result in rejection from peers, family, religious institutions, and cultural groups, all of which are vital in the Latino culture. The ability to "come out" to their families without being rejected is of great importance to Latino LGBTQ as exemplified in the report *Community-Defined Solutions for Latino Mental Health Care Disparities* (Aguilar-Gaxiola, et al., 2012). Participants indicated that coming out to family typically resulted in family members severing relationships with the LGBTQ individual due to a lack of knowledge and education. One Latino LGBTQ advocate and participant emphasized:

> Provide LGBTQ Latinos with [knowledge] and techniques to engage their family when they come out…when an LGBTQ Latino comes out to the family, the parents go through a grieving process and they sever relationships with family members due to lack of knowledge which becomes a potential issue to accessing care. The Latino LGBTQ experiences a sense of loss and is most vulnerable to substance abuse, HIV, depression, and suicide.

(LGBTQ Forums, personal communication, Spring, 2011)

Understandably some Latino LGBTQ can respond with a need to not only conceal their sexual orientation and/or gender identity, but their need for mental health services as well. The double stigma of having a mental health disorder and being LGBTQ may increase fears of public rejection as well as fears of not finding mental health providers knowledgeable and sensitive to the needs of LGBTQ people. Such a response only exacerbates untreated mental health concerns that in the most unfortunate cases can lead to suicide ideation, particularly among youth who suffer the rejection of their social supports. Without support or services, Latino LGBTQ must find other means to cope with the poor self-esteem, poor self-worth, and even self-hatred that sometimes result from public rejection, along with the possibility of anxiety, depression, substance abuse, and other mental health concerns (Dana, Glenn, & Der-Karabetian, 2008; Williamson, 2000).

LGBTQ-specific services and providers. Among Latino LGBTQ who seek mental health services, several describe a lack of culturally competent providers, limited availability of LGBTQ-specific services, providers who lack knowledge of the specific mental health needs of LGBTQ communities, as well as providers who express negative perceptions of LGBTQ individuals (Aguilar-Gaxiola, et al., 2012). In response, it is important to strive to increase the presence of mental health providers properly trained to treat Latino LGBTQ. Work with Latino LGBTQ requires cultural awareness to prevent the delivery of generalized services and supports, while also increasing recognition of cultural and individual differences in personal experience, values, beliefs, norms, and practices among Latino LGBTQ clients. The American Psychological Association's Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (2000) emphasizes awareness of "cultural values about gender roles, religious and procreative beliefs, degree of individual and family acculturation, and the personal cultural history of discrimination or oppression" (p. 1445), given that all of these factors contribute to a person's self-identity and integration into society.

Work with Latino LGBTQ also requires the ability to guide clients in the resolution of difficult situations, such as the decision to include or exclude family members in treatment depending on the best interest of the client. For example, one Latino LGBTQ participant noted: "It is critical that more attention be dedicated to improving the

It is critical that more attention be dedicated to improving the competence within mental health providers who are working with the LGBTQ Latino community… Be more familiarized with LGBT life experiences.

(LGBTQ Forums, 2011)

competence within mental health providers who are working with the LGBTQ Latino community… Be more familiarized with LGBT life experiences" (LGBTQ Forums, personal communication, Spring, 2011). This Latino LGBTQ participant recalled a previous experience with a provider who was not well informed about LGBTQ issues. This is a key finding, because the lack of LGBTQ-competent providers may influence an LGBTQ person's decision to seek services if they perceive the mental health system as not LGBTQ-competent. This finding is also consistent with previous research indicating that a perceived lack of LGBTQ-competent providers leads to an LGBTQ subculture of concealment and denial (Aguilar-Gaxiola, et al., 2012; Guarnero & Flaskerud, 2008).

Educational opportunities and community resources. Aguilar-Gaxiola, et al. (2012) highlight the provision of educational courses related to the mental health of Latino LGBTQ in secondary and post-secondary campuses as one of many opportunities to better inform the general public and mental health providers about LGBTQ issues and mental health disparities. For example, many Latino LGBTQ youth expressed disappointment stemming from the lack of classroom instruction and its alignment with LGBTQ issues. The lack of educational material about LGBTQ and mental health topics in secondary schools was perceived as a major obstacle to reducing stigma, homophobia, and discrimination against LGBTQ youth.

Another solution is found in training opportunities for current mental health providers and for both Latinos and Latino LGBTQ interested in careers in the mental health field (Aguilar-Gaxiola, et al., 2012). Continuing education and training programs can be made available to mental health providers currently working with the Latino LGBTQ community. It is also essential to work with schools to provide educators a series of workshops dealing with ways to incorporate key elements of the Fair, Accurate, Inclusive, and Respectful (FAIR) Education Act, which promotes classroom instruction about civil and social movements, and history of all people (e.g., people with disabilities, Latinos, and LGBTQ communities) in ways that reduce social exclusion (Aguilar-Gaxiola, et al., 2012). For example, it is possible to design LGBTQ educational standards and to integrate these standards with current academic standards (e.g., English, language arts, and history) or to facilitate ongoing curriculum alignment workshops to include LGBTQ issues with classroom instruction. The inclusion of LGBTQ instruction

in the classroom is essential for Latino LGBTQ youth who, just like everyone else, deserve to learn about their own history and current social issues.

For one Latino LGBTQ participant, excluding educational material about the LGBTQ experience from schools translated into being denied a rich learning experience in a safe environment and being respected as an individual. This participant noted, "I didn't feel like I belonged in my school, I felt foreign and did not feel like I had an identity or voice as a student." Another Latino LGBTQ participant emphasized that:

> LGBTQ Latinos are behind the non-Latino or white gay population in California with regard to social inclusion of our LGBTQ community. The current environment is not up to speed with Latino LGBTQ issues. An LGBTQ Latino experiences more challenges with feeling a sense of belonging in their community than does a white LGBTQ…the LGBTQ pop culture [Glee] is white. (LGBTQ Forums, personal communication, Spring, 2011)

An LGBTQ Latino experiences more challenges with feeling a sense of belonging in their community than does a white LGBTQ…the LGBTQ pop culture [Glee] is white.

(LGBTQ Forums, 2011)

Educational campaigns are also needed within middle schools and high schools in order to alleviate the bullying that some LGBTQ youth encounter or simply to encourage them to seek services, if needed. Larger scale educational media campaigns can also help the Latino community as a whole to further understand the needs of LGBTQ communities.

In summary, it is critical to increase mental health service access for the Latino LGBTQ community which has experienced multi-faceted obstacles when seeking services. Many Latino LGBTQ have reported feeling disappointed with a provider whom they did not identify with and perceived as lacking awareness of their life experiences. The failure of the mental health system and providers to attend to LGBTQ-specific issues will continue to contribute to mental health disparities among Latino LGBTQ. For many Latino LGBTQ, simply continuing the dialogue about LGBTQ issues is a huge step in the right direction toward confronting stigma, addressing shortages of well-trained human resources, and improving educational and community assets.

Native American—Two-Spirit

Native Americans from various tribes began migrating in significant numbers from the reservations to major urban areas like San Francisco during the 1950's as the result of federally mandated policies

such as the Bureau of Indian Affairs (BIA) Relocation Program. The BIA's failure to fulfill its promise of transitional assistance initiated the development of a chronically disenfranchised urban Native American population. Relocation has created a unique identity for urban Native Americans. Increases in inter-tribal and inter-racial marriages produced offspring who became more isolated from tribal-specific practices, while remaining invisible to the general population (Walters, 1999).

Currently, two-thirds of Native Americans are living in urban environments. Despite this growing trend and the federal trust responsibility of the United States to provide health care to all Native Americans, Urban Indian Health Program (UIHP) funding has remained only 1% of the total Indian Health Service funds (Forquera, 2001). The San Francisco Bay Area has one of the largest and most diverse Urban Indian populations in the United States with over one hundred tribes represented (Nebelkopf & Phillips, 2004). Diversity, however, extends beyond tribal affiliation. In fact, urban Native American identities are complex with varying levels of tribal identity and cultural connection represented. One aspect of this complexity is in relation to both sexuality and gender identity.

The term two-spirit has been adopted by many lesbian, gay, bisexual, and/or transgender urban Native Americans as an all encompassing term to define the fluidity of their identities.

(Jacobs, Lang, & Thomas, 1997)

The term two-spirit has been adopted by many lesbian, gay, bisexual, and/or transgender urban Native Americans as an all encompassing term to define the fluidity of their identities. It represents the belief that these individuals carry both masculine and feminine spirits and their identity can therefore result in multifaceted variations of sexuality and gender expressions. From a traditional perspective, most tribes have independent terms to define two-spirit members of their communities such as *nadleh* for the Navajo or *lhamana* for the Zuni (Jacobs, Lang, & Thomas, 1997). The overarching similarity across tribes was that these individuals held revered positions in tribal societies and were often healers or name-givers for their tribal communities.

The arrival of European religious beliefs negatively affected two-spirit people. Through genocide and colonization tactics directed toward assimilation, these individuals have often been ostracized and left to suffer with the additional stigma experienced by other LGBTQ populations. Oppression, homophobia, shame and historical trauma are some of the burdens two-spirits carry and consequently, the health disparities they suffer exceeds those of their non-two-spirit relatives. According to *Mental Health: Culture, Race, and Ethnicity–A Supplement*

to Mental Health: A Report of the Surgeon General, Native Americans are overrepresented among people who are homeless or incarcerated and people with alcohol and drug problems. The estimated rate of alcohol-related deaths for Native Americans as a whole is much higher than it is for the general population (U.S. Department of Health and Human Services, 2001).

Like many LGBTQ people, two-spirits relocated to San Francisco seeking acceptance of their identities and opportunities for a better quality of life. Particularly for Native American men who have sex with men (MSM), San Francisco is viewed as the "Gay Mecca," but few are educated on the prevalence rate of HIV infection or prepared for the prominence of the drug culture that is imbedded in the San Francisco scene. In 2008, males represented 90% of new HIV diagnoses in San Francisco, 70% were exposed through MSM activity and 10% were exposed through both MSM and intravenous drug use (IDU) activity. In addition, 80% of new diagnoses in 2008 were people between the ages of 25 and 49 (Raymond, 2010). In the 2010 San Francisco HIV Prevention Plan, substance use was identified as a driver and cofactor directly linked to the HIV prevalence rate in the San Francisco MSM community. In fact, drug use behaviors, both injection and non-injection, account for 29% of new infections in the San Francisco MSM population (Harder & Company, 2010).

For two-spirits, whether newly relocated or raised in urban environments, the San Francisco environment engulfs them with risk while providing them with limited culturally competent resources. Substance abuse, HIV and AIDS are major issues found within this population today (Vernon, 2001). Although persons of Native American ancestry make up a small percentage of the San Francisco population (roughly 1% to 2%), Native Americans ranked third in prevalence for new HIV infections (Centers for Disease Control, 2007). In San Francisco there are 142 cumulative cases of AIDS to date among Native Americans, with the second highest case rate (5,237.2/100,000) in the county, indicating an elevated burden in this population. The majority of transmission categories among these cases are injection drug use (14.8%), gay or bisexual male (46.5%) or either gay or bisexual male and IDU (34.5%) (San Francisco Department of Public Health, 2008). In addition to the Native Americans who acquire HIV while living in San Francisco, there are others who are drawn to the city for treatment. Because HIV

LGBTQ Native youth mask their identity with alcohol.

Native American Advisory Group member

and AIDS prevention and care services are often unavailable in rural, reservation environments, and/or many two-spirits are unwilling to seek treatment in their reservation communities to avoid the stigma associated with their sexual identities, substance use and/or their HIV sero-status, many infected Native Americans relocate to San Francisco for treatment (Vernon, 2001). For a community that has been struggling to rebuild itself since the arrival of European colonizers, HIV and AIDS has had a devastating impact.

Substance abuse is a serious problem among Native Americans and is key to issues of trauma, mental health, and HIV risk. The 2003 California Health Interview Survey (CHIS), conducted by the University of California, Los Angeles, showed that among those reporting alcohol use in the past 30 days, 34.3% of adult Native Americans reported binge drinking (five or more drinks in a sitting) in the past 30 days compared to 26.1% for non-Native Americans. In addition, 71% consumed two or more drinks daily compared to 57.9% of non-Native Americans (CHIS, 2003). The results of these studies are not surprising since substance use in Native American communities has arisen as a universal coping mechanism resulting from severe economic and social ailments such as poverty, depression, and historical trauma (Nebelkopf & Phillips, 2004). Substance use problems in Native American communities heighten the risk of HIV infection. Consequently, dual diagnoses (substance abuse/ HIV infection) are more common. In San Francisco, 37% of Native Americans diagnosed with AIDS were MSM/IDU, which was higher than any other ethnic group (Harder & Company, 2010). Native Americans ranked second for IDU heroin and methamphetamine use, which are identified as high risk co-factors for HIV infection (Harder & Company, 2010).

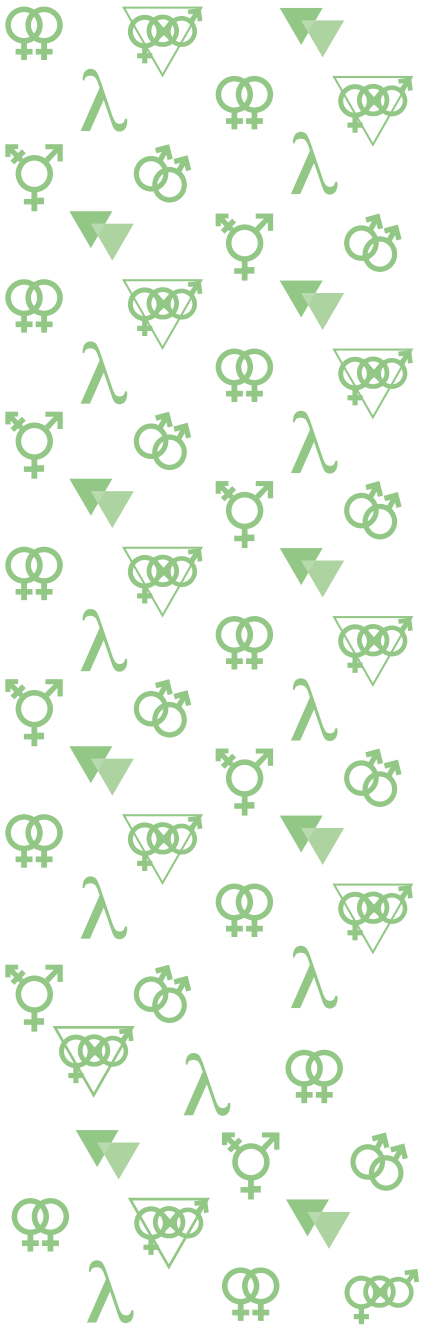
The San Francisco HIV Prevention Planning Council has determined that Native Americans are disproportionately affected by high-risk co-factors for HIV and recommend a culturally sensitive, holistic intervention that not only addresses HIV prevention, but all co-factors and drivers associated with it (Harder & Company, 2010). The struggles of two-spirits are also exacerbated by the lasting impacts of homophobia and historical trauma, including loss of identity. Historical trauma is defined as cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences (Yellow Horse Brave Heart, 2003). Historical

trauma theory was the result of over 20 years of clinical practice, observations, and quantitative and qualitative research. It explains behavior associated with the unresolved grief experienced in response to the long history of oppression experienced by Native Americans, which has had a devastating effect on their health and well-being. Some examples of this oppression include genocide, colonization, the outlawing of Native languages and spiritual practices, forced relocation, systematic incarceration, and forced assimilation through the Bureau of Indian Affairs (BIA) boarding school system. Oppression has created overwhelming mistrust of government programs and health institutions (Nebelkopf & King, 2003).

Specific to the two-spirit population, and in line with the Native American Reducing Disparities Population Report, is that:

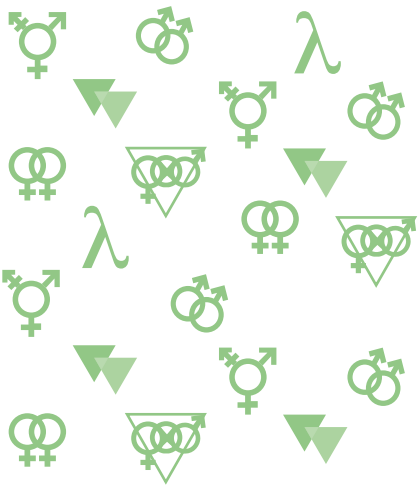
> the current mental health system is an outcropping of the American mainstream culture centered on the beliefs, norms, and values of white Americans. The mental health system is not equipped or trained to deal with the mental health concerns of ethnic groups, as the mental health system itself is rooted in racist practices toward diverse populations. (Native American Health Center [NAHC], p. 6)

Accessing and remaining in care of this current system is of no interest to Native American community members who are also two-spirit. Native Americans, including two-spirit community members, have experienced the detrimental effects of racism, homophobia/transphobia/biphobia, and attacks on their cultural identity. The system, which is pathologizing and individualistic, does not take into account the impact of historical trauma. It lacks the ability to properly diagnose both individuals and communities, and only further alienates the two-spirit community. Additionally, there is the issue of tribal enrollment status which oftentimes prevents accessing much needed health services at Indian Health Service (IHS) clinics. Tribal enrollment also plays out on a larger scale when we take the Native American population into account on the U.S. Census, where Native Americans are consistently undercounted or misclassified, which leads to underfunding of current organizations that offer much needed health services. Blood quantum and current practices of intertribal and interracial partnerships on and off reservations further complicate this issue, especially if the offspring have blood quantum below the defined levels needed for enrollment. These



Some times Western approaches misdiagnose or label people where traditional approaches may put it into a spiritual context.

Native American Advisory Group member



are all government-defined tools of measurement and further disempower and disconnect individuals, families, and communities from each other, and from health services. Other disparities which affect the two-spirit population is the lack of two-spirit specialized care and the way mental health care is billed. The Native American concepts of health and wellness are not considered billable in the current mental health system of care in spite of repeated testimony and reports from clients that those types of visits are just as effective, if not more so, than clinical visits (N. Tom, personal communication, July 6, 2012).

According to the Native American Reducing Disparities Population Report, the overarching message for this population is that it is overwhelmingly "clear that the preservation and revitalization of cultural practices in our California Native communities is imperative for Native mental health" (NAHC, 2012, p. 33). It is important to add that due to the intertribal nature of families in California, it is also imperative to recognize and support intertribal communities in their ongoing efforts and current cultural practices. More specifically, two-spirit community has been instrumental in supporting these preservation and revitalization efforts in their communities along with their fellow activists as advocates for mental health, substance abuse, and other types of funding for the community (N. Tom, personal communication, July 6, 2012).

The proposed five factors outlined in the Native American Reducing Disparities Population Report are in line with recommendations for the two-spirit population as well, since the identity of two-spirit community is inextricably intertwined with other aspects of Native American identity:

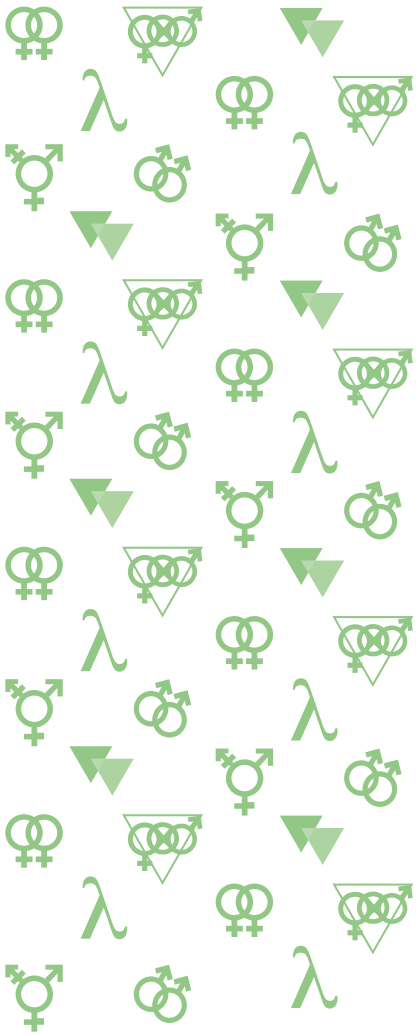
> 1) the establishment of a least-bureaucratic management and oversight structure; 2) strong technical assistance and training support to tribal communities; 3) the continued inclusion of Native communities in all aspects of implementation and evaluation; 4) reduction or elimination of county-level oversight of programming; and 5) empowerment of Native communities in all aspects of the project. (NAHC, 2012, p. 33)

These factors, along with the core principles below, tie into the well-being of Native communities, which include two-spirit community members. Two-spirit people are often at the forefront of identifying needs and disparities, as well as advocating for ways to remedy those needs and disparities.

The core principles for alleviating the mental health disparities of Native Americans in California must directly correlate to the root causes of the disparities. The disintegration of community empowerment and directed efforts to eliminate cultural responses to community ailments must be rectified through community re-empowerment:

1. Respect the sovereign rights of tribes, and urban Native American health organizations to govern themselves.
2. Support rights to self-determination for tribes and urban Native American health organizations to determine and implement programs and practices that will best serve their communities.
3. Value Native American cultural practices as stand-alone practices,validated through community-defined evidence.
4. Incorporate the use of Native American specific research and evaluation methods unique to each community. (NAHC, 2012, p. 28)

Finally, it is important to remember that homophobia/transphobia/biphobia were always around, even within Native cultures' pre-contact with Western cultures and traditions. The important distinction is that many Native American communities had traditional practices in place to deal effectively with these phobias through their various ceremonies, creation stories, developmental considerations of children, rituals, and community norms so that two-spirit individuals were included in the community. Two-spirit community members are advocating for a sustained commitment to supporting Native American communities in reclaiming, innovating, and reviving a return to Native ways of living that allow for the best mental health for the community, two-spirit or otherwise. For Native Americans, "culture is prevention." It is treatment as well as a way of life. It has been in existence since before the inception of the United States and the invention of the mental health system as we now know it (N. Tom, personal communication, July 6, 2012).



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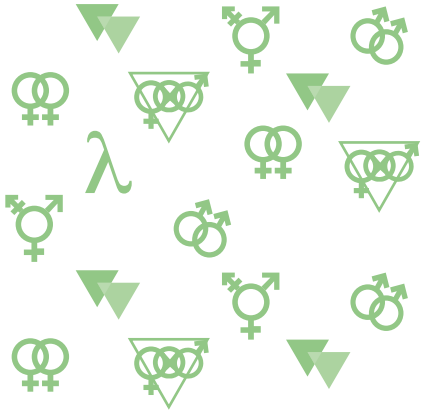
(N. Tom, personal communication)

Couples

In the few studies comparing same-sex and opposite-sex couples, same-sex couples "report similar levels of commitment to, and satisfaction with, their relationships as heterosexual couples" (Otis, et al., 2006, p. 82). LGBTQ couples face all the same challenges as



Committed couples have daily difficulties related to ever-present community responses to matters as simple as shopping together in public, renting hotel rooms when traveling California, being spotlighted by other consumers while dining, and the like. Outside of metropolitan areas it's not uncommon for an LGBTQ couple to be pointed at if they're holding hands on the street.

Black/African American Advisory Group member

Therapists who have only received education in working with heterosexual couples should not assume, however, they have the knowledge or expertise to work with same-sex or mixed-orientation couples.

(R.-J. Green, 2004)

non-LGBTQ couples. In addition, they face issues and stressors created by their minority and stigmatized status. Most were raised by non-LGBTQ parents and have had limited to no same-sex or trans-inclusive couple role models. They must find a way to develop a healthy intimate relationship without the ritual or social supports usually afforded to non-LGBTQ couples (Connolly, 2004; Otis, et al., 2006). As of the writing of this report, same-sex couples can only legally marry in six states and the District of Columbia (CNN Wire Staff, 2012). Unlike all other marriages in the United States, however, marriages between same-sex individuals have no Federal recognition, rights, benefits or protection (Kuvalanka, et al., 2006). Families-of-origin can often be unsupportive of same-sex or trans-inclusive couples. The relationship may be treated as not authentic or non-existent, and/or the partner may be excluded from family functions. The couple may have conflicts regarding who, when and how much to disclose regarding their relationship. The impact of both heterosexism and internalized homophobia can add additional stressors, particularly in the absence of external validation (Connolly, 2004; Lev, 2004; Otis, et al., 2006).

LGBTQ couples seeking counseling have many of the same needs as non-LGBTQ couples. Therapists who have only received education in working with heterosexual couples should not assume, however, they have the knowledge or expertise to work with same-sex or mixed-orientation couples (R.-J. Green, 2004). Couples therapists who lack LGBTQ training run the risk of attributing the struggles an LGBTQ couple faces to deficits within the couple, rather than additional challenges placed on them by society. Alternatively, they may also overemphasize a couple's issues as pertaining to their LGBTQ status. Therapists working with an LGBTQ couple need to assess which difficulties may have arisen from external oppression, internalized homophobia, and/or differences involving levels of self-disclosure versus issues with relationship dynamics faced by all couples (Connolly, 2004; R.-J. Green, 2004; Otis, et al., 2006). Bettinger (2004) posits that perhaps the most essential requirement for working with LGBTQ couples is the therapist's ability to be comfortable with same-sex love and sexuality—particularly in those areas which most challenge heteronormativity or religious beliefs.

Same-sex or trans-inclusive couples raising children face

additional challenges and prejudices. Because they may fear negative consequences if they reveal their same-sex partnership, some parents will appear for family counseling without their partner—presenting as a single-parent household. Therapists should be aware that any family may contain an LGBTQ member and should therefore inquire about other adults regularly involved in family life. Because LGBTQ-parented families exist in a culture of pervasive heterosexism and trans-negativity, perhaps the therapist's most important role is to validate and affirm these families, including reassuring LGBTQ parents that their sexual orientation and/or gender identity does not mean their family will not be as healthy as any other (Lev, 2004; Martin, 1998).

LGBTQ people who come out later in life, after having had children, may face additional complications. Homophobia or transphobia on the part of their partners may lead to separation and/or divorce, and estrangement from the children. Increasingly, though, families are able to overcome these pressures and remain together, in spite of the need for significant adjustments on the part of partners and children who may have to endure undeserved criticism from their peers. Research in this area with children and adolescents with transsexual parents suggests that these families may need support in focusing on the quality of family relationships (Freedman, Tasker, & di Ceglie, 2002).

Parents, Children and Families

In California, 21% of all same-sex couples are raising children (Movement Advancement Project [MAP], Family Equality Council [FEC] & Center of American Progress [CAP], 2011). LGBTQ-parented families are represented in every racial and ethnic community, and across the socio-economic spectrum. LGBTQ couples who choose to have children together or who bring children with them into the relationship face additional challenges, including choosing how to form a family. LGBTQ-parented family formation occurs in many ways, including through adoption, foster parenting, donor insemination, surrogacy, co-parenting, kinship care, and blended families, including children from previous heterosexual relationships (J.Appel, personal communication, July 6, 2012). Even so, parenting has predominantly remained in the heterosexual realm. Finding social support and community as both parents and as an LGBTQ couple may be complicated, and often they are required to straddle two worlds. Traditional parenting roles encompass

Almost all books, television programs and movies which children are exposed to validate only heterosexual love, romance, marriage and parenting. This essentially renders the relationship between LGBTQ parents and their children's experience of family invisible and unsupported.

(Long & Lindsey, 2004).

a gender binary not present with an LGBTQ couple. This gives the couple the opportunity of creating their own roles and delegating parenting responsibilities, but it also forces them to negotiate situations non-LGBTQ parents never have to face. Almost all books, television programs and movies which children are exposed to validate only heterosexual love, romance, marriage and parenting. This essentially renders the relationship between LGBTQ parents and their children's experience of family invisible and unsupported (Long & Lindsey, 2004). Research efforts have used heterosexual-parented families as the gold standard to which LGBTQ-parented families are compared. In addition, focus on the heterosexual status of the children in these studies intrinsically implies that raising an LGBTQ child continues to be seen as a negative and undesirable outcome—particularly if raised by LGBTQ parents. The notion that a parent is allowed to have a positive and healthy LGBTQ self-identity, yet is scrutinized should their own child grow up to identify as LGBTQ, is a mixed message that serves heterosexism and internalized homophobia (Kuvalanka, et al., 2006).

When they first interact outside the family, young children from LGBTQ-headed families face social assumptions about family structure that do not fit their experience—which can be invalidating and confusing unless they have the opportunity to interact with other families like theirs. Children of LGBTQ parents face widespread homophobia in school or after-school programs, and are frequently targeted for harassment and sometimes physical violence by their peers. Data from the California Safe Schools Coalition (O'Shaughnessy, S. T. Russell, Heck, Calhoun, & Laub, 2004) shows that such harassment is widespread in California schools and has a negative impact on well-being and school success. LGBTQ parents and caregivers communicate that staff of health, social service, early childhood, and elementary education institutions lack knowledge of how to welcome and work effectively with LGBTQ-parented families and, even when well-intentioned, need resources and information. More than 20% of respondents to Our Family Coalition's recent membership survey report they are aware that their children have been teased or bullied at school (Judy Appel, personal communication, July 6, 2012). Research from GLSEN (2008) documented for the first time that while LGBTQ parents are more likely to be involved in their children's education, they and their children also experience high levels of discrimination. As a result, children with LGBTQ parents

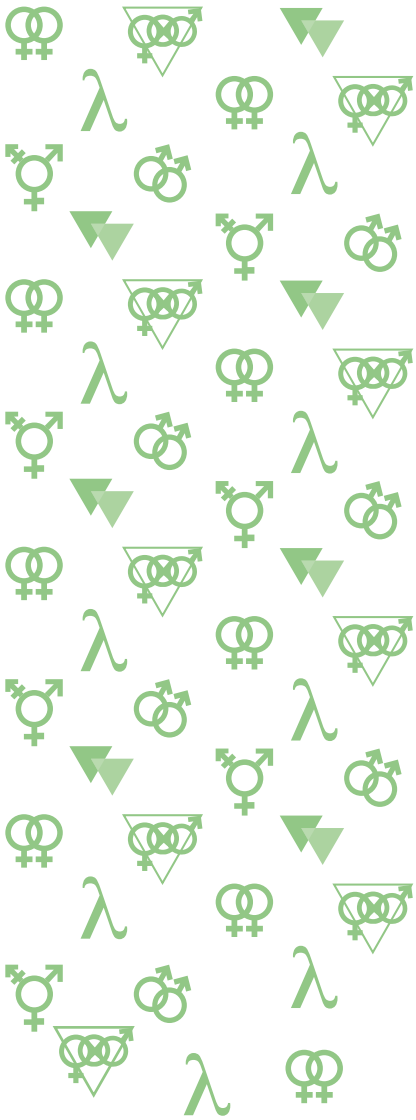
make decisions every day about what to reveal about their families, and whether or not to challenge slurs.

LGBTQ parents continue to face issues and stressors created by their minority and stigmatized status. Most LGBTQ parents were raised by non-LGBTQ parents and have had limited to no LGBTQ couple role models. Peer support is one of the most critical needs for LGBTQ parents, who are often subject to public messages that they are not good or appropriate parents, and who have to negotiate particular issues of disclosure and safety alongside the general issues that all parents face (J. Appel, personal communication, July 6, 2012).

Children of LGBTQ parents also experience additional stressors within educational and medical institutions plagued by heterosexism and homophobia. Many healthcare environments and medical providers can be unwelcoming to LGBTQ-parented families, or may simply be untrained to provide assistance with their unique needs. Health coverage disparities and unequal access to health insurance because of the lack of federal recognition of LGBTQ-parented families also add to this disparity in terms of access, since LGBTQ partners or their children may be denied health coverage because the family structure is not legally validated. In addition, low-income LGBTQ parents and their children often face multiple barriers to services (MAP, FEC & CAP, 2011).

All reports on the U.S. Census 2000 and 2010 data likely underestimate the number of LGBTQ couples raising children. Single LGBTQ people, including parents, were not counted in these figures. Specifically, the lack of data on transgender parents, whether they are self-identified as heterosexual or not, poses a significant challenge to the recognition and visibility of families.

Some of the most difficult challenges to health and well-being faced by LGBTQ parents and their children are due to economic and legal disparities in regard to family recognition. The combination of legal discrimination and social stigma limits the stability, security, and physical and mental health of LGBTQ-parented families. Due to their complex and changeable legal status, LGBTQ parents must often take additional legal steps to secure economic, guardianship, and inheritance rights for their children. Additional actions must be taken by same-sex couples to ensure a full legal relationship between more than one parent and a child. Since most free and reduced-fee legal assistance agencies do not offer these services, there is limited access to legal assistance in lower income



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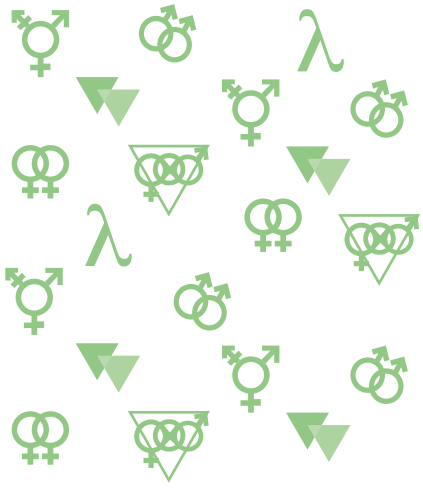


LGBTQ homes. While only 9% of married different-sex couples raising children live in poverty, 21% of same-sex male couples and 20% of same-sex female couples raising children live in poverty—illustrating how the economic protections of legal marriage can make a profound difference (MAP, FEC, & CAP, 2011).

Children of same-sex foreign-born LGBTQ parents may also face additional challenges, since they continue to be invisible under current immigration law (e.g. same-sex partners may not sponsor their spouses as such, which means that the family may have to be separated, or they may experience lack of access to services, xenophobic discrimination and violence). LGBTQ-parented families with undocumented immigrant family members are particularly vulnerable on a variety of fronts (MAP, FEC, & CAP, 2011). Such challenges negatively affect the health of both children and parents, because they are not afforded the same rights as foreign-born opposite-sex couples.

Youth

LGBTQ youth come up against many of the same obstacles experienced by their adult counterparts. In addition, LGBTQ youth are challenged to accomplish the normative developmental tasks of adolescence in the face of a homophobic and heterosexist society. They are frequently exposed to harassment, rejection, discrimination, abuse and violence from strangers, peers, and family members, as well as from those professionals charged to teach and support youth (Bontempo & D'Augelli, 2002; Burgess, 1999; Cianciotto & Cahill, 2003; D'Augelli, 2006; D'Augelli, et al., 2006; Ford, 2003; Frankowski, et al., 2004; Hill, et al., 2005; LaSala, 2000; I. H. Meyer, 2003; Miller, et al., 2007; Safren & Heimberg, 1999; Sullivan, 2003). Unlike prior generations of LGBTQ youth, coming out during adolescence today may also provide opportunities for self-actualization, for experiencing normative developmental tasks on time, for deepening relationships with family and others across the life course and for integrating their LGBTQ identity into all aspects of their lives. They are also coming out at a time when more social supports and resources are available to mitigate negative experiences, including wider access to accurate information about sexual orientation and gender identity and evidence-based guidance on supportive parenting (Ryan, 2012).

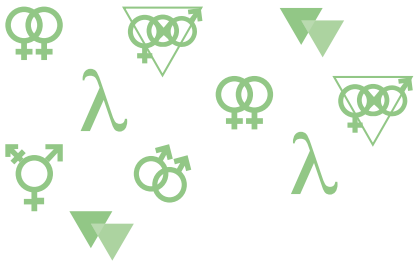
Due to the same research issues cited earlier in this review, the

population numbers for LGBTQ youth are not known. Some youth surveyed may not identify with the way in which questions are asked about sexual orientation and gender identity, while others may not be willing to share this information in a survey. In addition, youth surveyed may not have reached the developmental point where they recognize, acknowledge or are ready to state same-sex attraction, cross-gender identity or LGBQ orientation. Because LGBTQ identity can be stigmatizing for youth, studies which use self-identification, admission of same-sex attraction or behavior as their definition of sexual orientation or gender identity most likely underestimate the numbers of LGBTQ youth (Cianciotto & Cahill, 2003; S. T. Russell, 2006; Savin-Williams, 2001).

Youth sexual and dating behavior may not be indicators of sexual orientation or identity (S. T. Russell, 2003). D'Augelli (2006) found that 57% of the male respondents and 74% of the female respondents identifying as lesbian, gay or bisexual reported opposite-sex sexual activity. In addition, some youth self-identify as LGBQ before experiencing any sexual activity (Frankowski, et al., 2004). A comprehensive study of adolescent development of LGBT and queer-identified youth across California found that many adolescents knew they were LGBTQ during childhood (Ryan & Chen-Hayes, in press). The implication for mental health professionals is to not assume a youth's sexual orientation either by behavior or self-report. The above highlights why more research needs to be done in order to accurately identify sexual orientation and gender identity when addressing youth. In addition, whenever youth are surveyed for other demographic identifiers, sexual orientation and gender identity questions should be included—and continually assessed for how accurately such questions capture the true number of LGBTQ youth.

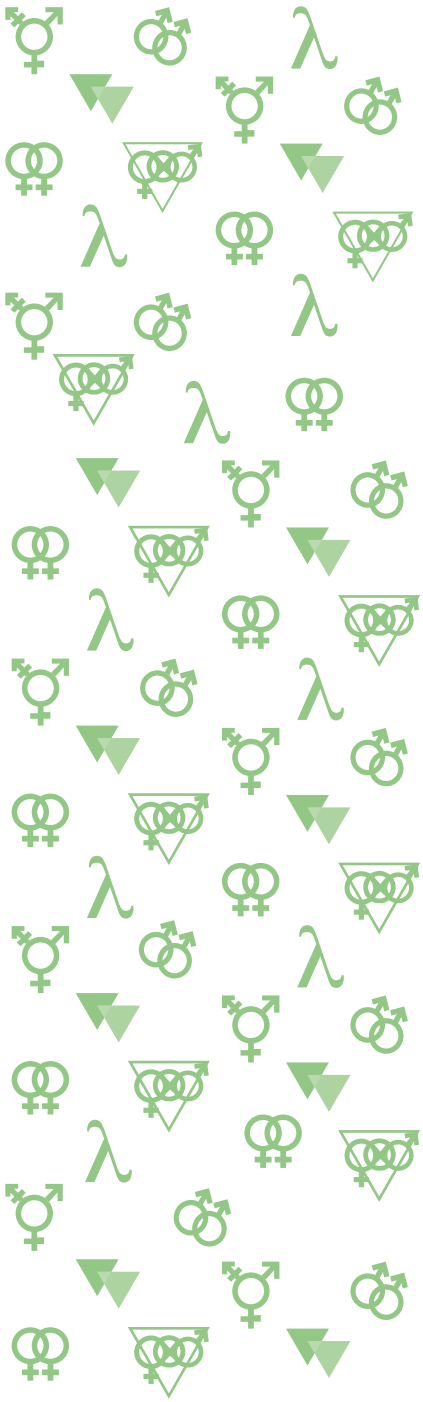
LGBQ youth are coming out at earlier ages than previous generations. D'Augelli, et al. (2006) found the average age of first disclosure to another person and/or to parents was approximately age 15. In the 1980s, self-identification as lesbian, gay or bisexual did not occur on average until ages 19 to 23 (Cianciotto & Cahill, 2003). Practitioners should therefore avoid generalizing to today's youth the sexual identity formation models based on and developed for a previous adult cohort (D'Augelli, 2006).

Approximately 75% of LGBQ participants in the D'Augelli,



Sometimes people don't need an actual service, they need to feel welcome. We want to feel comfortable in our own communities, in our own skins, and not have to feel judged all the time.

Oakland/East Bay Area Community Dialogue participant



[LGBTQ] Elders here help the younger generation with coming out, places to hang out, strategies for safety, mentorship—they are willing to lend an ear.

Humboldt County Community Dialogue participant

We need to create a culture where it is more comfortable [for youth] coming out to their peers.

Long Beach Community Dialogue participant

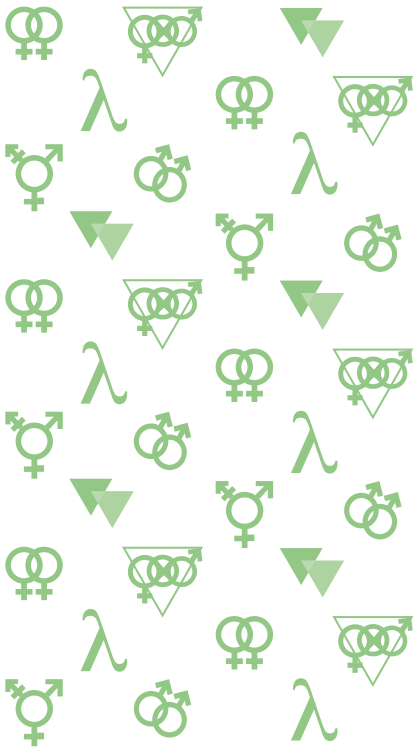
et al. (2006) study reported feeling different from other children, starting at about age 8. Awareness of same-sex attraction occurred on average around ages 10 to 11. The youth reported self-identifying as LGB approximately 5 years after first awareness of same-sex attraction. A qualitative study of LGBT and queer-identified youth and their families conducted across California found that adolescents self-identified as LGBQ, on average, at age 13.4, and their parent(s) found out, on average, about a year later. A number of youth in this study reported self-identifying as lesbian, gay or bisexual between ages 5 and 10. Moreover, research has shown that the average age of sexual attraction is about age 10 regardless of sexual orientation—LGB or heterosexual—and this has been confirmed in a range of studies over the past two decades (Ryan & Chen-Hayes, in press). In addition, anecdotal reports indicate that youth are identifying as transgender at younger ages than adults in prior generations and awareness of gender diversity and expression is much more widespread than in earlier periods (Ehrensaft, 2011).

These earlier ages of self-identifying as LGBTQ and coming out to others significantly expands the range of agencies, institutions, providers and services that need to understand and address issues related to sexual orientation and gender identity across systems that serve children, youth and families. Wider access to information about sexual orientation and gender identity online, through the media and increased availability of resources—including school diversity clubs and support groups for LGBTQ youth—have contributed to earlier ages of coming out. This affects risk and opportunity, well-being and life chances for LGBTQ children and youth in ways that, while not fully understood today, are likely to affect multiple outcomes across the life course (C. Ryan, personal communication, June 24, 2012).

