INNOVATIVE APPROACHES TO TRAINING MENTAL HEALTH SERVICE PROVIDERS FOR THE QUALITY SUPPORT OF LGBTQI+ PEOPLE

Handbook for trainers

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This publication may be downloaded free of charge from commonpoint.eu.

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Section 1
Introduction to the handbook and the training

About the CommonPoint Training

The Common Point Handbook for Trainers provides guidance for trainers who would like to implement trainings for mental health professionals with the goal of improving the professionals' attitudes, knowledge and skills related to LGBTQI+ persons. The Handbook and the training was developed in the framework of the CommonPoint project, which aims at developing innovative and easily accessible learning and training materials to train professionals in the field of mental health, in order to promote the design of personalised support programs for LGBTQI+ persons in their empowerment processes.

This book consists of three main sections: ***Section 1- Introduction to the handbook and the training*** provides an introduction including information on how the book was developed, who the training is targeted at, and how to prepare and implement the training. Section 1 also contains introductory and closing activity ideas for the training you implement.

Section 2 - LGBTQI+ 101, outlines the most important knowledge on LGBTQI+ persons lives, identities and challenges, complemented with suggested activities that can deepen participant's learning, shape their attitudes and enhance specific skills. Section 2 consists of 6 modules that provide an introduction to the most important LGBTI+ topics: *Terminology*; *Transgender, Sex-diverse and gender-diverse persons*; *Coming out*; *Human rights and the Systems of oppression*; *Mental health risk and minority stress*; *Personal and professional prejudices.*

Section 3 - Field-specific guides for training mental health professionals consists of four modules which provide knowledge and activities curated for mental health professionals working in specific fields. These fields are crisis lines, school psychology, clinical psychology and social work.

At the end of the handbook we also provide a comprehensive **Glossary** and a list of **References**.

How was this handbook developed?

This handbook and the training methodology were developed as part of the CommonPoint project by a consortium of four European partners, namely: Háttér Society (Hungary), Lesbian Organisation Rijeka - LORI (Croatia), Prague Pride (Czech Republic), and Single Step Foundation (Bulgaria), cofunded by the European Union's Erasmus+ Programme.

The four organisations have curated the materials from the most current professional literature, and also from their broad experiences in working with LGBTQI+ persons and in training professionals. The training program was piloted at a five day international training event organised online in November 2021.

The main objectives of the training

The overall goal of the CommonPoint projects and training is to increase the quality of mental health services supporting LGBTQI+ persons. The objective is to increase the number of mental health professionals in specific fields who are competent and conscious in the topics of LGBTQI+ persons lives, needs and challenges.

To create LGBTQI+ inclusive, safe practices and spaces, mental health professionals need progressive attitudes and awareness, through knowledge and the skills to apply it. Thus the CommonPoint training aims to increase knowledge about mental health needs of LGBTQI+ persons, to improve the skills and attitudes of mental health professionals.

Specific knowledge includes LGBTQI+ concepts and terminology, the specific psychological challenges and difficult circumstances LGBTQI+ persons face, and the personal and professional prejudices that are unfortunately still present in the practices and processes of specific mental health fields.

We expect the participants to have an increased awareness of their own beliefs, biases, and assumptions about LGBTQI+ persons and of the inclusiveness of their services, behaviours and methods. Inclusivity is not an "add-on", and creating an inclusive practice is not only about building skills and methods that can be added as a plus to make our established methods and

routines more friendly. Mental health professionals need to rethink their basic assumptions that form their practices, and the new thinking and skills should be present in all of their work - even with persons with less challenging social identities.

You can familiarise yourselves with several models that help with thinking critically and with a more collaborative, inclusive approach about mental health. All of the frameworks can be quite helpful, but they also can have drawbacks or lead to less than ideal outcomes if applied without due care.