In general, parents and practitioners are confused by issues related to gender identity and expression and do not know where to turn for information on how to help gender nonconforming and gender-variant youth. Research has found that parents and caregivers often conflate sexual orientation and gender nonconformity, assuming that children and youth who are gender-variant are lesbian, gay, or bisexual (Ryan & Diaz, 2006; Ryan, 2012). Youth struggling with gender identity issues often have the most difficult time when they reach puberty. Childhood gender nonconformity may have been tolerated, and the child may have been able to imagine they would grow up as the other sex. As their body

begins to mature, however, these childhood illusions are shattered. There may also be increased expectation from others that the adolescent will now adhere to stricter gender role behavior. Transgender youth may feel betrayed by their body and wish to hide developing secondary sexual characteristics with either baggy or binding clothing (Burgess, 1999). Therapists working with these youth "must truly embrace the philosophy of 'meeting clients where they are,' by providing a safe space where transgender youth can express themselves and discuss their identity formation free from bias" (Burgess, 1999, p. 45). Menvielle, Tuerk, and Perrin (2005) stress, however, that those who are competent working with other adolescent issues do not by default have the knowledge to work with gender nonconforming youth.

Mental health professionals working with LGBTQ youth need to adhere to the same cultural competence recommendations discussed earlier in this report. In addition, they should be aware that the needs of LGBTQ youth are not always the same as those of LGBTQ adults (D'Augelli, 2006). LGBTQ youth may come to counseling for a variety of issues which may or may not have to do with their sexual orientation or gender identity. Focusing too much or too little on a youth's sexual orientation or gender identity can inhibit the therapeutic process. Finally, the goal of working with LGBTQ youth is not to help them decide how to label themselves, but to help them develop the skills to explore their identity (Kulkin, et al., 2000). It is important for the mental health provider to provide a safe and affirmative environment where all their mental health needs can be explored.



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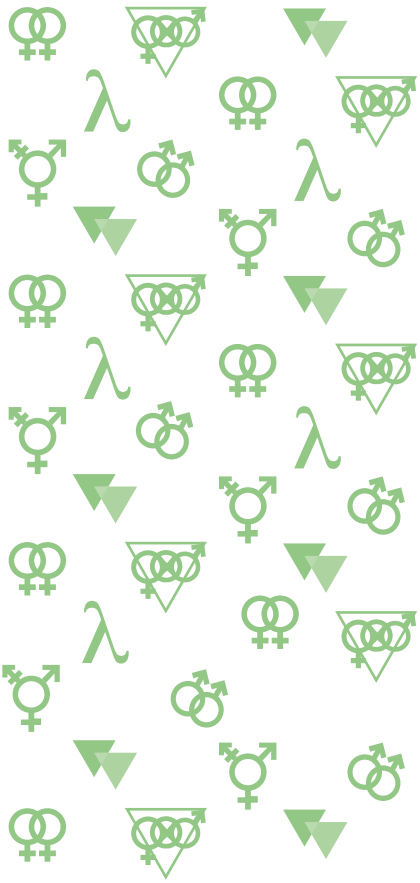
(Kulkin, et al., 2000)



Rejection. Youth who come out as LGBQ, or who display gender nonconforming behavior, encounter various levels of rejection and isolation from family and/or peers. A youth's self-esteem can be greatly affected by parents and and caregivers—as research on family acceptance and rejection has shown (Ryan, 2009; Ryan, S. T. Russell, Huebner, Diaz, & Sanchez, 2010). LGBQ youth are often given messages by their family, either covertly or overtly, that they are inadequate and worthless (Sullivan, 2003). D'Augelli (2006) found that, of those parents who were aware of their child's LGBQ status, 37% of father and 24% of mothers were either intolerant or completely rejecting of their child. Another study of lesbian and gay male youth found only 11% of the respondents reported a supportive reaction from their parents when coming out (as cited in Cianciotto & Cahill, 2003). Gender nonconforming youth are

also often openly rejected by their parents, with boys experiencing significantly more negative reactions than girls (D'Augelli, et al., 2006; Hill, et al., 2005). In one study, 30% of youth whose parents perceived them as gender nonconforming reported parental efforts to curb those nonconforming behaviors. These efforts included: "53% being told to change their behavior, 12% being punished or restricted in their activities, and 8% being sent to counseling" (D'Augelli, et al., 2006, p. 1469). In addition to rejection by family, D'Augelli found 36% of female and 44% of male youth identifying as LGBQ reported loss of friends due to coming out.

Coming out while still living with their family of origin may place an LGBTQ youth at risk. Parents who learn their child is LGBTQ may have feelings of anger, shame, guilt or embarrassment. Severe reactions may include emotional abuse, physical violence and/or estrangement from the family as well as expulsion from the home (Frankowski, et al., 2004; LaSala, 2000). Ford (2006) posits that if an LGBTQ youth "does not have adequate resources, coming out can cause a crisis for the family system and for the individual" (p. 102). LGBTQ young adults who reported high levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse, compared with peers from families that reported no or low levels of family rejection (Ryan, Huebner, Diaz, & Sanchez, 2009). Similarly, LGBTQ young adults who reported high levels of family acceptance showed significantly higher levels of self-esteem, social support, and better overall health compared to peers with low levels of family acceptance (Ryan, et al., 2010).

Mental health providers working with LGBTQ youth, or those youth who are questioning their sexual orientation or gender identity, need to be highly aware of the consequences of disclosure to family and friends. Many parents not only believe that being LGBTQ is negative in some way, but often feel they are somehow to blame for this happening to their child. Practitioners need to be prepared to offer support to the families of these youth, including providing accurate information regarding sexual orientation, gender identity and LGBTQ identity development (LaSala, 2000; Long, et al., 2006; Mallon, 2001; Swann & Herbert, 1999). Bontempo & D'Augelli (2002) emphasize

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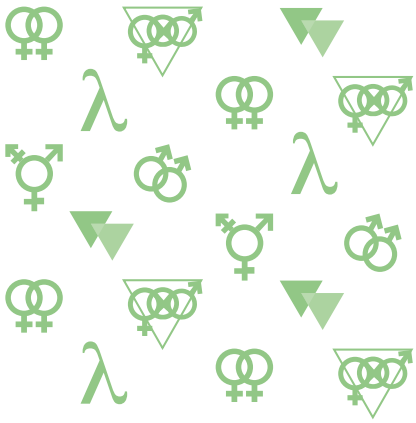
(Ryan, Huebner, Diaz, & Sanchez, 2009)

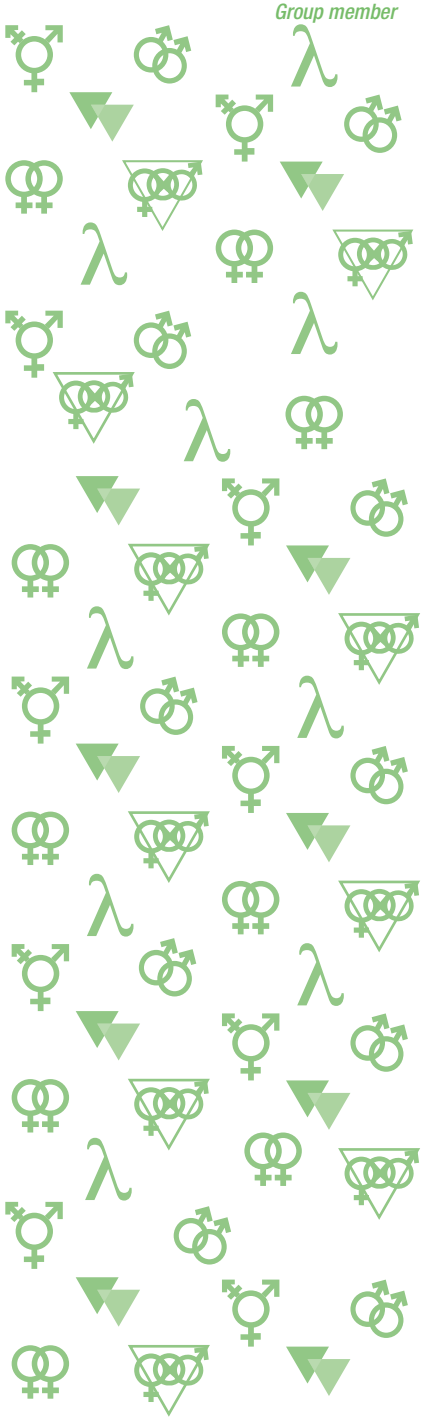
there is no one-size-fits-all technique which ensures LGBTQ youth will suffer no negative consequences upon self-disclosure. In some cases, "professionals who work with adolescents may be required to intervene on the adolescent's behalf" (p. 1830). In cases where the family is not willing to accept their LGBTQ youth, outside support from friends, mental health practitioners, school staff, and connections with LGBTQ communities can help to ameliorate the loss or estrangement experienced after coming out (Ford, 2003). In addition, a new evidence-based family intervention approach is being developed in California which can decrease family rejection and increase family support and well-being for LGBTQ children and youth (Ryan, 2010; Ryan & Chen-Hayes, in press).

School environment. Harassment and bullying in school have been widely documented as pervasive problems for LGBTQ and gender nonconforming youth across the U.S., with serious consequences on students' health, mental health, and academic achievement (Human Rights Watch, 2001; Kosciw, Greytak, Diaz, & Bartkiewicz, 2010; O'Shaughnessy, S. T. Russell, Heck, Calhoun, & Laub, 2004; S. T. Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Many young people conflate concepts of gender with sexual orientation resulting in the prolific use of sexual orientation slurs as a way of policing gender. For example, a gender nonconforming, effeminate young man may be called "fag" based on his gender expression. His peers are using gender expression and norms to create a perceived sexual orientation based on stereotyping (D. Reynolds, personal communication, August 6, 2012). A series of research briefs co-published by Gay-Straight Alliance (GSA) Network and The California Safe Schools Coalition report that harassment based on actual or perceived sexual orientation and gender identity/expression is prevalent in California schools (O'Shaughnessy, et al., 2004; S. T. Russell, Clarke, & Laub, 2009; S. T. Russell, et al., 2006; S. T. Russell, McGuire, Toomey, & Anderson, 2010). Teachers and other school staff are often influenced by societal heterosexism and homophobia, as well as anti-gay religious beliefs, which may affect their responses to LGBTQ students (Krieglstein, 2003). One nationwide study found 24% of LGBTQ students reported hearing anti-gay insults from school faculty (Cianciotto & Cahill, 2003). Students who have been harassed due to actual or perceived sexual orientation are more likely to report:



Parents need to know that by providing a sliver of support can lead to better times for youth.

School-Based Issues Advisory Group member



We need training for middle school parents about how to be supportive even when they are conflicted or it's not what they want and [school] districts should support this type of outreach because the legitimization and institutional message is a powerful message.

Coachella Valley Community Dialogue participant

- weaker feelings of connections to school, supportive adults or teachers, and community
- fewer resources for coping with problems
- being threatened or injured with a weapon at school
- being a victim of relationship violence
- personal property damage
- lower grade point averages
- missing school because they felt unsafe

(S. T. Russell, et al., 2006).

LGBTQ youth face particular risk in public schools from both staff and fellow students (Bontempo & D'Augelli, 2002; Cianciotto & Cahill, 2003; D'Augelli, 2006; Kosciw, et al., 2008; Krieglstein, 2003; Miller, et al., 2007). In the National School Climate Survey published by the Gay, Lesbian and Straight Education Network (GLSEN), Kosciw, et al. (2010) found high rates of verbal and physical assault experienced by LGBTQ students. Homophobic remarks were heard frequently at school by 72% of the respondents. The term "gay" used as a pejorative word was heard frequently by 89% of the students while at school—and most reported this caused at least some feelings of distress. In addition, almost 85% of LGBTQ students were verbally harassed or threatened as a result of their orientation, while almost 64% were verbally victimized as a result of their gender expression. Transgender youth are more likely than all other students to report being harassed, assaulted and feeling unsafe at school.

D'Augelli (2006) found 28% of LGBQ student respondents were afraid of being physically attacked at school. This corresponds with Kosciw, et al. (2008) who found physical harassment at school reported by almost half of the LGBTQ students, while "22.1% reported being physically assaulted (e.g. punched, kicked, injured with a weapon)" (p. xiii). Lesbian and bisexual female youth are at greater risk for sexual harassment (Cianciotto & Cahill, 2003). One study found 23% of lesbian and bisexual female respondents reported experiencing attempted rape or actual rape by their peers, as compared to 6% of their heterosexual counterparts (Miller, et al., 2007). A 5-year study of Washington State schools documented anti-LGBTQ violence within the school system, including eight gang rapes which harmed 11 students. The mental health effects of sexual harassment can include: "loss of appetite, loss of interest in school, nightmares, feelings of isolation from family and friends, and

sadness, nervousness, and anger" (Cianciotto & Cahill, 2003, p. 2). As a result of feeling unsafe, almost one third of LGBTQ students reported missing at least one day of school during the past month, compared to a national truancy rate of only 4.5%. A hostile school environment was cited by the New York State Department of Education as a major cause of LGBTQ students dropping out of school (Cianciotto & Cahill, 2003). Most LGBTQ students do not report victimization, either because they believe nothing will be done or out of fear of reprisal. Of those that do report, Kosciw, et al. (2008) found almost one third received no response or intervention from school staff. When LGBTQ students are harassed or attacked by their peers, the most common reaction from school staff is no response at all (Cianciotto & Cahill, 2003).

Considering these findings, it is not surprising that more than 60% of LGBTQ students report feeling unsafe at school as a result of their sexual orientation, and almost 40% feel unsafe due to their gender expression (Cianciotto & Cahill, 2003). Harassment based on gender nonconformity is more pervasive for LGBTQ students than for heterosexual students. Gender nonconformity harassment is more common in unsafe schools that do not have a clear, inclusive harassment policy, encourage teacher intervention, or include LGBTQ people and information in educational curriculum (S. T. Russell, et al., 2010).

Findings indicate that teachers and other school personnel rarely intervene in harassment based on gender nonconformity (S. T. Russell, et al., 2010). Research shows that transgender students often face unsafe school environments to a greater extent even than their LGB peers. Transgender students experience verbal and physical harassment and physical assault at levels much higher than non-transgender LBGQ students (Brill & Pepper, 2008). Lack of safety extends to students who have LGBTQ parents. The data indicate that 41% of LGBTQ students and 27% of heterosexual students said that their schools are unsafe for students with LGBTQ parents (S. T. Russell, et al., 2009).

In studying the experiences of gender nonconforming LGBTQ students, researchers found that LGBTQ young adults who did not socially conform to gender roles as adolescents reported higher levels of anti-LGBTQ victimization, with significantly higher levels of depression and decreased life satisfaction in young adulthood (Toomey, Ryan, Diaz, & S. T. Russell, 2010). Youth who experience high levels of school victimization in middle and high school report impaired health and

78% of students who learned about LGBTQ issues in school reported feeling safe, compared to 67% who had not learned about LGBTQ issues.

(S. T. Russel, et al., 2006)

mental health in young adulthood. Specifically, LGBTQ students who reported high levels of LGBTQ school victimization were 5.6 times more likely to report having attempted suicide, 5.6 times more likely to report a suicide attempt that required medical care, 2.6 times more likely to report clinical levels of depression, and more than twice as likely to have been diagnosed with a sexually transmitted disease and to report risk for HIV infection, compared with peers who reported low levels of school victimization (S. T. Russell, et al., 2011).

School curriculum. Data from the 2000-2001 California Healthy Kids Survey indicate that over 200,000 students (7.5%) in 7th, 9th, and 11th grade report being bullied based on actual or perceived sexual orientation (S. T. Russell, McGuire, Laub, & Manke, 2006). Data from the Preventing School Harassment (PSH) Survey indicate that 78% of students who learned about LGBTQ issues in school reported feeling safe, compared to 67% who had not learned about LGBTQ issues (S. T. Russell, Kostroski, McGuire, Laub, & Manke, 2006). Additionally, this same report notes students who learn about LGBTQ issues in school report fewer mean rumors or lies, and a decrease in harassment and bullying (S. T. Russell, Kostroski, et al., 2006). Data from the 2008 PSH Survey reveal that LGBTQ-inclusive lessons are less likely to be described as supportive of LGBTQ people/issues. While it is true that, in most cases, any mention of LGBTQ people/issues in a classroom setting result in higher rates of student reports of school safety, it is also true that students are even more likely to report positive outcomes regarding school safety when LGBTQ-inclusive lessons are described as "mostly supportive" as opposed to "neutral/mixed," or "mostly not supportive". There is a significant variation when it comes to physical education (PE) classes, where LGBTQ-inclusive lessons described as "neutral/mixed" or "mostly not supportive" have negative effects on individual students' feelings of safety. Furthermore, LGBTQ and allied students rate lessons in PE as "mostly not supportive" at twice the rate as lessons in other classes. The most positive impact of LGBTQ-inclusive lessons is found for students who are also members of their school's GSA. Conversely, LGBTQ students who are not involved with a local GSA and who do not have access to LGBTQ-inclusive lessons are the most likely to report a weaker sense of school belonging, and lower grade point averages (GPA), among other negative outcomes (Burdge, Sinclair, Laub, & S. T. Russell, 2012).

The recent passage of California's Fair, Accurate, Inclusive and

Respectful (FAIR) Education Act, which became law on January 1, 2012, updates the California Education Code to integrate age-appropriate, factual information about the roles and contributions of LGBT Americans and people with disabilities into social studies classes. In particular, it adds LGBT people to the list of already underrepresented groups that social studies and history teachers are required to include in class lessons.

District policies and training. Research consistently shows that feeling unsafe at school or experiencing harassment at school is linked to health and behavior risks for youth, as well as poor school performance. While bias-motivated harassment has been found to be common in schools, school non-discrimination policies have been shown to promote school safety and are a key strategy to prevent negative health and academic outcomes for youth (California Safe Schools Coalition, 2005).

School safety is an important factor for academic success. Research indicates that LGBTQ students who feel safe within their school environment demonstrate higher academic achievement than LGBTQ students who do not feel safe at school. Among LGBTQ students, school safety is linked to higher GPAs, especially for those achieving mostly A's and B's. Students with mostly B's and below tend to feel less safe at school (Clarke & S. T. Russell, 2009). In addition, LGBTQ students who feel safe at school are more likely to plan to go to college.

Bullying in schools also takes an economic toll. Each year, more than 200,000 individual students in California report being bullied based on actual or perceived sexual orientation. This harassment is linked to increased absences, increased risk behavior, poor grades, and emotional distress. Unsafe school environments result in increased school absences. These absences create a financial burden for California school districts of at least $39.9 million per year. Additionally, legal action taken against unsafe schools is contributing to rising costs associated with harassment and discrimination (S. T. Russell, Talmage, Laub, & Manke, 2009).

Disproportionate discipline of youth based on sexual orientation. Over one million students who start high school this year will not finish (Dignity in Schools, 2010b). LGBTQ and gender nonconforming youth continue to face high rates of high school pushout/dropout and disproportionate rates of school expulsions and other sanctions from the criminal justice system. LGBTQ youth are 1.4 times more likely to be expelled than straight youth. The majority of suspensions of LGBTQ students are for minor misbehavior, such as

Finding information on your own is hard…there is nothing referring to LGBTQ youth. Educate students about their history, their rights and responsibilities! When I first heard about Harvey Milk and Brandon Teena, my activism was inspired!

School-Based Issues Advisory Group member

LGBT Youth are at disproportionately high rates of being suspended from school… there are so many young people that are being pushed out of the school system.

School-Based Issues Advisory Group member

LGBQ middle school students report considerably more harassment and greater fear for their safety compared to heterosexual students.

(McGuire, Dixon, & S. T. Russel, 2009)

"disruptive behavior," "insubordination," or school fights, which can be interpreted in subjective and biased ways, even unintentionally (Majd, Marksamer, & Reyes, 2009). Additionally, school discipline policies may out LGBTQ students when they are reported to the students' parents. When a youth's parents/caregivers are told or discover the youth is LGBTQ, 50% face initial family rejection, while 30% of LGBTQ youth are kicked out of their homes into foster care or onto the streets (Ray, 2006).

School safety. There is a wide variation between and among schools regarding safety. Some schools are safer than others. Research indicates a link between daily LGBTQ slurs heard at school and levels of safety. Schools with safety strategies in place (e.g. harassment policies, resources and support services, intervention from teachers and staff) reported lower rates of harassment and slurs and higher rates of safety (S. T. Russell, McGuire, & Laub, 2009). The overall academic performance of schools is closely linked to school safety. Strategies that make schools safer for LGBTQ students may also improve overall academic achievement.

LGBQ middle school students report considerably more harassment and greater fear for their safety compared to heterosexual students. Findings indicate important gender differences in bullying at the middle school level. Female middle school students are more likely to experience social bullying—that is being bullied or harassed based on sex, perceived sexual orientation, disability, body size or looks, or having mean rumors or sexual jokes told about them. Male students are more likely to experience equal amounts of both social and physical bullying—being pushed, shoved or hit, threatened or injured with a weapon, being in a physical fight, or having property damaged or stolen (McGuire, Dixon, & S. T. Russell, 2009). The majority of LGBTQ students report bullying based on their sexual orientation. Although racial bullying was lower compared to LGBTQ bullying, 9% of students reported that they were bullied because of both race and sexual orientation. These students were more likely to feel unsafe compared to students who were bullied because of race or sexual orientation (Kosciw, et al., 2008; S. T. Russell, Clarke, & Laub, 2009). Across all forms of harassment, (e.g. racial, ethnic, body size, masculine/feminine appearance, etc.) LGBTQ students were more likely to be bullied than heterosexual students (Kosciw, Diaz, & Greytak, 2008). Teacher intervention to stop negative comments, slurs

and behaviors based on gender and sexual orientation, as well as other types of bullying, can help students feel safer on campus.

Gay-Straight Alliance Clubs. A 2002 study found that Gay-Straight Alliance (GSA) clubs positively impact academic performance, school/social/and family relationships, comfort level with sexual orientation, development of strategies to handle assumptions of heterosexuality, sense of physical safety, increased perceived ability to contribute to society, and an enhanced sense of belonging to school community (Lee, 2002). Szalacha (2003) found that the implementation of a GSA has a positive effect on a schools' sexual diversity climate. LGBTQ youth are also more likely than heterosexual youth to make negative assessments of their school's sexual diversity climate in a school without a GSA.

Research indicates that it is the overall cumulative effect of multiple steps and interventions that help improve the safety and climate in schools (S. T. Russell, McGuire, Larriva, et al., 2009). Data from the Preventing School Harassment survey (2006) show that having a GSA is linked with feelings of safety at school. Walls, Kane, and Wisneski (2010) also found that the presence of a GSA is associated with greater levels of school safety, fewer reports of missing school due to fear, and greater awareness of a safe adult in the school context. Research by Toomey, Ryan, Diaz and S. T. Russell (2011) found that the presence of a GSA, participation in a GSA, and perceived GSA effectiveness in promoting school safety were differently associated with young adult well-being and, in some cases, buffered the negative association between LGBTQ-specific school victimization and well-being. Another study by Heck, Flentje and Cochran (2011) found that youth who attended a high school with a GSA report significantly more favorable outcomes related to school experiences, alcohol use and psychological distress. Therefore, working to create more GSAs is a top priority in ensuring the safety and reduced risk behaviors of LGBTQ youth (Burdge, Sinclair, Laub, & S. T. Russell, 2012).

Foster care. LGBTQ youth may be placed in foster care due to familial abandonment or physical abuse, as well as for reasons unrelated to their LGBTQ status. Once in foster care, LGBTQ youth continue to be at risk for harassment within the foster home. Child welfare workers are often not educated in the special needs or issues of LGBTQ youth, nor are the foster parents these youth are placed with. LGBTQ foster

My community is pretty conservative. It's really hard to try to form GSAs. There's not a lot for kids around here in general! The one we could form was called the "Tolerance Club."

Rural Advisory Group member

Being apart of it [GSA] helped me maintain my sanity and kept me away from drugs.

Youth Empowerment Summit participant

youth experience multiple placements, remain in foster care for longer terms, and are less frequently reunited with their families. In addition, their status as LGBTQ may be shared without their consent by their child welfare worker to their foster parents. Foster parents are subject to the same heterosexist and homophobic messages as the rest of the population. The experiences of LGBTQ youth in foster care suggest that many foster parents regard the sexual orientation or gender identity of their foster child as a negative or undesired characteristic (Mallon, Aledort, & Ferrera, 2002; Ragg, Patrick, & Ziefert, 2006).

A study of LGBTQ foster youth in New York City group homes found all respondents reported verbal victimization within their group home (Cianciotto & Cahill, 2003). Studies show that between one- and two-thirds of foster care youth drop out or fail to graduate on time (Dignity in Schools, 2010a). The experiences of LGBTQ youth and staff in the child welfare system have been documented in communities across the U.S., including in California (Woronoff, Estrada, & Sommer, (2006). To address these concerns, remedial efforts have been underway in California for the past decade. Comprehensive guidelines have been developed for care of LGBTQ youth in out-of-home settings (Wilber, Ryan, & Marksamer, 2006) and have been disseminated widely across the state together with training and engagement efforts in key counties. Moreover, the Family Acceptance Project has developed an evidence-based training for foster families to support LGBTQ children and youth in foster care, decrease risk and promote their well-being (C. Ryan, personal communication, June 29, 2012).

Juvenile justice. Harmful environmental factors are also related to other negative consequences for LGBTQ youth. Because of familial rejection, they are overrepresented among the homeless population—with rates estimated as high as 40% in larger cities (Ray, 2006). Financially on their own, these youth may end up in the juvenile justice system for crimes of survival, such as theft or sex work (Cianciotto & Cahill, 2003). In the first national survey conducted of lesbian, gay, bisexual and gender nonconforming youth in the juvenile justice system in 2008, 15% of youth disclosed being LGB, questioning their sexual orientation or gender nonconforming. White, African American and Latino youth had the same disclosure rates for sexual orientation (10%) but multiracial youth, who represented 13% of youth in detention in the survey, had a disclosure rate of 18%. The majority of LGB, questioning and gender

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(C. Ryan, personal communication)

nonconforming youth in detention are youth of color. The survey also found that LGB, questioning and gender nonconforming youth were twice as likely to be removed from their homes due to abuse and twice as likely to be homeless after being kicked out or running away from their homes (Irvine, 2010).

Youth who self-identified as LGBQ were approximately 50% more likely to be stopped by the police than other teenagers (Himmelstein & Bruckner, 2010). Youth who reported feelings of attraction to members of the same sex, regardless of their self-identification, were more likely than other youth to be expelled from school or convicted of crimes as adults. In conversations with various officials working at detention centers throughout the country, some officials have reported LGBQ and gender nonconforming disclosure rates of up to a third of the youth they serve (A. Irvine, personal communication, July 6, 2012). Girls who identify as lesbian or bisexual were especially at risk for unequal treatment: they experienced 50% more police stops and reported about twice as many arrests and convictions as other girls who had engaged in similar behavior (Himmelstein & Bruckner, 2010). Moreover, girls who identified as lesbian, bisexual or questioning were twice as likely to be detained for prostitution (11%) as compared to girls who identified as straight (5%) (Irvine, 2010). Girls who identify as LGBQ appear to be at greater risk of school and criminal justice sanctions than even gay and bisexual boys, and both LGB boys and girls are at greater risk of sanctions as compared to their heterosexual counterparts (Himmelstein & Bruckner, 2010).

According to the National Coalition of Anti-Violence Programs survey (2011), transgender people of color are 2.38 times as likely to experience police violence compared to people who are not transgender people of color. LGBTQ and HIV-affected people of color under 30 are 2.06 times likely to experience police violence as compared with others. In addition, the majority of LGBQ and gender nonconforming youth in detention are youth of color (A. Irvine, personal communication, July 6, 2012) and LGBQ youth are also more likely to report being sexually victimized by other youth while in detention (Beck, Harrison, and Guerino, 2010).

Victimization and its consequences. LGBTQ youth are victimized verbally, physically and sexually due to their known or perceived sexual orientation and/or gender expression. Verbal victimization can be very damaging. D'Augelli, et al. (2006) found

Homelessness leads to couch surfing which leads to the street and destructive behaviors like drug addiction, alcohol, criminal behavior, sexual favors for board and room, disease etc. Try being 16 and out on the streets.

Long Beach Community Dialogue participant

80% of LGBTQ youth respondents experienced verbal abuse, with 73% reporting they were "very or extremely upset" (p. 1469) by their first experience of verbal victimization. The experience of verbal attacks began as early as age 6, with an average starting age of 13 years old. Female youth experienced verbal attacks from both males and females, while male youth were almost exclusively attacked by other males. Verbal victimization also focused on gender nonconformity, with 66% of girls called tomboys and 58% of boys called sissies as they were growing up. In addition, D'Augelli (2006) found 30% of LGBQ youth were afraid of verbal attacks when at home.

Youth who are victimized in childhood for gender nonconforming behavior may present with symptoms of trauma and possibly Post-Traumatic Stress Disorder (PTSD). D'Augelli, et al. (2006) found 9% of the LGBQ youth they surveyed met the criteria for a PTSD diagnosis. Those who had PTSD were 3 to 4 times more likely to have been called sissy or tomboy while growing up. In their study, D'Augelli, et al. (2006) found 14% of youth respondents had been physically attacked because they identified as or were perceived to be same-sex attracted or gender nonconforming. Almost all physical attacks were perpetrated by males. The average onset of physical victimization was age 13, but some youth experienced attacks as young as age 8. Gender nonconforming youth experienced significantly more lifetime physical abuse than those who did not display gender-variant behaviors. Coming out as LGBQ also creates a risk of physical abuse at home. Upon disclosure or discovery of their child's LGBQ identity, parents may become violent and/or expel their child from the family home (Frankowski, et al., 2004; LaSala, 2000).

D'Augelli (2006) found 13% of LGBQ youth expressed fear they would be physically abused at home. A study of LGBTQ foster youth found 70% of respondents suffered from physical attacks within their group home (Cianciotto & Cahill, 2003). Youth with a sexual orientation other than heterosexual are also more likely to report being sexually victimized by other youth while in detention (12.5% versus 1.3%) (Beck, et al., 2010). Nine percent of the respondents in the D'Augelli, et al. (2006) study reported sexual assault due to their LGBQ or perceived LGBQ status. All perpetrators of sexual assaults were reported to be male. Examples of sexual assault included:

> Female, at 18: "I was in a conversation at a party and mentioned that I was bi. One of the guys took me into a private room and

forced me to have sex."…Male, at 16: "I told an attendant in a hospital that I was gay, and he forced me to give him a blowjob." (p. 1471)

Suicide. LGBTQ youth appear to be at higher risk than heterosexual youth for suicidal ideation, suicide attempts, and possibly suicide completion (Bontempo & D'Augelli, 2002; Cianciotto & Cahill, 2003; Cochran & Mays, 2006; D'Augelli, 2006; de Graaf, et al., 2006; Koh & Ross, 2006; Kulkin, et al., 2000; Ritter & Terndrup, 2002; S. T. Russell, 2006). LGBTQ youth are at higher risk for abuse and victimization than LGBTQ adults. In addition, they may suffer more severe psychological consequences, including higher rates of suicidal ideation and attempts (Bontempo & D'Augelli, 2002). The Massachusetts Youth Risk Behavior Survey conducted in 1999 found nearly 50% of LGB-identified students had suicidal ideation in the past year (Cianciotto & Cahill, 2003). The same survey conducted in 2005 found 21% of LGB students had attempted suicide during the previous year compared to 5% of other students (Kosciw, et al., 2008). D'Augelli (2006) found 37% of LGB youth respondents reported at least one past suicide attempt.

The risk factors associated with suicidal behavior in LGBTQ youth include experience of past victimizations (Bontempo & D'Augelli, 2002; Cianciotto & Cahill, 2003; D'Augelli, 2006; Paul, et al., 2002), coming out stressors (Paul, et al., 2002), history of rejection and abuse related to gender nonconforming behavior (Langer & Martin, 2004), exposure to anti-gay religious teachings, internalized homophobia, and previous suicide attempts (Kulkin, et al., 2000). Experience of school-based anti-LGBTQ violence has been associated with both suicide attempts and completions (Cianciotto & Cahill, 2003).

While LGBTQ youth may be at risk for suicidal behavior during any stage of sexual identity development, studies suggest they experience the highest risk at the point of self-acknowledgment but prior to self-disclosing to anyone else. Recent first disclosure or recent first same-sex experience may also be high risk points, particularly for gay and bisexual males (Paul, et al., 2002). All these risk factors have in common their relationship to societal stigma, discrimination, homophobia, and heterosexism. LGBTQ youth do not contemplate, attempt or complete suicide because they are LGBTQ. They do so because their family, peers, teachers, counselors, and /or religious leaders have exposed them

Often times these [LGBTQ] youth will not contact [crisis centers] that are available because they feel like these folks will not understand them.

Inland Empire Community Dialogue provider participant

LGBTQ youth do not contemplate, attempt or complete suicide because they are LGBTQ. They do so because their family, peers, teachers, counselors, and /or religious leaders have exposed them to rejection, hostility, harassment and abuse—all environmental factors which could be ameliorated or prevented.

(Kulkin, et al., 2000)

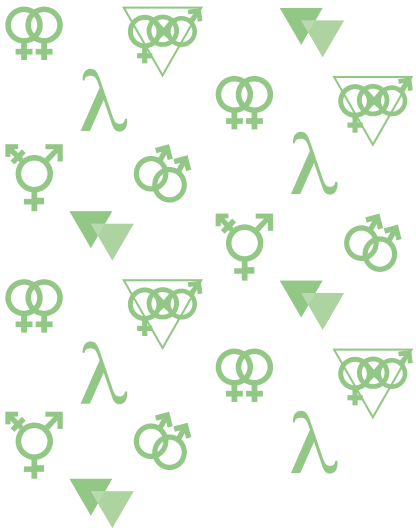
to rejection, hostility, harassment and abuse—all environmental factors which could be ameliorated or prevented (Kulkin, et al., 2000; Safren & Pantalone, 2006; Savin-Williams & Ream, 2003).

Family rejection is related to suicidal behavior and attempts, with research showing that high levels of family rejecting behaviors during adolescence are related to a more than 8 times greater likelihood of attempted suicide during young adulthood. In addition, LGBTQ young adults with low levels of family acceptance were over 3 times more likely to report suicidal thoughts and suicide attempts compared to peers with high levels of family acceptance (Ryan et al., 2010). These findings are consistent with other studies that have shown families play an important role in adolescent health. For example, Resnick, et al. (1997) found that connections to family are protective against major health risk behaviors including alcohol and other drug use, emotional distress, suicidality, and riskier sexual practices.

Transgender youth. Transgender youth face more harassment, discrimination, and barriers to education, employment, and health care than their peers, including their LGBQ peers. However, when they have supportive families and supportive environments, such as accepting school settings, they do very well and do not have to deal with nearly as many difficulties and disparities as those transgender youth who do not have supportive families and environments. Low self-worth, and mental health issues are commonly encountered among the transgender population, often as a result of untreated Gender Identity Disorder (GID). Further, transgender youth often face many traumatic psychosocial experiences, including family and peer rejection, discrimination, violence, harassment, poor access to medical care, educational barriers, economic marginalization, incarceration, social isolation, physical abuse and societal marginalization. They are at significantly higher risk than non-transgender youth for drug abuse, suicide, depression, violence, HIV, other STIs and homelessness (Corliss, et al., 2007). In addition, research has indicated that for any youth with depression, feelings of hopelessness, abuse of alcohol and experiences of victimization are also associated with suicidality (S. T. Russell & Joyner, 2001). Studies have estimated the rate of suicide attempts among transgender youth to be between 25% and 32% (Grossman & D'Augelli, 2007; Herbst, et al., 2007).

Transgender and gender nonconforming youth may also be subjected to "corrective" treatment strategies aimed to align gender

identity with biological sex. Many experts express serious concern about how "success" is defined in studies that have been published about "corrective" treatment strategies and about the serious harm done to youth by invalidating their sense of self. Pressure to conform to gender expectations has been shown to increase distress, whereas promoting comfort with one's gender identity and self-acceptance decreases distress and improves functioning (Olson, Forbes, & Belzer, 2011). Affirming therapy strategies are the most appropriate interventions for transgender and gender nonconforming youth—this approach affirms youths' sense of self, allows for exploration of gender and self-definition, and gives the message that it is entirely acceptable to be whoever you turn out to be (Olson, et al., 2011). In 2006, Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition published guidelines for caring for transgender youth; these guidelines advise a supportive, affirming treatment approach with an interdisciplinary team that includes physicians and mental health professionals (De Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006).



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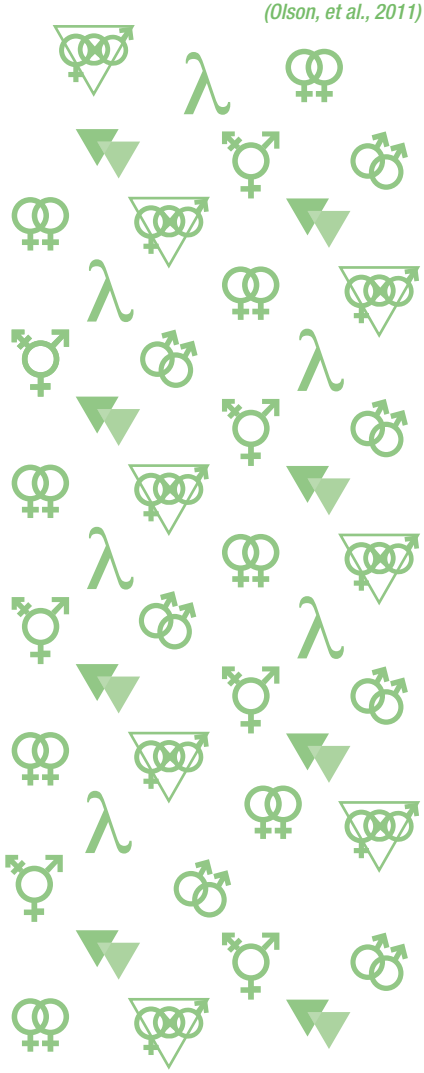
Culturally relevant mental health services are critical for transgender youth as they struggle with gender dysphoria, depression, low self-esteem, substance abuse, PTSD, suicidal thoughts and high-risk behaviors (Giordano, 2007). Despite the stressors that transgender youth struggle with, it is critically important to remember the vitality, inner strength and determination that propels them to seek full and open identity expression. Mental health providers should hold onto this fact when working with the transgender population to avoid the stereotyping that can often occur. It is crucial to celebrate, affirm and facilitate their burgeoning identities while building helpful coping skills (C. Forbes, personal communication, July 5, 2012).



Professionals within the field of transgender care recommend an interdisciplinary team approach for treatment of youth with gender dysphoria (Holman & Goldberg, 2006; Hembree, et al., 2008). Services offered for LGBQ and transgender youth should include comprehensive risk counseling, primary and secondary interventions, health education groups and hormone replacement. Mental health providers should confirm gender-related diagnoses, identify mental health concerns and develop a treatment plan that is best suited for each patient. Patients should then be referred for individual therapy, group therapy, skill-building group sessions

or any combination of these treatments. An ideal interdisciplinary LGBTQ program includes medical practitioners, mental health providers, case managers, and peer counselors. A best practice program would include LGBTQ staff who perform as positive role models (Burgess, 2000).

Older Adults

As is true for other Californians, LGBTQ people must negotiate the challenges of becoming "older adults," including the physical and emotional changes that are a part of the aging process. However, LGBTQ people must do so without the security of recognized relationships, without spousal benefits and while simultaneously negotiating the challenges simply of being LGBTQ.

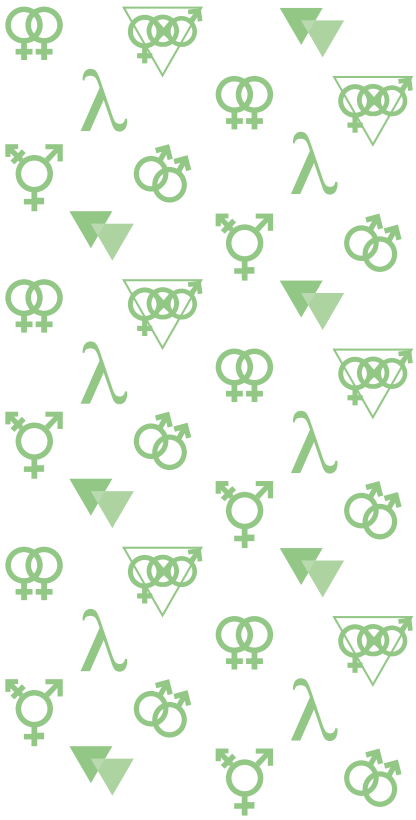
As reported by the U.S. Administration on Aging (2001), a major challenge in meeting the needs of LGBTQ older adults is the very limited research that currently exists. LGBTQ older adults are among the most overlooked and underserved populations. LGBTQ older adults share both the problems confronting all older adults, as well as face unique issues: double-stigma based on age and sexual orientation; limited biological family and social support; health disparities; insensitive and inadequate health care, nursing homes and senior housing facilities; and economic insecurity exacerbated by ineligibility for spousal or survivor's benefits. The study also notes that LGBTQ older adults are at particularly high risk for serious behavioral and physical health issues including alcohol use and obesity. Many LGBTQ people, as well as health care and human service providers, do not seem to be aware of these disparities. Such disparities underscore the importance of an open dialogue between LGBTQ patients and their health care providers. The Federal report concludes that "it is vitally important to learn more about the unique challenges of LGBT older people and develop specific policy and program solutions to support them" (as cited in Mounic, et al., 2001, p. 7).

There is little consensus regarding the age at which one becomes an older adult, and the definition of older adult varies according to study and/or author. Haber (2009) defines it as beginning at age 45. Others confine themselves to the group of people 65 years of age or older. Some authors have failed to define it at all, with the apparent assumption that their definition of older adult coincides with their readers' definition.

Most studies to date also treat "older adulthood" as a single age category, despite the diverse and distinct developmental life stage issues faced by older adults at different ages. As is true for the broader community, few studies seem to address the distinct experiences of LGBTQ adults 85 and older. This is despite the focus on increasing the cultural sensitivity of long-term care facilities, which has dominated initial efforts of LGBTQ advocates focused on older adult issues (D. Parker, personal communication, June 26, 2012).