- **Cultural Competency**: This framework has grown from the fields of social work and nursing. Cultural Competency is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations". Its central thesis is that practitioners should learn the norms and frameworks of the persons they interact with. If applied without reflexivity, it can lead to generalisations and the upholding of the distinction between "us" and "them", "default" and "different".
- **Cultural Humility**: The concept of cultural humility was developed by Melanie Tervalon and Jann Murray-Garcia in 1998 to address inequities in the healthcare field. Cultural humility goes beyond the concept of cultural competence to include lifelong commitment to reflexivity and self-awareness and the rebalancing of common power-dynamics. This framework decenters the practitioner as expert, and reconceptualises clients and service users as experts in themselves. If applied without deep consideration it can lead to putting the burden and responsibility of educating practitioners on the people they are supposed to serve.

Knowledge, skills, and attitudes

What kind of knowledge do mental health service providers need in order to be able to provide quality services for LGBTQI+ persons and to form their practices to be more inclusive? What skills and attitudes does a hotline operator, school psychologist, a clinical psychologist or a social worker need to give inclusive services? During the development of this training material our focus were on the following:

- Knowledge: It is important for professionals to be familiar with LGBTQI+ concepts and terminology; to be able to grasp the complex ways gender identity/experience, and sexual and/or romantic orientation can be related; to be able to use the terminology in a flexible way; to be aware of the specific psychological challenges LGBTQI+ persons face; to gain knowledge on the the process of coming out, on internalised homo-, bi and transphobia, sexism and heteronormativity, on minority stress and the social experiences of LGBTQI+ people, also on transitioning and legal gender recognition.
- Attitudes: Professionals should be open-minded, interested and treat social diversity or being "different" as something valuable; show empathy, solidarity; seek to be aware of and to decrease their prejudices, stereotypes and judgmental mentalities; inspect their value system and embody values aligned with human rights.
- Skills: Professionals should have the basic skill-set of any helping professional: the ability of active listening and setting appropriate boundaries; the profound awareness of the effect their thinking and behaviour has on the other, also of limitations of their knowledge and competences. They also should have the ability to examine the social circumstances and networks of their clients, and the way societal norms and practices affect those clients; to explore the intersecting social identities of their clients; to identify elements of their own methods and practices that are not affirmative or unhelpful regarding diversities; to use inclusive and open language around sexuality and gender.

Who is this training for?

This training course has been designed for providers and professionals working in specific mental health fields. We chose the following professions to be the main target groups for the CommonPoint training: crisis hotline operators, school counsellors, clinical psychologists and social workers. The professionals from these fields have enormous effect on the lives of people, and have a significant role in reforming the mental health infrastructures LGBTQI+ persons interact with to be more inclusive, or in even just improving some LGBTQI+ persons' individual experiences in the mental health infrastructure.

We recommend implementing the training for professionals already in the field, or for students who are currently undertaking their basic training. Some background knowledge in mental health fields and helping professions is a must, but participants of different knowledge and skill-levels can be taught with the CommonPoint training.

The course can also be integrated into an existing training for staff members and volunteers.

Who can implement this training?

It is recommended that two trainers co-facilitate this training course. The trainers are expected to be experienced in delivering training programs and have advanced skills for the moderation and facilitation of sensitive topics. The trainers are required to have knowledge on mental health fields and professionals working in those fields, the specificities of methods and practices of those fields in their country, also they should be quite well-versed in LGBTQI+ topics. Knowing the foundational concepts and terminology of LGBTQI+ persons is a good starting point to become a CommonPoint Trainer, but before implementing a training you should immerse yourself in the topic, familiarise yourself with the themes outlined in the Handbook and ask other knowledgeable professionals or supervisors for help. A good step would be to be a co-facilitator on the side of a more experienced trainer well-versed in LGBTQI+ topics

Structure and content of the training course

You can use this handbook for the implementation of a two-day training But the main idea of the CommonPoint handbook is to be a resource for various groups and different lengths of training. Think of the Handbook as a cookbook: you can curate knowledge and pick activities from the Handbook best suited to you participants' training needs, previous knowledge, attitudes and skill-levels. You can combine different modules, and the included theoretical parts and activities in them to build training of different length and intensity according to the principles defined below, or even integrate some of the activities from the Handbook into an already existing training course

Try your best at balancing theory and practice, frontal and interactive approaches

To create LGBTQI+ inclusive, safe practices and spaces, mental health professionals need knowledge and skills to apply it, thus the CommonPoint training uses both theoretical and interactive approaches. As a trainer, to be able to create a training around these needs, you need thorough background knowledge, also tried and tested activities that can enhance the delivery of the specific knowledge. Thus most of the modules in the Handbook contain background knowledge that you should familiarise yourself with and/or deliver to the training participants, and also sample activities which you can build upon. The trainers should facilitate active participation and seek to complement the interactive parts with the necessary information delivered frontally. Of course, the unique needs of the group should be taken into account.

1. Provide general and field-specific knowledge to your participants

The activities in **Section 1**, and knowledge and activities in **Section 2** are targeting mental health professionals generally - thus these sections can be used with all four specific target groups. The modules in **Section 3** are dedicated to mental health professionals working in specific fields, each module curates specific background knowledge, guidelines and sample activities for one of the four target groups. You can combine content from Section 1 -3 in your training however you think is best for your specific group of participants. However, the main idea is to

- Explore participants attitudes, previous knowledge and skills with the activities outlined in **Section 1**, then
- Deliver the theory, basic concepts and attitude-changing activities outlined in **Section 2**, then
- Teach the necessary knowledge and skills from the module(s) of **Section 3** written for the target group(s) and mental health field(s) you are working with.

For a group more well-versed in LGBTQI+ topics you would need to deliver less knowledge and activities from **Section 2**, and you would be able to put more emphasis on the field-specific knowledge outlined in **Section 3**; but for a group with less previous awareness and knowledge, the training would be more of a sensitivising training built on the contents of **Section 2**.

For diverse groups which include participants from more than one mental health field, you will need more creativity to tailor the field-specific training part to the group's need, and to use content from more than one module of **Section 3**.

2. Deepen the topic and the conversations gradually

While it is primarily the trainers' responsibility to find the most appropriate structure or sequence of activities, as a rule of thumb activities should gradually guide the participants from easier and lighter topics towards more in-depth discussions and activities. The usual sequence starts with some icebreakers and getting-to-know activities to establish a safe environment for the participants.

3. Leave time for introduction, questions and closing

At the beginning also reserve time for sharing expectations about the training and for establishing basic rules. For each activity it is important to clearly outline what is expected from the participants and to set how much time they have to complete the task. Always leave time for questions and comments when introducing terminology or other theoretical parts of the training.

Section 1 - Introduction to the handbook and the training

Section 2 - LGBTQI+ 101

Module 1 - **Terminology**

Basic termonology; Foundational concepts of sex, gender identity and gender expression; Terminology; Sexual orientation and gender identity; Thinking outside the box and non-binary thinking

Module 2 - **Transgender, gender-diverse and sex-diverse persons**

Transgender and gender-diverse persons; Transitioning and gender recognition; Affirmative practices and creating affirming spaces; Transphobia

Module 3 - **Coming out**

Coming out: the process; Identity development models; Factors affecting the coming out process; People surrounding the LGBTQI+ person; Safety during coming out

Module 4 - **Human rights and the systems of oppression**

Topics in this module: Human rights; Violence experienced by LGBTQI+ persons, Systems of oppression

Module 5 - **Mental health risk and minority stress**

Minority stress, Internalised homo/bi/transphobia, Mental health risks of LGBTQI+ persons

Module 6 - Personal and professional prejudices

Personal and professional prejudices – awareness and consequences; Implicit bias; Harmful professional practises towards LGBTQI+ people

Section 3 - **Field-specific guides for training mental health professionals**

Module A – **Hotline/Chat Operators**

Active listening/ models of support; Boundaries; How to handle difficult questions and aggressive behaviour; How to handle frequent callers/users; Critical situations