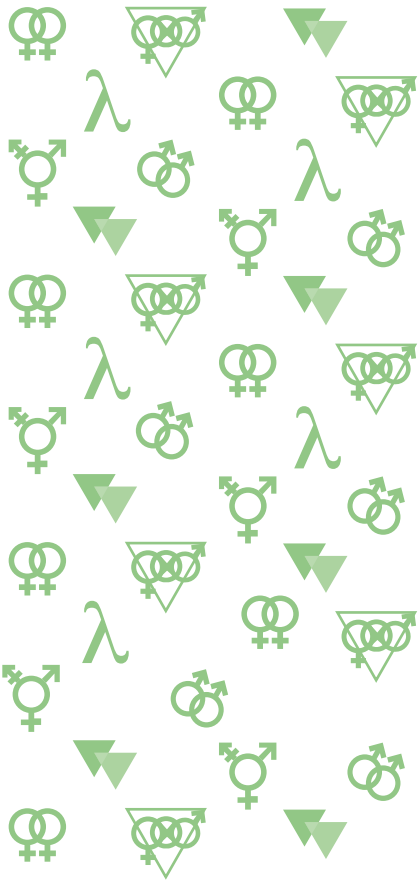
LGBTQ people have unique historical and cultural concerns of which service providers should be aware (Hughes, Harold, & Boyer, 2011). Older adult LGBTQ have been witness to an era of change with regard to the status of LGBTQ individuals. While most Americans have been taught about the McCarthy era in the 1950's, very few textbooks include the fact that being homosexual made one a target for the Senator's investigations. And while Americans are quite familiar with the first moon landing on July 24, 1969, most are only vaguely familiar (if at all) with a series of riots that took place in Greenwich Village, New York, over a police action at a small gay bar known as the Stonewall Inn a month earlier. These riots led to a new openness in the movement for civil rights for LGBTQ people in the United States (Carter, 2004). For older adults who came out prior to 1973, many were subjected to cruel and unusual treatments to change their sexual orientation or gender, including electric shock treatments and induced vomiting (aversive therapies) and other traumatic experiences (Drescher, 2003; Krajeski, 1996). The removal of homosexuality from the list of mental illnesses in 1973 and the advent of the AIDS epidemic a decade later have implications for the life course of LGBTQ older adults, as well as how they view themselves in relation to American society as a whole. Finally, the enactment of the Defense of Marriage Act (DOMA) and the lack of legal recognition of same-sex relationships can and does have catastrophic effects on the financial security of LGBTQ older adults.

Social support and relationships are critical for the mental well-being of LGBTQ older adults. LGBTQ older adults living with partners have better overall current mental health, higher self-esteem and less suicidal thinking compared to LGBTQ older adults who live alone (D'Augelli, et al., 2001). Unfortunately, even those older adults who live with partners experience stress and anxiety due to a second-class citizen status imposed upon them by state and federal statutes. DOMA allows discriminatory practices at the Federal level against LGBTQ people and



Many individuals in their 70s and 80s fear accessing mental health services because of how they were treated prior to homosexuality being removed from the DSM.

Older Adult Advisory Group member



DOMA is a barrier for all of us [LGBTQ people]! Even as a partner to a non-federal employee, I have difficulties in accessing equal benefits that my wife's heterosexual co-workers are able to.

Women's Issues Advisory Group member

As we age into these situations [nursing homes and assisted living facilities], many are forced back into the closet.

Older Adult Advisory Group member

Older [LGBTQ] adults are extremely impoverished because of a lack of ability to access resources…for many, this is not the time of relaxation.

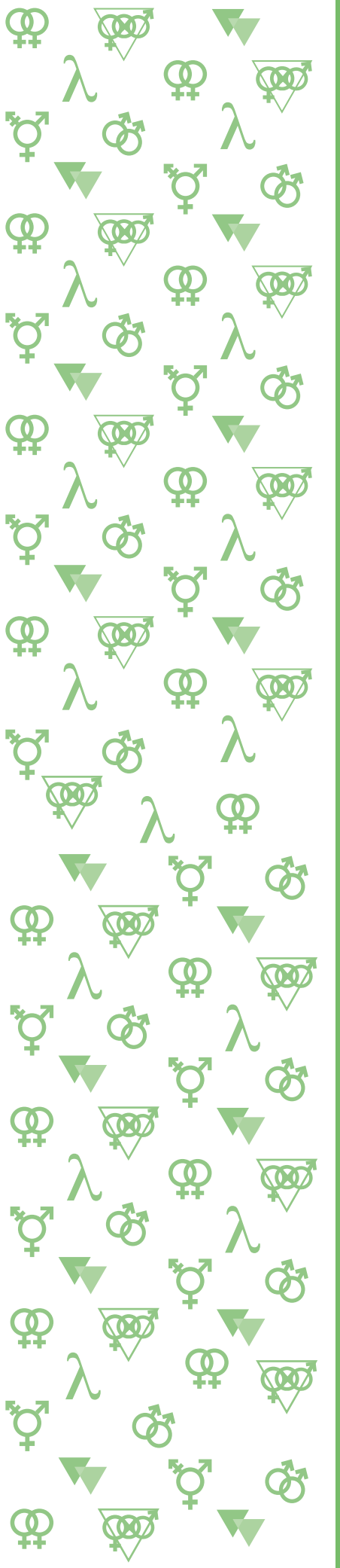
Older Adult Advisory Group member

their families, including in housing, Social Security, and Medicaid. Unlike heterosexual married couples, LGBTQ couples—legally married, in a civil union or a domestic partnership—do not receive Social Security benefits when their spouse or partner dies. They also are not eligible for Medicaid spousal impoverishment protection. For couples in a Federally-recognized marriage, the community-dwelling spouse does not become impoverished due to the costs of their spouse's nursing home care (Hughes, et al., 2011).

All LGBTQ older adults, but particularly those who are bisexual or transgender, have been overlooked in the literature on aging, even though a more general discussion of LGBTQ medicine and public health concerns has taken place for years (Witten, 2012). The recent Institute of Medicine Report (2011) did highlight these disparities and called for a more attentive approach in research and practice. One of the greatest concerns for transgender people of any age is the mismatch between their genital anatomy and their gender presentation (in some cases, even if they have had genital reconstruction), which can result in disclosure of transgender status. Additional concerns for transgender older adults are confusion on the part of care providers when dealing with unexpected or unusual genital anatomy, and probable difficulty in obtaining appropriate, sensitive health services at all levels, including long-term care. As noted earlier, many trans people are very concerned about being mistreated, ridiculed, or physically abused, particularly when they are most vulnerable (Witten, 2012).

Although most LGBTQ older adults are in good mental health, the subset of those with depression, anxiety, and substance abuse is higher than the general population (King, et al., 2008). Frederiksen-Goldsen and Muraco (2010) reviewed the research on LGBTQ aging and found that predictors of poor mental health included experiences of discrimination, particularly within health care systems; loneliness; living alone; low self-esteem, internalized homophobia; and having had experiences of victimization based on sexual orientation. Because of the combination of ageism and heterosexism, LGBTQ elders have fewer resources in the community and within health care systems for prevention, earlier identification, and treatment; and may not seek out services or ask for assistance. As LGBTQ older adults continue to remain active in the workforce and other areas of community life for longer periods (into their 70s or beyond) (Freedman, 2007, 2011), a broader and different range of

mental health concerns are likely to arise for this cohort, with a stronger focus on cognitive and emotional wellness and resilience, in combination with management and minimization of chronic illness (Laidlaw & Pachana, 2009).



Part 2:
Research Methodology

Community Engagement

The LGBTQ Reducing Disparities Project was charged by the former California Department of Mental Health (DMH) to identify "new service delivery approaches defined by multicultural communities for multicultural communities using community-defined evidence to improve outcomes and reduce disparities" (DMH, 2010, p. 1). To accomplish this task it was crucial to engage LGBTQ communities from across California throughout the project. This was done in a variety of ways designed to capture as many perspectives as possible, while ensuring the confidentiality of participants who may not be comfortable publicly disclosing information about their sexual orientation or gender identity.

Information Gathering: A Multi-Method Approach

One task of this project was information gathering, which involved a multi-method approach, including facilitating Community Dialogue meetings, consulting Strategic Planning Workgroup and Advisory Group members, reviewing the literature of published studies, implementing online surveys, collecting promising practices information from providers and inviting subject matter experts (key informants) to contribute written material for the report. The rationale behind the multi-method approach is two-fold. First, just a review of the literature would not tap the needs, experiences, and recommendations for many of the LGBTQ populations. Second, this approach provided multiple opportunities for community members to provide information in ways they felt most comfortable.

Strategic Planning Workgroup

The Strategic Planning Workgroup (SPW) was developed to serve as the decision making body of the LGBTQ Reducing Disparities Project. Comprised of community leaders, mental health providers, clients/consumers and family members, its overarching goal was to develop a report outlining mental health disparities in LGBTQ communities and recommendations to reduce those disparities.

SPW member recruitment efforts spanned across California to engage a diverse membership reflective of the broad range of LGBTQ people and their experiences.

The following criteria were used to select members for the SPW. Items marked with an asterisk were preferred, but not required.

- Represents one or more demographic priorities (i.e., geography, age, socioeconomic status, sexual orientation spectrum, gender identity spectrum, race/ethnicity)
- Knowledge of LGBTQ-specific mental health needs and issues, including the unique needs resulting from institutional discrimination, heterosexism, stigma, and familial rejection
- Knowledge of public mental health systems and services and/or personal experience with public mental health systems and services
- Knowledge of prevention and early intervention programs and services*
- Have existing key allies and relationships that will help the project
- Relevant connection to LGBTQ communities and people
- Supports the mission of the LGBTQ SPW
- Committed to the goals of the California Department of Mental Health (DMH) and the Mental Health Services Act (MHSA)
- Basic understanding of research and/or program evaluation*
- Strong writing/editing skills*
- Technology capacity to participate in conference calls and communicate via email regularly
- Commitment to participation in once monthly SPW meetings/ conference calls with attendance at 75% of all meetings
- Commitment to attend at least one in-person SPW meeting per year
- Commitment to participate in at least one Advisory Group with attendance at 75% of meetings
- Commitment to contribute to the information gathering, writing and other activities that will be necessary for completing the LGBTQ Reducing Disparities Population Report
- Commitment to meet project deadlines, including responding to requests from Project Staff in a timely manner
- Commitment to help Project Staff recruit community volunteers and Advisory Group members to help the SPW meet its mission and goals
- Commitment to positively promote and represent the SPW publicly
- Commitment to act in the best interest of the SPW and its goals

Community Dialogue Meetings

Once the SPW was formed, members helped sponsor 12 Community Dialogue meetings across California:

- Butte County (January 2011)
- Humboldt County (January 2011)
- Inland Empire (January 2011)
- Long Beach (January 2011)
- Oakland/East Bay Area (January 2011)
- Orange County (January 2011)
- Palm Springs/Coachella Valley (January 2011)
- Sacramento County (December 2010)
- San Francisco (January 2011)
- Tulare County (November 2010)
- West Hollywood/Los Angeles (January 2011)
- Youth Empowerment Summit (December 2010)

These meetings engaged over 400 people from LGBTQ communities, providing an opportunity to learn about the LGBTQ Reducing Disparities Project and ways they could become more involved. Most importantly, the Community Dialogue meetings allowed members of LGBTQ communities to give voice to their needs and concerns, what additional services and supports are needed to improve their lives, and what positive services and programs are already in place in their local area. For many participants, these meetings also offered a chance to network with other LGBTQ individuals in ways that had not happened before. In addition, many of the project's Advisory Group members were recruited from these important meetings.

Feedback from the Community Dialogues contributed toward the development of the Community Survey, as well as providing first-person quotes for this report. During a facilitated group discussion, participants were asked two questions:

1. What in the [city, county or region] makes it easier to be LGBTQ?
2. What support or services are needed to improve the lives of LGBTQ people in the [city, county or region]?

Volunteer note takers recorded participants' statements on large easel pads, in order for everyone to view the feedback. The information gathered was used by the Research Advisory Group as a foundation for forming the Community and Provider Survey questions.

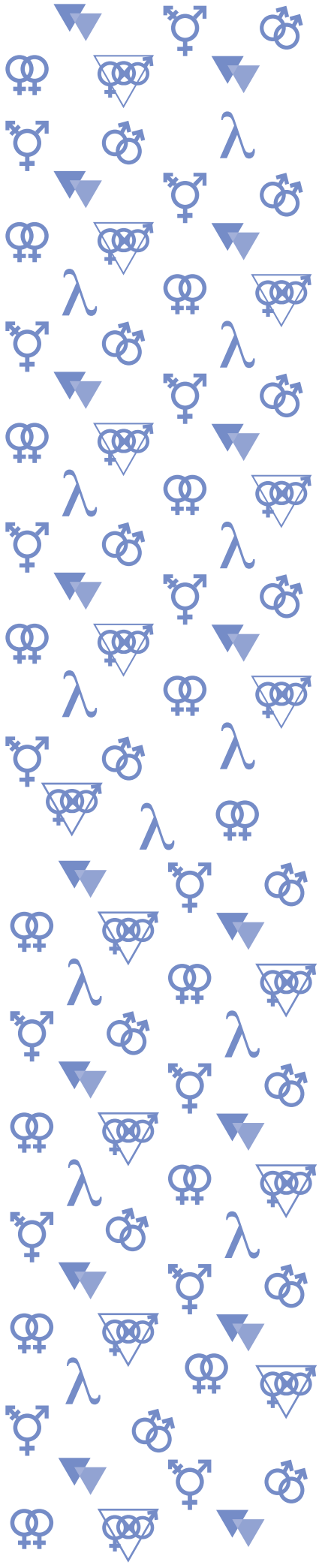
Advisory Groups

SPW members were tasked to determine the scope of the 14 Advisory Groups (AG) that would be formed for this project. This was a difficult undertaking due to the diverse nature of LGBTQ communities and the desire to represent as many communities as possible. The following topics, populations and geographic region were chosen:

- Asian American & Native Hawaiian/Pacific Islander
- Bisexual/Pansexual/Sexually Fluid
- Black/African American/African Descent
- Consumers/Clients/Survivors & Family Members
- County Staff
- Latino
- Native American/Alaska Native
- Older Adult
- Research
- Rural
- School-Based Issues
- Transgender
- Women's Issues
- Youth

AGs acted as sub-workgroups of the larger SPW. Each group consisted of 6 to 10 community members representing the specific topic, population or geographic region of that AG. With help and guidance from the SPW, AGs performed community outreach, provided the SPW with additional information, and gave feedback during the development of the surveys and the final report.

During their first meetings, AG members were asked to discuss the major concerns that affect mental health for the populations they represent. Their comments and observations were reported back to the SPW and Research AG. Research AG members used this information to further inform the questions they composed for the Community and Provider Surveys.



Community and Provider Surveys

The online surveys were developed through a collaborative process between the Research Advisory Group, the SPW and the other Advisory Groups. The Research AG was the primary developer of each survey. During development of the Community Survey, members of the other 13 AGs reviewed questions and provided feedback from their unique points of views. SPW members also provided feedback on questions via SPW meetings, email and discussions in a survey subcommittee. The Community Survey was pretested by all AG and SPW members. All feedback was reviewed by the Research AG and taken into consideration during the final development of the Community Survey.

A similar process was used to develop and pretest the Provider Survey but in a less extensive manner. While all members were eligible to provide feedback on questions and topics on the Provider Survey, the County Staff and School-Based Issues AGs provided direct feedback on questions related to their institutions. To pretest the Provider Survey, Project Staff enlisted the help of providers from each AG including those from the County Staff AG and the School-Based AG.

Sampling design. The sampling design for the online Community Survey consisted of a purposeful, snowball sampling design to gather input from members of LGBTQ communities. Unlike convenience samples which often sample from clinical populations and which lack a more representative composition, a snowball sampling design should allow for inclusion of LGBTQ persons with mental health needs who are not receiving services, those who are located in rural areas and subpopulations which have been not been represented in past research. The online Provider Survey also utilized a purposeful, snowball sampling design in order to gather input from service providers across the State.

Participant consent. The welcome page of both the Community and Provider Surveys included a brief description of the goal of the survey, a note about who should take this survey, how long the survey was expected to take, a notice that participation was completely voluntary, that participation was confidential and anonymous, and a summary of any risks and/or benefits related to participation.

The Community Survey was available to anyone in California who: identified as LGBTQ, ever wondered if they might be LGBTQ, or

who were parents of LGBTQ children. There was no age requirement. The survey was expected to take about 30 minutes to complete and participants were asked to complete the survey in one sitting. There was no option to save and continue the survey at a later time. The Provider Survey was available to medical and mental health professionals, educators, administrators, office staff, support staff and anyone who comes in contact with clients, patients, students and/or family members, whether or not they provided services for LGBTQ individuals.

Both surveys were voluntary. Participants were informed that they may "skip any question on the survey that you do not want to answer." Participants were also informed that they may "stop taking the survey at any point," and finally that, "consent to participate is implied by your completing and submitting the survey." Participation in the surveys was anonymous. Names and other identifying information (if provided) were carefully removed from the data by the Data Analyst. Participants were informed that the Internet is not secure and that, to maintain privacy, all information would be stored in password-protected files available only to the survey research team. Participants were also informed that the information in this report would be presented in aggregate form so that no individuals could be identified.

Two hotline numbers (the Trevor Project and the LGBT National Hotline) were provided for any respondent that experienced distress following their participation in this survey. In addition, the contact information for the Project Director, Pasha "Poshi" Mikalson, was provided for anyone who had questions about the project. Finally, the consent form presented participants with a financial disclosure statement about who was sponsoring this project.

Survey dissemination. Using a snowball technique, Project Staff, SPW and AG members disseminated each of the surveys across California. They used their personal and professional networks, posted the survey link on social media sites, such as Facebook and Twitter, and hosted the survey link on organization websites. The Equality California email database was also used. Project Staff developed several email templates to assist Project members and partners with dissemination. Over 3,000 California-resident LGBTQ individuals completed the Community Survey. Over 1,200 California-resident providers completed the Provider Survey, including over 350 providers who also identified as LGBTQ.

Language and translation. In an effort to make the Community Survey accessible to as many participants as possible, the survey was made available in both English and Spanish. The Community Survey was translated into Spanish and back-translated into English through a translation company contracted through the former Department of Mental Health. Both the Spanish and English back-translations were reviewed by Spanish-speaking LGBTQ community members to help ensure consistency and accuracy of the translation. Every effort was made to match community and/or identity-specific terms such as "Queer" in the translation.

Hosting. Both Community and Provider surveys were hosted online using Qualtrics Survey Software (Qualtrics Labs, Inc., 2009) through a partnership with the Data Analyst and Research Advisory Group member, Dr. Seth T. Pardo. Data was regularly downloaded into IBM SPSS Statistics Version 18 (2010) and identifying information was removed from the data.

Data cleaning. The first step in data cleaning is to identify and remove all false cases (e.g., entries that did not have any intelligible responses to any of the survey questions; identifiable patterns such as extreme answers to all of the survey questions). Second, cases from participants or providers who indicated that they were not California residents were removed from the datasets. Third, for the Community Survey, cases of non-LGBTQ respondents were removed (e.g., sex-gender congruent heterosexuals who did not report having a child known to be or suspected of being part of any LGBTQ community). This is an understandably tricky process. Careful attention was given to both forced choice and open response questions for any indication that a participant identified or felt they were a member of an LGBTQ community. If there was any question or uncertainty for a given entry, the respondent was left in. In total, this data cleaning process reduced our Community Survey sample size from an initial set of 3,781 survey entries to 3,023. This process reduced our Provider Survey sample size from an initial set of 1,986 to 1,247.

Data Analysis and Preparation of Findings

After preparing a clean data set for analysis, survey responses were summarized with frequency counts and sample proportions. For more complex intra- or inter-group comparisons, statistical tests were

conducted using IBM SPSS Statistics Version 18 (2010). Demographic data was computed for age, gender, sexual orientation, race, income, education, parental status, and geographical region. Sample statistics including proportions and frequency counts for the outcome variables, which included experiences with providers, health coverage, access and use of mental health services, satisfaction rates with mental health services and providers, coming out rates, discrimination and harassment, suicidality, and barriers to care were then analyzed and summarized. Outcome variables were also analyzed by the demographic subgroups and are summarized in the findings sections below. Because one of the aims of this project was to survey population prevalence statistics of service utilization and barriers to care, in many cases statistical significance testing was not conducted. However, in specific circumstances, statistical group comparisons were made. Wherever a group comparison was identified as a significant difference in text, it is significant at least at the $p<.05$ level. For the purpose of the presentation of results here, any result indicated as "significant" had a p-value less than .05; that is, the difference was found to be due to factors other than chance.

For questions related to identity, both forced choice and open-ended text boxes were provided to all participants (providers and community members) and considered in the analyses. For example, a forced choice question for sexual orientation read, "Not everybody uses the same labels to describe their sexual orientation; however, if you had to pick a label from the following list, which term BEST describes your sexual orientation." Answer choices included "heterosexual/straight", "gay", "lesbian", "bisexual", "pansexual", "queer", and "I'm questioning whether I'm straight or not straight." An example of an open-ended question for sexual orientation read, "People are different in their sexual and/or romantic attractions to other people. In your own words, how would you describe your sexual orientation?" Several other questions were asked in the Community Survey to assess the complex nuances in sexual attraction and the "mostly" heterosexual identities. Some of which surveyed sexual behavior, such as, "Have you ever been sexually intimate with a female/woman (transwomen included)?" and others that surveyed sexual attraction on a Likert rating scale, "If you had to choose, which BEST describes your sexual and/or romantic attractions: Females only, Females mostly, Females somewhat more, both females and males, males somewhat more, males mostly, or males only?"

Similar effort was given to surveying the complex diversity in gender identities. For example, comparable forced choice and open-ended response questions were asked for gender identity. In addition, birth sex, intersex history, and preferred clothing style, behavior, and overall self-reported gender (as more or less masculine and more or less feminine on a 7-point Likert scale) were assessed in the Community sample.

Results are presented as valid percentages, meaning that the statistic was computed based on the number of people who answered that particular question. Missing data for a given question was not included in the computation of outcome data. Thus, sample totals may vary from question to question. Moreover, for some questions—such as those regarding parenting or experiences with child services—data were computed based on those participants for whom the question was relevant (e.g., for respondents who indicated that they were parents or that they were a guardian of at least one child). Data limitations due to sample size are indicated where relevant in sections below.

In some sections of the report, the voices from the survey participants are quoted directly to provide examples of lived experience. All identifying information (if present) was carefully removed to protect the confidentiality of the participant.

Study Limitations

There are several limitations inherent in a research study of gender nonconforming and LGBQ-identified populations. First, the range of gender and sexual identities and their meanings across samples and across multiple-minority populations are both inconsistent (different identities), non-corollary (even the same identity labels may mean different things in different groups), and are constantly changing. Consequently, research samples may underrepresent the full complexity of sexual and gender identities, and may overrepresent the lived experiences of those whose identities fall within more traditional or more popular understandings of that identity.

Second, data from this survey, as is unfortunately common with most other state and national probability samples, reveals several demographic limitations to the generalization of this data to the LGBTQ populations. It should be noted that, although almost a quarter of the sample reported queer-spectrum identities (e.g., not just gay or lesbian)

most of the demographic characteristics reported here refer to the experiences of mostly white, English-speaking, gay men and lesbians; demographic information on bisexual, pansexual, and queer subgroups are limited, and demographic information on transgender individuals (transwomen in particular) are extremely limited. Therefore, although every effort was made to target recruitment amongst LGBTQ individuals who self-identified in the more marginalized subgroups of the larger LGBTQ population in the state of California, the data here still may not represent those sub-populations.

Third, although the use of Internet and social network sampling may have provided a more effective method for sampling hard-to-reach populations (Rosser, Oakes, Bockting, & Miner, 2007), it is possible that participants recruited via LGBTQ listserves or social networks were individuals who were already out in LGBTQ communities. LGBTQ-oriented community centers increase visibility and provide a unified and centralized base from which members of LGBTQ communities can get to know one another. Online sampling via listserves and social network sites where public postings reach vast numbers of individuals who may or may not be active in those networks increase the chance of a more representative sample. Moreover, sampling from multiple such venues (as was done with this survey) should provide a viable spread for network-driven sampling. A caveat is that the referral networks must be dense enough to sustain long referral chains in order to maintain sociometric depth and non-zero proportion sampling; in other words, referral chains must sufficiently extend to even the least active population members to assure that the recruited study participants are representative.

In this study, the methods used for study recruitment were intended to provide diversity in sampling venues and stable population networks needed to achieve adequate representative sampling. Study recruitment was facilitated by both online and hard copy means of study participation. Hard-copy tabbed flyers in addition to online survey distribution allowed for more portable advertisement whereby interested participants could fill out the survey at their convenience, and in private. Where personal referral networks were used, these networks began with embedded community members. Community-based participatory research methods support the recruitment benefits afforded to in-group community recruitment efforts (Israel, Eng, Schulz, Parker, & Satcher, 2005; Paxton, Guentzel, & Trombacco, 2006).

Research has also suggested that special incentives may not be necessary for study recruitment when population members want to share their personal narratives (Heckathorn & Jeffri, 2005). Thus, although survey respondents were not monetarily compensated for their participation, LGBTQ communities have a long history of feeling misrepresented (Lev, 2004; Savin-Williams, 2005). Thus, by surveying the health care service experiences, satisfaction, and problem areas, as well as by using open-ended questions to tap narratives of sexuality and gender, respondents may have felt a greater incentive or even a personal responsibility to share their own true experiences.

In this study, the target population was anyone who self-identified as a member of an LGBTQ community. The authors acknowledge that although some individuals may self-identify as part of an LGBTQ community, some may not be actively connected to this community in any way, and therefore, may not be represented in the findings presented in this report. Therefore, although every effort was made to reach the less vocal and more marginalized individuals within larger LGBTQ networks, it is possible that these findings may not be generalizable to all LGBTQ individuals.

Finally, it was not possible to determine a response rate because it was unknown how many individuals saw the survey and chose not to participate.

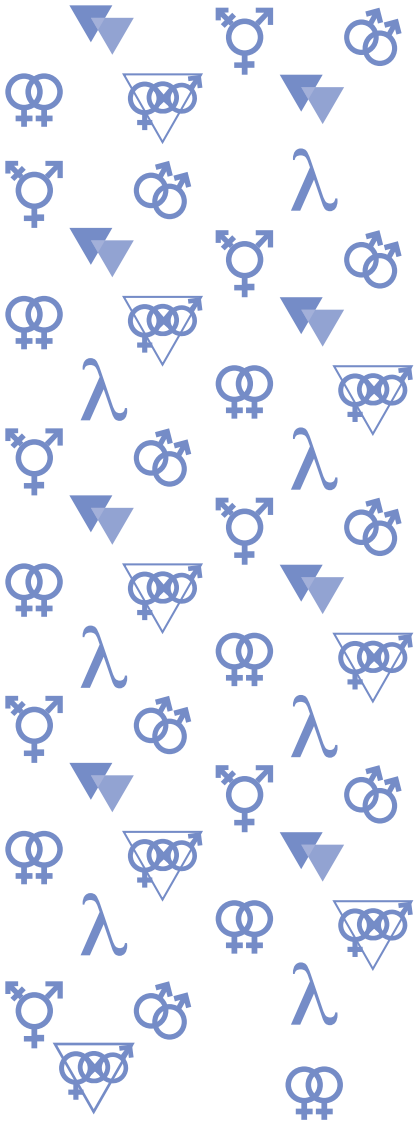
Part 3:
Findings and Recommendations

Community Survey

The LGBTQ Reducing Disparities Community Survey was the primary research tool used to gather quantitative information about LGBTQ-identified Californians. This method was chosen to complement the in-person outreach of the Community Dialogue meetings, as well. as the continual input from Advisory Group and SPW members. The intent of using an online survey was to provide an avenue for reaching populations traditionally hidden or invisible. Over 3,000 California residents (N = 3,023) who identify somewhere on the LGBTQ spectrum responded to the Community Survey (CS), surpassing the initial goal of 2,500 respondents.

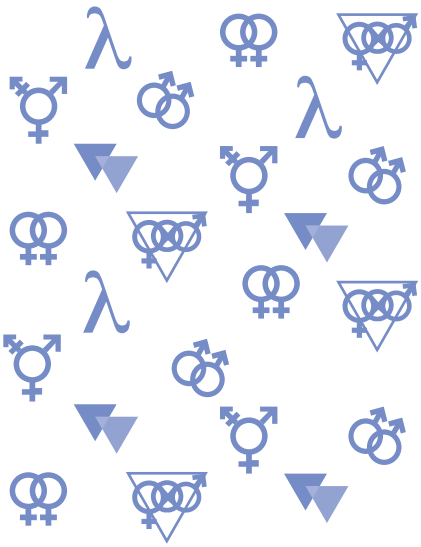
One of the major concerns regarding using an online process as a survey tool is one of access. Those who may be facing the most severe disparities may also not have access to, or be reached by, a survey tool that is totally Internet-based. Many agencies and programs serving hard to reach LGBTQ populations promoted the CS and allowed clients access to computers. While some of the most vulnerable individuals were able to respond to the survey due to these outreach efforts, in general the survey results do not reflect the deepest disparities within the most at-risk LGBTQ populations.

Another concern regarding using an online process is one of cultural bias favored toward Western methods of collecting data. AA & NHPI, Black, Latino, Native American and other non-Western racial or ethnic groups may not feel comfortable with or respond to a long, quantitative (English) online survey. In addition, they may not respond to outreach from organizations considered part of white-led LGBTQ communities, which they may perceive as insensitive or prejudiced against LGBTQ people of color. To address this concern, AA & NHPI, Black, Latino and Native American Advisory Group and SPW members made a concerted effort to outreach to their respective populations and encourage participation in the CS. Despite these efforts, the goal to fully represent LGBTQ Asian Americans, Blacks and Latinos was not met. The percentage of Native Americans and NHPI respondents, however, does exceed that of their relative numbers in the general California population. In the case of all these populations, whether fully represented



Black people are very averse to research because of how we have been treated, so I had my own level of survey fatigue because it's more of the same ol' same ol'.

Black/African American Advisory Group member



in the CS or not, further research conducted in a culturally preferred manner is absolutely needed and recommended.

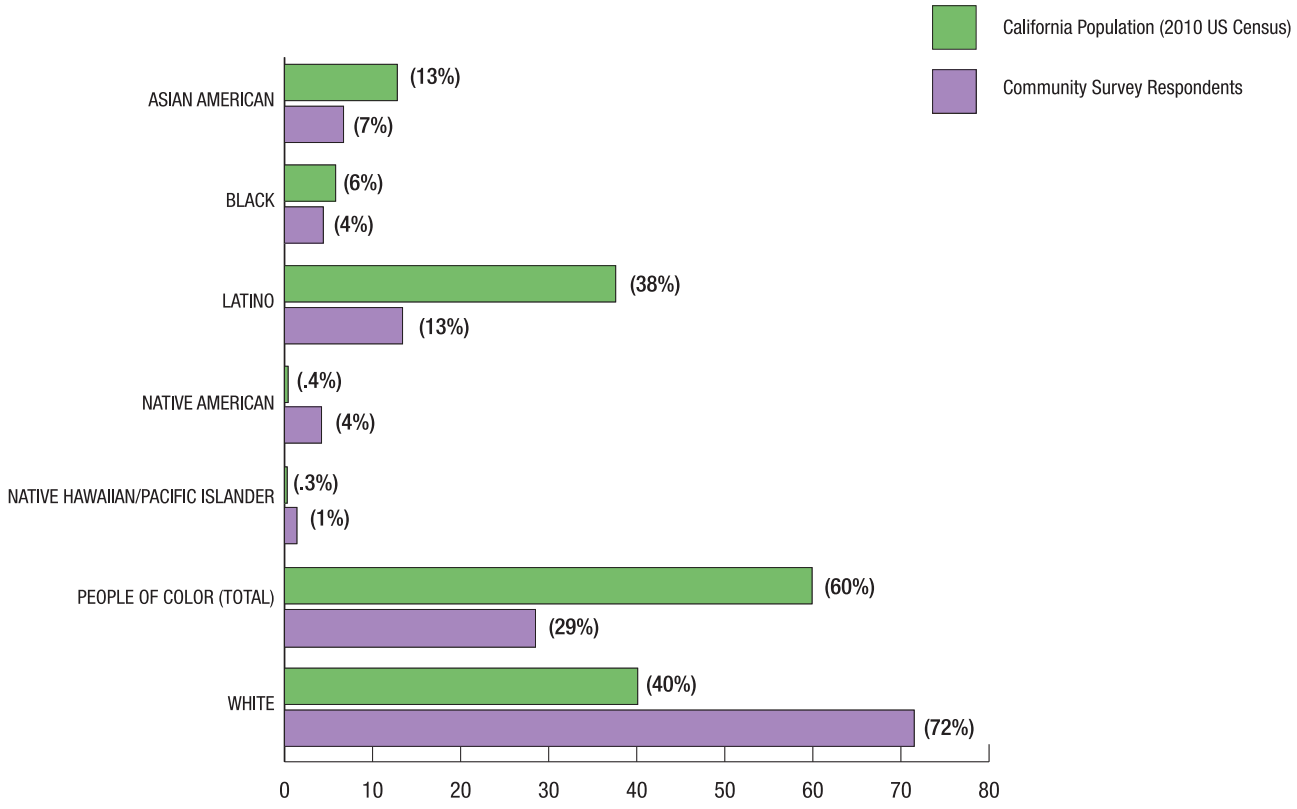
General Demographics

Urban and rural. Disparities in services and other issues which negatively impact mental health may be affected by geographic location. In order to establish whether they live in an urban or rural area, CS respondents were asked to provide their zip code. The Four-Tier Consolidation of Secondary RUCA Codes (Washington State Department of Health, 2008) was used as guide to determine that 8% of CS respondents live in rural areas, with the remaining 92% residing in urban areas.

Age range. The age of the participants ranged from 13 to 89, with the average approximately at age 42. Using the Mental Health Services Act (MHSA) age classifications, 19% were *Transition Age Youth* (ages 16-25), 66% were *Adults* (ages 26-59) and 15% were *Older Adults* (age 60 and older). Eighteen of the respondents were ages 14 or 15, and would be considered *Children* under MHSA age groups. For the purposes of the CS data analysis, these respondents were included with Transition Age Youth (TAY) and will be referred to in this report simply as "youth," except where otherwise noted.

Race and ethnicity. As discussed previously, despite attempts to outreach specifically to Asian American, Black and Latino communities and individuals, these populations were underrepresented among CS respondents. According to the 2010 U.S. Census, people of color (POC) make up almost 60% of California's population, yet less than 30% of CS respondents identified as a person of color. When describing their race or ethnicity, respondents were allowed to check all categories that applied to them. Rather than report individuals who checked multiple boxes as "mixed" or "other," they are identified by each of the categories they picked. For example, if a person checked both Black and Native American, they are included in the percentages for each of those groups. The category "white" includes those individuals who only checked "white" (and no other category) as their race or ethnicity. For a comparison of the racial and ethnic make up of California's population and CS respondents see Graph 1 on next page.

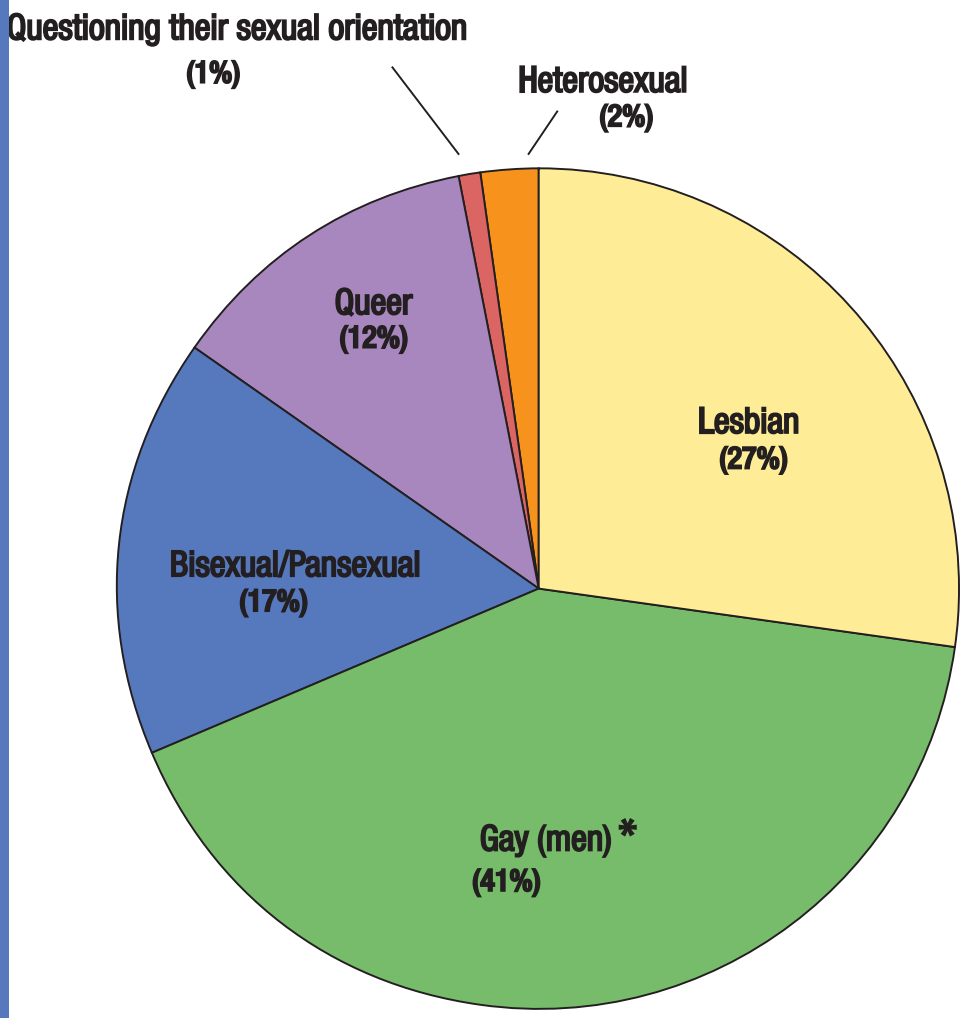
Graph 1: Race and Ethnicity



Education. The reported education level of CS adults age 26 years and older (n = 2402) was much higher than the California's general adult population age 25 years and over. Using data from the 2010 American Community Survey, almost all (97%) of the CS adults completed high school or higher compared to 81% of California adults (U.S. Census American Fact Finder, 2010a). Twice as many CS adults (64%) reported attaining a bachelor's degree or above as compared to California adults (32%). When youth (ages 14-25) from the CS are added into the sample, the totals for both completing high school or above and attaining a bachelor's degree or above remain the same. Educational disparities begin to appear when comparing between CS subgroups. Latino, Native American, Bisexual and rural respondents all had lower attainment of bachelor's degrees or above when compared to other CS subgroups. (See Graph 2 on p. 143)

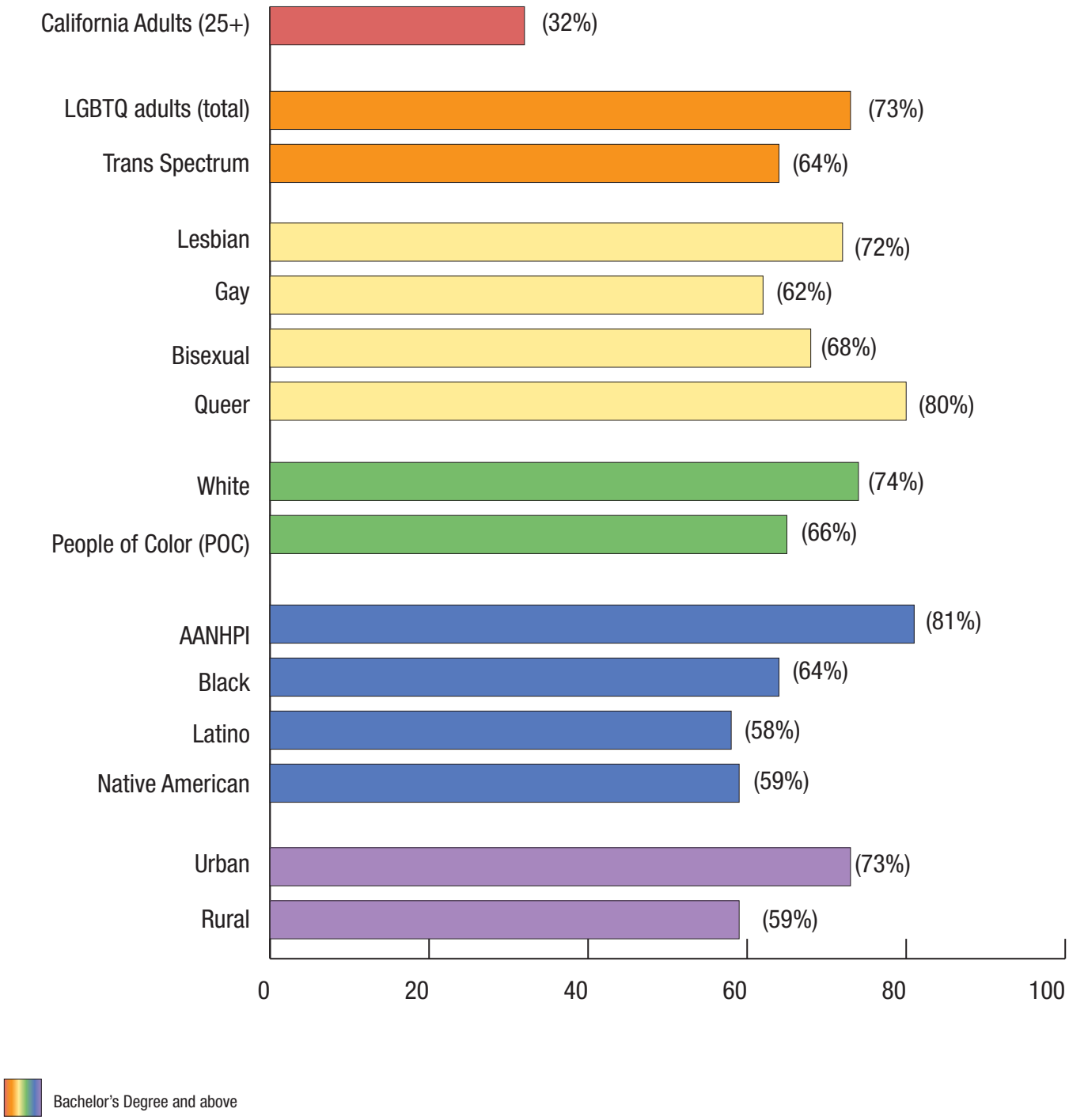
Home ownership. According to the 2009 California Health Interview Survey (CHIS), 60% of Californians identifying as heterosexual own or are purchasing their own home. For CS respondents as a whole, purchasing or owning a home is comparatively far less at 39%. Older adults reported the highest rate of home ownership/

Sexual Orientation of Community Survey Respondents



* The term gay can be used by any gender to denote they are attracted to a sex or gender the same as their own. For purposes of the CS, Gay refers to male-identified individuals who, when asked, chose the term Gay to best describe their sexual orientation.

Graph 2: Education Levels (Bachelor's Degree and above) of Community Survey respondents



purchasing (65%), with those identifying as Queer reporting the lowest rates (12%). While POC and white LGBTQ respondents both reported lower rates of home ownership/purchasing than heterosexuals, white respondents still had a higher rate (44%) than POC (26%)—with Black respondents reporting an even lower rate of 23%.

Respondent Groups	Own/Purchasing a home
Heterosexual adults 18-70 (CHIS data)	60%
LGBTQ (total)	39%
Trans Spectrum	24%
Lesbian	43%
Gay	49%
Bisexual	28%
Queer	12%
Adult	44%
Older Adults	65%
White	44%
People of color (POC)	26%
AA & NHPI	24%
Black/African American	23%
Latino	25%
Native American	25%
Urban	39%
Rural	33%

Health insurance. The CS sample reported slightly lower rates of health insurance coverage than the general California population. CHIS (2009) states 85.5% of Californians have health insurance coverage, while 85.2% of CS respondents reported having health insurance coverage. Bisexual, Queer, Trans Spectrum, Black, Latino and Native American individuals all report lower than average rates of health insurance coverage. LGBTQ respondents living in rural areas report the lowest rate of health insurance coverage at 73%.

For those who do have health insurance coverage, the type of insurance coverage they have may affect access to and quality of services

they want or need. According to CHIS (2009), 55% of Californians have private health insurance. CS respondents among all demographic groups report higher rates of private health insurance coverage than the general California population, although Native Americans and LGBTQ living in rural areas report the lowest rates at approximately 58%.

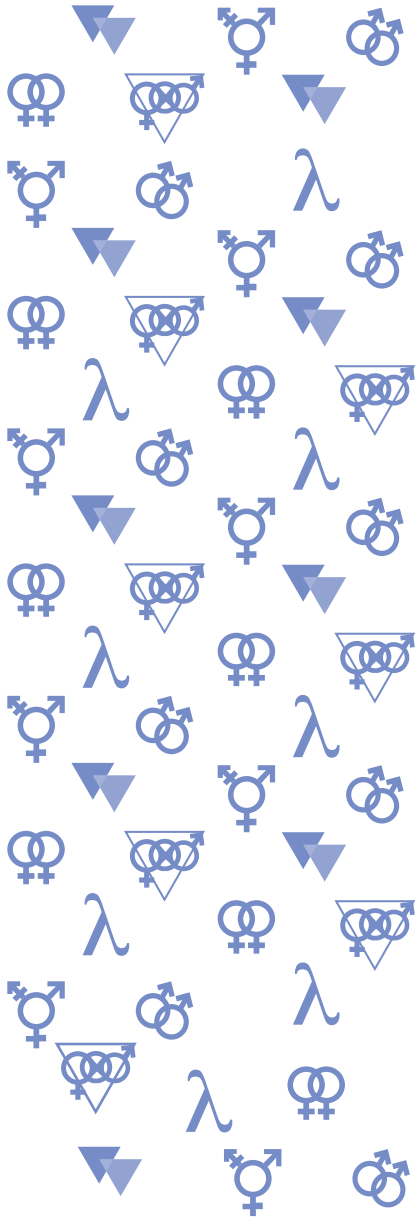
Further illustrating that CS results do not fully represent the most vulnerable members of LGBTQ communities are the lower than average rates of those with Medi-Cal coverage. As a whole, only 5.0% reported having Medi-Cal as their health insurance compared to 14% of the general California population (CHIS, 2009). While this does give the appearance of relative prosperity, Bisexual, older adult, Black, Latino and rural individuals reported Medi-Cal coverage at rates up to two times higher than the overall CS sample. The highest rate of Medi-Cal coverage was reported by Native American respondents (12%).

Sexual Orientation

CS respondents were given a list of specific terms and asked to pick which term *best* describes their sexual orientation. For all respondents identifying within the LGBTQ spectrum the breakdown is shown in the chart on p. 142. It is important to note this chart does not necessarily represent the sexual orientation labels respondents use for themselves or that there are not other terms they prefer over the choices they were given—including more culturally specific terms, such as Two-Spirit, Same Gender Loving or Downe.

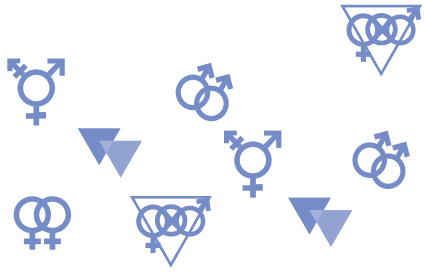
Bisexual/Pansexual. For the purposes of data analysis, these terms were combined. Bisexual is an older term and continues to be widely used—as indicated in the acronym LGBTQ. Those individuals preferring the term *pansexual* do so, in general, because *bisexual* implies there are only two sexes or genders. Pansexual refers to a person who is attracted to others regardless of their gender identity or sex assigned at birth. The two terms do not necessarily denote a difference in attraction, but rather a difference in terminology. Rural area, Trans Spectrum, Black, Native American and youth respondents chose bisexual/pansexual at higher rates than the overall CS sample. Youth chose the terms at the highest rate (26%) and older adults at the lowest (10%).

What is *Queer*? The term *queer*, unlike lesbian, gay or bisexual/pansexual, reveals very little about the person's sexual orientation other than they are not identifying as straight or heterosexual. When



I would describe myself as pansexual, meaning that gender identity doesn't determine whether or not I am attracted to someone. To me, "bisexual" delineates a gender binary and therefore excludes androgynous and some genderqueer people (or people who have gender identities other than male or female).

Community Survey participant



I consider myself "queer." I don't know what my preference is in terms of sexual and romantic relationships. I have had relationships with both men and women. I also do not believe in the gender binary, so a label such as "bisexual" feels ill-fitting and wrong for me.

Community Survey respondent

developing the CS, there was a concern among the Research Advisory Group members that the term *queer* would not be useful for data analysis purposes. There is also no empirical study identifying *queer* as a sexual orientation. The term has become so widely adopted by LGBTQ communities, however, that there was consensus it needed to be included. All CS respondents were given the opportunity to describe their sexual orientation in their own words. The narrative descriptions for those who chose the term queer were sorted into more "traditional" sexual orientation terms in order to demonstrate the wide variety this term represents:

"Traditional" term	Approximate % of Queer respondents based on their narrative description
Gay or Lesbian	26%
Bisexual/Pansexual	60%
Heterosexual/Straight	4%
Description only said Queer	7%
No description	4%

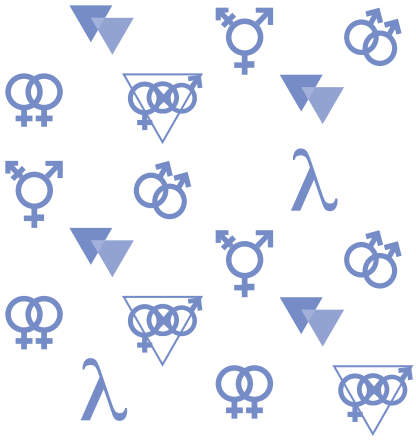
Where is the "H" in LGBTQ? Sexual orientation is different from, but related to, gender identity in that a person's sexual orientation label is often influenced by their gender identity. For example, the common definition of lesbian is based on a *woman* who is attracted primarily to other *women*. If, however, a person is assigned female at birth, but identifies themself as a *man* who is primarily attracted to *women*, that person might use the term heterosexual or straight to describe their sexual orientation. The CS sample includes individuals whose gender identity places them along the Trans Spectrum. Slightly over 10% of Trans Spectrum individuals chose the term "heterosexual/straight" to describe their sexual orientation.

Coming out. As stated previously in this report, children become aware of attraction at around age 10. LGBQ respondents were asked at what age they told someone else about their sexual orientation. Of those who answered (n = 2,892), 21% reported coming out at age 15 or younger—the age range classified as *child* under MHSA guidelines. In the CS sample, 43% of transition age youth came out as "children," compared to 16% of adults and 12% of older adults who came out at age 15 or younger. Although the majority of respondents came out by age 25, it should be noted that 16% did not come out until adulthood, with 7 respondents coming out as older adults.

Gender Identity

The survey asked respondents what sex they were assigned at birth. The results were 49% of respondents were assigned male at birth and 51% were assigned female. CS respondents were also given a list of specific terms and asked to pick which term *best* describes their gender identity. For all respondents identifying within the LGBTQ spectrum the breakdown was as follows:

Gender Identity	Approximate %
Man/boy	46%
Woman/girl	42%
Androgynous	4%
Genderqueer	5%
Transgender	2%
Transman	2%
Transwoman	1%

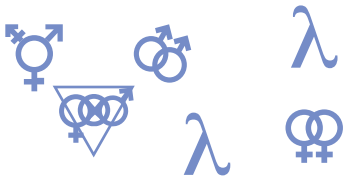


I identify as transgender, more specifically gender fluid and genderqueer…Above all, I always feel that my spirit is of a gender that is neither male nor female, and being born in a female human body, it is not possible to have a body that matches the gender in which I spiritually exist.

Community Survey respondent

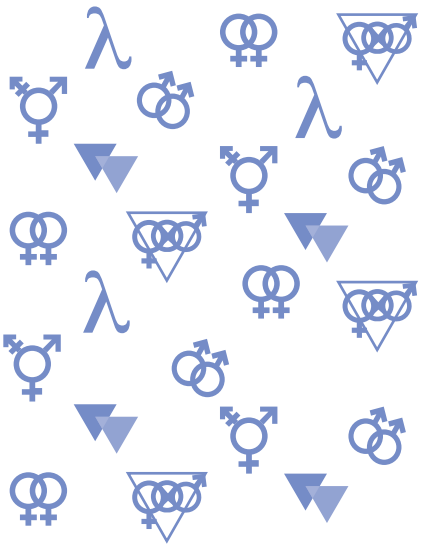
For the purposes of this report, all individuals whose birth sex did not match their gender identity are included in the Trans Spectrum group. When analyzed this way, 44% of respondents identified as men who were assigned male at birth, 41% identified as women assigned female at birth and 15% fall within the Trans Spectrum definition. Within the Trans Spectrum group, gender identity labels were reported as follows:

Gender Identity	Approximate %
Man/boy	9%
Woman/girl	7%
Androgynous	24%
Genderqueer	32%
Transgender	11%
Transman	11%
Transwoman	6%



I'm a woman. If I had to choose between "woman" and "transwoman" I'll choose "woman" because I don't want to imply that being trans makes me less of a woman.

Community Survey respondent



As also stated about sexual orientation terms, it is important to note this list does not necessarily represent the gender identity labels respondents use for themselves or that there are not other terms they prefer over the choices they were given.

Trans identity. Not all Trans Spectrum respondents chose a trans identity label—a particularly important point for providers who only ask if a client is male, female or transgender. The terms man/boy and woman/girl were chosen by 16% of Trans Spectrum respondents. In fact, only

11% of Trans Spectrum respondents chose the actual term "transgender."

Coming out. Trans Spectrum respondents were asked at what age they told someone else about their gender identity. As with sexual orientation, the majority of respondents told someone else by age 25, with 20% coming out when they were children. Somewhat more respondents came out about their gender identity when they were adults (27%) when compared to coming about sexual orientation. Four respondents reported coming out as an older adult.

The "T" is also part of LGBQ. Most Trans Spectrum respondents also identified as part of the LGBQ spectrum. While gender identity and sexual orientation are very different, there is often an intersection of identities that needs to be recognized, understood and affirmed by providers working with Trans Spectrum individuals. Within the Trans Spectrum group, sexual orientation labels were reported as follows:

Sexual Orientation	Approximate %
Lesbian	25%
Gay	9%
Bisexual/Pansexual	22%
Queer	32%
Questioning their sexual orientation	1%
Heterosexual/Straight	10%

Intersex

Intersex was not identified by the former California Department of Mental Health as part of the LGBTQ communities to be covered by this report. Many community members, however, add an "I" to the acronym (e.g. LGBTQI or LGBTIQ) to represent intersex and some, but not all, intersex individuals identify as part of LGBTQ communities. CS respondents were therefore asked if they *believe* they have an intersex condition, with 3% reporting they do. Only 21 of these individuals (less than 1% of the entire CS sample) were able to state their intersex condition had been diagnosed by a medical provider. Of those who *believe* they have an intersex condition but have not been diagnosed, almost two-thirds are part of the Trans Spectrum group.

Intersex issues, while not part of the charge for this project, were nevertheless a part of the considerations the SPW kept in mind throughout the project because of the overlaps between LGBTQ identities

and other human characteristics. While only 21 people out of over 3,000 respondents to the CS reported having an intersex diagnosis, those individuals have unique bodies that must be taken into account when mental health is provided to them. Intersex conditions are wide-ranging, and have no correlation to sexual orientation or gender identity, but mental health providers should become educated about these conditions and remain alert to the effect such a diagnosis might have on any particular client/patient, their partner(s) and their family.

Mental Health and Minority Stressors

CS respondents were asked how much they agreed with the following statement: "I have experienced emotional difficulties such as stress, anxiety or depression which were directly related to my sexual orientation or gender identity/expression." Over 75% somewhat or strongly agreed that they had. The Trans Spectrum group reported the highest rate of agreement (89%). Queer, Native American and youth respondents also reported higher rates than other subgroups. Even though older adult respondents had the lowest rate, almost two-thirds of the group still somewhat or strongly agreed.

Respondents were also given a similar statement which asked them to think about *all* areas of their life (not just sexual orientation or gender identity/expression). The rates of agreement for experiencing emotional difficulties for "all areas of their life" compared to "directly related to sexual orientation or gender identity/expression" were similar for all groups, with the exception of Bisexual (up 10%), Black (up 7%) and older adult (up 7%) respondents. Trans Spectrum and Native American respondents still reported the highest rates of agreement for experiencing emotional difficulties.

When asked if they had ever sought any type of mental health services of support for emotional difficulties, 77% of CS respondents reported they had. Youth and AA & NHPI had the lowest rates of seeking services/support, although approximately two-thirds of each group still did so. Adult, Native American, Bisexual, Queer and Trans Spectrum respondents had the highest rates compared to the overall sample. For a comparison between experiencing emotional difficulties related to sexual orientation or gender identity/expression and the seeking of mental health services or support, please see the table on p. 150.

Respondent Groups	Experienced emotional difficulties (e.g. stress, depression, anxiety) due to sexual orientation or gender identity/expression	Sought mental health services or support for emotional difficulties (e.g. counseling, support groups, medication, etc.)
LGBTQ (total sample	77%	77%
Trans Spectrum	89%	85%
Lesbian	76%	77%
Gay	77%	74%
Bisexual	72%	88%
Queer	87%	84%
Youth	82%	65%
Adult	79%	81%
Older Adult	63%	75%
White	76%	79%
POC	79%	72%
AA & NHPI	80%	68%
Black	71%	71%
Latino	79%	71%
Native American	83%	80%
Urban	77%	77%
Rural	73%	77%

Suicide. Nearly one quarter (23%) of CS respondents stated they had seriously considered suicide during the past 5 years. Seriously considering suicide was greater for youth (46%), Trans Spectrum (43%), Native American (37%), Bisexual (33%), AA & NHPI (32%), Latino (31%), Queer (31%), and rural respondents (29%). These eight groups also reported the highest numbers for making a plan. Native American (17%), youth (17%), Trans Spectrum (15%) and Latino (12%) respondents ranked highest for actual suicide attempts. Compared to other groups, rural (56%) and Black (50%) respondents also reported almost twice as many attempts which needed to be treated by a doctor or nurse. Even so, less than half of most subgroups reported seeking mental health services or support prior to considering, planning or attempting suicide. Barriers to seeking and receiving services will be discussed later in this report, but it is important to note that approximately half of youth and POC respondents who stated they needed or wanted a Suicide Prevention Hotline did not have access to this service.

Discrimination and stress. Over 80% of CS respondents reported experiencing discrimination at least 1 to 3 times a year (if not more frequently) because of their actual or perceived sexual orientation. One-fourth of Trans Spectrum, Black and Gay respondents reported feeling discriminated against on a daily or weekly basis. Overall (daily to yearly), Lesbian, Queer, adult, youth and Native American respondents reported the highest rates (84% or more) of feeling discriminated against because of their actual or perceived sexual orientation.

Over 80% of Trans Spectrum respondents also reported experiencing discrimination at least 1 to 3 times a year (if not more frequently) based on their gender identity/expression. However, Trans Spectrum respondents reported more frequent discrimination, with 34% reporting feeling discriminated against on a daily or weekly basis. Black and Native American Trans Spectrum respondents reported even higher rates of over 41%. Overall (daily to yearly), 92% of Black Trans Spectrum respondents reported feeling discriminated against because of their gender identity/expression.

CS respondents were asked how much distress the discrimination they felt caused them. For every subgroup, 90% or more experienced some level of distress caused by sexual orientation discrimination. For all subgroups except older adults, 40% or more of respondents reported feeling moderate to extreme distress, with Latino respondents reporting the highest rate at 51%. Stress experienced due to gender identity/expression discrimination was reported at even higher rates for certain subgroups. Trans Spectrum, and particularly AA & NHPI, Latino and Native American Trans Spectrum respondents reported rates of 65% and higher for experiencing moderate to extreme distress.

There is a significant relationship between the frequency of discrimination experienced and the distress the discrimination caused. Respondents who were discriminated against more frequently also reported feeling more distress, and those who felt the most distress experienced discrimination more frequently. Approximately 75% of respondents who reported feeling no distress experience discrimination 1 to 3 times per year, whereas about 68% of people who experience discrimination daily reported moderate to extreme distress.

Discrimination by referendum and continued distress. In November, 2008—6 months after the California Supreme Court legalized same-sex marriage—voters passed Proposition 8, which defined marriage

There is a need to find safe spiritual places.

Older Adult Advisory Group member

as between one man and one woman, thus ending the right for same-sex couples to legally marry in California. CS participants were asked how much distress the passage of Proposition 8 caused them. Over 90% of almost all respondents reported experiencing some type of distress, with approximately three-fourths experiencing moderate to extreme distress during the passage of Proposition 8. The one exception were Black respondents, 82% of whom reported experiencing some type of distress and 61% experiencing moderate to extreme distress.

The constitutionality of Proposition 8 continues to be debated in Federal court. CS participants were asked how much distress the continuing legal process is causing them. Approximately half of all respondents (with youth, Lesbian, rural and Native American subgroups at over 60%) reported experiencing moderate to extreme distress. While the severity of distress levels has appeared to lessen compared to the passage of Proposition 8, approximately 90% of all respondents (again, with the exception of Black respondents at 77%) reported experiencing some type of distress regarding the ongoing legal process.

Social Supports—Rejection and Outness

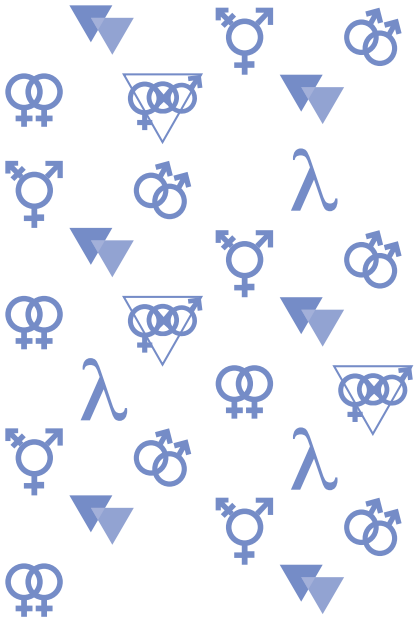
A matter of faith. Respondents were asked what religion or spiritual practice they were raised with, as well as how accepting or rejecting their childhood religion is of their current sexual orientation or gender identity/expression. For those religions which were most reported by CS respondents, the following tables show a comparison of rejection rates (somewhat to very rejecting):

Religion	Rejection Rate for Sexual Orientation
Latter Day Saints (Mormon)	77%
Catholic	76%
Non-denominational Christian	65%
Protestant	63%
Muslim	56%
Wiccan	53%
Shaman	50%
Native/Indigenous Traditions	40%
Buddhist	35%
Jewish	33%
Unitarian Universalist	32%
Hindu	29%

Religion	Rejection Rate for Gender Identity	
	Trans Spectrum	All LGBTQ
Latter Day Saints (Mormon)	88%	46%
Catholic	81%	37%
Protestant	81%	31%
Non-denominational Christian	76%	38%
Muslim	67%	27%
Unitarian Universalist	67%	16%
Buddhist	64%	28%
Wiccan	60%	30%
Shaman	50%	39%
Jewish	47%	17%
Native/Indigenous Traditions	40%	23%
Hindu	(none reported)	15%

Almost all subgroups ranked their childhood religion/spiritual practice as the number one rejecting group in their lives for both sexual orientation and gender identity/expression. The only exceptions were Black respondents who ranked this as their second most rejecting group for sexual orientation, and AA & NHPI who ranked this as their second most rejecting group for both sexual orientation and gender identity/expression. This rejection may in part explain why 71% of respondents are no longer involved with the religion/spiritual practice they were raised with. In fact, responses from this sample show that the more rejecting the person perceives their childhood religion/spiritual practice to be, the more likely they are to no longer be involved with that group. As reported rejection increases—or alternatively, as acceptance decreases—respondents are significantly less involved with their childhood religion/spiritual practice. More specifically, respondents who felt more rejected by their childhood religion/spiritual practice were 1.7 times more likely to no longer be involved with that group.

One-third of the overall LGBTQ sample and 43% of Trans Spectrum respondents answered that they are currently involved with a different religion or spiritual practice than the one they were raised with. Reported rejection rates for current religion/spiritual practice were lower than for childhood religion/spiritual practice, however all subgroups ranked their current religion/spiritual practice the top fifth or sixth rejecting group in their lives for sexual orientation and almost all did the same for gender identity/expression. In addition, Lesbian, Gay, adult, older

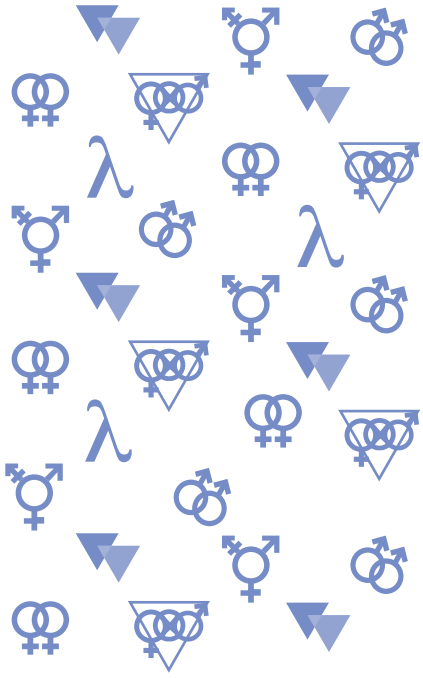


Religious beliefs that promote homophobia/transphobia/ heterosexism that impact one identifying as LGBT potentially cut one off from a source of support and resources—Black LGBT communities.

Black/African American Advisory Group member

Supportive spiritual communities creates inclusion—spiritual health is part of over all mental wellness.

Humboldt County Community Dialogue participant



The African American LGBT experience is often met by unwillingness on the part of African American culture to openly embrace or support their LGBT brothers and sisters. This closed door ends the opportunity to seek help before it even begins.

Black/African American Advisory Group member

Nothing feels worse than being called *faggot* at school only to come home and have your father call you *faggot*.

Orange County Community Dialogue participant

adult, and Black respondents all ranked their current religion/spiritual practice as one of the top six groups they are not out to about both sexual orientation and gender identity/expression. It should be noted that the rejection rates do not include those who reported they "are not out."

Community rejection. CS respondents were asked to rate how accepted their current sexual orientation is. Childhood religion/spiritual practice ranked as the number one rejecting group by almost all the CS subgroups and racial/ethnic community was ranked number two—with two exceptions. Both Black and AA & NHPI ranked their racial/ethnic community as the most rejecting group in their life. In addition, all but one subgroup (adult) ranked their racial/ethnic community as one of the top six groups they are not out to about their sexual orientation.

The results for rejection of current gender identity/expression are similar, with AA & NHPI ranking their community as the most rejecting group in their life. A majority of subgroups also ranked their racial/ethnic community as one of the top six groups they are not out to about their gender identity/expression.

Family rejection. For almost all subgroups, family of origin ranked third and extended family ranked fourth as the most rejecting groups in their lives for both sexual orientation and gender identity/expression. For Bisexual, older adult, Native American and rural respondents, family of origin was the second most rejecting group in their lives regarding their gender identity/expression. Notably, only older adult respondents ranked their children as one of the top six rejecting groups in their lives.

Family of origin was also ranked as one of the top six groups respondents are not out to for both sexual orientation and gender identity/expression. For older adult respondents, family of origin ranked second for not being out about their sexual orientation and youth ranked family of origin second for not being out about their gender identity/expression. Almost all subgroups ranked extended family as the number one group they are not out to about their sexual orientation and they ranked extended family among the top three for not being out about their gender identity/expression.

The CS did not appear to reach youth who are currently in foster care. It is notable, however, that Black respondents ranked "foster family" as one of the top six groups in their lives who are rejecting of their gender identity/expression and Latino respondents ranked "foster

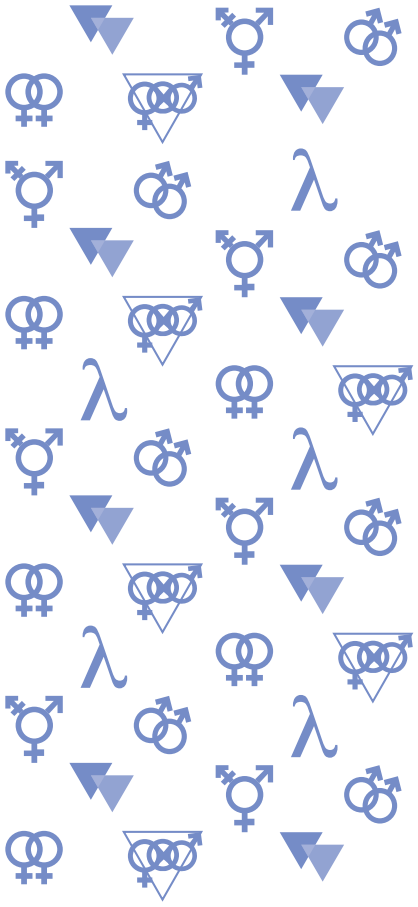
family" as one of the top groups they are not out to about their gender identity/expression.

Rejection at school and work. The majority of subgroups, including the entire CS sample, ranked "other students at my school" as one of the top six most rejecting groups in their lives regarding their current sexual orientation or gender identity/expression, as well as one of the top six groups they are not out to. Co-workers appear to be more accepting of sexual orientation, as only respondents from the Queer, Black and adult subgroups ranked co-workers among the top six most rejecting groups. Far more subgroups ranked their co-workers as being one of the most rejecting groups for gender identity/expression. All subgroups reported that co-workers were one of the top groups in their lives that they are not out to about their sexual orientation or gender identity/expression.

Support from LGBTQ communities. CS respondents were asked, "In general, how supported do you feel by LGBTQ communities?" and given the choices of "strongly," "somewhat" and "not at all." For all subgroups, less than half of respondents reported feeling strongly supported by LGBTQ communities. Within categories:

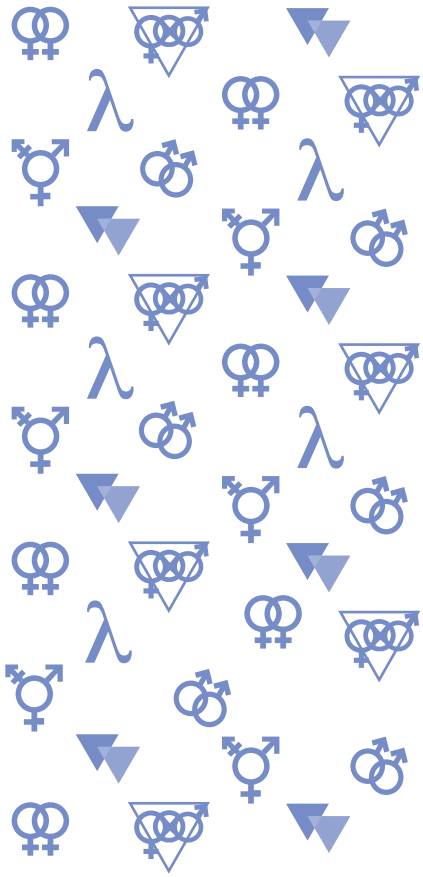
- LGBQ (41%) felt more strongly supported compared to the Trans Spectrum group (32%)
- Gay men (46%) felt more strongly supported compared to:
  - o Lesbian (45%)
  - o Bisexual (31%)
  - o Queer (27%)
- The older adult group (44%) felt more strongly supported compared to:
  - o Youth (42%)
  - o Adult (39%)
- Both Latino and white respondents (42%) felt more strongly supported compared to:
  - o AA & NHPI (33%)
  - o Black (31%)
  - o Native American (38%)
- Rural respondents (43%) felt more strongly supported compared to urban respondents (41%)

"Somewhat supported" is an ambiguous category, as it implies respondents not only felt supported to a degree, but also felt non-supported. Approximately half of respondents reported feeling "somewhat supported"



I don't feel welcome in lesbian and gay communities.

Bisexual Advisory Group member



by LGBTQ communities, with Queer (66%) and AA & NHPI (61%) reporting at higher rates.

Overall, 8% of LGBTQ respondents reported feeling not at all supported by LGBTQ communities. The subgroups reporting the highest rates of non-support were (in order): Black (12%); Trans Spectrum, older adult and Native American (10%); and Bisexual (9%).

Socializing with other LGBTQ individual (outside of relatives and partners) has a significant affect on how supported a person feels by LGBTQ communities. Three quarters of the respondents (76%) who reported feeling very satisfied with their amount of socializing with other LGBTQ individuals also reported feeling strongly or somewhat supported by LGBTQ communities. Conversely, 63% of respondents who felt not at all supported also reported feeling dissatisfied with their amount of socializing with other LGBTQ individuals.

A common thread among LGBTQ people is loneliness and fear that drives them away from social contact with other people. It makes us pull back from the thing that heals us—which is being in contact with others.

Rural Advisory Group member

Service Providers—Outness, Rejection and Difficult to Find

"I am not out to this provider." CS participants were asked to rate (for the past 5 years) how accepting or rejecting service providers have been of their sexual orientation and gender identity/expression. A service provider cannot accept or reject a person, however, for something that person has not revealed. Many respondents responded to the questions of acceptance/rejection with the choice, "I am not out to this provider." As stated previously in this report, fear of negative judgment from their provider may be one reason why LGBTQ clients/patients do not always reveal their sexual orientation or gender identity.

For all subgroups, the providers with the highest frequencies of "I am not out" for sexual orientation were (in general order) dentists, primary care doctors, nurses/nurse practitioners and specialist doctors, followed closely by gynecologists (except Gay men). The majority of subgroups also report not being out to their pediatricians. A few subgroups reported not being out to their mental health provider (Gay, Black and Native American) or their psychiatrist (Queer, adult and rural) in higher frequencies. In addition, Gay, Queer, Latino and rural subgroups reported not being out to their school counselor or school psychologist.

There are cultural barriers that make for an uncomfortable set of interactions between African American sexual minorities and professional mental health providers. Even the presence of African American providers is often problematic if they are not sensitive to the needs of sexual minorities.

Black/African American Advisory Group member

The results for "I am not out" regarding gender identity/expression are similar to that of sexual orientation (in general order): dentists, primary care doctors, nurses/nurse practitioners and specialist

doctors, followed closely by gynecologists (except Gay men). The difference for gender identity/expression is most subgroups report higher frequencies of not being out to their mental health providers. In addition, AA & NHPI, Black, Latino and Native American subgroups all report higher frequencies of not being out to their school counselor or school psychologist. Notably, Bisexual respondents report their pediatrician as the number one provider they are not out to about their gender identity/expression.

Rejection. Although the order varies somewhat between subgroups, primary care doctors, nurses/nurse practitioners and gynecologists—followed by specialist doctors, adoption agencies and dentists—were ranked among the top six providers who are rejecting of respondents' sexual orientation. In addition, Trans Spectrum, Bisexual, youth, AA & NHPI, Black, Latino, Native American and rural subgroups all reported mental health providers and/or psychiatrists as among the top rejecting providers.

Rejection by providers of gender identity/expression is more difficult to report. Which providers are more rejecting than others differs much more widely between subgroups than it does for sexual orientation. All providers listed in the CS were ranked among the top six most rejecting by at least four or more subgroups. Trans Spectrum respondents reported (in order) nurses/nurse practitioners, gynecologists, primary care doctors, specialist doctors, social workers/case managers and dentists as the most rejecting of their gender identity/expression.

Difficulty finding providers. CS respondents were asked, "In the past 5 years, how difficult has it been to find providers that are accepting of LGBTQ concerns?" Primary care doctor was the number one provider reported by all subgroups as difficult to find. All subgroups (with exceptions noted) also reported the highest frequencies of difficulty finding mental health providers, nurse/nurse practitioners, dentists, specialist doctors, psychiatrists (except AA & NHPI) and gynecologists (except Gay men) who are accepting of LGBTQ concerns.

> One of the scariest things I have ever had to experience was looking for a doctor.
>
> *Butte County Community Dialogue participant*

Access to Services

Not all health insurance is created equal. For CS respondents who have health insurance, what type they have appears to affect their ability to access services. There were significant differences in access to couples or family counseling, Western medical interventions (e.g. medication such as antidepressants, hormones, etc.) and peer support

groups, depending on what type of insurance respondents have. Respondents who reported having only Medi-Cal had *more difficulty* accessing these services when they needed and wanted them than those who reported having private insurance, Medicare, another type of government insurance (e.g. VA, Tri-Care, Indian Health) and/or a combination of the above. Only 45% of Medi-Cal respondents were able to access couples or family counseling compared to 69% of those with private insurance. Only 40% were able to access Western medical interventions compared to 75% with private insurance and 84% with Medicare. Finally, only 37% were able to access peer support groups compared to 77% with private insurance, 71% with other governmental insurance, 91% with Medicare and 81% of those with some combination of the above.

Seeking services. Overall, approximately three quarters (77%) of CS respondents indicated they had sought mental health services of some kind. Trans Spectrum individuals reported seeking services at an even higher rate (85%). The services CS respondents most reported needing, wanting or receiving in the past 5 years were:

- Individual counseling/therapy (67%)
- Peer support group (66%)
- Western medical intervention, such as medication (41%)
- Couples/family counseling (31%)
- Non-Western medical intervention, (e.g. cultural medicine, homeopathy, acupuncture, etc.) (28%)
- Group counseling/therapy (27%)

Seeking does not mean receiving. CS participants were asked to indicate which mental health services they needed or wanted, but did not receive. Individual counseling/therapy, couples or family counseling, peer support groups and non-Western medical intervention were ranked by all subgroups as 4 of the top 6 services they reported seeking, but not receiving. All subgroups (except youth) also ranked group counseling/therapy among the top six services they sought, but did not receive. For the general CS sample (all subgroups combined), Western medical intervention was ranked sixth of those services sought, but not received. Youth, older adult, Queer and POC subgroups all indicated seeking but not receiving ethnic/community-specific services. Notably, Trans Spectrum respondents ranked "counseling/therapy or other services directly related to a gender transition" and Latino respondents ranked

There is a lack of respect or support for other modalities of treatment outside of the Western perspective. There is a narrow view of what works.

Native American Advisory Group member

"suicide prevention hotline" as the number six service they sought but did not receive.

Mental Health Services—Barriers, Problems and Satisfaction

Barriers when seeking mental health services or support. CS respondents were provided a list of barriers to seeking mental health services or support which individuals might face, regardless of their sexual orientation or gender identity. These barriers came from the Community Dialogue meetings and Advisory Group discussions. CS respondents were asked to indicate whether each item listed was a barrier for them in the past 5 years. The barriers have been ranked by frequency two ways: 1) those reported as "always a barrier;" and 2) those where the categories of "sometimes" and "always a barrier" were combined.

All subgroups (with one exception), in both forms of ranking reported, "I cannot afford the mental health services that I want or need" as the number one barrier to seeking mental health services. All subgroups also indicated, "The wait time to be seen by a mental health service provider was too long" as one of the top barriers in both forms of ranking.

The following are the top 15 barriers to seeking mental health services reported by CS respondents. All barriers listed were ranked as both "always a barrier" or "always" and "sometimes a barrier" combined. They are listed here in the order of "always a barrier":

1. I cannot afford the mental health services I want or need.
2. I was not eligible for the services I need / want.
3. The wait time to be seen by a mental health service provider was too long.
4. I feel ashamed to seek out mental health services.
5. I had a harmful or traumatic experience in the past with mental health services.
6. I am concerned that my mental health care will not be kept confidential.
7. The mental health services I have been using have been cut.
8. The provider hours did not work with my schedule.
9. There were no couples or relationship counseling services offered.
10. I have chronic physical health problems which limit my ability to access services.
11. My culture (e.g. racial, ethnic, religious) does not support mental health services.
12. I was only offered group services instead of individual services.

When it comes to getting help, if you are a low income situation, or if you don't fill out forms correctly you get booted.

Black/African American Advisory Group member

When an LGBTQ API seeks help, we carry the burden of not bringing shame to the family.

AA & NHPI Advisory Group member

There is a large taboo in the African American community around seeking mental health services.

Black/African American Advisory Group member

13. I do not have transportation to mental health services.
14. There are no mental health services in my neighborhood / on my reservation.
15. I am concerned that the mental health provider will mistreat me due to my race or ethnicity.

It is important to note that POC subgroup respondents were 3 times more likely ($P < .001$) than the white subgroup to have the barrier "My culture does not support mental health services," and 7 times more likely ($P < .001$) to be "concerned my mental health provider will mistreat me due to my race or ethnicity."

LGBTQ-specific barriers. In addition to barriers anyone might face, CS respondents were given a list of LGBTQ-specific barriers to seeking mental health services. The barriers faced by all or most subgroups in both ranking categories are listed below in "always a barrier" order for all LGBTQ:

1. I do not know how to find a mental health provider that is LGBTQ competent—*all subgroups*.
2. I cannot find a provider I am comfortable with who is also LGBTQ knowledgeable—*all subgroups*.
3. I am concerned that my provider would not be supportive of my LGBTQ identity or behavior—*all subgroups*.
4. There are no LGBTQ knowledgeable mental health services in my neighborhood / on my reservation—*all subgroups*.
5. I am afraid that my sexual orientation or gender identity will not be kept confidential—*most subgroups*.
6. Several of the "out" providers I would visit are in the same social circle as me (e.g. attends the same social events)—*most subgroups.*

Problems with mental health providers. CS respondents were provided a list of problem areas that was developed from Community Dialogue feedback and Advisory Group discussions. CS respondents were asked to indicate whether each area listed was a problem for them in the past 5 years. The areas most frequently reported as a "severe problem" by all or most subgroups were:

1. Did not know how to help me with my sexual orientation concerns—*all subgroups.*
2. Did not know how to help me with my gender identity/expression concerns—*all subgroups.*

When you have LGBT therapists that are also involved with the community there is a higher potential for inappropriate behavior, boundary and ethics issues.

Long Beach Community Dialogue participant

3. My sexual orientation or gender identity/expression became the focus of my mental health treatment, but that was not why I sought care—*all subgroups.*
4. Made negative comments about my sexual orientation—*most subgroups.*
5. Did not know how to help same-sex couples—*most subgroups.*
6. Did not know how to help mixed-orientation couples (e.g. one partner straight/one partner gay or one partner lesbian/one partner bisexual)—*most subgroups.*

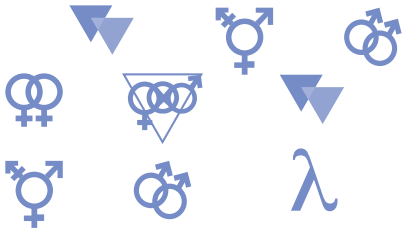
It should be noted that "Made negative comments about my gender identity/expression" was also one of the most frequently reported "severe problems" by Trans Spectrum, Queer, youth, AA & NHPI, Black, Latino and urban subgroup respondents. Trans Spectrum respondents were 4 times as likely ($P < .001$) to have this problem than non-Trans Spectrum respondents. In addition, they were 5 times more likely to have mental health providers who "did not know how to help me with my gender identity/expression concerns."

Satisfaction. CS participants were asked how satisfied they were, in general, with the mental health service(s) they had received in the past 5 years. Only 40% of LGBTQ respondents stated they were "very satisfied," although satisfaction rates differed among subgroups. Older adults reported the highest rate (60%) and youth the lowest (23%) for "very satisfied". Trans Spectrum (31%), Bisexual (32%), Queer (25%), AA & NHPI (24%), Latino (36%), Native American (29%) and rural (35%) subgroups all had even lower rates of "very satisfied" than the overall sample.

Participants were also asked how satisfied or dissatisfied they were with how their mental health provider(s) had met their needs in certain areas. Below is the list of needs most frequently reported by respondents who were "somewhat" to "very dissatisfied" with how their needs were met:

1. Sexual orientation concerns—*all subgroups*
2. Grief—*all subgroups*
3. PTSD / Trauma—*all subgroups*
4. Women-specific concerns—*all subgroups (except Gay men)*
5. Intersecting identities (e.g. Asian and gay)—*most subgroups*

For the Trans Spectrum subgroup, "Gender identity concerns" had the highest dissatisfaction rate. The four racial/ethnic subgroups (AA & NHPI, Black, Latino, and Native American) and the POC subgroup, reported the

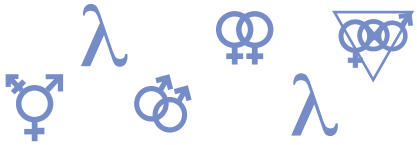


Therapists need to recognize that gender identity is not always the problem. It makes it harder to access services when you don't know if you are going to have to discuss gender identity issues—something the therapist thinks is more interesting and exotic.

Long Beach Community Dialogue participant

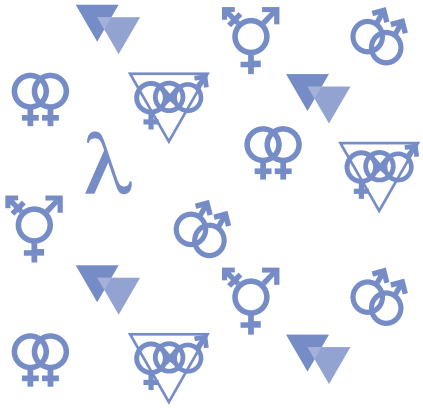
I wish that I could go to a therapist and be open and honest and that my bisexuality would be a statement—not invalidated, or over emphasized.

Bisexual Advisory Group member



They should use the pronouns we ask…they should not f*** up the pronouns.

Long Beach Community Dialogue participant



Transportation is an issue—we don't even have a bus to go from town to town. When you have to ship folks off they get more lost because they have lost all of their other supports.