Module B – **School Counsellors**

Discrimination and bullying of LGBTQI+ students; Individual work with LGBTIQ+ students; Improving the climate at the school; General recommendations

Module C - **Clinical psychologists** *Treatment considerations; Affirmative practices; Overcoming heterosexism; Developmental models; Conflicts regarding sexual orientation; Clinical manifestations of internalised homo-bi-transphobia; Working with trans clients*

Module D - **Social Workers and Services**

Aspects of ethics in social work with LGBTQI+ users; Education, skills and qualities of social workers working with LGBTQI+ clients; The principles of the LGBTIQ+-friendly social service; Barriers for LGBTQI+ persons

Implementation of this training

Participants

In order to achieve the best possible results, it is recommended to limit the maximum number of participants to 15 people. For smaller groups, you can implement a training that is more focused on the experiences and attitudes of participants, and for groups larger than 15, the training curricula should be a little bit more focused on knowledge delivery and teaching skills. It is also best to keep the group of the participants as homogenous as possible, for example groups of psychologists, social workers or hotline operators, as the achievable skills and topics covered are specific to each group.

The key to a successful training is assessing the training needs of the participants thoroughly: a good understanding of their current level of knowledge, experiences and commitment to the topic is important. We encourage the trainers to interact with the participants or relevant stakeholders during the planning process: getting insight into the group's unique needs is possible with a few tools (forms, interviews, focus groups, etc.). You can also use the *Indicators of Success or Self-Assessment Checklist for Personnel Providing Culturally and Linguistically Competent Services* questionnaries from the Enhancing Cultural Competence: Welcoming Lesbian, Gay, Bisexual, Trangender, Queer People in Mental Health Services document below.

Enhancing Cultural Competence: Welcoming Lesbian, Gay, Bisexual, Trangender, Queer People in Mental Health Services. (n.d.). Retrieved 2 November 2021, from http://www.lgbtqi2stoolkit.net/pdf/Planned-Parenthood_Enhancing-Cultural-Competence_2007.pdf

It is necessary to have a coherent plan, but flexibility is also recommended: the participants might need something different from the original plan. You might adjust what parts of the training are emphasised according to the needs and expectations they share at the beginning of the training.

Or if new expectations come up during the training, the trainers should be able to make some changes on the spot, thus they are recommended to prepare backup activities.

How to prepare as a trainer?

Prior to the implementation it is essential that both of the trainers take time to study thoroughly all the necessary materials. Besides this handbook the trainers should also familiarise themselves with:

- the correct terminology in the language of the training - for this you can use the Glossary at the end of the handbook as a base reference
- country-specific information regarding legislation and the availability of specialised health services.

To present up-to-date materials on the European and/or national context during the training, trainers can consult the Rainbow Europe website of ILGA-Europe where they can find current data on legislation on LGBTI+ rights, or they can consult local (or international) LGBTI+ organisations for additional information.

Trainers should also clearly divide responsibilities amongst them, both in terms of preparation, and their roles during the training (managing tasks and leading activities).

The role and competencies of the trainer

As a trainer it is your job to

- model open-mindedness, curiosity and empathy;
- be a role model of LGBTQI+ inclusive thinking and behaviour;
- facilitate the activities and stimulate discussions;
- provide a safe environment;
- enable all participants to express their opinions and share their experiences;
- keep the group cohesion;
- keep track of time and moderate activities.

Facilitate the activities and stimulate discussions

Some activities require work in small groups. Depending on the sensitivity of the activities, encourage participants to get in a pair/group with those with whom they have not worked before, or you can also randomly assign participants to groups. Give clear instructions and guidelines for small groups before starting their discussion: how much time they will have to work, whether they are expected to present their process/conclusions to the whole group, etc.

During small group work, moving between the groups enables the trainers to help the participants and facilitate group work if necessary. There are many ways a trainer can facilitate group activities:

- Encouragement: prompting the participants to actively take part in the discussion/activities.
- Suspension: if an interesting point comes up, the trainers can pause the activity to have a discussion, or give more information on the topic.