Inland Empire Community Dialogue participant

highest dissatisfaction rates for both "Intersecting identities" and "Race / Ethnicity concerns."

Money matters: income as a barrier. Approximately half (49.6%) of CS respondents reported a household income of $49,999 or less, with 23% reporting income under $15,000 per year. After accounting for the effects predicted by both race/ethnicity and gender identity, household income is a significant predictor for most barriers, problems and dissatisfaction rates listed. As income level decreases, the likelihood of having barriers, problems and dissatisfaction increases. For example, respondents with a household income of under $15,000 per year were 3 times as likely ($P < .001$) to not have transportation to mental health services and more than twice as likely ($P < .001$) to not have mental health services in their area. They were also 5 times as likely ($P < .001$) to be dissatisfied with how their mental health provider met their needs regarding women-specific concerns.

Provider Survey

The LGBTQ Reducing Disparities Provider Survey (PS) was developed to complement the Community Survey, allowing the Research AG to develop questions specifically intended to assess barriers providers may face in providing culturally appropriate, sensitive and competent care to LGBTQ people. In addition, the PS included questions to address the intersection of being both LGBTQ and a service provider. The PS was made available to mental, behavioral and physical health care professionals, educators, administrators, office staff, support staff, and anyone who comes in contact with clients, patients, students and/or family members, whether or not they provide services specifically for LGBTQ individuals. Over 1,200 ($N = 1,247$) providers working or volunteering in California completed the Provider Survey, including over 350 providers who also identified as LGBTQ.

One possible limitation of the PS was its voluntary nature. No employers required their employees to participate in the survey and many employees had to take the survey on personal time. Therefore, the sample is made up of self-selected individuals, which could produce a sample bias. Providers who choose to participate in an LGBTQ-focused survey may already have a positive interest in the subject matter, as well as be more familiar with, have more knowledge about and feel more comfortable providing services for LGBTQ individuals.

Workplace Environment

PS respondents were asked how often in their current workplace had they witnessed or were told about:

- Negative remarks or jokes about LGBTQ people
- Thoughtless treatment of an LGBTQ family member
- Thoughtless treatment of an LGBTQ employee
- Harassment of an LGBTQ client/student
- Harassment of an LGBTQ employee
- Discriminatory treatment of an LGBTQ client/student
- Discriminatory treatment of an LGBTQ employee

The most common incident witnessed was "negative remarks or jokes about LGBTQ people," which was reported occurring "sometimes," "usually" or "always" by approximately 22% of respondents. Although all participants on average only "sometimes" or "rarely" heard negative remarks in the workplace toward LGBTQ employees, clients/students or their family members, when analyzing each of the seven contexts listed above, overall straight providers reported observing significantly fewer incidences of negative events in the workplace than LGBTQ providers. In addition, POC providers reported observing "harassment" or "discriminatory treatment of an LGBTQ employee" significantly more often than white providers observed each of these events.

The workplace for school-based providers was defined as "the day-to-day performance of their duties, either on campus or during extra-curricular activities." Across all seven negative incident types listed previously, school-based providers reported observing significantly more frequent incidences of negative events in the workplace than mental/behavioral or physical health care providers. The most frequently occurring incident was the observance of "negative remarks or jokes about LGBTQ students." Other frequent incidents school-based providers reported observing or being told about were "harassment" or "discriminatory treatment of LGBTQ students."

Disparities for LGBTQ-Identified Providers

LGBTQ providers were asked to indicate if they felt they had experienced any negative workplace-related incidents in the past five years because of their sexual orientation or gender identity/expression. From the list provided on the PS, over half (53%) of LGBTQ providers reported experiencing one incident, 44% reported experiencing more than

one, and about one-fifth (19%) reported experience four or more negative incidents in the past 5 years. Lesbians reported experiencing significantly more incidents than Gay men or Bisexual/Pansexual providers. However, Queer providers reported experiencing significantly more negative workplace-related incidents than any of the other sexual orientation or gender identity groups. For LGBTQ providers, the most frequently reported negative incidents which occurred *because of their sexual orientation or gender identity/expression* were (in order):

1. Sought after as an expert on LGBTQ.
2. Treated differently by colleagues.
3. Verbally harassed by colleagues, students or parents/guardians/ family members.
4. Assigned LGBTQ clients/patients.
5. Socially excluded by colleagues.
6. Instructed to keep my sexual orientation or gender identity hidden or quiet.

All PS respondents were asked how much they agreed with the following statement: "If I advocate for LGBTQ concerns at work, I will be accused of bias or promoting a personal agenda." More than twice as many LGBTQ providers (24%) agreed with this statement compared to straight providers (9.5%). All PS respondents were also asked about the statements: "When I am at work I can wear clothing which matches my gender identity/expression" and "I can behave in ways which match gender identity/expression (e.g. body movements, how deep my voice sounds, etc.)." Again, approximately twice as many LGBTQ providers (8%) disagreed with these statements than straight providers (4% and 3% respectively).

LGBTQ providers are not always out to colleagues about their sexual orientation or gender identity. Only two-thirds (64%) of LGBQ providers report being "completely out" about their sexual orientation to other LGBTQ staff and less than half (47%) are "completely out" to straight staff members. Only about half (56%) of Transgender respondents are "completely out" to other LGBTQ staff about their gender identity and about half (52%) report being "completely out" to straight staff members.

Barriers to Providing Services

While members of LGBTQ communities may experience barriers

accessing culturally competent care, the PS sought to learn what barriers providers themselves might be facing in trying to provide such care. PS respondents were provided a list of barriers to providing culturally competent services for LGBTQ clients/patients/students. These barriers came from the Community Dialogue meetings and Advisory Group discussions. PS respondents were asked to indicate whether each item listed was a barrier for them in the past 5 years. The barriers have been ranked by frequency two ways: 1) those reported as "always a barrier;" and 2) those where the categories of "sometimes" and "always a barrier" were combined.

The following are the top barriers to providing culturally competent mental health services reported by PS respondents. All barriers listed were ranked as both "always a barrier" or "always" and "sometimes a barrier" combined. They are listed here in the order of "always a barrier":

1. Not enough access to training on the concerns and needs of transgender clients/patients/students.
2. Not enough access to training on the concerns and needs of LGBTQ parents.
3. Not enough access to training on the coming out process.
4. Not enough access to training on the concerns and needs of lesbian, gay or bisexual clients/patients/students.
5. No access to supervision/consultation with providers who have expertise in LGBTQ concerns and needs.
6. Not able to provide services in clients'/patients' native language.
7. Personal religious beliefs.

Comfort Matters

As stated previously in this report, a provider's comfort level when working with LGBTQ people is one indicator of cultural competence and affirmative care. PS participants were asked about their personal comfort level (not their professional competency) when working with lesbian, gay (men), bisexual, and gender nonconforming/transgender/transsexual clients/patients/students. The majority of providers reported feeling "comfortable" to "very comfortable" working with lesbian, gay and bisexual clients/patients/students. LGBTQ providers were significantly more comfortable than heterosexual providers with each of these groups. For example, about half of the straight providers reported being "very comfortable" compared to approximately three-quarters of LGBTQ

providers. It is interesting to note, however, that both LGBQ and straight providers were overall significantly less personally comfortable working with gender nonconforming/transgender/transsexual people.

Comfort affects beliefs. The mean comfort level ratings were compared with how PS respondents agreed or disagreed with certain belief statements. Even after controlling for LGBTQ identity, as mean comfort ratings with LGBTQ people increases, overall providers:

- Significantly disagree more with the statement, "With therapy, LGBTQ people can change their sexual orientation or gender identity."
- Significantly agree more with the statement, "LGBTQ individuals should have all the same rights as heterosexual individuals under United States law."
- Significantly agree more with the statement, "Same-sex couples should be allowed to legally marry."
- Significantly agree more with the statement, "It is okay for students in public schools to learn about the role and contributions of LGBTQ individuals in their social science classes."

As a side note, straight providers appear to perceive a difference between LGBTQ individuals having "all the same rights as heterosexual individuals under United States law" and "same-sex couples should be allowed to legally marry." Ninety percent (90%) of straight providers agreed with the first statement, yet only 83% agreed with the second. More striking, twice as many straight providers strongly disagreed (11%) with the second statement (legal marriage) than strongly disagreed (5%) with the first (all the same rights under United States law). These differences did not appear with LGBTQ providers. This finding is particularly interesting, as legally recognized marriage is one of the rights heterosexual individuals have under United States law.

Religion affects comfort. PS respondents were how asked how much their "current religion/spiritual practice supports equal civil rights for LGBTQ individuals." There is a significant positive correlation between a supportive religion/spiritual practice and a provider's average personal comfort working with LGBTQ people. In other words, the more supportive a provider's current religion/spiritual practice, the more personally comfortable they report to be working with LGBTQ clients/patients/students. For this correlation, the group mean comfort ratings are significantly different, with LGBTQ providers personal comfort level significantly higher than straight providers.

Training Matters

As stated above, PS respondents indicated "not enough access to training" as their top four barriers to providing culturally competent LGBTQ services. PS participants were asked: "In the past 5 years, how many continuing education, workshops, in-service or professional development trainings (events that lasted 1 hours or more) about LGBTQ topics have you attended?" They were also asked: "How many of these workshops or trainings that you attended occurred in the past 12 months?" Overall, 75% of respondents had participated in at least one LGBTQ-specific training in the past 5 years. Moreover, over half of the providers (67.2%) had participated in at least one of those trainings in the past 12 months. Over the past five years, LGBTQ providers reported completing significantly more LGBTQ workshops/trainings than their straight colleagues, as well as participating in more trainings in the past 12 months.

Gay Affirmative Practice Scale. A section of the PS contained an adapted version of the Gay Affirmative Practice (GAP) Scale developed by Catherine Crisp (2006). The adapted scale measures levels of affirming practice behavior for both sexual orientation and gender identity. The GAP Scale was presented only to those providers who answered "yes" to the question, "Do you personally provide mental health services for LGBTQ clients?" The GAP Scale total score was used to assess the extent to which providers engage in principles consistent with gay affirmative practice.

While on average LGBTQ providers scored 10 points higher on the GAP Scale than straight providers, overall, it matters how many trainings providers had in the past 5 years. After controlling for LGBTQ identity, the more trainings a provider participated in, the higher their GAP total score. More specifically, each additional workshop/training session in the past 5 years (between 0 and 4+ trainings) significantly increased participants GAP score overall by almost 3 points.

More trainings had a positive effect on GAP scores regardless of provider sexual orientation. That is, each additional training over the past 5 years resulted in 2.5 points higher GAP scores regardless of whether the provider is LGBTQ or not. This suggests that, aside from LGBTQ status, more trainings yield more affirming providers overall.

Asking *the* questions. As stated previously, Community Survey respondents reported they are often not out to providers about their sexual orientation or gender identity. Perhaps one reason is that many providers do not ask about sexual orientation or gender identity. In addition, there

is the question of how a provider would be able to provide LGBTQ culturally competent services if they do not know the sexual orientation or gender identity of their client/patient. Only 29% of PS mental/behavioral and physical health care providers indicated they ask clients/patients about their sexual orientation, and only 26% ask about gender identity or if clients/patients have questions about their gender.

There is a *positive* correlation between the number of trainings a provider had in the past 5 years and how often they reported asking clients/patients about their sexual orientation or gender identity. That is, the more trainings a provider participated in, the more often that provider asked clients/patients about their sexual orientation or gender identity. This was true for all providers. However, the data also showed that LGBTQ providers ask about sexual orientation and gender identity more often than straight providers, regardless of the number of trainings the straight providers participated in.

Training affects beliefs. Number of trainings attended in the past 5 years were compared with how PS respondents agreed or disagreed with certain belief statements. As providers participate in more LGBTQ-specific trainings, they:

- Significantly disagree more with the statement, "With therapy, LGBTQ people can change their sexual orientation or gender identity."
- Significantly agree more with the statement, "LGBTQ individuals should have all the same rights as heterosexual individuals under United States law."
- Significantly agree more with the statement, "Same-sex couples should be allowed to legally marry."
- Significantly agree more with the statement, "It is okay for students in public schools to learn about the role and contributions of LGBTQ individuals in their social science classes."

In addition, LGBTQ providers more strongly disagreed than straight providers with the statement: "With therapy, LGBTQ people can change their sexual orientation or gender identity." LGBTQ providers more strongly agreed than straight provides with the remaining three statements listed above.

Overall, LGBTQ providers agree significantly more than straight providers with the statement: "My current religion / spiritual practice supports equal civil rights for LGBTQ individuals." When examining agreement ratings by number of LGBTQ-specific trainings in the past

5 years, there is a positive correlation between number of trainings and straight provider agreement. In other words, the more trainings a straight provider attended, the more they agreed with the above statement. The number of trainings did not affect agreement by LGBTQ providers. It is possible that straight providers who attend more LGBTQ-specific trainings choose to affiliate themselves with more LGBTQ-supportive religions/spiritual practices. However, it is also possible that straight providers whose religion/spiritual practice supports LGBTQ equal rights choose to attend more LGBTQ-specific training. A conclusion cannot be made about this without further research.

Summary

The Community Survey (CS) findings show that respondents, either as the entire sample or among specific subgroups, face disparities in numerous ways. The majority experience stress, anxiety or depression directly related to their sexual orientation or gender identity/expression and seek mental health services or support at very high rates. There are many who report, however, not being able to access the services they want or need. When accessing services, CS respondents may not be out to one or more of their provider(s). For those who are out to their provider(s), they report differing levels of rejection regarding their sexual orientation or gender identity. They also report difficulty finding providers who are accepting of LGBTQ issues.

CS respondents report facing discrimination on a daily, weekly, monthly and yearly basis—with higher frequencies of distress causing higher distress levels. They face rejection from their religious/spiritual practices, racial and ethnic communities, families of origin, extended family, classmates and co-workers.

CS respondents report a number of barriers to seeking mental health services, with "lack of financial resources to pay for services" reported as the number one general barrier and "not knowing how to find an LGBTQ-competent mental health provider" as the number one LGBTQ-specific barrier. Once services are accessed, CS respondents encounter problems with their mental health providers, including their provider not knowing how to help with sexual orientation or gender identity/expression concerns. Many are also not very satisfied with the services they receive. Household income is a significant factor in service disparities. The lower the household income, the greater the likelihood respondents experience most barriers and problems, as well as having

lower satisfaction rates for mental health services.

The Provider Survey (PS) findings show that providers—both straight and LGBTQ—face barriers to providing culturally competent services for LGBTQ people, including lack of training, inability to provide services in the client's native language and personal religious beliefs. In addition, LGBTQ providers face disparities in the workplace. Over half of LGBTQ respondents have experienced a negative workplace-related incident because of their sexual orientation or gender identity/expression. Negative incidents include being treated differently or socially excluded by colleagues, as well as verbal harassment by colleagues, students or parents/guardians/family members.

As stated previously in this report, in order to work effectively with LGBTQ clients, providers must assess, understand and continually be aware of their internal barriers and biases regarding LGBTQ populations and individuals—as negative perspectives can inhibit proficient practice with LGBTQ individuals, including the possibility of causing harm. PS respondents were therefore asked about personal comfort levels working with and beliefs about LGBTQ people.

LGBTQ providers report significantly higher comfort levels than straight providers when working with LGB clients. However, both LGBQ and straight providers are less personally comfortable when working with gender nonconforming/transgender/transsexual clients. The more comfortable providers report they are working with LGBTQ clients, the more they support LGBTQ civil rights and teaching about the contributions of LGBTQ individuals in public schools. In addition, those providers whose religion/spiritual practice supports equal civil rights for LGBTQ individuals are also more comfortable working with LGBTQ clients.

PS findings indicate that number of LGBTQ-specific trainings attended is a very important factor in how LGBTQ-affirming a provider is. While LGBTQ providers scored higher on the Gay Affirmative Practice (GAP) Scale than straight providers, the more trainings a provider participated in—whether or not they are LGBTQ—the higher the GAP score. The GAP score also rose for providers with each training they participated in. Training also affects how often providers ask their clients about sexual orientation or gender identity. In addition, providers with more trainings in the past 5 years are more supportive of LGBTQ civil rights and teaching about the contributions of LGBTQ people in public schools.

Recommendations

As stated in the introduction to this report, LGBTQ is not a homogenous, monolithic entity. Each population represented by the acronym has its own needs as well as its own issues of diversity. Age, gender, sex assigned at birth, socioeconomic status, education, differences in abilities, religious upbringing, and ethnic and racial backgrounds all play a role in how an individual experiences their sexual orientation or gender identity. Therefore, all following recommendations should be viewed with this diversity in mind and the implementation differentiated accordingly.

In general, LGBTQ individuals are raised with racial, ethnic and/or cultural identities, traditions and norms which influence not only how they experience their sexual orientation or gender identity, but how they experience their life as a whole. As such, treating an individual as if they are "only" LGBTQ without considering their racial, ethnic or cultural background will not produce culturally competent services. The California Reducing Disparities Project includes four additional population reports—African American, Asian and Pacific Islander, Latino and Native American—each with their own set of specific recommendations. The LGBTQ recommendations should not be viewed as separate from or in competition with the racial/ethnic/cultural recommendations from the four other reports. Rather, the recommendations from all five reports should be viewed as an intersecting body of work, with the LGBTQ recommendations as an important addition to achieving culturally competent services and equitable treatment for all California populations.

The following recommendations are directed to all relevant parties, including but not limited to: the California Department of Public Health (DPH), the Office of Health Equity (OHE), the California Department of Health Care Services (DHCS), the Mental Health Services Oversight and Accountability Commission (MHSOAC), the California Mental Health Directors Association (CMHDA), the California Mental Health Services Authority (CalMHSA), the California Mental Health Planning Council, the California Department of Education, the Governor's office, the State Assembly, and the State Senate.

Focus 1: Data Collection, Research and Evaluation

Recommendation 1.1:

Demographic information should be collected for LGBTQ people across the lifespan, and across all demographic variations (race, ethnicity, age, geography) at the State and County levels. Standardization of sexual orientation and gender identity measures should be developed for demographic data collection and reporting at the State and County levels. Race, ethnicity, culture and age should be considered and the measures differentiated accordingly.

> ***Implementation examples:*** Whenever demographic data (e.g. race, ethnicity) is collected as a tool to evaluate and improve services, sexual orientation and gender identity data should be included.
>
> Intake, data collection and reporting systems should be modified to count—and analyze data trends for—LGBTQ populations in order to identify possible mental and physical health disparities, gaps in service, successes in service provision, and to support appropriate resource allocation. Data collection and analysis should not be predicated on the assumption that LGBTQ individuals will self-identify on intake forms or interviews. Due attention should also be given in the design of these systems to the need for anonymity among many LGBTQ individuals.

Recommendation 1.2

This report represents a snapshot in time of certain LGBTQ people living in California. Not everyone that could be or should be is included in the picture. In many ways, LGBTQ cultural competency work is still in its infancy—with growth and changes occurring rapidly. This report, therefore, cannot and should not be the final word in reducing disparities for LGBTQ Californians. The work begun by the LGBTQ Strategic Planning Workgroup, including community engagement, advocacy, data collection and community-based recommendations, needs to be continued and the LGBTQ Reducing Disparities Project should remain funded beyond the dissemination of this report.

Recommendation 1.3:

There is a gap in research for LGBTQ people of color, including African Americans, Latinos, Asian Americans, Native Hawaiians, Pacific Islanders, and Native Americans. There is a heavy reliance on convenience samples and other research methods that are not effective in reaching these LGBTQ sub-populations. Therefore, funding should be made available to support LGBTQ researchers of color and research organizations with demonstrated access to these populations in order to close the gap in information about these populations.

Recommendation 1.4:

All domestic violence programs in California should be required to include information about the gender and sexual orientation of clients in their statistical documentation and recognize the partnerships of LGBTQ persons as "domestic."

Focus 2: Policy

Recommendation 2.1:

All elected California representatives should be supported and encouraged to advocate for full LGBTQ equality at the Federal level.

Implementation examples:

Amend the Federal Family and Medical Leave Act (FMLA) to extend coverage beyond those related by blood or marriage.

Ensure the economic security of LGBTQ older adults and their loved ones by extending Social Security and other Federal benefits to same-sex partners.

Recommendation 2.2:

There are California state laws and regulations already in place which have a direct impact on the mental and physical wellness of LGBTQ populations and individuals. These laws and regulations should be supported, promoted and enforced.

Implementation examples:

Governing agencies should be allotted appropriate resources (i.e. funding, staffing, training) to properly enforce existing laws and regulations.

Seth's Law: tightens anti-bullying policies in California schools by ensuring that all schools have clear and consistent policies and by establishing timelines for investigating claims of bullying. Seth's Law helps to create a respectful and safe environment for all students.

The Fair Education Act, which became law in 2012, updates the California Education Code to integrate age-appropriate, factual information about the roles and contributions of LGBT Americans and people with disabilities into social studies classes. Implementation of the Fair Education Act for all California public schools is imperative.

Hospital policies should not prohibit the delivery of trans-related or gender-affirming specific medical care and treatments.

Recommendation 2.3:

Development and implementation of *effective* anti-bullying *and* anti-harassment programs should be mandated for all California public schools at all age and grade levels and should include language addressing sexual orientation, perceived sexual orientation, gender, gender identity and gender expression issues. In addition, implementation of evidence-based, evaluated interventions that specifically address physical bullying and social bullying should be mandated for all California public schools at all age and grade levels.

Implementation example:

All California public schools should be in compliance with current state law and have in place policies and procedures that explicitly protect students from harassment and discrimination on the basis of actual or perceived sexual orientation, gender identity and gender expression.

Recommendation 2.4:

All organizations applying for State or County funded Requests For Proposals (RFP) should be required to adopt LGBTQ-relevant anti-discrimination policies for the hiring of employees and treatment of clients. These policies should be monitored and enforced by the funding agency.

Implementation examples:

LGBTQ-relevant anti-discrimination policies should be inclusive of, but not limited to, equal benefits protections for employees.

Services for racial and ethnic populations are often located in faith-based or church-affiliated organizations. LGBTQ individuals, however, will not receive culturally competent services in faith-based or church-affiliated organizations which are openly anti-LGBTQ. Therefore, any programming funded by the State or County which takes place in a faith-based or church-affiliated organization should be required to have LGBTQ-relevant anti-discrimination policies.

Recommendation 2.5:

A statewide social marketing campaign should be implemented that is informed and endorsed by LGBTQ communities to:

1) address and eliminate stigma directed toward LGBTQ individuals and families; and
2) decrease the stigma surrounding the seeking of mental and behavioral health services by LGBTQ individuals and families.

Components of the campaign should be designed and tailored specifically to reach racial, ethnic, linguistic, and cultural segments within the overall LGBTQ community.

Recommendation 2.6:

Legislation and policy should be created which bans the use of reparative therapy practices by mental health providers.

Implementation examples:

The State or Counties should be prohibited from awarding any contracts to agencies or providers who use or promote reparative therapy practices.

Senate Bill 1172 (Sexual Orientation Change Effort), which bans mental health professionals from subjecting minors to a dangerous and emotionally-scarring practice of trying to change their sexual orientation, should be supported and implemented.

Recommendation 2.7:

A cultural competence certification program should be developed for mental health providers. Mental health providers should be certified in specific competency categories pertaining to individual race, ethnicity, culture, sexual orientation or gender identity and have standards for training and knowledge. Providers who do not have certification in a particular area should either be required to refer the client to a certified provider or receive supervision/consultation from a certified provider.

Recommendation 2.8:

State and County funded suicide prevention programs should be required to include LGBTQ populations across the lifespan.

Recommendation 2.9:

Creating safe spaces for LGBTQ youth is critical to addressing harmful school behavior. Gay-Straight Alliances (GSA) and other such LGBTQ affirming clubs should be supported by school administration and staff, including the reducing of barriers to forming and maintaining such clubs at middle and high school campuses.

Focus 3: Workforce Training

Recommendation 3.1:

Statewide workforce training and technical assistance should be required in order to increase culturally competent mental, behavioral and physical health services, including outreach and engagement, for all LGBTQ populations across the lifespan, racial and ethnic diversity, and geographic locations.

Training of service providers in public mental/behavioral and physical health systems should focus on the distinctiveness of each sector of LGBTQ communities—lesbians, gay men, bisexual, transgender, queer and questioning—within an overarching approach to mental health throughout the lifespan for the racial, ethnic and cultural diversity of LGBTQ communities. Cultural competency training, therefore, cannot only be a general training on LGBTQ as a whole, but also needs to include separate, subgroup-specific training sessions (e.g. older adult, youth, bisexual, transgender, Black, Latino, etc.).

Agencies and individuals providing LGBTQ trainings—whether general or subgroup-specific—should meet CEU standards and have community-based endorsement(s).

Implementation examples:

Education and training about bisexuality should be provided in a separate module; when it is "Gay and Bisexual men" or "Lesbian and Bisexual women" the issues specific to bisexuality are lost.

Culturally competent training curricula on sexual orientation and gender identity/expression should be identified, developed, implemented, and evaluated for pre-professional trainees, service providers, clients/consumers, family members, and non-degreed professionals, including traditional/indigenous healers and interpreters.

Recommendation 3.2:

Statewide workforce training and technical assistance should be required for all California public school staff and administrators in order to increase culturally competent and sensitive treatment of all students who are, or are perceived to be, LGBTQ.

Training of all personnel in public school systems should focus on the specific health and safety needs of each sub-group within LGBTQ communities including lesbian, gay, bisexual, transgender, queer and questioning. LGBTQ cultural competency training should address identity and behavior of each subgroup as well as racial, ethnic and cultural diversity of LGBTQ communities.

Agencies and individuals providing LGBTQ trainings—whether general or subgroup-specific—should meet CEU standards and have community-based endorsement(s).

Implementation examples:

A *reoccurring*, district-wide training program should be required for all school administrators, teachers, police and security officers, school and expulsion hearing officers on the mental health challenges, strains, and duress endured by LGBTQ students, students of color, low-income youth, and all other students who face bullying and harassment.

The targeting/bullying of youth who are Native males with long hair are perceived to be effeminate when they are identifying with and expressing their Native identity. The training would include training on Native identity as well as targeting of this identity with homophobic bullying. This might be detrimental to a Native youth who is male and also identifies as Two-Spirit.

Focus 4: Funding and Services

Recommendation 4.1:

State and County RFPs should support innovative community-based efforts and require providers that claim to work with LGBTQ communities to provide a historical record of such work in such communities in addition to documentation of internal policies and procedures that are inclusive of, and designed specifically for, LGBTQ communities.

Recommendation 4.2:

LGBTQ Community Based Organizations (CBOs) are often small non-profits that do not have the capacity to meet traditional requirements for State or County funded projects. In addition, many LGBTQ people do not have access to LGBTQ CBOs—and agencies which serve formerly incarcerated individuals, homeless, or racial/ethnic populations may not be LGBTQ-specific. Therefore:

1) Barriers encountered by LGBTQ CBOs when they are seeking State and County funding should be reduced.
2) LGBTQ CBOs should be assisted in increasing their capacity to respond to State and County RFPs.
3) Non-LGBTQ CBOs serving LGBTQ populations should be assisted in increasing their capacity to better meet the needs of their LGBTQ clients.

Recommendation 4.3:

All locations where State or County funded mental/behavioral and physical health care services are offered should be required to be safe, welcoming and affirming of LGBTQ individuals and families across all races, ethnicities, cultures, and across the lifespan.

Recommendation 4.4:

State and County mental/behavioral health and physical health care departments should create an environment of safety and affirmation for their LGBTQ employees.

Implementation examples:

LGBTQ employees should not receive negative repercussions for being out in the workplace.

LGBTQ employees should be supported by their department when seeking to implement or improve services for LGBTQ clients/ consumers/patients.

Recommendation 4.5:

Mental, behavioral and physical health care and educational materials provided to LGBTQ clients should be made available in the client's primary language—particularly if the client speaks a threshold language.

Recommendation 4.6:

LGTBQ individuals are at high risk for tobacco use, substance use disorders, suicide, stigma, homelessness, mental health issues, etc. Programs do not necessarily know to include them without LGBTQ being identified as a high-risk population. It is difficult for some staff to explain why they are doing outreach in LGBTQ settings where the population congregate, such as LGBTQ Pride events. Therefore, language that specifically identifies LGBTQ as high-risk should be in all RFPs which target high-risk populations.

Recommendation 4.7:

In order to receive funding, the U.S. Department of Health and Human Services (HHS) requires that California implement HHS Culturally and Linguistically Appropriate Services (CLAS) standards. CLAS standards, however, do not address cultural competency when

serving LGBTQ individuals and families. Without standards of care and training, many LGBTQ clients will experience the same harassment, discrimination, or invalidation as they experience elsewhere in society. Such experiences may harm LGBTQ clients; decrease rates of program enrollment, engagement, and retention; and diminish positive outcomes. CLAS standards should be updated to include LGBTQ cultural competency. Standards for California which include LGBTQ cultural competency should be implemented, whether or not HHS updates their CLAS standards.

Implementation examples:

The following are standards for culturally responsive services for LGBTQ clients and communities:

Standard #1: Agency policies and procedures are inclusive of LGBTQ staff, clients, and communities.

Standard #2: Staff members at mental/behavioral health, and medical care agencies receive LGBTQ basic training as part of their larger diversity training experiences, and receive appropriate supervision to provide inclusive services. Staff members who provide poor quality care are appropriately sanctioned.

Standard #3: Written forms and documents, and oral language used in assessment and interventions are inclusive and respectful of LGBTQ people.

Standard #4: The climate of mental/behavioral health and medical care agencies is welcoming and inclusive of all clients.

Standard #5: Mental/behavioral health, and medical care agencies shall create linkages with local LGBTQ communities and use appropriate referral sources and resources for their LGBTQ clients.

Recommendation 4.8:

Funding should be allocated to develop a statewide resource guide listing agencies, programs and services which have been determined to be LGBTQ-sensitive, affirming and culturally competent. Rating guidelines used for the resource guide should be community-defined and evaluated through a community-based process.

Part 4:
Community-Defined and Promising Practices

Many of the accepted and evidence-based practices in use today by mental health providers have not been validated for use with LGBTQ individuals and/or have not been developed with the needs of LGBTQ individuals in mind. The LGBTQ Reducing Disparities Project was charged to identify "new service delivery approaches defined by [LGBTQ] communities for [LGBTQ] communities using community-defined evidence to improve outcomes and reduce disparities" (DMH, 2010, p. 1). For the purposes of this report, both community-defined and promising practices are those practices members of LGBTQ communities "have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community" (Martinez, 2008, pp. 9-10).

The following section contains a sample of community-defined and promising practices for members of LGBTQ communities. These practices were submitted by programs and service providers from across California who believe they have community-defined evidence to show these practices improve the mental health of the LGBTQ individuals they are serving. Not all providers, programs or agencies providing LGBTQ-specific services in California knew of or responded to the call for submission of community-defined and promising practices. Therefore, the following section should not be viewed as a complete listing.

As stated at the beginning of this report, LGBTQ individuals are being harmed on a daily, weekly, monthly, yearly, and sometimes lifetime basis due to stigma, discrimination, prejudice, rejection and legal inequality. For LGBTQ individuals who are also members of other disparity groups, such as Asian American, Black/African American, Latino, Native American, and Native Hawaiian/Pacific Islander, the harm they experience is compounded on multiple levels. While community-defined and promising practices are important tools to help improve mental health, as well as prevent mental health issues, the following section should not be viewed as the only solution to reducing disparities for LGBTQ communities and individuals. To truly prevent mental health disparities and promote mental wellness the California Department of Public Health, the Office of Health Equity, the Department of Health

Care Services, the Mental Health Services Oversight and Accountability Commission, the California Mental Health Directors Association, the Californian Mental Health Planning Council, California legislators, school administrators, and service providers of all types must be committed to preventing the harm LGBTQ individuals are exposed to by society at large.

Index by Practice Focus

Descriptions of practices are listed after the index in alphabetical order.

Behavioral Health

Lyon-Martin Health Services
Native American Health Center

Case Management

Rainbow Community Center of Contra Costa County

Domestic Violence / Violence

CATS (Counseling and Therapy Services)
The Center Long Beach
Communities United Against Violence (CUAV)
Los Angeles Gay and Lesbian Center (LAGLC) — STOP DV
Rainbow Community Center of Contra Costa County
The Sisters of Perpetual Indulgence, Inc. (San Francisco) — Stop the Violence Campaign

Families and Parenting

Family Acceptance Project
Our Families Coalition—Parent-Centered Collaborative
Rainbow Community Center of Contra Costa County

HIV and AIDS Services and Prevention Programs

Asian and Pacific Islander Wellness Center
CATS (Counseling and Therapy Services)
The Center Long Beach
Outlet—*De Ambiente*
The Sisters of Perpetual Indulgence, Inc. (San Francisco) — Harm Reduction Ministry & Play Fair 2012

Mental Health Counseling

CATS (Counseling and Therapy Services)
The Center Long Beach
Family Acceptance Project
Gender Health Center
The LGBT Center of the Desert
LGBTQ Youth Space
Lyon-Martin Health Services
OC ACCEPT
Pacific Center for Human Growth
Rainbow Community Center of Contra Costa County
Sacramento City Unified School District LGBTQ Support Services
Transgender Program Medicine and the Behavioral Health Program—
Children's Hospital Los Angeles

Older Adult-Specific

Lavender Seniors of the East Bay
The LGBT Center of the Desert
Los Angeles Gay and Lesbian Center (LAGLC) —
Senior Services Department
Peer Support Groups
Rainbow Community Center of Contra Costa County

Physical Health

Asian and Pacific Islander Wellness Center
LGBT Center of the Desert
Lyon-Martin Health Services
Native American Health Center

Race/Ethnic and Language-Specific

Asian and Pacific Islander Wellness Center
Native American Health Center
Outlet—*De Ambiente*
Peer-Support Groups

Religion

Center for Gay and Lesbian Studies in Religion and Ministry —
Pacific School of Religion
Rainbow Community Center of Contra Costa County

School-Based

Gay-Straight Alliance Network
Sacramento City Unified School District LGBTQ Support Services
University of California, Riverside LGBT Resource Center

Suicide Prevention

Family Acceptance Project
Trevor Project

Transgender-Specific

Gender Health Center
Lyon-Martin Health Services
Peer Support Groups
Rainbow Community Center of Contra Costa County
Transgender Program Medicine and the Behavioral Health Program—Children's Hospital Los Angeles

Youth-Specific

The Center Long Beach—Mentoring Youth Through Empowerment
Family Acceptance Project
Gay Straight Alliance Network
The LGBT Center of the Desert
LGBTQ Youth Space
Our Circle
Our Family Coalition
Outlet
Pacific Center for Human Growth
Peer Support Groups
Rainbow Community Center of Contra Costa County
Rainbow Pride Youth Alliance—Q*Camp
Sacramento City Unified School District LGBTQ Support Services
The Sisters of Perpetual Indulgence, Inc. (San Francisco)
Transgender Program Medicine and the Behavioral Health Program—Children's Hospital Los Angeles
Trevor Project
University of California, Riverside LGBT Resource Center

Description of Practices

Asian and Pacific Islander Wellness Center

Asian and Pacific Islander Wellness Center (APIWC) was born out of an immense community need. Culturally and linguistically specific services for HIV-positive AA & NHPIs—including those who identify as LGBTQ—always have been a standing need for these communities. By providing culturally and linguistically appropriate services, APIWC helps to empower HIV-positive AA & NHPIs. Clients are aware they can express themselves without the fear of being ridiculed because of how they speak or their accents. Clients know agency staff are there to help them feel comfortable as they deal with HIV and AIDS issues. Through APIWC, clients have advocates who can speak on their behalf so they do not get lost in the system. The majority of clients served by APIWC are HIV-positive who identify as men who have sex with men (MSM). APIWC also serves HIV-positive clients who identify as Male-to-Female (MTF) Transgender.

APIWC helps clients meet their basic needs—shelter, food, and medication—in order to help clients eventually reach their full potential. By connecting them to vital, life-saving services, they have less to worry about and can deal with more pressing issues. Although APIWC does not exclusively serve LGBTQ, program services (case management, medical and psychiatric care, psychotherapy, treatment advocacy, peer advocacy, peer-support groups) are highly sensitive to the needs of their HIV-positive clients who identify as LGBTQ.

CATS (Counseling and Therapy Services)

CATS is a program of Community Human Services in partnership with Central Coast HIV/AIDS Services. Funding is provided by Monterey County Behavioral Health Department. CATS provides a supportive space for individuals and their families to talk confidentially with an LGBTQ-friendly staff and LGBTQ-identified professionals. CATS provides the HIV/AIDS and LGBTQ communities in Monterey County with priority services for individuals and groups, including free Drop-In Counseling Groups. HIV/AIDS and LGBTQ-specific counseling issues include:

- Raising children in LGBTQ families
- Adjusting to a loved one's LGBTQ identity

- Coming out
- Living with HIV/AIDS
- Gender identity
- Intersexuality
- Adjusting to a loved one's HIV/AIDS status
- Living in a homophobic culture

Center for Gay and Lesbian Studies in Religion and Ministry — Pacific School of Religion

The Center for Gay and Lesbian Studies at the Pacific School of Religion was established in 2000 and seeks to advance the well-being of LGBTQ people and to transform faith communities and the wider society by taking the leading role in shaping a new public discourse on religion and sexuality.

Coalition of Welcoming Congregations (CWC). CWC brings together religious leaders, LGBTQ people of faith and their allies from a wide range of religious traditions in the nine-county San Francisco Bay Area. The CWC connects local religious leaders, religious congregations/communities, and individuals of faith who are highly motivated to act as agents of positive social change for LGBTQ people. The CWC is made up of over 200 congregations across the San Francisco Bay area that include Jewish, Buddhist and Christian communities. The CWC helps congregations to bring spirituality out of the closet by encouraging them to:

- engage in the "best practice" of inclusion for lesbian, gay, bisexual, transgender, intersex, queer and questioning individuals into their spiritual communities;
- and engage in "sacred activism": take their spiritual convictions for social justice/public witness outside the walls of their meeting space.

The Center Long Beach

Mental health counseling. The mental health counseling program is staffed by volunteer MFTIs with a paid clinical supervisor. The counseling environment is 100% LGBTQ-affirming. The Center is also a recognized provider of mental health services to victims of violent crimes.

Support groups. The Center also hosts peer-led groups and groups in collaboration with other local organizations. Groups held in

collaboration include: a non-LGBTQ-specific grief and bereavement group facilitated by LGBTQ staff from a local hospice, and an HIV support group that is offered in collaboration with C.A.R.E, a local HIV health care and social support organization.

Mentoring Youth Through Empowerment (MYTE). MYTE is an after-school drop-in program (open 3:00-7:00 PM) for LGBTQ youth ages 13-17. The program provides both structured and unstructured activities and a safe space to socialize with other LGBTQ youth. MYTE is empowerment-based and free of charge. It has 12 volunteers and a coordinator. They serve approximately 70 youth every month. Activities include a dance for youth from 26 area highs schools, tutoring, SAT preparation, educational workshops, field trips and movie night.

Communities United Against Violence (CUAV)

CUAV, located in San Francisco, develops their programs through an examination of their participants' needs. Building healing skills, leadership skills, and new relationships are key components to empowering participants as agents of change in their lives and communities. CUAV uses an approach that shifts "clients" to "participants" and focuses on self-determination instead of directives as a fundamentally empowering and necessary shift in service provision. CUAV uses educational practices which make content accessible and relevant for the low- to no-income LGBTQ people who access their services. Their programs are bilingual in both English and Spanish. CUAV's services come from outside of a heterosexual perspective, approaching violence with a framework open to all genders and sexualities, rather than the frequently-used viewpoint of violent men battering women.

CUAV has many success stories of participants who have gained self-confidence and control over their lives while attending CUAV's programs. Many have reported feeling more able to make choices, set boundaries, and trust their own intuition. In addition, CUAV has conducted surveys regarding participants' experiences at Wellness Wednesdays. These surveys have shown positive feedback.

Wellness Wednesdays. Through their Wellness Wednesdays program, CUAV provides group support to predominately low-income LGBTQ people of color around issues of domestic violence, hate violence, and police violence. Participants eat dinner together while

discussing skills and practices related to self-determination, healthy relationships, setting boundaries, and other ways to build safety and resilience in their lives and communities. They practice these skills together and express themselves through art and healing activities.

Membership Meetings. During monthly meetings, participants connect issues of violence and skills learned during Wellness Wednesdays with the bigger systems of oppression that affect LGBTQ lives. They discuss the impact of these systems and the action they can take to empower themselves.

Peer advocacy. CUAV offers one-on-one peer advocacy, providing emotional support through short-term counseling, as well as referrals to other resources and court accompaniment.

Warmline. CUAV provides a warmline which is available for LGBTQ survivors of violence to call when they are seeking support or resources.

Family Acceptance Project

Family services. The Family Acceptance Project (FAP), in collaboration with Child & Adolescent Services at San Francisco General Hospital/UCSF, provides confidential family support services to help ethnically diverse families decrease rejection and increase support for their LGBTQ children, including those who are questioning their sexual orientation or gender identity. These free, confidential services are available to families with LGBTQ children in the Bay Area and are available in English, Spanish and Cantonese.

FAP family services are based on research from the Family Acceptance Project that has linked health, mental health and well-being—including risk for suicide, substance abuse and HIV, and positive outcomes such as self-esteem—to behaviors that parents and caregivers use to express acceptance and rejection of their children's LGBTQ identity.

FAPrisk Screener. *The FAPrisk Screener for Assessing Family Rejection & Related Health Risks in LGBT Youth* is a research-generated screening instrument based on findings from Family Acceptance Project studies. The studies have identified and measured family and caregiver behaviors which are highly predictive of negative physical and mental health outcomes for LGBTQ youth. This new instrument is intended to screen LGBTQ youth and young people to identify those who are

experiencing especially harmful types of family rejection from parents, foster parents and caregivers and to guide practice and follow up care. FAP staff provides training and guidance for providers on using this screener and on engaging in appropriate follow up with families.

Family Education Booklet. The FAP family education booklets have been designated as a "Best Practice" resource for suicide prevention for LGBTQ youth by the national Best Practices Registry for Suicide Prevention.

Gay-Straight Alliance Network

GSAs are student-run clubs, typically in a high school or middle school, that bring together LGBTQ and straight students to support each other, provide a safe place to socialize, and create a platform for activism to fight homophobia, transphobia and other related oppressions such as racism, classism and sexism. GSA membership involves straight allies who are often leaders. Involvement of straight allies helps create a safer campus environment for LGBTQ youth. Research has shown that GSAs may help to make schools safer for LGBTQ students by sending messages that biased harassment will not be tolerated. They make schools more accessible to LGBTQ students by contributing to a more positive environment, and they enable students to connect with supportive staff (GLSEN, 2007). Currently, there are 880 schools in California, including public high schools, public middle schools, and a handful of private high schools, with GSAs.

Gender Health Center

The Gender Health Center (GHC) is a non-profit organization meeting the counseling needs of underserved LGBTQ people in Sacramento.

Transgender mental health services. Though GHC providers are available for all members of LGBTQ communities, they have particular training in transgender issues including transition, medical and mental health matters, hormone therapy, surgery, the WPATH Standards of Care, gender nonconforming youth, and family concerns. Services are provided on a sliding scale to help make them easily accessible and available to everyone. Resources and referrals to other LGBTQ-affirming organizations are also provided.

Feedback-informed treatment (FIT). GHC uses an approach to therapy called *feedback-informed treatment* (FIT) which utilizes the

client's feedback to inform their treatment. FIT is a promising and community-defined practice that is moving quickly towards an evidence-based model. FIT creates a "culture of feedback" that is committed to empowering the client and increasing the client's voice in therapy. Privileging the client's experience in therapy is particularly important with LGBTQ people whose voices have been marginalized by a heteronormative society.

GHC has collected extensive data using *FIT-Outcomes*, a web-based outcome management system designed to support the use of the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). FIT-Outcomes measures two key statistics for determining treatment success: "effect size" and "percentage of clients reaching target baseline". Data collected by GHC indicates positive outcomes.

Lavender Seniors of the East Bay

Lavender Seniors of the East Bay is fiscally sponsored by Bay Area Community Services. Services include: Friendly Visitors, Congregate Meals, and Volunteerism/Civic Engagement for improving health disparities among Alameda County LGBTQ elders. These services help keep LGBTQ seniors connected to their community to reduce isolation and depression, help those coping with loss, and educate those that do not attend mainstream senior informational programs for fear of being "outed" as LGBTQ.

Congregate Meals. Congregate Meals were developed by Lavender Seniors as a means of providing social support to LGBTQ seniors in Alameda County that had no access to social programs. Each meal is one hour followed by a one-hour educational, interactive, or entertaining presentation. Presentations include long-term and general healthcare information, story sharing or "Life Enrichment" stories, policy discussions, or entertainment from musicians or other artists. Locations include senior centers in Oakland, Fremont, and a church in San Leandro.

Friendly Visitors. The Friendly Visitors program provides visits, telephone support and shopping assistance for frail, isolated, and home-bound seniors by trained volunteers. Seniors in 24-hour care facilities can also receive this service. There are no qualifying parameters but the program targets low-income LGBTQ seniors over 60.

Volunteerism / civic engagement. Lavender Seniors is a volunteer-driven organization with a variety of opportunities, such as:

Friendly Visitor volunteers, panel speakers, newsletter writers, lunch and outreach event assistance. They also deploy volunteers to provide testimony at town hall meetings, hearings, city commission and council meetings, as well as engage in other advocacy efforts that protect the health and well-being of seniors.

The LGBT Center of the Desert

The Center is located in Palm Springs and provides community-based services to LGBTQ people in East Riverside County. The Center uses a model common among LGBTQ community centers, which is to offer some mental health assessment, time-limited counseling services, and referrals to other LGBTQ-sensitive community providers and agencies. Clients have access to a range of social, art and recreational, health education, substance use treatment/recovery support, benefits counseling, grief counseling and nutrition classes and a food bank program. The support and social groups are vital tools in keeping LGBTQ community members connected, while also providing invaluable support and information on community resources. These groups provide a safe space in which LGBTQ community members can gather with one another in an affirmative setting.

Older Adults. The model used at The Center was developed after a review of promising and community-defined practices being used by other LGBTQ older adult organizations around the United States. The program has a philosophy consistent with current emphases on healthy or positive aging, including an emphasis on older LGBTQ adults themselves developing the programs and services and, to a large extent, staffing them.

Services are provided outside of a traditional mental health clinic setting (in a community center), including individual, group and couples counseling, and are offered with the *Living a Healthy Life with Chronic Conditions: Chronic Disease Self-Management Program* for those for whom this is relevant. While not conducted as a research study, pre- and post-therapy levels of depression were evaluated using the PHQ-9, a depression symptom inventory. A summary of the first year's results were promising, with a significant majority of clients reporting clinically significant decreases in levels of depressive symptoms following treatment. Anecdotal reports suggest that offering *Living a Healthy Life with Chronic Conditions* is a useful adjunct to therapy for many clients, and large majorities of clients using services reported satisfaction with them.

SAGE Works is a course for lesbian, gay, bisexual and transgender older adults. The seven-week course is designed to provide in-depth instruction on how to increase one's competitive edge in the job market. The course covers job skills training, software proficiency, resume writing, interviewing, and job search strategies.

Youth. The Counseling Department sponsors a facilitated group for youth in need of support.

LGBTQ Youth Space

LGBTQ Youth Space is a safe, confidential and fun community drop-in center for LGBTQ young people in Santa Clara County. They serve LGBTQ and allied youth ages 13 to 25 with social, support and leadership development programs, as well as counseling, case management and psychiatry services.

Since the program's inception in 2009, it has served more than 1,000 young people from Santa Clara County and provided outreach visits to more than 25,000 youth and youth service providers. There have been measurable improvements for youth in terms of meeting counseling treatment goals. Anecdotal evidence of healthy transitions to adulthood are seen as youth learn to identify and express their boundaries and needs. Lastly, great improvements have been seen in social and communication skills when youth can access both individual counseling services and opportunity for social interaction with peers in the drop-in center.

Los Angeles Gay and Lesbian Center (LAGLC)

STOP DV— Partner Abuse/Domestic Violence Program. In 1988, LAGLC developed and began offering the first lesbian- and gay-specific domestic violence services in Southern California. In 2002, *STOP (Support, Treatment/Intervention, Outreach/Education, Prevention) Partner Abuse/Domestic Violence Program* was selected by the National Crime Prevention Council as one of the nation's most innovative programs that had been implemented to prevent domestic violence crimes.

STOP DV offers a multi-faceted, broad-based and comprehensive continuum of domestic violence services that address the unique and complex needs of LGBTQ individuals, families, and those in affiliated populations throughout the lifespan in the visible LGBTQ communities, ethnically underserved LGBTQ populations, and segments of LGBTQ communities who have traditionally been unserved. Reaching individuals

who experience isolation due to the multiple and complex barriers of domestic violence, fear of disclosure, ethnic diversity, and the geographic vastness of Southern California, STOP DV strives to foster an environment that provides intervention with sensitivity and cultural relevancy. Current services include:

- Empowerment/survivors' groups
- Specialized safety planning
- Court-approved batterers' intervention program
- Crisis intervention & counseling
- Brief and ongoing individual counseling
- Domestic violence prevention groups and workshops
- Referral to LGBTQ-sensitive shelters
- Referral to LGBTQ-specific legal services
- Advocacy with law enforcement, criminal justice personnel and agencies, service providers and others
- LGBTQ domestic violence training, education, and consultation

STOP DV also works in close collaboration with LAGLC's Domestic Violence Legal Advocacy Project (DVLAP). DVLAP offers court accompaniment and advocacy, documentation of domestic violence incidents, preparation of temporary restraining orders, and legal representation.

Senior Services. The Seniors Services department of LAGLC provides over 70 classes, workshops, field trips and special events every month to LGBTQ people and their allies in the greater Los Angeles region—all at little or no cost. The department is comprised of six full-time staff members, including two Case Managers, two Activities Coordinators, a Director and a Department Assistant. Seniors Services strives to create a safe, welcoming and respectful community where LGBTQ people age 50 and older can come together to learn, connect, build friendships, gain support and thrive. Services include health and wellness activities, intergenerational programming (Senior-Youth Photo Project, dinners and field trips), support groups, *Grupo en Espanol Social y de Apollo LGBT 50+*, and case management support.

Lyon-Martin Health Services

Lyon-Martin Health Services, founded in 1980 and located in San Francisco, is a provider of both primary and mental health services. They provide care to lesbians, women of color, low-income women, older

women, women with disabilities and transgender people. Lyon-Martin has also been at the forefront of educating other medical providers in lesbian and transgender health care issues.

Mental health. Lyon-Martin's philosophy is to offer a holistic approach to care, attempting to address the physical, emotional and psychological aspects of a patient's health. Their mental health providers closely collaborate with their medical providers to offer a range of services which support patients' emotional and psychological well-being. These services are affirmative, sex-positive, respectful and culturally sensitive.

Integrated behavioral health (IBH). Lyon-Martin has a dedicated staff of IBH specialists who assist individuals in finding community resources as well as providing brief, focused behavioral interventions. Both the mental and IBH programs are staffed with professionals who have expertise in gender transition and in lesbian, gay, bisexual, transgender, queer and questioning identities.

Gender Spectrum Group. The Gender Spectrum Group is a weekly therapy group that provides a safe, confidential group environment in which clients can build community, provide and receive feedback, and explore questions related to gender. It is open to all clients who identify as trans, genderqueer, gender nonconforming or are exploring their gender identity.

Native American Health Center

Native American Health Center has locations in Oakland, Richmond and San Francisco. They serve interracial and intertribal people of all ages, including those identifying as two-spirit. The Center uses the consistent approach to health and wellness for Native community that "culture is prevention."

Two-spirit Talking Circles. Two-spirit Talking Circles typically involve a more open discussion about two-spirit specific issues, such as homophobia, the ability to speak about partnerships, and a general sense that those present in the Talking Circle will not need clarification or education regarding topics being discussed. Additionally, Talking Circles usually are run by staff who are culturally affirming of two-spirit identity and know the impact of colonization on gender, sexuality, sexual orientation, and the loss of many cultural stories that were inclusive of all community members.

Traditional healing. Traditional healing includes varied cultural

and traditional tribal-based practices to improve behavioral health wellness. Traditional Healers who are chosen to work with two-spirit community have a culturally affirming stance with this population. There are specific Healers who offer a traditional perspective on two-spirit identity that significantly affirms two-spirit community members' experience of their long history of belonging in most communities. This experience for two-spirit community allows for a depth of healing and renewed sense of safety and belonging inside of their affiliation with their Native American community.

Two-spirit Gathering of Native Americans (GONA). Two-spirit GONA is limited to anyone who identifies as Native and LGBT/two-spirit so they can discuss and address substance abuse issues in a safe, welcoming and supportive space. The two-spirit GONA allows participants to talk about the impact of homophobia/biphobia/transphobia and the complexities of gender, sexual orientation and sexuality inside of a cultural context.

OC ACCEPT

OC ACCEPT (Orange County Acceptance through Compassionate Care, Empowerment, and Positive Transformation) provides community-based mental health and supportive services to individuals identifying as LGBTQ, as well as the people important in their lives. The program specializes in addressing issues such as isolation, grief and loss, depression, anxiety, suicidal thoughts, self-medicating with drugs and high risk behaviors, self-esteem challenges, victims of bullying, trauma, homelessness, and lack of familial support. OC ACCEPT seeks to provide a safe environment with acceptance and compassion for individuals to express their feelings, build resilience, become empowered and connected with others for support.

Our Circle

Our Circle—originally called *Circle of Friends*—was founded in 2001. Our Circle, now housed at the North County LGBTQ Resource Center, meets weekly, is free to attend and open to ages 14 to 24. Although not a therapy group, Our Circle has been facilitated by a dedicated LMFT for the past 11 years. The group is a friendly and casual gathering that allows members to share the highs and lows of their lives. The facilitator is present to provide support, answer questions, and to assist members with connecting to other support services if necessary.

Our Circle also provides information about helpful resources and support programs such as scholarship opportunities and retreats that are just for LGBTQ youth.

Our Family Coalition—Parent-Centered Collaborative

Our Family Coalition (OFC), located in San Francisco, offers LGBTQ parents programs and resources using a Parent-Centered Collaborative model. This model allows for effective engagement and community development where parents and caregivers are represented at every level of OFC program development and planning. LGBTQ parents can learn how to effectively address a wide-range of challenges specific to LGBTQ parenting, including homophobia in their children's school environment, rejection from their own parents or from their children, coming out to their kids about transitioning into a new gender, or questions about family formation, sperm donors, and family protections. Services provided at OFC include:

- Educational programming on both LGBTQ-specific and general parenting issues within an LGBTQ-sensitive environment
- Social forums and community-building events that facilitate the development of social support networks for LGBTQ parents and their children, and allow the children to see their families reflected in others around them
- Parent discussion groups that help build healthy parent support networks
- Parent leadership training to support advocacy for safe and welcoming environments for their children

OFC has also expanded its work to support youth with one or more LGBTQ parents to address challenges they face as a result of homophobia and heterosexism at school or in their communities. Regular community-building, empowerment activities, support and discussion groups, and public speaking skills development help reduce the isolation of youth from LGBTQ families and support them in advocating for themselves and their families.

All programs seek to develop relationships across time and activities so that LGBTQ parents build lasting peer relationships as they move through various programs, and children participate in activities together from childhood through adolescence. All of the programs are designed to increase knowledge of parenting and child development, and support children and youth in developing social and emotional competency.

Outlet

Outlet serves LGBTQ youth ages 13 to 24 in Santa Clara County. All staff and steering committee members are people who identify as part of the LGBTQ community. Support and social groups are age, language and culture appropriate, free and confidential for youth who identify as LGBTQ. Most youth who come to any of the support groups, including *De Ambiente*, have reported an increase in self-esteem, an increase in personal comfort with their sexual orientation and gender identity and decreased feelings of isolation.

De Ambiente. Created in 2007 as part of Outlet's core programming for LGBTQ youth, *De Ambiente* was originally formatted as an HIV and STD prevention program for young Latino men who preferred speaking Spanish. *De Ambiente* seeks to address the socio-cultural contextual factors that affect the risk for HIV and STDs among all LGBTQ Spanish-speaking youth by providing the space and the resources to empower youth and help them become agents for change.

Pacific Center for Human Growth

The Pacific Center, located in Berkeley, is the third oldest LGBTQ Center in the country. They offer culturally aware mental health counseling for young people and adults of all ages. All services are offered with an understanding and sensitivity to issues specific to LGBTQ communities.

Mental health services. All clinicians at the Pacific Center work on a yearly contract basis and are supervised by licensed clinicians who are members or allies of the LGBTQ community. Therapists include a wide range of age groups, backgrounds and ethnicities. Therapists at the Center not only have a strong desire to work with those in the LGBTQ community but have taken extra steps to be well-trained and sensitive to the concerns of those the Center serves.

Peer-support groups. The Pacific Center houses about 15 peer-support groups. Volunteers who are trained by clinical staff lead the support groups. These groups provide connection, support, information, and enjoyment.

Library. The Pacific Center has a great catalog of books that cover a range of topics for LGBTQ people. Books are lent to visitors based on an honor system. The library catalog has been put together entirely by donations and volunteer work.

LOUD (Loving Ourselves and Uniting Diversity). LOUD is an after-school program that provides a safe space and peer support for LGBTQ youth, their allies and friends. Each week youth gather, share laughter, meet new friends, share a snack, watch LGBTQ movies, or embark on field trips. Volunteer mentors and special guests from the LGBTQ community lead discussions ranging from dating and safe relationships, health and wellness, activism, dealing with issues at home, achieving at school, and responding to bullying. Mental health therapists also lead discussions and are available for one-on-one counseling for any youth and/or members of their families.

Safer School Speaker's Bureau. Youth have the opportunity to lead anti-bullying workshops in Berkeley and other Bay Area Schools, to provide outreach to and to invite other LGBTQ youth to the Center, and to share their coming out stories with their peers. Students and local educators have said hearing the personal stories, as well as personal interaction with Pacific Center youth, make the lives and experiences of LGBTQ youth more real than reading about them in a book.

Peer-Support Groups

Peer-support groups have been created out of a need to gather with other individuals whose sexual orientation and/or gender identity is similar to one's own in order to receive support for and affirmation of one's identity and experience. Peer-support groups can be found in various LGBTQ centers, programs and communities across California. Peer-support groups are usually led by nonprofessionals, but they may have a trained facilitator and/or a service provider affiliated with the group. Many are run solely through volunteer efforts. For many LGBTQ individuals, peer-support groups are often the first and sometimes the only contact they have with other LGBTQ community members. Anecdotal feedback shows that peer-support groups can be a vital and sometimes life-saving support for LGBTQ individuals. (For examples of specific peer-support groups, see individual programs listed in this section.)

The Rainbow Community Center of Contra Costa County

The Rainbow Community Center (RCC), located in Concord, provides an important base for the delivery of opportunities and services to members of LGBTQ communities in Contra Costa County. In partnership with the Contra Costa County Behavioral Health Services

Division, community-based services include:

Mental health and case management. Counseling services assist community members to meet personal and clinical goals, reduce isolation and/or develop positive identity development. Case management services provide advocacy to assist LGBTQ community members in accessing mainstream medical and social services. The program is staffed by two licensed clinicians with support from 12 mental health trainees and interns who are members or allies of the LGBTQ community.

Operation-Q. A youth center offering support groups, drop-in programming, one-on-one mentoring, and referral to on-site case management and counseling for LGBTQ youth and their allies. The program is staffed by "youth mentors," including graduates of the center's youth program and other young adults (20-26) who serve as mentors. Mentors are supervised by a youth director with MSW credentials.

LGBTQ Youth Advocacy Collaborative. The collaborative is using a service model that is grounded in an Appreciative Inquiry/ Community-Based Participatory Research (CBPR) investigation. They have developed a community-based partnership that includes participation from over two dozen local churches, schools, mental health centers and community-based agencies. They are using concepts from the Family Acceptance Project (FAP) to highlight the impact of rejection on LGBTQ youth. They have expanded the FAP model beyond the family to incorporate social settings—addressing policy and practice changes within schools, faith-based and mainstream social service and medical-based settings.

Senior programming. Specialized services include congregate meals, home visitors, social and support groups, food pantry, case management/advocacy. Case management and advocacy focus on rebuilding of social networks among LGBTQ seniors, with phone-based groups to reach shut-ins.

Stand-in-Pride. A collaboration with two local agencies that is funded to address intimate partner violence, sexual assault and/or hate crimes targeting LGBTQ community members. The project includes ongoing cultural competency trainings with local law enforcement agencies and within the county's domestic violence shelter and the local rape crisis center.

Everything Under the Rainbow. Provides a community job training program housed within the RCC's thrift store. The project is

designed to provide on-site support for gender-variant and young adults at risk for homelessness and sexual exploitation.

Rainbow Pride Youth Alliance—Q*Camp

The Rainbow Pride Youth Alliance (RPYA) is a non-profit organization dedicated to addressing the needs of LGBTQ youth in San Bernardino and Riverside counties.

Q*Camp. RPYA's Q*Camp provides the opportunity for LGBTQ young people to create networks and bonds that can assist the youth of the Inland Empire in combating homophobia. It also provides them with tools to make healthier choices and encourage their peers to do the same. The camp holds collective education programs, workshops, self-esteem building, and team-building activities that further a young person's understanding of themselves, their sexuality, their peers, and the greater community, as well as create a better understanding of how to access mental and physical health care. Evaluations of Q*Camp show 97.3% of participants indicated the camp made them more confident in their ability to plan and accomplish their goals and 89.2% of participants reported feeling more comfortable taking on a leadership role in a Gay-Straight Alliance organization.

Sacramento City Unified School District LGBTQ Support Services

These services are specifically provided to LGBTQ students under the umbrella of services offered through the Connect Center's LGBTQ Supportive Services division. Services are primarily provided by the district's LGBTQ Focus Intern, who has been specifically trained to identify and meet the needs of LGBTQ students. The LGBTQ Focus Intern is supervised by a licensed mental health professional who is knowledgeable regarding the unique needs of LGBTQ students. Since the program's inception, several success stories have lead the district to believe this program is beneficial. The program provides a comprehensive approach to supporting LGBTQ students, families and staff through four areas of focus:

Mentoring and youth leadership. Sacramento City Unified School District (SCUSD) works closely with students and faculty through the Gay-Straight Alliances (GSA) at high schools and middle schools to support their efforts in creating safer and more accepting schools. A half-time Youth Advocate visits GSAs to identify their needs, communicate

important information and assist where needed. The Youth Advocate may also provide mentoring to students on specific issues of concern and connect them with additional resources if needed.

Counseling, support and consultation. Through the SCUSD Connect Center, LGBTQ students and their families are offered culturally-responsive support services, which may include short-term counseling, case management and school-based intervention. When longer term counseling is needed, referrals will be made to appropriate community mental health providers. Connect Center staff also provide consultation to school staff on issues of concern to LGBTQ students to assist them in responding appropriately and sensitively.

Policy development and advocacy. In conjunction with the district's LGBT Task Force, the LGBTQ Support Services program identifies school, district and state-wide policy issues that affect LGBTQ students and works to address these issues systematically.

Education, training and awareness. The LGBTQ Support Services program provides training to school staff, community professionals and parents on a wide range of LGBTQ topics. Training is offered through an annual conference and periodic workshops co-hosted with community partners. In addition, the program seeks to raise awareness of the needs of LGBTQ students by promoting events such as Harvey Milk Day, the Day of Silence and others throughout the school community. The program also works in conjunction with the district's academic office to provide resources to help support the teaching of LGBTQ history as per the FAIR Education Act.

The Sisters of Perpetual Indulgence, Inc. (San Francisco)

The Sisters have been dedicated since 1979 to promoting joyful equality of opportunity and experience within the LGBTQ community and beyond. They serve LGBTQ minority urban youth, homeless queer youth, urban Trans community, gay and bisexual men, men who have sex with men, lesbian and bisexual women, queer, questioning and intersex youth, sex workers, LGBTQ seniors and HIV-positive men and women.

Personal Practice Discussions. Facilitated by members of the Sisters of Perpetual Indulgence at the San Francisco LGBTQ Center, these monthly drop-in sessions focus on how individual belief systems can be harnessed to reinforce positive self-images and encourage behavior which promotes harm reduction and relationship building. The

program offers a safe space in which individuals find encouragement to understand their own belief system without judgment and develop self-respect and appreciation for their own unique world view.

Harm Reduction Ministry. Sisters and members have developed information cards using wit and street vernacular to promote re-engagement with practices that promote harm reduction for sexually active members of LGBTQ communities. The cards offer a swift and easy way to engage people on the streets, in bars and in clubs, creating a safe and humorous way to open conversations about safer-sex practices and self-esteem. In these brief sessions, Sisters offer a supportive voice and can provide referral to important Web-based and community-based services including HIV testing at the Magnet Clinic in the Castro neighborhood.

Stop the Violence Campaign. Recognizing an increase in crime and hate crime violence within San Francisco, the Sisters partnered with local neighborhood watch patrols, the Mission District Police Division and the City of San Francisco to develop a street-level response to these assaults, promoting personal safety awareness, community action and empowerment. "Flyering," bar-cards, and free safety whistles are distributed broadly through the community. Sisters have collaborated with the local police division to introduce police officers to the community. Sisters also encourage community members to see police officers as part of the community, and as safety partners that can be trusted and called upon when a situation seems unsafe. The program recognizes the particular danger of hate crimes to the LGBTQ community and has fostered relationships with openly LGBTQ police offers to reinforce connections.

Play Fair 2012. Partnering with community and City health agencies, the Sisters are updating the groundbreaking "Play Fair" information guide first published in 1982 as a response to HIV and AIDS. The new guide features up-to-date information about harm reduction techniques, treatment information and information about how best to avoid HIV infection, and to remain healthy if infected with HIV.

Transgender Program Medicine and the Behavioral Health Program—Children's Hospital Los Angeles

In 1996, the Children's Hospital Los Angeles (CHLA) Division of Adolescent Medicine began to provide comprehensive services in

response to the needs of trans youth who came to the drop-in free clinic for services. It has evolved into one of the largest clinics in the United States providing trans-affirming community-based services to trans youth. CHLA is part of the Los Angeles Transgender Service Providers Network (TSPN)—a collaborative of providers and consumers who advocate for fair and balanced community-based services for trans people.

Trans-affirming care. A wide range of interdisciplinary services is provided to trans youth (up to 25 years old) that emphasize acceptance, understanding, affirmation, safe and supportive care. Some staff members openly identify as either transgender, gay or lesbian and act as positive role models and peer support for youth who are currently struggling with transitioning or disclosure issues.

The Division of Adolescent Medicine provides comprehensive care and support services specifically designed for transgender-identified youth, as well as gender-variant, gender-questioning, and gender-spectrum children, adolescents and young adults through the age of 25. Care is provided by a team of physicians, psychologists, social workers, nurses, case managers and health educators.

Gender-sensitive services include:

- Consultations with gender specialists
- Hormone therapy for youth interested in transitioning their bodies
- General medical care for adolescents and young adults.

Mental health services include:

- Initial mental health and gender identity assessment
- Individual therapy
- Group therapy
- Advocacy/consultation
- Interdisciplinary collaboration with physicians, nurses, and case managers

Trans-affirming mental health and medical care are considered promising practices by CHLA staff and other providers around the world. Dr. Jo Olson, of CHLA, has secured research funding to examine the outcomes for youth utilizing transgender care, including trans-affirming mental health services. In addition, CHLA is developing an assessment tool which will help provide empirical evidence of the validity of trans-affirming care.

Trevor Project

The Trevor Project is a national organization providing crisis intervention and suicide prevention services to LGBTQ youth ages 13 through 24. Trevor's mission is to end suicide among LGBTQ youth by providing life-saving and life-affirming resources including a nationwide, 24/7 crisis intervention lifeline, digital community and advocacy/educational programs that create a safe, supportive and positive environment for everyone. Resources offered include the following:

The Trevor Lifeline. The Trevor Lifeline is the only nationwide, around-the-clock suicide prevention and crisis intervention lifeline for LGBTQ youth. It is a free and confidential service open 24/7 that offers young people hope and someone to talk to. The Trevor Lifeline has achieved professional recognition from the American Association of Suicidology, which granted the program the highest level of accreditation.

Trevor Space. Trevor Space is an online, social networking community for LGBTQ youth ages 13 through 24, their friends and allies.

Trevor Chat. Trevor Chat is a free, confidential, secure online messaging service that provides live help to young LGBTQ not at risk for suicide. It's available Mondays and Fridays between the hours of 1:00 PM Pacific (4:00 PM Eastern) and 7:00 PM Pacific (9:00 PM Eastern).

Ask Trevor. Ask Trevor is an online, non-time sensitive question and answer resource for young people with questions surrounding sexual orientation and gender identity.

Team Trevor Lifeguard Workshops. The Trevor Lifeguard Workshop Program uses a structured, age-appropriate curriculum with trained facilitators to address topics including sexual orientation and gender identity, the impacts of language and behavior on LGBTQ youth and suicide prevention skills in schools.

University of California, Riverside LGBT Resource Center

The LGBT Resource Center of the University of California, Riverside (UCR) primarily serves LGBTQ college students. They also provide services and support to faculty, staff and straight allies.

Peer Connections. An anonymous and confidential online peer chat and mentor program staffed by peer trained mentors who are knowledgeable about coming out issues, and the intersections of race, culture, sexual orientation, gender, class, etc. Mentors are UCR students and include LGBTQ-identified people as well as allies.

Allies Safe Zone & Trans Allies. A network of UCR students, staff and faculty who are supportive of LGBTQ people and anyone dealing with sexual orientation or gender identity issues. Allies attend a 3-hour training seminar on the benefits and responsibilities of becoming an ally.

Tuesday Talks. Tuesday Talks are weekly peer-support groups facilitated by a staff member. Students are not given counseling, but a safe and supportive space to make connections and find support.

Pride Prom. An annual event for local high school students hosted by UCR which begins with an educational workshop on the LGBTQ college student experience and finishes with a safe and inclusive prom dance experience.

T-Camp: An InterCampus Retreat for Trans/Genderqueer and Gender Questioning (TGQQ) College Students. A 3-day retreat which brings together TGQQ students from 17 campuses in California. It is the first retreat of its kind in the nation.

Glossary

Androgynous: Having characteristics or behaviors that are common to both men and women.

Biphobia: Comparable to homophobia, but specifically referring to anti-bisexual prejudice.

Bisexual: A person, adult or youth, who is emotionally, physically, romantically and erotically attracted in varying degrees to persons of the same or different sexes and/or genders.

Boi: A male-identified, female bodied person. May also refer to masculine lesbian identities (e.g. tomboy, stud, butch).

Boy: A male child or youth.

Gay male: An adult male or male youth who is predominantly or exclusively emotionally, physically, romantically and erotically attracted to other males.

Gender: The set of attributes society labels as masculine, feminine, or androgynous (or other terms associated with "in-between" states). These attributes may vary over time and between cultures; often (incorrectly) used to refer to a person's sex.

Gender-diverse: see gender nonconforming

Gender expression: How a person externally expresses their gender to others; this may or may not reflect the person's gender identity. A person's gender expression does not denote their sexual orientation, although gender expression—particularly when perceived as gender nonconforming—is often mistakenly used as an indicator of sexual orientation.

Gender identity: A person's internal sense of themselves as male, female, or something in-between. A person may identify as male, female, a combination of male and female, somewhere in-between, or they may have a gender identity which cannot be accurately verbalized. A person's gender identity may or may not be congruent with their biological sex, society's perception of their gender, their assigned gender role, or their gender expression (J. Green, 2000).

Gender nonconforming: Refers to people who do not follow society's expectations or stereotypes (whether deliberately or involuntarily) regarding how they should look or act based on the sex they were assigned at birth (Silvia Rivera Law Project, n.d.). The term reflects the interactive nature of gender perception, its dependence on stereotypes, and alludes to the problems that can arise for individuals because of it. For some people (but not all) gender nonconforming implies agency in the act of refusing or not caring whether one conforms or not.

Genderqueer: A catch-all term for gender identities other than man and woman, thus outside of the gender binary and heteronormativity. People who identify as genderqueer may think of themselves as one or more of the following:

1. both man and woman (bigender, pangender);
2. neither man nor woman (genderless, agender);
3. moving between genders (genderfluid);
4. third gender or other-gendered; includes those who do not place a name to their gender;
5. having an overlap of, or blurred lines between, gender identity and sexual orientation.
6. Some genderqueer people also identify as transgender, and may or may not wish for physical

modification or hormones to suit their preferred expression (Wikipedia, 2012).

Gender spectrum: Western culture has come to view gender as a binary concept, with two rigidly fixed options: male or female. Rather than just two distinct boxes, biological gender occurs across a continuum of possibilities. This spectrum of anatomical variations by itself should be enough to disregard the simplistic notion of only two genders. But beyond anatomy, there are multiple domains defining gender. In turn, these domains can be independently characterized across a range of possibilities. Instead of the static, binary model produced through a solely physical understanding of gender, a far more rich texture of biology, gender expression, and gender identity intersect in multidimensional array of possibilities. Quite simply, the gender spectrum represents a more nuanced, and ultimately truly authentic model of human gender (Gender Spectrum, 2012).

Gender role: The "culturally determined behaviors expected of men and women" (Lev, 2004, p. 84) which are dictated and reinforced by society, and may vary over time and between cultures.

Gender-variant: see gender nonconforming

Girl: A female child or youth.

Heterosexual: A person, adult or youth, who is predominantly or exclusively emotionally, physically, romantically and erotically attracted to persons of another sex or gender identity.

Homonegative: Negative views of gay men and lesbians based on traditional moral and religious beliefs and misconceptions about homosexuality (M. A. Morrison & Morrison, 2002).

Intersex: Intersex is a socially constructed category that reflects biological variation. The natural spectrum of sex anatomy includes body parts that vary in size, shape and morphology. Natural variations also include sex chromosomes. The sex categories of male and female, and sometimes intersex, are generalizations that simplify social interactions, but tend to erase variations (Intersex Society of North America, 2008).

Heterocentric: Comparable to the term ethnocentric, viewing heterosexuality as primary and assumed.

Heterosexism: Comparable to racism and sexism, heterosexism is a "set of beliefs that heterosexuality…is normal, natural, and superior to homosexuality" (Lev, 2004, p. 397). As a social system, heterosexism subjugates LGBTQ people.

Homophobia: Although implied in the direct translation of the word, "homophobia seldom refers to a phobic or fearful response. Often, though, it is used to indicate anti-homosexuality prejudice" (Ritter & Terndrup, 2002, p. 12).

Lesbian: An adult female or female youth who is predominantly or exclusively emotionally, physically, romantically and erotically attracted to other females.

LGBTQ: Represents lesbians, gay males, bisexuals, transgender and transsexual persons, and queer or questioning persons when addressed as a group rather than as individual sexual or gender minorities. Various versions of this acronym are used, depending on the populations referred to. For example, LGBQ refers to lesbian, gay, bisexual, queer and questioning—but not to transgender or transsexual.

Man: An adult male-identified person.

MSM: Acronym for men who have sex with men. Often used as a behavioral description for those men who do

not attribute this behavior to a sexual orientation identity.

Pansexual: A person, adult or youth, who is emotionally, physically, romantically and erotically attracted in varying degrees to others regardless of their gender identity or sex assigned at birth. *See also bisexual.*

Queer: Used as an umbrella identity term encompassing lesbians, gay men, bisexual people, questioning people, non-labeling people, transgender people, and anyone else who does not strictly identify as heterosexual. "Queer" originated as a derogatory word. Currently, it is being reclaimed by some people and used as a statement of empowerment. Some people identify as "queer" to distance themselves from the rigid categorization of "straight" and "gay"(International Spectrum, n.d.). Not all individuals embrace this term and some—particularly older adults—may find it offensive.

Questioning: A person who is in the process of exploration and is unsure about their sexual orientation or gender identity. Although practice literature has increasingly included "questioning" as a category related to LGBT populations, little is known about youth or adults who are questioning their sexual orientation or gender identity and this category has not been validated empirically (Hollander, 2000; Ryan & Chen-Hayes, in press). "Questioning" is not a sexual orientation, although some authors may incorrectly use it as such. This point is relevant to the discussion of research related to LGBT youth and families, which has focused on established identities and parental/caregiver behaviors that can be measured, rather than unexpressed feelings or self-perceptions that have not been empirically defined (C. Ryan, personal communication, July 7, 2010).

Sex: The anatomical and biological factors that are used to categorize someone as male or female.

Sexual minority: Refers to people who identify as gay, lesbian, bisexual/pansexual, queer or other non-heterosexual identity, or who are emotionally, physically, romantically and erotically attracted to persons of the same sex and/or gender.

Sexual orientation: A term which refers to the gender or genders and sex or sexes to which an individual is "emotionally, physically, romantically, and erotically attracted" (Carroll, Gilroy, & Ryan, 2002).

Important note on transgender-related terminology:

Transgender terminology is relatively new, extremely subjective, and rapidly evolving. There are many nuances associated with identity-related terms, and it is very possible that clinicians will meet clients who do not identify with the terms as defined below. According to clinical advisories from the Center of Excellence for Transgender Health at the University of California, San Francisco, when working with transgender clients, the most important principle to remember is to respect each client's self-definition, as well as respect and use the terms each client prefers.

Trans people (also transpeople or trans person/transperson). Some trans people prefer to combine the adjective "trans" with the noun as a political statement that they are claiming their trans experience; others prefer the adjective to be separate from the noun to signify that their trans history is not their primary identity. Some people who have transgender or transsexual histories prefer to be known as the men or

women that they presently are, and do not identify with a "trans" descriptor, though they may offer it as an indicator of their physical history, particularly when this information may be relevant (such as in medical settings).

Trans Spectrum: For the purposes of this report, Trans Spectrum refers to those Community Survey participants whose reported gender identity did not match their assigned birth sex.

Transgender: Transgender is a community-based term (in opposition to medical and psychiatric terms) which describes a "range of behaviors, expressions, and identifications that challenge the pervasive gender [binary] system in a given culture" (Carroll, et al., 2002, p. 139). Transgender individuals encompass a wide range on the gender spectrum, and though grouped together under one term, should not be assumed to identify or express their gender in any uniform manner. Refers to individuals who cross or transcend culturally defined categories of gender (Bockting, 1999).

Transman (also trans man; see also trans people). Describes people who were assigned female at birth and who are now living as men (sometimes referred to as Female-to-Male or FTM, to describe their physical trajectory if they are engaged in a medical/physical transition).

Transphobia: Comparable to homophobia, but specifically referring to anti-transgender or anti-transsexual prejudice; can be manifested through aversion and even sudden, unprovoked violence toward a transgender person; may also refer to a fear of change in sex or gender, which are often presumed to be stable categories, where the perceived instability is frightening; (internalized) the fear of being or being perceived as transgender or transsexual.

Transsexual: A medical term describing individuals who strongly feel their gender identity does not correspond with their sex assigned at birth, who identify with another sex, and who generally wish to live full time in their preferred gender role. Transsexual people often, but not always, seek medical intervention and legal recognition in order to live as their experienced gender. Transsexual people may or may not also consider themselves transgender.

Transwoman (also trans woman; see also trans people). Describes people who were assigned male at birth and who are now living as women (sometimes referred to as Male-to-Female, or MTF, to describe their physical trajectory, if they are engaged in a medical/physical transition).

Two-spirit: Adopted in 1990 at the third annual spiritual gathering of LGBT Natives, the term derives from the northern Algonquin word niizh manitoag, meaning "two-spirits," and refers to the inclusion of both feminine and masculine components in one individual (Anguksuar, 1997, as cited in Institute of Medicine, 2011).

Woman: An adult female-identified person.

References

Abraham, F. (1997). Genital reassignment on two male transvestites. *The International Journal of Transgenderism, 2*(1). Retrieved October 19, 2008 from http://www.symposion.com/ijt/ijtc0302.htm

Administration on Aging. (2001). *The many faces of aging: Lesbian, gay, bisexual and transgender older persons*. Washington, D.C.

Aguilar-Gaxiola, S., Loera, G., Mendez, L., Sala, M., Latino Mental Health Concilio, & Nakamoto, J. (2012). *Community-defined solutions for Latino mental health care disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup population report.* Sacramento, CA: UC Davis.

Alexander, C. J. (1998). Treatment planning for gay and lesbian clients. *Journal of Gay & Lesbian Social Services, 8*(4), 95-106.

Alexander, C. J. (2002). Homosexuality and risk for psychiatric disorders. *Journal of Gay & Lesbian Social Services, 14*(3), 103-107.

American Academy of Pediatrics. (2004). Position statement: Ensuring culturally effective pediatric care: Implications for education and health policy. *Pediatrics, 114*(6), 1677-1685.

American Psychiatric Association. (1973). *Homosexuality and sexual orientation disturbance: Proposed change in DSM-II, 6th printing, page 44: Position statement (retired).* Retrieved October 2, 2008, from http://www.psychiatryonline.com/DSMPDF/DSM-II_Homosexuality_Revision.pdf

American Psychiatric Association. (1992). *Homosexuality: Position statement.* Retrieved October 12, 2008, from www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/199216.aspx

American Psychiatric Association. (2000a). *Diagnostic and statistical manual of mental disorders* (4th ed., Text revision). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2000b). *Therapies focused on attempts to change sexual orientation (reparative or conversion therapies): Position statement.* Retrieved October 13, 2008, from http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200001.aspx

American Psychiatric Association. (2011). DSM-5: The future of psychiatric diagnosis. Retrieved from http://www.dsm5.org/Pages/Default.aspx

American Psychological Association. (1996). *Violence and the Family: Report of the American Psychological Association Presidential Task Force on Violence and the Family.* Washington, D.C.: American Psychological Association.

American Psychological Association. (2000). Guideline for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist, 55*(12), 1440-1451.

American Psychological Association. (2008). *Guidelines for psychotherapy with lesbian, gay, & bisexual clients.* Retrieved October 12, 2008, from http://www.apa.org/pi/lgbc/guidelines.html

American Psychological Association Council of Representatives. (1997). *Resolution on appropriate therapeutic responses to sexual orientation.* Retrieved October 13, 2008, from http://www.apa.org/pi/sexual.html

Amezcua, T., Chestnut, S., Dixon, E., Jindasurat, C., Ahmed, N., Frazer, S., & Rodkin, J. (2012). *Lesbian, gay, bisexual, transgender, queer, & HIV-affected intimate partner violence, 2011.* New York: National Coalition of Anti-Violence Programs.

Arana, G. (2012, April 11). My so-called ex-gay life. *The American Prospect*. Retrieved from http://prospect.org/article/my-so-called-ex-gay-life.

Arm, J. R., Horne, S. G., & Levitt, H. M. (2009). Negotiating connection to GLBT experience: Family members' experience of anti-GLBT movements and policies. *Journal of Counseling Psychology, 56*(1), 82-96.

Badgett, M. V. L. (2000). The myth of gay & lesbian affluence. *The Gay & Lesbian Review, 7*(2), 22-25.

Bailey, J. M. (2004). *The man who would be queen: The science of gender-bending and transsexualism*. Washington, D.C.: Joseph Henry Press.

Battle, J., & Crum, M. (2007). Black LGB health and wellbeing. In I. H. Meyer & Northridge M. (Eds.) *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (pp. 320-353). New York: Springer.

Bartlett, N. H., Vassey, P. L., & Bukowski, W. M. (2000). Is gender identity disorder in children a mental disorder? *Sex Roles, 43*(11/12), 753-785.

Beck, A. J., Harrison, P., & Guerino, P. (2010). Sexual victimization in juvenile facilities reported by youth, 2008-09 (BJS Publication No. NCJ 228416). Washington, DC. Retrieved from http://bjs.ojp.usdoj.gov/content/pub/pdf/svjfry09.pdf

Benjamin, H. (1966). *The Transsexual Phenomenon.* New York: Warner Books.

Berkman, C. S., & Zinberg, G. (1997). Homophobia and heterosexism in social workers. *Social Work, 42*(4), 319-332.

Bettinger, M. (2004). A systems approach to sex therapy with gay male couples. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples,* (pp. 65-74). New York: Haworth Press.

Bieschke, K. J., McClanahan, M., Tozer, E., Grzegorek, J. L., & Park, J. (2000). Programmatic research on the treatment of lesbian, gay, and bisexual clients: The past, the present, and the course for the future. In R. M. Perez, K. A. DeBord & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients,* (pp. 309-335). Washington, DC: American Psychological Association.

Bith-Melander, P., Sheoran, B., Sheth, L., Bermudez, C., Drone, J., Wood, W., Schroeder, K. (2010). Understanding Sociocultural and Psychological Factors Affecting Transgender People of Color in San Francisco. *Journal of the Association of Nurses in AIDS Care*, *21*(2), 207-220. doi:10.1016/j.jana.2010.01.008

Boehmer, U. (2002). Twenty years of public health research: Inclusion of lesbian, gay, bisexual, and transgender populations. *American Journal of Public Health, 92*(7), 1125-1130.