After activities in small groups, it is recommended to discuss the experiences of the participants, especially if the activity includes learning about themselves. Pay attention to the participants' personal experience and give each of them the opportunity to share their thoughts and concerns if needed.

Regardless of how long your training course is, you should always have time reserved for the wrap-up at the end of each training day. Ask participants to think about what the key take-aways are for them and what they can implement in their professional lives - for these wrap-ups you can use for example the "Introductory Activity 4. - The tree exercise" or the "Closing Activity 1. - Developing action plans". Leave time for a longer wrap-up at the end of the whole training to share conclusions, experiences and personal transformations.

Participants learn best from activities if the trainers deepen the topic and help to form powerful insights around their experiences. The following questions are great starting points:

- *What happened?* Get participants to share their opinions and experiences, and facilitate vulnerable sharing safely!

- *What was important for you? What came up for you?* Help to summarise what has happened, what aspects of the experience were the most important for the participants, and facilitate the interpretation of the activities.
- *How can you use this/how can this help you in the future?* After sharing it is important to help participants to think about the ways they might use the new knowledge in their work and practice, and identify the acquired skills and strengths that will help them to provide better help for LGBTI+ people.

During this process you can ask open questions, let participants find their own answers, and encourage the group to formulate what topics/activities are important and useful for them. Be open to new directions, but be aware of the limits of your own competence and the aims and boundaries of the training: don't let the group go into directions (emotional or other) where you can't handle the situation.

How to deal with the limits of your knowledge?

The topic of LGBTQI+ mental health is vast - to say the least. There may be times when you will encounter questions as a trainer that you are not sure how to answer. It is important for you to model curiosity and open-mindedness to the participants, thus saying "I don't know." can be a great opportunity to model these values. You can say: "I am not sure about how to answer this/I don't know the answer to this." You can share ideas about how to search for the answer, you could do a mini research process with the participants. As a general rule, a lot of the time there are no "right" answers to complex questions, there are a lot of things we simply just don't know about sexuality and gender. The whole point is exactly this: sexuality and gender are much more complex and diverse structures than the dominant narratives led us to think. Arriving at a point where we can allow for uncertainty and complexity is a good place to be, and is a precursor to more empathy and more inclusivity. As a trainer your role is to model how to confidently own your lack of knowledge and bring a perspective of curiosity to matters. You can also point out that in the heteronormative narrative a lot of things are framed as "true", "real" and "natural", and the reality is much more uncertain and complex thant that - thus it is okay to have questions and not to know things for sure.

Provide a safe environment

Keep in mind that even though this training is aimed at professionals who have the intention to broaden their professional knowledge and set of tools regarding LGBTQI+ topics, they may express hostility or negative attitudes towards LGBTQI+ persons - even unintentionally. Direct attacks against anyone (including participants) should not be tolerated, especially if it is based on their sexual orientation, gender identity or sex characteristics. This should be covered and clarified when discussing the rules at the beginning of the training.

Even though not openly hostile, participants may still make negative comments based on unconscious stereotypes and/or lack of knowledge. The topic of LGBTQI+ concepts and LGBTQI+ mental health can be new to some participants, who might hold unintentional prejudicial views on LGBTQI+ topics or have only superficial knowledge. Professional differences unrelated to LGBTQI+ issues might also result in difficult comments or conversations.

It is the trainer's responsibility to address and deal with these incidents. Trainers should maintain a safe environment for all participants, but provide opportunities for everyone to ask questions and share doubts or misconceptions.

With proper preparation and sensitivity, the trainers should be able to deal with LGBTQI+-phobic behaviour and heated discussions, while maintaining group cohesion. You can prepare yourself for such situations by getting fully familiar with the Handbook, having answers to the most frequent questions/misconceptions/stereotypes, and having the necessary knowledge and being comfortable enough with the topic. Reading the section on Microaggressions from Module 4 can be helpful, as you can possibly utilise heated debates and microaggressions that occur as a teaching moment in the training. You can also use the resources listed below to come up with ideas about how to react when debate or subtle aggression takes place at your training.