Bologna, M. J., Waterman, C. K., & Dawson, L. J. (1987). *Violence in gay male and lesbian relationships: Implications for practitioners and policy makers.* Paper presented at the Third National Conference for Family Violence Researchers, Durham, NH.

Bontempo, K. E., & D'Augelli, A. R. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health, 30*(5), 364-374.

Bostwick, W. B., Hughes, T. L., & Johnson, T. (2005). The co-occurrence of depression and alcohol dependence symptoms in a community sample of lesbians. In E. Ettorre (Ed.), *Making lesbians visible in the substance use field,* (pp. 7-18). New York: Harrington Park Press.

Boysen, G., Vogel, D., Madon, S., & Wester, S. R. (2006). Mental health stereotypes about gay men. *Sex Roles*, *54*(1/2), 69-82.

Bradford, M. (2004). Bisexual issues in same-sex couple therapy. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples,* (pp. 43-52). New York: Haworth Press.

Bradford, M. (2006). Affirmative psychotherapy with bisexual women. In R. C. Fox (Ed.), *Affirmative psychotherapy with bisexual women and bisexual men,* (pp. 13-25). New York: Harrington Park Press.

Breiner, S. (n.d). *Transsexuality Explained*. Retrieved from http://narth.com/docs.transexpl.htm

Brill, S. & Pepper, R. (2008) *The transgender child: A handbook for parents and professionals*, San Francisco, Cleis Press, Inc.

Brooks, V. R. (1981). *Minority stress and lesbian women.* Lexington, Massachusetts: Lexington Books.

Brown, L. S. (1996). Preventing heterosexism and bias in psychotherapy and counseling. In E. D. Rothblum & L. A. Bond (Eds.), *Preventing heterosexism and homophobia* (pp. 36-58). Thousand Oaks, CA: Sage Publications.

Brownlie, E. B. (2006). Young adults' construction of gender conformity and nonconformity: A Q methodological study. *Feminism & Psychology, 16*(3), 289-306.

Burack, C., & Josephson, J. J. (2005). A report from "Love Won Out: Addressing, understanding, and preventing homosexuality" *Minneapolis, Minnesota*, September 18, 2004. New York: National Gay and Lesbian Task Force Policy Institute. Retrieved from http://www.thetaskforce.org/downloads/reports/reports/LoveWonOut.pdf

Burdge, H., Sinclair, K., Laub, C., Russell, S. T. (2012). *Lessons that matter: LGBTQ inclusivity and school safety.* (Gay-Straight Alliance Network and California Safe Schools Coalition Research Brief No. 14). San Francisco, CA: Gay-Straight Alliance Network.

Burke, P. (1996). *Gender shock: Exploding the myths of male and female*. New York: Anchor Books.

Burke, L. K., & Follingstad, E. R. (1999). Violence in lesbian and gay relationships: Theory, prevalence, and correlational factors. *Clinical Psychology Review, 19*(5), 487-512.

Burgess, C. (1999). Internal and external stress factors associated with the identity development of transgendered youth. In G. P. Mallon (Ed.), *Social services with transgendered youth* (35-47). New York: Harrington Park Press.

Burgess, C. (2000). Internal and external stress factors associated with the identity development of transgendered youth. *Journal of Gay & Lesbian Social Services*, *10*(3-4), 35-47.

Buxton, A. (2006). Healing an invisible minority: How the Straight Spouse Network has become the prime source of support for those in mixed-orientation marriages. In J. J. Bigner & A. R. Gottlieb (Eds.), *Interventions with families of gay, lesbian, bisexual, and transgender people: From the inside out,* (pp. 49-92). New York: Harrington Park Press.

Cahill, S. (2000). Preface. In P. Currah & S. Minter (Authors), *Transgender equality: A handbook for activists and policymakers* (pp. iii-iv). New York: The National Gay and Lesbian Task Force Policy Institute. Retrieved from http://www.thetaskforce.org/downloads/reports/reports/TransgenderEquality.pdf

California Department of Mental Health. (2008). *Definitions for consideration.* (California mental health stigma & discrimination reduction advisory committee). Retrieved from http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec2/DefinitionsStigmaDiscr.pdf

California Department of Mental Health. (2010, January). *California Reducing Disparities Project* [Fact sheet]. Retrieved from http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp#CRDPDownloads

California Department of Public Health. (2011). *HIV/AID surveillance in California*. Retrieved from www.cdph.ca.gov/programs/aids/Documents/SSSemiAnnualRptJun2011.pdf

California Health Interview Survey. (2003). CHIS 2003. AI/AN Binge Drinking. Los Angeles, CA: UCLA Center for Health Policy Research.

California Health Interview Survey. (2009). CHIS 2009. AskCHIS [data file]. Accessed May 2012. Los Angeles, CA: UCLA Center for Health Policy Research.

California Safe Schools Coalition, A Project of the Tides Center. (2005). *District Policies and Trainings* (California Safe Schools Coalition Research Brief). San Francisco, CA: California Safe Schools Coalition. Retrieved from http://www.casafeschools.org/DistPolFACTSHEET_rev1a.pdf

Carey, B. (2012, May 18). Psychiatry Giant Sorry for Backing Gay 'Cure'. *The New York Times*. Retrieved from http://www.nytimes.com/2012/05/19/health/dr-robert-l-spitzer-noted-psychiatrist-apologizes-for-study-on-gay-cure.html?_r=1&pagewanted=all

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling & Development, 80*(2), 131-139.

Carter, D. (2004). *Stonewall: The riots that sparked a gay revolution.* St. Martin's Press.

Centers for Disease Control. (2008, August). *HIV/AIDS among American Indian and Alaska Natives* [Fact sheet]. Retrieved from http://www.cdc.gov/hiv/resources/factsheets/PDF/aian.pdf

Chu, J. P., & Sue, S. (2011). Asian American mental health: What we know and what we don't know. *Online Readings in Psychology and Culture, Unit 3.* Retrieved from http://scholarworks.gvsu.edu/orpc/vol3/iss1/4

Chung, B., & Katayama, M. (1998). Ethnic and sexual identity development of Asian American and gay adolescents. *Professional School Counseling*, *1*(3), 21-25.

Chung, H. (2002). The challenges of providing behavioral treatment to Asian Americans: Identifying the challenges is the first step in overcoming them. *West J Med. 176*(4): 222–223. PMCID: PMC1071732

Cianciotto, J., & Cahill, S. (2003). Education policy: Issues affecting lesbian, gay, bisexual, and transgender youth. New York: The National Gay and Lesbian Task Force Policy Institute. Retrieved from http://www.thetaskforce.org/downloads/reports/reports/EducationPolicy.pdf

Clarke, T. J., & Russell, S. T. (2009). School Safety and Academic Achievement. (California Safe Schools Coalition Research Brief No. 7). San Francisco, CA: California Safe Schools Coalition. Retrieved from http://www.casafeschools.org/FactSheet7final.pdf

CNN Wire Staff. (2012, May 11). North Carolina passes same-sex marriage ban, CNN projects. *CNN Politics.* Retrieved from www.cnn.com

Cochran, S. D., & Mays, V. M. (2006). Estimating prevalence of mental and substance-using disorders among lesbians and gay men from existing national health data. In A.M. Omoto & H. S. Kurtzman (Eds.), *Sexual orientation and mental health,* (pp. 143-165). Washington, DC: American Psychological Association.

Cochran, S. D., Mays, V. M., Alegria, M., Ortega, A. N., & Takeuchi, D. (2007). Mental health and substance use disorders among Latino and Asian American lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology*, *75*(5), 785-794.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Counseling and Clinical Psychology, 71*(1), 53-61.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., … Zucker, K. (2011). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. Minneapolis: World Professional Association for Transgender Health (WPATH). Retrieved from http://www.wpath.org/documents/SOC%20V7%2003-17-12.pdf

Coleman, V. E. (1991). Violence in lesbian couples: A between groups comparison. (Doctoral dissertation, California School of Professional Psychology, Los Angeles, 1990). *Dissertation Abstracts International 51,* 5634B.

Coleman, V. E. (1994). Lesbian battering: The relationship between personality and the perpetration of violence. *Violence and Victims, 9*(2), 139-152.

Collins, J. F. (2004). The intersection of race and bisexuality: A critical overview of the literature and past, present, and future directions of the "borderlands". In R. C. Fox (Ed.), *Current research on bisexuality,* (pp. 99-116). New York: Harrington Park Press.

Connolly, C. M. (2004). Clinical issues with same-sex couples: a review of the literature. In J. J. Bigner & J. L Wetchler (Eds.), *Relationship therapy with same-sex couples* (pp. 3-12). New York: The Haworth Press.

Cook-Daniels, L. (2006). Trans aging. In K. Kimmel, T. Rose & S. David (Eds.), *Lesbian, gay, bisexual, and transgender aging* (pp. 21-35). New York: Oxford University Press.

Courvant, D. & Cook-Daniels, L. (1998). *Trans and intersex survivors of domestic violence: Defining terms, barriers and responsibilities*. Portland, OR: Survivors Project.

Corliss, H. L., Grella, C. E., Mays, V. M., & Cochran, S. D. (2006). Drug use, drug severity, and help-seeking behaviors of lesbian and bisexual women. *Journal of Women's Health*, *15*(5), 556-568.

Corliss, H., Belzer, M., Forbes, C., & Wilson, E. C. (2007). An evaluation of service utilization among male to female transgender youth: Qualitative study of a clinic-based sample, *Journal of LGBT Health Research*, *3*(2), 49-61.

Council on Social Work Education. (1994). *CSWE curriculum policy statement.* Retrieved October 13, 2008, from http://www.apsu.edu/socialwork/cswe_policy.htm

Crisp, C. (2006). The Gay Affirmative Practice Scale (GAP): A new measure for assessing cultural competence with gay and lesbian clients. *Social Work, 51*(1), 115-126.

D'Augelli, A. R. (2006). Developmental and contextual factors and mental health among lesbian, gay, and bisexual youths. In A. M. Omoto & H. S. Kurtzman (Eds.), *Sexual orientation and mental health,* (pp. 37-53). Washington, DC: American Psychological Association.

D'Augelli, A. R., Grossman, A. H., Hershberger, S. L., & O'Connell, T. S. (2001). Aspects of mental health among older lesbian, gay, and bisexual adults. *Aging & Mental Health, 5*(2), 149-158.

D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence, 21*(11), 1462-1482.

Dana, R. H., Gamst, C.G., Der-Karabetian, A. (2008). *CBMCS multicultural training program*. Thousand Oaks, CA: Sage Publications, Inc.

Dang, A. & Hu, M. (2005). *Asian Pacific American lesbian, gay, bisexual and transgender people: A community portrait. A report from New York's Queer Asian Pacific Legacy Conference, 2004*. New York: National Gay and Lesbian Task Force Policy Institute

Dang, A., & Vianney, C. (2007). *Living in the margins: A national survey of lesbian, gay, bisexual and transgender Asian and Pacific Islander Americans.* New York: National Gay and Lesbian Task Force Policy Institute.

Davis, K. (Producer & Director). (2001). *Southern Comfort* [Motion picture]. USA: HBO Documentary

de Graaf, R., Sandfort, T. G. M., & ten Have, M. (2006). Suicidality and sexual orientation: Differences between men and women in a general population-based sample from the Netherlands. *Archives of Sexual Behavior, 35*(3), 253-262.

De Vries, A. L. C., Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A. (2006). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism, 9(3)*, 83-94.

Denny, D. (2004). Changing models of transsexualism. In U. Leli & J. Drescher (Eds.), *Transgender subjectivities: A clinician's guide,* (pp. 25-40). New York: The Haworth Medical Press.

Denny, D. & Green, J. (1996). Gender identity and bisexuality. In Firestein, B (Ed.), *Bisexuality: The psychology and politics of an invisible minority*, (pp. 84-102). Thousand Oaks: Sage Publications.

Denny, D., Green, J., & Cole, S. (2007). Gender Variability: Transsexuals, Crossdressers, and Others. In A. Owens & M. Tepper (Eds.) *Sexual health, volume 4: State-of-the-art treatments and research,* (pp. 153-187). Westport: Praeger.

Drescher, J. (2003). An interview with Robert Spitzer, M.D., *Journal of Gay and Lesbian Psychotherapy, 7*(3), 97-111.

Devor, H. (1997). *FTM Transsexuals in Society*. Bloomington: Indiana University Press

Diamond, L. M. (2006). What we got wrong about sexual identity development: Unexpected findings from a longitudinal study of young women. In A. M. Omoto & H. S. Kurtzman (Eds.), *Sexual orientation and mental health,* (pp. 73-94). Washington, DC: American Psychological Association.

Dignity in Schools. (2010a). Fact sheet on school discipline and the pushout problem [Fact sheet]. Retrieved from http://www.dignityinschools.org/sites/default/files/DSC%20National%20Pushout%20Fact%20Sheet%2012.10.pdf

Dignity in Schools. (2010b). Pathways to pushout [Fact sheet]. Retrieved from http://www.dignityinschools.org/document/pathways-pushout-fact-sheet

DiPlacido, J. (1998). Minority stress among lesbians, gay men, and bisexual: A consequence of heterosexism, homophobia, and stigmatization. In G. M. Herek (Ed.), *Psychological perspectives on lesbian and gay issues: Vol 4. Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals,* (pp. 138-159). Thousand Oaks, California: Sage Publications.

Dixon, E., Frazer, S., Mitchell-Brody, M., Mirzayi, C., & Slopen, M. (2011). *Hate violence against lesbian, gay, bisexual, transgender, queer, & HIV affected communities in the United States, 2010: A report from the National Coalition of Anti-Violence Programs.* New York: National Coalition of Anti-Violence Programs.

Dworkin, S. H. (2006). The aging bisexual: The invisible of the invisible minority. In K. Kimmel, T. Rose & S. David (Eds.), *Lesbian, gay, bisexual, and transgender aging* (pp. 36-52). New York: Oxford University Press.

Ehernsaft, E. (2011). Gender born, gender made: Raising health gender-nonconforming children. New York: The Experiment, LLC.

Ellis, H., & Symonds, J. A. (1897). *Sexual inversion.* London: Wilson and MacMillan.

Erwin, T. M. (2006). A qualitative analysis of the lesbian connection's discussion forum. *Journal of Counseling & Development, 84*(1), 95-107.

Farley, N. (1992). Same-sex domestic violence. In S. H. Dworkin & F. J. Gutierrez (Eds.), *Counseling gay men and lesbians: Journey to the end of the rainbow* (pp. 231-242). Alexandria, VA: American Association for Counseling and Development.

Fieland, K. C., Walters, K. L., Simoni, J. M., (2007). Determinants of health among two-spirit American Indians and Alaska Natives. In I. H. Meyer & M. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations*, (pp. 268-300). Northridge, Maine: Springer.

Ford, V. E. (2003). Coming out as lesbian or gay: A potential precipitant of crisis in adolescence. In M. K. Sullivan (Ed.), *Sexual minorities: Discrimination, challenges, and development in America,* (pp. 93-110). New York: The Haworth Social Work Practice Press.

Forquera, R. (2001). *Urban Indian Health.* Menlo Park, CA: The Henry J. Kaiser Foundation

Fountain, K., Mitchell-Brody, M., Jones, S.A., & Nicols, K. (2009). *Lesbian, gay, bisexual, transgender and queer domestic violence in the United States in 2008.* New York: National Coalition of Anti-Violence Programs.

Fountain, K. & Skolnik, A. (2007). *Lesbian, gay, bisexual and transgender domestic violence in the United States in 2006: A report of the National Coalition of Anti-Violence Programs*. New York, NY: National Coalition of Anti-Violence Programs.

Fox, R. C. (2006). Affirmative psychotherapy with bisexual women and bisexual men: An introduction. In R. C. Fox (Ed.), *Affirmative psychotherapy with bisexual women and bisexual men,* (pp. 1-11). New York: Harrington Park Press.

Frankowski, B. L., Kaplan, D. W., Diaz, A., Feinstein, R. A., Fisher, M. M., & Klein, J. D. (2004). Sexual orientation and adolescents. *Pediatrics, 113*(6), 1827-1832.

Frederiksen-Goldsen, K., & Erera, P. I. (2003). Lesbian-headed stepfamilies. In M. K. Sullivan (Ed.), *Sexual minorities: Discrimination, challenges, and development in America,* (pp. 171-187). New York: The Haworth Social Work Practice Press.

Frederiksen-Goldsen, K. I. & Muraco, A. (2010). Aging and sexual orientation: A 25-year review of the literature. *Research on Aging, 32*(3)*,* 372-413.

Freedman, D., Tasker, F., & di Ceglie, D. (2002). Children and adolescents with transsexual parents referred to a specialist gender identity development service: A brief report of key developmental features. *Clinical Child Psychology and Psychiatry*, *7*(3), 423-432.

Freedman, M. (2007). *Encore: Finding work that matters in the second half of life.* New York: Public Affairs Books.

Freedman, M. (2011). *The big shift: Navigating the new stage beyond midlife.* New York: Public Affairs Books.

Freud, S. (1951). Letter to an American mother. *The American Journal of Psychiatry, 107,* 786-787.

Friess, S. (1997, December 9). Behind closed doors: Domestic violence. *The Advocate*, *748*, 48-52.

Fukuyama, M. A., & Ferguson, A. D. (2000). Lesbian, gay, and bisexual people of color: Understanding cultural complexity and managing multiple oppressions. In R. M. Perez, K. A. DeBord & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients,* (pp. 81-105). Washington, DC: American Psychological Association.

Garnets, L., & Peplau, L. A. (2006). Sexuality in the lives of aging lesbian and bisexual women. In K. Kimmel, T. Rose & S. David (Eds.), *Lesbian, gay, bisexual, and transgender aging* (pp. 70-90). New York: Oxford University Press.

Gates, G. J., & Konnoth, C. J. (2011). *Same-sex couples & immigration in the U. S.* Retrieved from http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/same-sex-couples-and-immigration-in-the-united-states/

Gates, G. J., & Ramos, C. (2008). *Census snapshot: California's Asian/Pacific Islander LGB population*. Retrieved from: http://williamsinstitute.law.ucla.edu/experts/gary-gates/census-snapshot-californias-asianpacific-islander-population/

Gee, G. C., Jorge, D. & Takeuchi, D. T. (2007). Relationships between self-reported unfair treatment and prescription medication use, illicit drug use, and alcohol dependence among Filipino Americans. *American Journal of Public Health, 97*(5), 933-940

Gee, G. C., Spencer, M. S., Chen, J., & Takeuchi, D. (2007). A nationwide study of discrimination and chronic health conditions among Asian Americans. *American Journal of Public Health*, *97*(7), 1275-1282.

Gentlewarrior, S. (2009). *Culturally competent service provision to lesbian, gay, bisexual and transgender survivors of sexual biolence*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence. Retrieved month/day/year, from: http://www.vawnet.org

Gibson, M. (1997). Clitoral corruption: Body metaphors and American doctors' constructions of female homosexuality, 1870-1900. In V. A. Rosario (Ed.), *Science and homosexualities,* (pp. 108-132). New York: Routledge.

Gil Gerald & Associates, Inc. (2009). *Assessing the feasibility of a focused HIV prevention initiative for African American MSM in the San Francisco Bay Area.* California HIV/AIDS Research Program, AIDS Partnership California, funded by the Evelyn and Walter Haas, Jr. Fund.

Giordano, S. (2007). Gender atypical organisation in children and adolescents: Ethico-legal issues and a proposal for new guidelines. *International Journal of Children's Rights, 15* 365-390.

GLBT Domestic Violence Coalition & Jane Doe, Inc. (2005). *Sheltering/housing needs for gay, lesbian, bisexual, and transgender (GLBT) victims of domestic violence: Analysis of public hearing testimony October 27, 2005 Massachusetts State House.* Massachusetts: Authors.

Goetstouwers, L. (2006). Affirmative psychotherapy with bisexual men. In R. C. Fox (Ed.), *Affirmative psychotherapy with bisexual women and bisexual men* (pp. 27-49). New York: Harrington Park Press.

Grant, J. M., Mottet, L. A., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2010). *National transgender discrimination survey report on health and health care*. Washington, D.C.: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Green, H. B., Payne, N. R., & Green, J. (2011). Working bi: Preliminary findings from a survey on workplace experiences of bisexual people. *Journal of Bisexuality*, *11*, 300-316.

Green, J. (2000). Introduction to transgender issues. In P. Currah & S. Minter (Authors), *Transgender equality: A handbook for activists and policymakers* (pp. 1-12). New York: The National Gay and Lesbian Task Force Policy Institute.

Green, J. (2004). *Becoming a visible man*. Nashville: Vanderbilt University Press.

Green, J. (2011). *Forces in motion: Law, medicine, the media and the religious right in Kantaras V.* Kantaras. Manchester, England: School of Law, Manchester Metropolitan University.

Green, R. -J. (2000). "Lesbians, gay men, and their parents": A critique of LaSala and the prevailing clinical "wisdom". *Family Process, 39*(2), 257-266.

Green, R. -J. (2004). Foreword. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples,* (pp. xiii-xvii). New York: Haworth Press.

Greenwood, G. L., Relf, M. V., Huang, B., Pollack, L. M., Canchola, J. A., & Catania, J. A. (2002). Battering victimization among a probability-based sample of men who have sex with men. *American Journal of Public Health, 92*, 1964-1969.

Greytak, E. A., Kosciw, J. G., & Diaz, E. M. (2009). *Harsh Realities: The experiences of transgender youth in our nation's schools*. New York: GLSEN.

Grindley, L. (2012). "Researcher Robert Spitzer Puts His Retraction of 'Ex-Gay' Study on Video". *The Advocate*. May 30. Retrieved from http://www.advocate.com/health/2012/05/30/researcher-robert-spitzer-puts-his-apology-gay-people-video

Grossman, A. H., & D'Augelli, A. R. (2007). Transgender youth and life threatening behaviors. *Suicide and Life Threatening Behavior*, *37*(5), 527-537.

Grov. C., Bimbi, D. S., Nanin, J. E., & Parsons, J. T . (2006) Race, ethnicity, gender, and generational factors associated with the coming-out process among lesbian, and bisexual individuals. *Journal of Sex Research*, *43*(2),115-21.

Guarnero, P., & Flaskerud, J. (2008). Latino gay men and depression. *Issues in Mental Health Nursing*, *29*(6), 667–670.

Guthrie, C. (2006). Disclosing the therapist's sexual orientation: The meaning of disclosure in working with gay, lesbian, and bisexual patients. *Journal of Gay & Lesbian Psychotherapy, 10*(1), 63-77.

Haber, D. S. (2009). Gay Aging. *Gerontology & Geriatrics Education, 30*, 267-280.

Haldeman, D. C. (2000). Gender atypical youth: Clinical and social issues. *School Psychology Review, 29*(2), 192-200.

Harder+Company Community Research. (2010). *2010 San Francisco HIV prevention plan*. San Francisco: San Francisco Department of Public Health.

Harper, G., Jernewall, N., & Zea, M. (2004). Giving voice to emerging science and theory for lesbian, gay, and bisexual people of color. *Cultural Diversity and Ethnic Minority Psychology, 10*(3)*,* 187-199.

Healing Arts: Training in Spousal or Partner Abuse Act. (2002). Retrieved June 5, 2012 from http://www.leginfo.ca.gov/pub/01-02/bill/sen/sb_05510600/sb_564_bill_20020912_chaptered.html

Heck, N. C., Flentje, A., Cochran, B. N. (2011). Offsetting risks: High school gay-straight alliances and lesbian, gay, bisexual and transgender (LGBT) youth. *School Psychology Quarterly, 26*(2), 161-174.

Heckathorn, D. & Jeffri, J. (2005, June). Assessing the feasibility of respondent-driven sampling: Aging artists in New York City. Retrieved May 5, 2007 from, http://www.tc.columbia.edu/rcac/acrobat/IOA3_aging_feasibility.pdf

Hellman, R. E., & Drescher, J. (2004). Coming out in the public sector: Introduction. In R. E. Hellman & J. Drescher (Eds.), *Handbook of LGBT issues in community mental health,* (pp. 1-9). New York: Haworth Medical Press.

Hembree W. C., Cohen-Kettenis P., Delemarre-van de Waal H. A., Gooren L. J., Meyer W. J., Spack, N. P.,… Montori, V. M. (2009). Endocrine treatment of transsexual persons: An endocrine society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 94*(9), 3152-3154. First published ahead of print June 9, 2009 as doi:10.1210/jc.2009-0345.

Herbst, J. H., Jacob, E. D., Finlayson, T. J., McKleroy, V. S.; Neumann, M. S., Crepaz, N. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *Journal AIDS and Behavior*. *12*(1), 1-17.

Herek, G. M. (1990). The context of anti-gay violence: Notes on cultural and psychological heterosexism. *Journal of Interpersonal Violence, 5*(3), 316-333.

Herek, G. M. (1998). Bad science in the service of stigma: A critique of the Cameron group's survey studies. In G. M. Herek (Ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals* (pp. 223-255). Thousand Oaks, CA: Sage.

Herek, G. M. (2000). The psychology of sexual prejudice. *Current Directions In Psychological Science, 9*(1), 19-22.

Herek, G. M., Cogan, J. C., & Gillis, J. R. (1999). Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology, 67*(6), 945-951.

Herek, G. M., Kimmel, D. C., Amaro, H., & Melton, G. B. (1991). Avoiding heterosexist bias in psychological research. *American Psychologist, 46*(9), 957-963.

Herrell, R., Goldberg, J., True, W. R., Ramakrishnan, V., Lyons, M., Eisen, S., & Tsuang, M. T. (1999). Sexual orientation and suicidality: A co-twin control study in adult men. *Archives of General Psychiatry, 56*(10) 867-64.

Hightow-Weidman, L., Smith, J., Valera, E., Matthews, D., & Lyons, P. (2011). Keeping them in "style": Finding, linking, and retaining young HIV-positive Black and Latino men who have sex with men in care. *AIDS Patient Care and STDs, 25*(1), 37-45.

Hill, D. B., Rozanski, C., Carfagnini, J., & Willoughby, B. (2005). Gender identity disorders in childhood and adolescence: A critical inquiry. In D. Karasic & J. Drescher (Eds.), *Sexual and gender diagnoses of the Diagnostic and Statistical Manual (DSM): A reevaluation,* (pp. 7-34). New York: The Haworth Press.

Himmelstein, K. E. W., & Bruckner, H. (2010). Criminal justice and school sanctions against nonheterosexual youth: A national longitudinal study. *Pediatrics, 127*(1), 49-57. DOI: 10.1542/peds.2009-2306

Hixson, L., Hepler, B. B., & Kim, M. O. (2012) The Native Hawaiian and Other Pacific Islander population: 2010. *2010 Census Briefs*. Retrieved from *www.census.gov/prod/cen2010/briefs/c2010br-12.pdf*.

Hoburg, R., Konik, J., Williams, M., & Crawford, M. (2004). Bisexuality among self-identified heterosexual college students. In R. C. Fox (Ed.), *Current research on bisexuality,* (pp. 25-36). New York: Harrington Park Press.

Hoeffel, E., Rastogi, S., Kim, M. O., & Shahid, H. (2012). *The Asian population: 2010*. 2010 Census Briefs (U.S. Census Publication C2010BR-11). U.S. Census Bureau.

Holman, C. W., & Goldberg, J. (2006a). Ethical, legal and psychosocial issues in care of transgender adolescents. *International Journal of Transgenderism*, *9*(3/4), 95-110.

Holman, C. W., & Goldberg, J. (2006b). Social and medical transgender case advocacy. *International Journal of Transgenderism,9*(3/4), 197-217.

Holt, S. (2011). *Lesbian, gay, bisexual, and transgender intimate partner violence: The California report.* Los Angeles, CA: L.A. Gay & Lesbian Center.

Hostetler, A. J., & Herdt, G. H. (1998). Culture, sexual lifeways, and developmental subjectivities: Rethinking sexual taxonomies. *Social Research, 65*(2), 249-290.

Howey, N. & Samuels, E. (2000). *Out of the ordinary: Essays on growing up with gay, lesbian, and transgender parents*. New York: St. Martin's Press.

Huebner D. M., Rebchook, G. M., & Kegeles, S. M. (2004). Experiences of harassment, discrimination, and physical violence among young gay and bisexual men. *American Journal of Public Health*, 94(7), 1200-1203.

Hughes, A. K., Harold, R. D., & Boyer, J. M. (2011). Awareness of LGBT aging issues among aging services network providers. *Journal of Gerontological Social Work*, *54*(7), 659-677.

Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *The Journal of Primary Prevention, 22*(3), 263-298.

Human Rights Campaign. (n.d.). HRC issue brief: Federal taxation. Retrieved from http://www.hrc.org/resources/entry/hrc-issue-brief-federal-taxation

Human Rights Campaign. (2011). *Equality from state to state 2011: A review of state legislation affecting the lesbian, gay, bisexual and transgender community and a look ahead to 2012.* Washington, DC.: Human Rights Campaign. Retrieved from http://www.hrc.org/files/assets/resources/EqualityfromStatetoState_2011.pdf

Human Rights Watch. (2001). *Hatred in the hallways: Violence and discrimination against lesbian, gay, bisexual, and transgender students in U.S. schools.* New York, NY: Human Rights Watch.

Hunter, S. (2005). *Midlife and older LGBT adults: Knowledge and affirmative practice for the social services.* New York: The Haworth Press.

Hunter, S., & Hickerson, J. C. (2003). *Affirmative practice: Understanding and working with lesbian, gay, bisexual, and transgender persons.* Washington, DC: NASW Press.

Hyeouk, C.H., & Adkins, C. (2009). A model of Asian and Pacific Islander sexual minority acculturation. *Journal of LGBT Youth*. *6*(2-3),155-173.

In re Marriage Cases, Nos. A110449, A110450, A110451, A110463, A110651, A110652, Cal. App. 3d (Cal. App. 3d 2008)

Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.* Washington, DC: The National Academies Press. Available from http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx

International Spectrum at the University of Michigan. (2012). LGBT terms and definitions. Retrieved from http://internationalspectrum.umich.edu/life/definitions

Intersex Society of North America. (2008). What is intersex? Retrieved from http://www.isna.org/faq/what_is_intersex

Irvine, A. (2010). "We've had three of them": Addressing the invisibility of lesbian, gay, bisexual and gender non-conforming youths in the juvenile justice system. *Columbia Journal of Gender and Law, 19*(3), 675-701.

Island, D., & Letellier, P. (1991). *Men who beat the men who love them: Battered gay men and domestic violence.* New York: Harrington Park Press.

Israel, B. A., Eng, E., Schulz, A. J., Parker, E., & Satcher, D. (2005). *Methods in community-based participatory research for health*. San Francisco: Jossey-Bass.

Israel, T., & Mobr, J. J. (2004). Attitudes toward bisexual women and men: Current research, future directions. In R. C. Fox (Ed.), *Current research on bisexuality,* (pp. 117-134). New York: Harrington Park Press.

Israelski ,D., Prentiss, D., Lubega, S., Balmes, G., Garcia, P., Muhammad, M., … & Coopman, C. (2007). Psychiatric co-morbidity in vulnerable populations receiving primary care for HIV/AIDS. *AIDS Care, 19*(2), 220-225.

Jacobs, S. E., Lang, S., & Thomas, W. (1997). *Two-spirit people: Native American gender identity, sexuality and spirituality.* Champaign, Illinois: University of Illinois Press.

Jenkins, D. & Johnston, L. B. (2004). Unethical treatment of gay and lesbian people with conversion therapy. *Families in Society: The Journal of Contemporary Social Services, 85*(4), 557-561.

Jewell, E. J., & Abate, F. (Eds.). (2001). *The New Oxford American Dictionary.* Oxford, England: Oxford University Press.

Jordan, K. M., & Deluty, R. H. (1998). Coming out for lesbian women: Its relation to anxiety, positive affectivity, self-esteem, and social support. *Journal of Homosexuality, 35*(2), 41-63.

Juang, R. M. (2006). Transgendering the Politics of Recognition. In Stryker, S. and Whittle, S. (Eds.), *The Transgender Studies Reader*. New York: Routledge

Karslake, D. (Producer/Director). (2007). *For the Bible tells me so* [motion picture]. United States: First Run Features.

Kenen, S. H. (1997). Who counts when you're counting homosexuals? Hormones and homosexuality in mid-twentieth-century America. (1997). In V. A. Rosario (Ed.), *Science and homosexualities,* (pp. 197-218). New York: Routledge.

Kennedy, H. (1997). Karl Heinrich Ulrichs: First theorist of homosexuality. In V. A. Rosario (Ed.), *Science and homosexualities,* (pp. 26-45). New York: Routledge.

Keppel, B. (2006). Affirmative psychotherapy with older bisexual women and men. In R. C. Fox (Ed.), *Affirmative psychotherapy with bisexual women and bisexual men,* (pp. 85-104). New York: Harrington Park Press.

Kettner, P. M., Moroney, R. M., & Martin, L. L. (1999). *Designing and managing programs: An effectiveness-based approach* (2nd ed.). Thousand Oaks, CA: Sage Publications.

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay, and bisexual people. *BMC Psychiatry, 18*(8), 70.

Koh, A. S., & Ross, L. K. (2006). Mental health issues: A comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33-57.

Kosciw, J. G., Diaz, E. M., & Greytak, E. A. (2008). *2007 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools* [Electronic version]. New York: GLSEN. Retrieved from http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1290-1.pdf

Kosciw, J. G., Greytak, E. A., Diaz, E. M., and Bartkiewicz, M. J. (2010). *The 2009 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools* [Electronic version]. New York: GLSEN. Retrieved from http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1675-2.pdf

Krajeski, J. (1996). Homosexual and the mental health professions. In Cabaj, R., & Stein, T. (Eds). Textbook of homosexuality and mental health, Washington, DC: APA Press.

Krehely, J. (2009). How to close the LGBT health disparities gap. *Center for American Progress Issue Brief.* Retrieved from http://www.americanprogress.org/issues/2009/12/pdf/lgbt_health_disparities.pdf

Krieglstein, M. (2003). Heterosexism and social work: An ethical issue. In M. K. Sullivan (Ed.), *Sexual minorities: Discrimination, challenges, and development in America,* (pp. 75-91). New York: The Haworth Social Work Practice Press.

Kulkin, H. S., Chauvin, E. A., & Percle, G. A. (2000). Suicide among gay and lesbian adolescents and young adults: A review of the literature. *Journal of Homosexuality, 40*(1), 1-29.

Kumashiro, K. K. (2004). *Restored selves: Autobiographies of queer Asian/Pacific American activists*. Binghamton, NY: Harrington Park Press.

Kutchins, H., & Kirk S. A. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders.* New York: Free Press.

Kuvalanka, K. A., Teper, B., & Morrison, O. A. (2006). COLAGE: Providing community, education, leadership, and advocacy by and for children of GLBT parents. In J. J. Bigner & A. R. Gottlieb (Eds.), *Interventions with families of gay, lesbian, bisexual, and transgender people: From the inside out,* (pp. 71-92). New York: Harrington Park Press.

Lai, D. S. (1998). Self-esteem and unsafe sex in Chinese-American and Japanese-American gay men. *Dissertations Abstracts International*, 59, 5093A.

Laidlaw, K., & Pacjama, N. (2009). Aging, mental health, and demographic change: Challenges for Psychotherapists. *Professional Psychology: Research and Practice, 40*(6), 601-608.

Langer, S. J., & Martin, J. I. (2004). How dresses can make you mentally ill: Examining gender identity disorder in children. *Child and Adolescent Social Work Journal, 21*(1), 5-23.

LaSala, M. C. (2000). Lesbians, gay men, and their parents: Family therapy for the coming-out crisis. *Family Process, 39*(1), 67-81.

LaSala, M. C. (2004). Monogamy of the heart: Extradyadic sex and gay male couples. *Journal of Gay & Lesbian Social Services, 17*(3), 1-24.

Lasala, M. C. (2006). Cognitive and environmental interventions for gay males: addressing stigma and its consequences. *Families in Society, 87*(2), 181-189.

Lee, C. (2002). The impact of belonging to a high school gay/straight alliance. *The High School Journal, 85*(3), 13-26.

Lee, E., & Mokuau, N. (2002). *Cultural diversity series: Meeting the mental health needs of Asian and Pacific Islander Americans*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning & National Association of State Mental Health Program Directors.

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families.* New York: The Haworth Clinical Practice Press.

Lev, A. I. (2005). Disordering gender identity: Gender Identity Disorder in the *DSM-IV-TR*. In D. Karasic & J. Drescher (Eds.), *Sexual and gender diagnoses of the Diagnostic and Statistical Manual (DSM): A reevaluation,* (pp. 35-69). New York: The Haworth Press.

Levitt, H. M., Ovrebo, E., Anderson-Cleveland, M. B., Leone, C., Jeong, J. Y., Arm, J. R., … Horne, S. G. (2009). Balancing dangers: GLBT experience in a time of anti-glbt legislation. *Journal of Counseling Psychology, 56*(1), 67-81.

Lie, G. & Gentlewarrior, S. (1991). Intimate violence in lesbian relationships: Discussion of survey findings and practice implications. *Journal of Social Service Research, 15*(1/2) 47.

Lie, G., Schillit, R., Bush, J., Montague, M., & Reyes, L. (1991). Lesbians in currently aggressive relationships: How frequently do they report aggressive past relationships? *Violence and Victims, 6*(2), 121-135.

Logie, C., Bridge, T. J., & Bridge, P. D. (2007). Evaluating the phobias, attitudes, and cultural competence of Master of Social Work students toward the LGBT populations. *Journal of Homosexuality, 53*(4), 201-221.

Long, J. K., & Bonomo, J. (2006). Revisiting the sexual orientation matrix for supervision: Working with GLBTQ families. In J. J. Bigner & A. R. Gottlieb (Eds.), *Interventions with families of gay, lesbian, bisexual, and transgender people: From the inside out,* (pp. 151-166). New York: Harrington Park Press.

Long, J. K., Bonomo, J., Andrews, B. V., & Brown, J. M. (2006). Systemic therapeutic approaches with sexual minorities and their families. In J. J. Bigner & A. R. Gottlieb (Eds.), *Interventions with families of gay, lesbian, bisexual, and transgender people: From the inside out,* (pp. 7-37). New York: Harrington Park Press.

Long, J. K., & Lindsey, E. (2004). The sexual orientation matrix for supervision: A tool for training therapists to work with same-sex couples. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples,* (pp. 123-135). New York: Haworth Press.

Los Angeles Gay and Lesbian Center. (2005). Unpublished Community-based Survey Results. Los Angeles, CA. STOP Partner Abuse/Domestic Violence Program.

Loulan, J. (1987). *Lesbian passion*. San Francisco: Spinsters/Aunt Lute.

Majd, K., Marksamer J., & Reyes C. (2009) *Hidden injustice: Lesbian, gay, bisexual, and transgender youth in juvenile courts*. Legal Services for Children, National Juvenile Defender Center, and National Center for Lesbian Rights. Retrieved from http://www.equityproject.org/pdfs/hidden_injustice.pdf

Malebranche, D. J., Peterson, J. L., Fullilove, R. E., & Stackhouse, R. W. (2004). Race and sexual identity: perceptions about medical culture and healthcare among Black men who have sex with men. *Journal of the National Medical Association, 96*(1)*,* 97-107.

Mallon, G. P. (2001). *Lesbian and gay youth issues: A practical guide for youth workers.* Washington, DC: CWLA Press.

Mallon, G. P., Aledort, N., & Ferrera, M. (2002). There's no place like home: Achieving safety, permanency, and well-being for lesbian and gay adolescents in out-of-home care settings. *Child Welfare, 81*(2), 407-439.

Mann, D. M., (2000). The influence of individualism, collectivism, and Asian cultural values on the identity formation of European-American and Asian-American gay men. *Dissertations Abstracts International*, 62, 1644B.

Martin, A. (1998). Clinical issues in psychotherapy with lesbian-, gay-, and bisexual-parented families. In C. J. Patterson & A. R. D'Augelli (Eds.), *Lesbian, gay, and bisexual identities in families,* (pp. 270-291). New York: Oxford University Press.

Martinez, K. (2008). Defined evidence: What is it? and what can it do for Latinas/os? *El Boletín: The Newsletter of the National Latina/o Psychological Association, Fall/Winter*, 9-10. Retrieved from http://www.nlpa.ws/assets/docs/newsletters/el%20boletin%20fall-winter%202008.pdf

Matthews, C. R., Lorah, P., & Fenton, J. (2006). Treatment experiences of gays and lesbians in recovery from addiction: A qualitative inquiry. *Journal of Mental Health Counseling*, *28*(2), 111-132.

Matthews, C. R., & Selvidge, M. M. D. (2005). Lesbian, gay, and bisexual clients' experiences in treatment for addiction. In E. Ettorre (Ed.), *Making lesbians visible in the substance use field,* (pp. 79-90). New York: Harrington Park Press.

McGuire, J. K., Clarke, T. J., Anderson, C. R., & Russell, S. T. (2010). *Understanding school safety for transgender youth.* (California Safe Schools Coalition Research Brief No. 13). San Francisco, CA: California Safe Schools Coalition.

McGuire, J. K., Dixon, A., & Russell, S. T. (2009). *School safety for middle school students.* (California Safe Schools Coalition Research Brief No. 11). San Francisco, CA: California Safe Schools Coalition.

McGuire, J. K., Russell, S. T., & Anderson, C. (2007). *Assessment of resources and needs for transgender identified adolescents within the context of sexual minority focused community centers.* Society for the Psychological Study of Social Issues: Internship Award Report.

McLaughlin, E. M. & Rozee, P. D. (2001). Knowledge about heterosexual versus lesbian battering among lesbians. *Women & Therapy, 23*(3), 39-58.

McLean, K. (2004). Negotiating (non)monogamy: Bisexuality and intimate relationships. In R. C. Fox (Ed.), *Current research on bisexuality,* (pp. 83-97). New York: Harrington Park Press.

Menvielle, E. J., Tuerk, C., & Perrin, E. C. (2005). To the beat of a different drummer: The gender-variant child, *Contemporary Pediatrics, 22*(2), 38-46.

Merrill, G. S. & Wolfe, V. A. (2000). Battered gay men: An exploration of abuse, help seeking, and why they stay. *Journal of Homosexuality, 39*(2), 1-30.

Meyer, I. H. (2003). Bias, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697.

Meyer, W., Bockting, W. O., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H.,…Wheeler, C. C. (2001). The standards of care for gender identity disorder: Sixth version. *International Journal of Transgenderism, 5*(1). Retrieved October 20, 2008, from http://www.symposion.com/ijt/soc_2001/index.htm

Meyerowitz, J. (2002). *How Sex Changed: A history of Transsexuality in the United States*. Cambridge: Harvard University Press.