- Addressing microaggressions in the classroom. (n.d.). *Center for Teaching and Learning*. Retrieved 25 October 2021, from https://teaching.washington.edu/topics/inclusive-teaching/addressing-microaggressions-in-the-classroom/
- University, C. M. (n.d.). *If you notice a microaggression, acknowledge it. - Eberly Center—Carnegie Mellon University*. Retrieved 25 October 2021, from https://www.cmu.edu/teaching/designteach/teach/classroomclimate/strategies/microaggression.html

We also encourage you to look up some trauma-informed facilitation guides or checklists, reflect on your facilitation practices and reach out to colleagues who are more experienced with dealing with trauma and facilitating sensitive topics. Get to know the definition and meaning of safe space, trauma and triggers. The sources below might be a good starting point.

- Carello, J. (2020). *Creating Trauma-Informed Teaching and Learning Environments: Self-Assessment Questions for Educators*. Google Docs. https://drive.google.com/file/d/1YgIDq6zTcYvUAHFZF7X1mFjb73tyrHHi/view?usp=sharing&usp=embed_facebook

- Carello, J., & Butler, L. (2015). Practicing What We Teach: Trauma-Informed Educational Practice. *Journal of Teaching in Social Work*, *35*, 262–278. https://doi.org/10.1080/08841233.2015.1030059

- Sweeney, M.-M. (2017, May 8). *Trauma-Informed Facilitation • FacilitatingXYZ*. FacilitatingXYZ. https://www.facilitating.xyz/trauma-informed-facilitation/

Preparing the training materials

In the introduction of each training activity, you can find the exact materials to prepare. In case you adapt the methodology of implementation to your specific target group, add further materials to your list based on your needs. Take into consideration the size of the group you will train, as well as pay attention to participants with possible special needs.

Overview of the training activities

Section 1 - Introduction to the handbook and the training

	"Mapping our narratives about LGBTQI+ persons" *Introductory Activity 1.* *45 mins, Sensitivity: Moderate level, Max. 14 participants*
	"Comfort Zones" (Introductory Activity) *30 mins, Sensitivity: Low level, Max. 25 participants*
	"Fears and concerns around LGBTQI+ clients" (Introductory Activity) *30 mins, Sensitivity: High level, Max. 14 participants*
	"The tree exercise" (Introductory Activity Activity) *30 mins, Sensitivity: Moderate level, Max. 30 participants*
	"99 problems of an LGBTQI+ person"(Introductory Activity). *15-30 mins, Sensitivity: Low level, Any number of participants*
	"Developing action plans" (Closing Activity) *10-15 mins, Sensitivity: Low level, Max. 25-30 participants*

Section 2 - LGBTQI+ 101

Module 1 - Terminology	**"Vocabulary Extravaganza"** *40 mins, Sensitivity: Low level, At least 5 participants*
	"F(earfully) Asked Questions" *30 mins, Sensitivity: Medium level, Large group*
	"This is what an LGBTQI+ person should look like" *30 mins, Sensitivity: missing, Max. 25-30 participants*
	"Act like a lady" *50 mins, Sensitivity: High level, 15 participants*
	"Circles of Human Sexuality" *45 mins, Sensitivity: Medium level, 5-12 participants*
Module 2 - Transgender, gender-diverse and sex-diverse persons	**"Gender Confusion"** *90 mins, Sensitivity: Medium level, 10-30 participants*
	"Gender Roles" *60 mins, Sensitivity: Moderate level, 15-30 participants*
	"Gender Identification" *30 mins, Sensitivity: Moderate level, 20-30 participants*
Module 3 - Coming out	**"Coming out in a reversed world"** *20-60 mins, Sensitivity: Moderate level, 6-30 participants*
	"Icebergs and snowflakes of our identity" *30 mins, Sensitivity: High level, Max. 12 participants*