Miller, M., André, A., Ebin, J., & Bessonova, L. (2007). *Bisexual health: An introduction and model practices for HIV/STI prevention programming*. New York: National Gay and Lesbian Task Force Policy Institute, the Fenway Institute at Fenway Community Health, and BiNet USA. Retrieved from http://www.thetaskforce.org/downloads/reports/reports/bi_health_5_07.pdf

Mills, T. C., Paul, J., Stall, R., Pollack, L., Canchola, J., Chang, Y. J., …Catania, J. A. (2004). Distress and depression in men who have sex with men: The urban men's health study. *American Journal of Psychiatry, 161*(2), 278-285.

Mitchell-Brody, M., & Ritche, A. J. (2010). *Hate violence against the lesbian, gay, bisexual, transgender, and queer communities in the United States in 2009.* New York: National Coalition of Antiviolence Programs.

Mizock, L., & Fleming, M. Z. (2011). Transgender and gender variant populations with mental illness: Implications for clinical care. *Professional Psychology Research and Practice, 42*(2), 208-213.

Monro, S. (2000). Theorizing transgender diversity: Towards a social model of health. *Sexual and Relationship Therapy, 15*(1), 33-45.

Moore, M. R. (2010). Black and gay in L.A.: The relationships black lesbians and gay men have to their racial and religious communities. In Hunt, D., and Ramon, A. (Eds.), *Black Los Angeles: American dreams and racial realities* (pp. 188-212). New York: NYU Press.

Morrison, M. A., & Morrison, T. G. (2002). Development and validation of a scale measuring modern prejudice toward gay men and lesbian women. *Journal of Homosexuality*, *43*(2), 15–37.

Morrow, D. F. (2004). Social work practice with gay, lesbian, bisexual, and transgender adolescents. *Families in Society, 85*(1), 91-99.

Morrow, S. L. (2000). First do no harm: Therapist issues in psychotherapy with lesbian, gay, and bisexual clients. In R. M. Perez, K. A. DeBord & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients,* (pp. 137-156). Washington, DC: American Psychological Association.

Mossakowski, K. N., (2003). Coping with perceived discrimination: Does ethnic identity protect mental health?. *Journal of Health and Social Behavior*, *44*(3), 318-331.

Mounic, G., Shelton, M., Blose, K., Lucker, G., Cooke, J., Nardone, M.,…Dechman, K. (2001 Winter). Lesbian, gay, bisexual, and transgender older persons: From the Administration on Aging. *The Networker: The Official Newsletter of the Network for Lesbian, Gay, and Bisexual Concerns in Occupational Therapy, 8*(2), 1-8. Retrieved from http://diverseot.org/June2001Networker.pdf

Movement Advancement Project, Family Equality Council & Center for American Progress (2011). *All children matter: How legal and social inequalities hurt LGBT families* (full report) [Electronic version]. Retrieved from http://www.lgbtmap.org/all-children-matter-full-report

Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health*, *100*(12), 2426–2432.

National Association for Research & Therapy of Homosexuality. (2012a). *NARTH officers.* Retrieved from http://www.narth.com/menus/officers.html

National Association for Research & Therapy of Homosexuality. (2012b). *The three myths about homosexuality.* Retrieved from http://www.narth.com/menus/myths.html

National Association of Social Workers. (1999). *Code of ethics* (rev.). Washington, DC: Author.

National Association of Social Workers National Committee on Lesbian, Gay, and Bisexual Issues. (2000). *Position Statement: "Reparative" and "conversion" therapies for lesbians and gay men.* Retrieved from http://www.socialworkers.org/diversity/lgb/reparative.asp

National Association of Social Workers National Committee on Racial and Ethnic Diversity. (2001). *NASW standards for cultural competence in social work practice.* Retrieved October 13, 2008, from http://www.socialworkers.org/sections/credentials/cultural_comp.asp

National Resource Center on Domestic Violence. (2007). *Lesbian, gay, bisexual & transgender (LGBT) communities and domestic violence: Information & resources*. Harrisburg, PA: Pennsylvania Coalition Against Domestic Violence.

National Women's Law Center. (n.d.). *Title IX protections from bullying & harassment in school: FAQs for students.* Retrieved from: http://www.nwlc.org/sites/default/files/pdfs/titleixfrequentlyaskedquestions_2.pdf

Native American Health Center. (2012). *Native vision: A focus on improving behavioral health wellness for California Native Americans.* Oakland, CA: Native American Health Center.

Nebelkopf, E., & King, J. (2003). A holistic system of care for Native Americans in an urban environment. *Journal of Psychoactive Drugs, 35*(1), 43-52.

Nebelkopf, E., & Phillips, M. (Eds.). (2004). *Healing and mental health for Native Americans: Speaking in red*. Walnut Creek: Altamira Press.

Nemoto, T., Operario, D., Keatley, J., Han, L. H., & Soma, T. (2004). HIV risk behaviors among male-to-female transgender persons of color in San Francisco. *American Journal of Public Health*, *94*(7), 1193-1199.

Newman, B. S., Dannenfelser, P. L., & Benishek, L. (2002). Assessing beginning social work and counseling students' acceptance of lesbians and gay men. *Journal of Social Work Education, 38*(2), 273-288.

Newman, L. K. (2002). Sex, gender and culture: Issues in the definition, assessment and treatment of gender identity disorder. *Clinical Child Psychology and Psychiatry, 7*(3), 352-359.

Nicolosi, J. (2009). The "Dr. Phil Show" Explores the Issue of Transgender Children. Retrieved from http://narth.com/docs/drphil09.html

Nicolosi, J., & Nicolosi, L. A. (2002). *A parent's guide to preventing homosexuality.* Downers Grove, Illinois: InterVarsity Press.

No On 8. (2008). Don't eliminate marriage for anyone. Retrieved October 2, 2008, from http://noonprop8.com/home

O'Shaughnessy, M., Russell, S. T., Heck, K., Calhoun, C., Laub, C. (2004) *Safe place to learn: Consequences of harassment based on actual or perceived sexual orientation and gender non-conformity and steps for making schools safer.* San Francisco, CA: California Safe Schools Coalition.

Office of Victim Services. (2009). *Dating 101* [Pamphlet]. Washington, D.C.: *N.P.*

Olson, J., Forbes, C., Belzer, M. (2011). Management of the Transgender Adolescent. *Archives of Pediatric and Adolescent Medicine, 165(2),*171-176.

Ossana, S. M. (2000). Relationship and couples counseling. In R. M. Perez, K. A. DeBord & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients,* (pp. 275-302). Washington, DC: American Psychological Association.

Otis, M. D., Rostosky, S. S., Riggle, E. D. B., & Hamrin, R. (2006). Stress and relationship quality in same-sex couples. *Journal of Social and Personal Relationships, 23*(1), 81-99.

Otterman, S. (2008, October 10). Connecticut ruling overturns ban on same-sex marriage [Electronic version]. *New York Times,* pp. A1.

Page, E. H. (2004). Mental health services experiences of bisexual women and bisexual men: An empirical study. In R. C. Fox (Ed.), *Current research on bisexuality,* (pp. 137-160). New York: Harrington Park Press.

Pan American Health Organization. (2012a). "Therapies" to change sexual orientation lack medical justification and threaten health [Press release]. Retrieved from http://new.paho.org/hq/index.php?option=com_content&task=view&id=6803&Itemid=1926

Pan American Health Organization. (2012b). "Cures" for an illness that does not exist. Retrieved from http://new.paho.org/hq/index.php?option=com_content&task=view&id=6803&Itemid=1926

Parents, Families and Friends of Lesbians and Gays (PFLAG). (n.d.). *Report bullying, harassment, or discrimination of lesbian, gay, bisexual, and transgender (LGBT) students.* Retrieved from: http://community.pflag.org/page.aspx?pid=1321

Park, P., & Manzon-Santos, J. (2000, October). Testimony submitted to the President's Advisory Commission on Asian Americans and Pacific Islanders. *Issues of transgendered Asian Americans and Pacific Islanders*. Retrieved from http://www.apiwellness.org/article_tg_issues.html

Paul, J. P., Catania, J., Pollack, L., Moskowitz, J., Canchola, J., Mills, T., … Stall, R. (2002). Suicide attempts among gay and bisexual men: Lifetime prevalence and antecedents. *American Journal of Public Health, 92*(8), 1338-1345.

Paxton, K. C., Guentzel, H., & Trombacco, K. (2006). Lessons learned in developing a research partnership with the transgender community. *American Journal of Community Psychology*, 37(3-4), 349-356.

Perrin, E. C. (2002). *Sexual orientation in child and adolescent health care.* New York: Kluwer Academic/ Plenum Publishers.

Perry, S.M. (1995). Lesbian alcohol and marijuana use: Correlates of HIV risk behaviors and abusive relationships. *Journal of Psychoactive Drugs, 27*(4), 413-419.

Peterman, L.M. & Dixon, C.G. (2003). Domestic Violence between same-sex partners: Implications for counseling. *Journal of Counseling & Development*, *Winter*(81), 40-47.

Pettis, R. M. (2004). Ellis, Havelock (1859-1939). Retrieved September 29, 2008, from http://www.glbtq.com/social-sciences/ellis_h.html

Phillips, D. A. (2006). Masculinity, male development, gender, and identity: Modern and postmodern meanings. *Issues in Mental Health Nursing, 27*(4), 403-423.

Political Research Associates. (2006). Running against Sodom and Osama: The Christian right, values, voters, and the culture wars in 2006. Retrieved from http://www.publiceye.org/pdfs/Running_Against_Sodom_and_Osama.pdf

Protect Marriage. (2008). Why Proposition 8. Retrieved October 2, 2008, from http://www.protectmarriage.com/about/why

Ragg, D. M., Patrick, D., & Ziefert, M. (2006). Slamming the closet door: Working with gay and lesbian youth in care. *Child Welfare, 85*(2), 243-265.

Ray, N. (2006). *Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness*. New York: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless.

Raymond, H. F., Rebchook, G., Curotto, A., Vaudrey, J., Amsden, M., Levine, D., & McFarland, W. (2010). Comparing Internet-based and venue-based methods to sample MSM in the San Francisco Bay Area. *AIDS & Behavior*,14(1), 218-224.

Razzano, L. A., Cook, J. A., Hamilton, M. M., Hughes, T. L., & Matthews A. K. (2006). Predictors of mental health services use among lesbian and heterosexual women. *Psychiatric Rehabilitation Journal, 29*(4), 289-298.

Renzetti, C. M. (1992). *Violent betrayal: Partner abuse in lesbian relationships*. Newbury Park, CA: Sage Publications, Inc.

Reynolds, A. L., & Hanjorgiris, W. F. (2000). Coming out: Lesbian, gay, and bisexual identity development. In R. M. Perez, K. A. DeBord & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients,* (pp. 35-55). Washington, DC: American Psychological Association.

Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., & Udry, J. R. (1997). Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association, 278*(10)*,* 823–832.

Ristock, J. L. (2001). Decentering heterosexuality: responses of feminist counselors to abuse in lesbian relationships. *Women & Therapy, 23*(3), 59-72.

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men.* New York: The Guilford Press.

Robinson, J. D., & Parks, C. W. (2003). Lesbian and bisexual women's sexual fantasies, psychological adjustment, and close relationship functioning. In R. M. Mathy & S. K. Kerr (Eds.), *Lesbian and bisexual women's mental health,* (pp. 185-203). New York: The Haworth Press.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2004). Ethnic/racial differences in the coming-out process of lesbian, gay, and bisexual youths: A comparison of sexual identity development over time. *Cultural Diversity and Ethnic Minority Psychology, 10*(3)*,* 215-228.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2006). A model of sexual risk behaviors among young gay and bisexual men: Longitudinal associations of mental health, substance abuse, sexual abuse, and the coming-out process. *AIDS Education & Prevention, 18*(5), 444-460.

Rosario, V. A. (1997). Inversion's histories/history's inversions: Novelizing fin-de-siècle homosexuality. In V. A. Rosario (Ed.), *Science and homosexualities,* (pp. 89-107). New York: Routledge.

Rosser, B. R. S., Oakes, J. M., Bockting, W. O., & Miner, M. (2007). Capturing the social demographics of hidden sexual minorities: An Internet study of the transgender population in the United States. Sexuality Research and Social Policy. 4(2), 50-62.

Rostosky, S., Riggle, E. D. B., Horne, S. G., & Miller, A. D. (2009). Marriage amendments and psychological distress in lesbian, gay and bisexual (LGB) adults. *Journal of Counseling Psychology, 56*(1), 56-66.

Rothberg, B., & Weinstein, D. L. (1996). A primer on lesbian and gay families. In M. Shernoff (Ed.), *Human services for gay people: Clinical and community practice* (pp. 55-68). New York: Harrington Park Press.

Rothblum, E. D. (2000). "Somewhere in Des Moines or San Antonio": Historical perspectives on lesbian, gay, and bisexual mental health. In R. M. Perez, K. A. DeBord & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients,* (pp. 57-79). Washington, DC: American Psychological Association.

Russel, C. J., & Keel, P. K. (2002). Homosexuality as a specific risk factor for eating disorders in men. *International Journal of Eating Disorders, 31*(3), 300-306.

Russell, G. M. (2000). *Voted out: The psychological consequences of antigay politics.* New York: New York University Press.

Russell, G. M. (2004). Surviving and thriving in the midst of anti-gay politics. *Angeles: The Policy Journal of the Institute for Gay and Lesbian Strategic Studies, 7*(2), 1-8.

Russell, G. M., Bohan, J. S., McCarroll, M. C., & Smith, N. G. (2010). Trauma, recovery, and community: Perspectives on the long-term impact of anti-LGBT politics. *Traumatology 17*(2), 14-23.

Russell, G. M. & Richards, J. A. (2003). Stressor and resilience factors for lesbians, gay men, and bisexual confronting antigay politics. *American Journal of Community Psychology, 31*(3/4), 313-328.

Russell, S. T. (2003). Adolescent romance and emotional health in the United States: Beyond binaries. *Journal of Clinical Child and Adolescent Psychology, 32*(4), 499-508.

Russell, S. T. (2006) Substance use and abuse and mental health among sexual-minority youths: Evidence from ADD Health. In A. M. Omoto & H. S. Kurtzman (Eds.), *Sexual orientation and mental health,* (pp. 13-35). Washington, DC: American Psychological Association.

Russell, S. T., Clarke, T. J., & Laub, C. (2009). *Multiple forms of bias-related harassment at school* (California Safe Schools Coalition Research Brief No. 8). San Francisco, CA: California Safe Schools Coalition.

Russell, S. T. & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study, *American Journal of Public Health*, *91*(8), 1276-1281.

Russell, S. T., Kostroski, O., McGuire, J. K., Laub, C., & Manke, E. (2006). *LGBT issues in the curriculum promotes school safety.* (California Safe Schools Coalition Research Brief No. 4). San Francisco, CA: California Safe Schools Coalition.

Russell, S. T., McGuire, J.K., & Laub, C. (2009). *Understanding differences between schools in overall LGBT school safety.* (California Safe Schools Coalition Research Brief No. 9). San Francisco, CA: California Safe Schools Coalition.

Russell, S. T., McGuire, J. K., Larriva, J., Laub, C., Manke, E., & Rosen, A. (2009). *School safety for students with LGBT parents*. (California Safe Schools Coalition Research Brief No. 6). San Francisco, CA: California Safe Schools Coalition.

Russell, S. T., McGuire, J. K., Laub, C., & Manke, E. (2006). *LGBT student safety: Steps schools can take*. (California Safe Schools Coalition Research Brief No. 3). San Francisco, CA: California Safe Schools Coalition.

Russell, S. T., McGuire, J. K., Laub, C., & Manke, E., O'Shaughnessy, M., Heck, K., Calhoun, C. (2006). *Harassment in school based on actual or perceived sexual orientation: Prevalence and consequences* (California Safe Schools Coalition Research Brief No. 2). San Francisco, CA: California Safe Schools Coalition.

Russell, S. T., McGuire, J. K., Toomey, R., & Anderson, C.R. (2010). *Gender non-conformity and school safety: Documenting the problem and steps schools can take.* (California Safe Schools Coalition Research Brief No. 12). San Francisco, CA: California Safe Schools Coalition.

Russell, S. T., `., Toomey, R. B., Diaz, R., & Sanchez, J. (2011). Lesbian, gay, bisexual and transgender adolescent school victimization: Implications for young adult health and adjustment. *Journal of School Health, 81*(5), 223-230.

Russell, S. T., Talmage, C., Laub, C., & Manke, E (2009). *The economic costs of bullying at school.* (California Safe Schools Coalition Research Brief No. 5). San Francisco, CA: California Safe Schools Coalition.

Ryan, C. (2009). *Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children*. San Francisco, CA: Marian Wright Edelman Institute, San Francisco State University.

Ryan, C. Engaging families to support lesbian, gay, bisexual and transgender (LGBT) youth: The Family Acceptance Project, *The Prevention Researcher,* 17(4), 11-13, 2010

Ryan, C. (2012). *Raising happy, healthy LGBT children and adolescents: A guide for parents, foster parents and caregivers.* Unpublished manuscript, Dept, San Francisco State University, San Francisco: California.

Ryan, C., & Chen-Hayes, S. (2012). Educating and empowering families of LGBTQ K-12 students. (Manuscript submitted for publication). In E. S. Fisher & K. Komosa-Hawkins (Eds.), *Creating school environments to support lesbian, gay, bisexual, transgender, and questioning students and families: A handbook for school professionals*. New York, NY: Routledge.

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay and bisexual young adults. *Pediatrics*, *123*(1), 346–352.

Ryan, C., Russell, S. T., Huebner, D. M., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, *23*(4), 205-213.

Safren, S. A., & Heimberg, R. G. (1999). Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology, 67(*6), 859-866.

Safren, S. A., & Pantalone, D. W. (2006). Social anxiety and barriers to resilience among lesbian, gay, and bisexual adolescents. In A. M. Omoto & H. S. Kurtzman (Eds.), *Sexual orientation and mental health,* (pp. 55-71). Washington, DC: American Psychological Association.

Safren, S. A., & Rogers, T. (2001). Cognitive-behavioral therapy with gay, lesbian, and bisexual clients. *Journal of Clinical Psychology, 57*(5), 629-643.

Sandfort, T. G. M., Bakker, F., Schellevis, F. G., & Vanwesenbeeck, I. (2006). Sexual orientation and mental and physical health status: Findings from a Dutch population survey. *American Journal of Public Health, 96*(6), 1119-1125.

Saltzman, L. E., Fanslow, J. L., McMahon, P. M., Shelley, G. A. (2002). *Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0.* Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Savin-Williams, R. C. (2001). Suicide attempts among sexual-minority youths: Population and measurement issues. *Journal of Consulting and Clinical Psychology, 69*(6), 983-991.

Savin-Williams, R. (2005). *The New Gay Teenager*. Cambridge, MA: Harvard University Press.

Savin-Williams, R. C., & Ream, G. L. (2003). Suicide attempts among sexual-minority male youth. *Journal of Clinical Child and Adolescent Psychology, 32*(4), 509-522.

Savin-Williams, R. C., & Ream, G. L. (2007). Prevalence and stability of sexual orientation components during adolescence and young adulthood. *Archives of Sexual Behavior, 36*(3), 385-394.

Stall, R., Mills, T., Williamson, J., Hart, T., Greenwood, G., Paul, J., … Catania J. (2003). Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. *American Journal of Public Health, 93*(6), 939-942.

Szalacha, L.A. (2003). Safer sexual diversity climates: Lessons learned from an evaluation of Massachusetts Safer Schools Program for gay and lesbian students. *American Journal of Education 110*(1), 58-88.

Schilit, R., Lie, G. Y., Bush, J., Montagne, M., & Reyes, L. (1991). Intergenerational transmission of violence in lesbian relationships. *Affilia 6*(1), 72-87.

Senate Health Committee Analysis (2006). *Analysis of assembly bill 2051 (Cohn)*. Available from http://www.leginfo.ca.gov./pub/05-06/bill/asm/ab_2051-2100/ab_2051_cfa_20060621_093713_sen_comm.html

Senior Health. (2012). Lesbian, Gay, Bisexual and Transgender Older Persons. Retrieved from http://seniorhealth.about.com/library/news/blles.htm

Serano, J. (2007). *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity*. Emeryville: Seal Press.

Sevelius, J., Keatley, J., Rouse Iñiguez, J., Reyes, E. M. (2008). *Serving transgender people in California: Assessing progress, advancing excellence*. University of California, San Francisco: The Center of Excellence for Transgender HIV Prevention.

Shernoff, M. (2006). Condomless sex: Gay men, barebacking, and harm reduction. *Social Work*, *51*(2), 106-113.

Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice, 33*(3), 249-259.

Shoptaw, S., & Reback, C. J. (2007). Methamphetamine use and infectious disease-related behaviors in men who have sex with men: Implications for interventions. *Addiction, 102*(Suppl. 1), 130-135.

Skegg, K., Nada-Raja, S., Dickson, N., Paul, C., & Williams, S. (2003). Sexual orientation and self-harm in men and women. *American Journal of Psychiatry, 160(*3), 541-546.

Skolnik, A. A., Middlestadt, C., Cervantes, E., Finney, J., Ringer, J., Barretto, J., … Cruz, V. (2009). *Hate violence against lesbian, gay, bisexual, & transgender people in the United States*. New York: National Coalition for Anti-Violence Programs.

Smith, G. (2003, May 15). Transmissions 67: Not a man; not the queen. *Bay Area Reporter*. Retrieved from http://www.gwensmith.com/writing/transmissions67.html

Snively, C. A., Kreuger, L., Stretch, J. J., Watt, J. W., & Chadha, J. (2004). Understanding homophobia: Preparing for practice realities in urban and rural settings. *Journal of Gay & Lesbian Social Services, 17*(1), 59-81.

Spitzer, R. (2001). Can some gay men and lesbians change their sexual orientation? 200 participants reporting change from homosexual to heterosexual orientations. *Archives of Sexual Behavior, 32*(5), 419-472.

Stacey, J., & Biblarz, T. J. (2001). (How) does the sexual orientation of parents matter? *American Sociological Review, 66*(2), 159-183.

Stryker, S. (2008). *Transgender history*. Berkeley: Seal Press.

Sullivan, M. K. (2003). Homophobia, history, and homosexuality: Trends for sexual minorities. In M. K. Sullivan (Ed.), *Sexual minorities: Discrimination, challenges, and development in America,* (pp. 1-13). New York: The Haworth Social Work Practice Press.

Swank, E., & Raiz, L. (2007). Explaining comfort with homosexuality among social work students: The impact of demographic, contextual, and attitudinal factors. *Journal of Social Work Education, 43*(2), 257-279.

Swann, S., & Herbert, S. E. (1999). Ethical issues in the mental health treatment of gender dysphoric adolescents. In G. P. Mallon (Ed.), *Social services with transgendered youth,* (pp. 19-34). New York: Harrington Park Press.

Swanson, C. (2010). Progress postponed: graduation rate continues decline. *Education Week*, *29*(34), 22

Switzer, G. E., Scholle, S. H., Johnson, B. A., & Kelleher, K. J. (1998). The Client Cultural Competence Inventory: An instrument for assessing cultural competence in behavioral managed care organizations. *Journal of Child and Family Studies, 7*(4), 483-491.

Szymanski, D. M. & Sung, M. R. (2010). Minority stress and psychological distress among Asian American sexual minority persons. *The Counseling Psychologist*, *38*(6), 848-872.

Toomey, R. B., Ryan, C., Diaz, R. M., & Russell, S. T. (2011). High school gay-straight alliances (GSAs) and young adult well-being: An examination of GSA presence, participation, and perceived effectiveness. *Applied Developmental Science 15*(4), 1-11.

Tunnell, G., & Greenan, D. E. (2004). Clinical issues with gay male couples. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples,* (pp. 13-26). New York: Haworth Press.

Twist, M., Murphy, M. J., Green, M. S., & Palmanteer, D. (2006). Therapists' support of gay and lesbian human rights. *Guidance and Counselling*, *21*(2), 107-113.

Uldall, K. K., & Palmer, N. B. (2004). Sexual minorities and mental health: The need for a public health response. In R. E. Hellman & J. Drescher (Eds.), *Handbook of LGBT issues in community mental health,* (pp. 11-24). New York: Haworth Medical Press.

UCLA Asian American Studies Center. (2012). 2012 Statistical Portratit of Asian Americans, Native Hawaiians, and other Pacific Islanders. Retrieved from http://www.aasc.ucla.edu/archives/stats2012.asp

U. S. Census Bureau. (2010). *State and county quick facts: California* [data file]. Retrieved from http://quickfacts.census.gov/qfd/states/06000.html

U. S. Census Bureau, American Fact Finder. (2010a). DP202. *Selected social characteristics in the United States: 2010 American Community Survey 1-Year estimates* [Data file]. Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_DP02&prodType=table

U. S. Census Bureau, American Fact Finder. (2010b). PCT7. *Asian alone or in combination with one or more other races, and with one or more Asian categories for selected groups* [data file]. Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_PCT7&prodType=table#tab_map

U. S. Department of Education, Office for Civil Rights. (2010). *Dear colleague letter and legal guidance.* Retrieved from: http://www2.advocate.com/pdfs/dear_colleague.pdf

U. S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: U. S. Department Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U. S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—a supplement to mental health: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

U. S. Department of Health and Human Services. (2009). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Valentine, D. (2007). *Imagining Transgender: an ethnography of a category*. Durham: Duke University Press.

Van Den Bergh, N., & Crisp, C. (2004). Defining culturally competent practice with sexual minorities: Implications for social work education and practice. *Journal of Social Work Education, 40*(2), 221-238.

Van Voorhis, R., & Wagner, M. (2002). Among the missing: Content on lesbian and gay people in social work journals. *Social Work, 47*(4), 345-354.

Vermeire, Diana T. (2010) *Discipline in California schools: Legal requirements and positive school environments*. N. Adess (Ed.). Evelyn and Walter Haas Jr. Fund.

Vernon, I. (2001). *Killing us quietly: Native Americans and HIV/AIDS*. Lincoln and London: University of Nebraska Press.

Waldner-Haugrud, L. D., Gratch, L. V., & Magruder, B. (1997). Victimization and perpetration rates of violence in gay and lesbian relationships: Gender issues explored. *Violence and Victims, 12*(2), 173-184

Walters, K. (1999). Urban American Indian identity attitudes and acculturation styles. *Journal of Human Behavior in the Social Environment, 2*(1-2), 163-178.

Walls, N. E., Kane, S. B., & Wisneski, H. (2010). Gay-straight alliances and school experiences of sexual minority youth. *Youth & Society, 41*(3), 307 – 332.

Washington State Department of Health. (2008). Table 3: Four-tier consolidation of secondary RUCA codes. *Guidelines for using rural-urban classification systems for public health assessment* (pp. 1-17). Retrieved from www.doh.wa.gov/Portals/1/Documents/5500/RuralUrbGuide.pdf.

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction: Understanding bisexuality.* New York: Oxford University Press.

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (2001). Bisexuals at midlife: Commitment, salience, and identity. *Journal of Contemporary Ethnography, 30*(2), 180-208.

Wells, G. B., & Hansen, N. D. (2003). Lesbian shame: Its relationship to identity integration and attachment. *Journal of Homosexuality, 45*(1), 93-110.

Wierzalis, E. A., Barret, B., Pope, M., & Rankins, M. (2006). Gay men and aging: Sex and intimacy. In K. Kimmel, T. Rose & S. David (Eds.), *Lesbian, gay, bisexual, and transgender aging* (pp. 91-109). New York: Oxford University Press.

Wikholm, A. (1999). Kertbeny coins "homosexual." Retrieved September 29, 2008, from http://www.gayhistory.com/rev2/events/1869b.htm

Wikipedia. (2012). Genderqueer. Retrieved June 19, 2012, from http://en.wikipedia.org/wiki/Genderqueer

Wilchins, R. A. (1997). *Read my lips: Sexual subversion and the end of gender*. Ithaca, New York: Firebrand Books.

Wilkinson, W. (2010). Culturally competent approaches for serving Asian and Pacific Islander lesbian, gay, bisexual, and transgender populations in California. LGBT-TRISTAR, Best Practices Report Series. Retrieved from http://www.lgbt-tristar.com/resources/lgbttristarpublications.html

Williamson, I. R. (2000). Internalized homophobia and health issues affecting lesbians and gay men. *Oxford Journals of Medicine and Health Education Research, 15*(1) 97-107.

Wilson, K.J. (2006). *When violence begins at home: A comprehensive guide to understanding and ending domestic abuse* (2nd ed.). Alameda, CA: Hunter House.

Wilson, P. A., & Yoshikawa, H. (2007). Improving access to health care among African-American, Asian and Pacific Islander, and Latino LGB populations. In I. H. Meyer, & Northridge, M. (Eds.) *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (pp. 609-637). New York: Springer.

Winters, K. (2005). Gender dissonance: Diagnostic reform of Gender Identity Disorder for adults. In D. Karasic & J. Drescher (Eds.), *Sexual and gender diagnoses of the Diagnostic and Statistical Manual (DSM): A reevaluation,* (pp. 71-89). New York: The Haworth Press.

Witten, T. M. (2003). Life course analysis—the courage to search for something more: Middle adulthood issues in the transgender and intersex community. In M. K. Sullivan (Ed.), *Sexual minorities: Discrimination, challenges, and development in America,* (pp. 189-224). New York: The Haworth Social Work Practice Press.

Witten. T. M. (2012). The Aging of sexual and gender minority persons: An overview. In Witten, T. M. & Eyler, A. E. (Eds), *Gay, lesbian, bisexual & transgender Aging: Challenges in research, practice & policy*. Baltimore: The Johns Hopkins University Press.

Yegidis, B. L., Weinbach, R. W., & Morrison-Rodriguez, B. (1999). *Research methods for social workers* (3rd ed.). Boston, MA: Allyn and Bacon.

Yellow Horse Brave Heart, M. (2003). The historical trauma response among natives and its relationship with substance abuse: a Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7-13.

Yoshino, K. (2006). *Covering: The hidden assault on our civil rights.* Random House, New York.

Young, A. (2000). *Women who become men: Albanian sworn virgins.* New York: Berg.

Zea, M. C. (2010). Reaction to the special issue on centralizing the experiences of LGB people of color in counseling psychology. *The Counseling Psychologist, 38*(3), 425-433.

Zucker, K. J. (2003). The politics and science of "reparative therapy." *Archives of Sexual Behavior, 32*(5), 399-402.

Zuna Institute. (July 2010). *Black Lesbians Matter: An examination of the unique experiences, perspectives, and priorities of the Black Lesbian Community* [Electronic version]. New York: Arcus Foundation. Retrieved from http://zunainstitute.org/2010/research/blm/blacklesbiansmatter.pdf

Appendix A
Additional Population and Subject-Specific Recommendations

Policy

Juvenile Justice

- Policies should be developed within the Juvenile Justice system to ensure the equitable treatment and safety of LGBTQ youth.
- Family rejection is at the heart of many offenses committed by LGBTQ youth. Counseling and support for families can help mediate the negative effects of rejection and increase the well-being of LGBTQ youth. Therefore, family crisis protocols should be developed for pre-trial detention involving LGBTQ youth.
- Policy for the Juvenile Justice system should be developed regarding detention alternatives for LGBTQ and all youth who are not a risk to the community or at risk of running away.

Transgender

- Legislation should be developed and passed which requires all health insurance policies cover transition-related health care in California.

Workforce Training

Domestic Violence

- All mental/behavioral and physical health care providers should receive comprehensive training on LGBTQ-specific domestic violence issues.

Juvenile Justice

- Training and education should be provided to law enforcement and criminal justice organizations, courts, divisions, precincts and academies throughout California about instituting or strengthening written policies, procedures and practices that are non-discriminatory toward LGBTQ populations.

School-Based

- School staff should be trained how to effectively intervene if they witness bullying and harassment as it pertains to gender, gender expression, sexual orientation and perceived sexual orientation, as well as any bias-related comments and slurs.
- Administrators and teachers should be required to participate in continuing education which offers current information on safe schools laws and best practices as pertains to gender identity, sexual orientation and perceived sexual orientation.

Transgender

- Medical curricula should include training on how to provide gender-affirming medical care and treatment.

Funding and Services

Domestic Violence

- LGBTQ outreach, intervention and prevention efforts for domestic violence must include services and public education across the entire life span of the individual—from first relationships in youth to relationships among elders.
- Funds for the development, stabilization, and expansion of LGBTQ-specific domestic violence programs should be allocated, increased and earmarked for treatment, education and prevention of LGBTQ domestic violence.
- Law enforcement and other services which respond to domestic violence should develop standard practice guidelines to appropriately identify, document and intervene in all cases of LGBTQ-specific domestic violence.
- Emergency Protective Orders should be issued consistently regardless of gender identity and/or sexual orientation of those involved.
- Law enforcement and criminal justice personnel should work in close collaboration with LGBTQ domestic violence specialists in dual arrest cases involving LGBTQ individuals.

Families

- State and County agencies which provide support, education and services to families should provide support, education and services to specifically meet the needs of LGBTQ parents and their families.

Juvenile Justice

- Juvenile justice professionals should create, lead or join community-based collaborations and task forces to reduce the detention of LGBTQ and gender nonconforming youth.

Older Adult

- Funding should be allocated to meet the need for affordable and accessible LGBTQ-sensitive older adult programs and services for both those who are mobile as well as those who are homebound.

School-based

- Funding dedicated to school police, security officers, metal detectors, and surveillance cameras should be reassessed and most or all should be reallocated toward more guidance counselors, social workers, school psychologists, and nurses who are able to address students' academic, behavioral and mental health issues.

- The State should develop and implement a plan for addressing disparities affecting students of color, LGBTQ students, and students with disabilities in the use of exclusionary discipline and justice-system intervention.
- School districts should ensure students know where to go for support or information related to sexual orientation or gender identity.

Appendix B
Additional Resources

As stated at the beginning of this report, the diversity of California LGBTQ communities is limited only by the diversity of the California population in general. Therefore this report represents only a fraction of knowledge and does not cover all LGBTQ individuals and their myriad intersecting needs and identities. For those providers who aspire to cultural competence when working with LGBTQ individuals, for administrators and policy makers who wish to create a more LGBTQ-affirming environment, and for the general public who want to learn more—this appendix contains additional resources. The reports and research listed below have been published within the past 6 years, are free to the general public and can be found using a simple Internet search, going directly to the organization listed or using the link provided in this report.

Organizations Publishing Research

The organizations listed below frequently conduct research and produce reports about LGBTQ communities across the United States, as well as internationally. These are available to the public free of charge.

- **American Institute of Bisexuality**
  www.bisexual.org
- **The Center for Excellence for Transgender Health**
  http://transhealth.ucsf.edu
- **Gay, Lesbian, and Straight Education Network (GLSEN)**
  www.glsen.org
- **Gay Straight Alliance Network**
  www.gsanetwork.org
- **Human Rights Campaign**
  www.hrc.org
- **Lambda Legal**
  www.lambdalegal.org
- **Movement Advancement Project**
  www.lgbtmap.org
- **The National Gay and Lesbian Task Force**
  www.thetaskforce.org
- **The Williams Institute**
  http://williamsinstitute.law.ucla.edu/

California Reducing Disparities Population Reports

African American Health Institute of San Bernardino County. (2012). *"We ain't crazy, just copin' with a crazy system": Pathways into the black population for eliminating mental health disparities.* V. D. Woods, N. J. King, S. M. Hanna, & C. Murray (Eds.). San Bernardino, CA. Available from: http://www.aahi-sbc.org/

Aguilar-Gaxiola, S., Loera, G., Méndez, L., Sala, M., Latino Mental Health Concilio, & Nakamoto, J. (2012). *Community-defined solutions for latino mental health care disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup population report.* Sacramento, CA: UC Davis. Available from: http://www.latinomentalhealthconcilio.org/mhsa/crdp-latino-population-report/

Native American Health Center. (2012). *Native vision: A focus on improving behavioral health wellness for California Native Americans. California Reducing Disparities Project Native American Strategic Planning Workgroup Report.* Oakland, CA. Available from: http://www.nativehealth.org/content/publications

Pacific Clinics. (2012). *California Reducing Disparities Project, Asian Pacific Islander Strategic Planning Workgroup population report: In our own words.* Arcadia, CA: Pacific Clinics. Available from: http://crdp.pacificclinics.org

LGBTQ Reports

General

Dixon, E., Jindasurat, C., & Tobar,V. (2011). *Hate violence against gay, lesbian, bisexual, queer, and HIV-affected communities in the United States in 2011: A report from the National Coalition of Anti-Violence Programs.* New York: The National Coalition of Anti-Violence Programs. Available from: www.ncavp.org

Human Rights Campaign. (2009). *Degrees of equality: A national study examining workplace climate for LGBT employees.* Available from: http://preview.hrc.org/about_us/13575.htm

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.* Washington, DC: The National Academies Press. Available from: http://www.iom.edu/Reports.aspx?Search=LGBT

Bisexual

San Francisco Human Rights Commission: LGBT Advisory Committee. (2011). *Bisexual invisibility: Impacts and recommendations*. Available from: http://www.sf-hrc.org

The National Gay and Lesbian Taskforce. (2007). *Bisexual health: An introduction and model practices for HIV/STI prevention programming.* Available from: http://www.thetaskforce.org/reports_and_research/bisexual_health/

Transgender

Dunn, M., & Moodie-Mills, A. C. (2012). *The state of gay & transgender communities of color in 2012: The economic, educational, and health insecurities these communities are struggling with and how we can help them.* Center for American Progress. Available from: http://www.americanprogress.org/issues/2012/04/lgbt_comm_of_color.html

Grant, J. M., Mottet L. A., Tanis J., Harrison J., Herman J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey.* Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force. Available from: http://www.thetaskforce.org/reports_and_research/ntds

Hartzell, E., Frazer, M. S., Wertz, K. & Davis, M. (2009). *The state of transgender California: Results from the 2008 California Transgender Economic Health Survey.* Transgender Law Center: San Francisco, CA. Available from: www.transgenderlawcenter.org

Asian American

Satrang & South Asian Network. (2006). *No more denial! Giving visibility to the needs of the South Asian LGBTIQ community in Southern California.* Available from: http://www.satrang.org/

Black/African American

Moodie-Mills, A. C. (2012). *Jumping beyond the broom: Why black, gay, and transgender Americans need more than marriage equality.* Washington: Center for American Progress. Available from: http://www.americanprogress.org/issues/2012/01/black_lgbt.html

Ramsey, F., Hill, M. J., & Kellam, C. (2010). *Black lesbians matter.* Sacramento: Zuna Institute. Available from: http://www.zunainstitute.org

Latino

De La Torre, M. A., Castuera, I., Rivera, L. M. (2012). *A la familia: A conversation about our families, the bible, sexual orientation and gender identity.* New York: National Gay and Lesbian Task Force, the Human Rights Campaign Foundation and UNID@S. Available from: http://www.thetaskforce.org/reports_and_research/a_la_familia

Native American

Frazer, S. M. & Pruden, H. (2010). *Reclaiming our voice: Two spirit health & human service needs in New York State.* NYS DOH AIDS Institute: Albany, NY. Available from: http://www.health.ny.gov/

Genovese, M., Rousell, D., & The Two Spirit Circle of Edmonton Society. (2011). *Safe and caring schools for Two spirit youth: A Guide for teachers and students.* Available from: www.nnaapc.org/publications/TwoSpiritBook.pdf

The National Native American AIDS Prevention Center. (2010). *HIV prevention online toolkit for Native communities.* Available from: www.nnaapc.org/resources/toolkit/index.htm

O'Brien-Teengs, D. (2008). *Two Spirit Women (2nd ed.). Toronto, Canada: 2-Spirited people of the 1st Nations and the Ontario Aboriginal HIV/AIDS strategy.* Available from: www.2spirits.com/Two%20Spirit%20Women.pdf

Families

Movement Advancement Project, Family Equality Council & Center for American Prograss. (2011). *All children matter: How legal and social inequalities hurt LGBT families (Full report).* Available from: http://www.lgbtmap.org/all-children-matter-full-report

Ryan, C. (2009). *Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children.* San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University. Available from: http://familyproject.sfsu.edu/publications

Youth

Human Rights Campaign. (2012). *Growing up LGBT in America: Key findings.* Available from: http://hrc.org/youth#.UAWV-nDCrgQ

Majd, K., Marksamer, J. & Reyes, C. (2009). *Hidden injustice: LGBT youth in juvenile courts.* National Center for Lesbian Rights. Available from: http://www.nclrights.org

Wornoff, R., Estrada, R., & Sommer, S. (2006). *Out of the margins: A report on regional listening forums highlighting the experiences of lesbian, gay, bisexual, and transgender youth in care.* New York: Lambda Legal Defense & Education Fund. Available from: http://www.lambdalegal.org/publications/youth-in-the-margins/

School-based

Burdge, H., Sinclair, K., Laub, C., & Russell, S. T. (2012). *Lessons that matter: LGBTQ inclusivity and school safety. (Gay-Straight Alliance Network and California Safe Schools Coalition Research Brief No. 14).* San Francisco, CA: Gay-Straight Alliance Network. Available from: http://gsanetwork.org/resources/research-reports/california-research

Diaz, E. M. & Kosciw, J. G. (2009). *Shared differences: The experiences of lesbian, gay, bisexual, and transgender students of color in our nation's schools.* New York: GLSEN. Available from: http://www.glsen.org/cgi-bin/iowa/all/research/index.html

Greytak, E. A., Kosciw, J. G., & Diaz, E. M. (2009). *Harsh realities: The experiences of transgender youth in our nation's schools.* New York: GLSEN. Available from: http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1375-1.pdf

Kosciw, J. G. & Diaz, E. M. (2008). *Involved, invisible, ignored: The experiences of lesbian, gay, bisexual and transgender parents and their children in our nation's K–12 schools.* New York: GLSEN. Available from: http://www.glsen.org/cgi-bin/iowa/all/research/index.html

Kosciw, J. G., Greytak, E. A., Diaz, E. M., & Bartkiewicz, M. J. (2010). *The 2009 national school climate survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools.* New York: GLSEN. Available from: http://www.glsen.org/cgi-bin/iowa/all/library/record/2624.html

Older Adults

Redman, D., & Wilmott, D. (2011). *Navigating the system: A know-your-rights guide for lesbian, gay, bisexual, and transgender elder* Californians. National Center for Lesbian Rights. Available from: http://www.nclrights.org

Services & Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders, & Movement Advancement Project. (2010). *Improving the lives of LGBT older adults.* Available from: http://www.sageusa.org

Fredriksen-Goldsen, K. I., Kim, H-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., Goldsen, J., & Petry, H. (2011). *The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults.* Seattle: Institute for Multigenerational Health. Available from: http://caringandaging.org/

Mental Health America
of Northern California
www.mhanca.org

Equality California
Institute
www.eqcai.org

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