Module 4 - Human rights and the systems of oppression	**"Quiz: How much do you know about the human rights of LGBTQI+ persons?"** *15 mins, Sensitivity: Low level, Max. 25 participants*
	"The privilege walk" *40 mins, Sensitivity: High level, Min. 10 participants*
	"Everyday violence" *15 mins, Sensitivity: Moderate level, Min. 5 participants*
Module 5 - Mental health risk and minority stress	**"The sound of silence"** *15 mins, Sensitivity: Moderate level, Min. 5 participants*
	"The body keeps the score" *15 mins, Sensitivity: Moderate level, Min. 8 participants*
Module 6 - Personal and professional prejudices	**"First thoughts"** *60 mins, Sensitivity: High level, 20-25 participants*
	"The stereotypes game" *15-20 mins, Sensitivity: Medium level, 30 participants*
	"Your Stereotypical Life Story" *10 mins, Sensitivity: High level, Large group*
	"The road to hell is paved with good intentions (role play)" *60 mins, Sensitivity: Highlevel, 25-30 participants*

Section 3 - Field-specific guides for training mental health professionals

Module A – Hotline/Chat Operators	**"Open discussions and case studies"** *60 mins, Sensitivity: Moderate level, any number of participants*
Module B – School Counsellors	**"Create relevant case studies"** *30 mins, Sensitivity: Moderate level, any number of participants*
Module C - Clinical psychologists	**"Elephants in your field"** *60-90 mins, Sensitivity: Moderate level, Groups of 5 participants*
	"Guidelines" *50 mins, Sensitivity: Low level, Groups of 5 participants*
	"Trust journey" *30 mins, Sensitivity: Low level, Max. 20 participants*
	"Imagine alternative paths" *40 mins, Sensitivity: Moderate level, Max 16 participants*
Module D - Social Workers and Services	**"Reflecting on one's own values"** *60 mins, Sensitivity: Low level, Max. 30 participants*
	"Resources" *60 mins, Sensitivity: Low level, Max. 50 participants*
	"Key questions" *60 mins, Sensitivity: Low level, Max. 50 participants*
	"Social situations" *60 mins, Sensitivity: Medium level, 15 participants*

Checklist for trainers

Before the training

- [ ] Study the handbook and additional materials you need for the training
- [ ] Familiarise yourselves with the mental health fields your participants are working in
- [ ] Reach out to someone to supervise the planning process, if necessary
- [ ] Think through your facilitation practices and adjust them to be more trauma-informed
- [ ] Adapt training materials to the local context and to the professional profile of the participants
- [ ] Curate a list of useful, locally relevant information to participants
- [ ] Prepare and print supporting material:
    - [ ] Agenda
    - [ ] Handouts
    - [ ] List of useful information for professionals
        - [ ] List of available health and legal services for clients
        - [ ] List of LGBTI+ organisations and services provided
- [ ] Plan the schedule of the training and divide roles between trainers

During the training

- [ ] Establish ground rules
- [ ] Encourage active participation
- [ ] Provide clear instructions
- [ ] Keep track of time
- [ ] Deepen the conversations and facilitate insight
- [ ] Be ready to address microaggressions or other hostility
- [ ] Reserve time for comments and questions where needed, and for wrap up at the end of the day/training

Introductory activities

You can use these activities in the beginning of your training for assessing participants' previous knowledge, attitudes, skills and experiences. These activities can also be used with little modifications for deepening the knowledge and theory delivered in the target group specific modules (Module A-D), to bring theory closer to mental health professionals' everyday practices.

Introductory Activity 1. - "Mapping our narratives about LGBTQI+ persons"

Time: 45 mins

Sensitivity: Moderate level

Purpose:

- To assess and explore participants' narratives about LGBTQI+ persons
- To map beliefs, knowledge and attitudes through participants' life journey
- To help participants think critically about social situations and knowledge
- To help participants explore

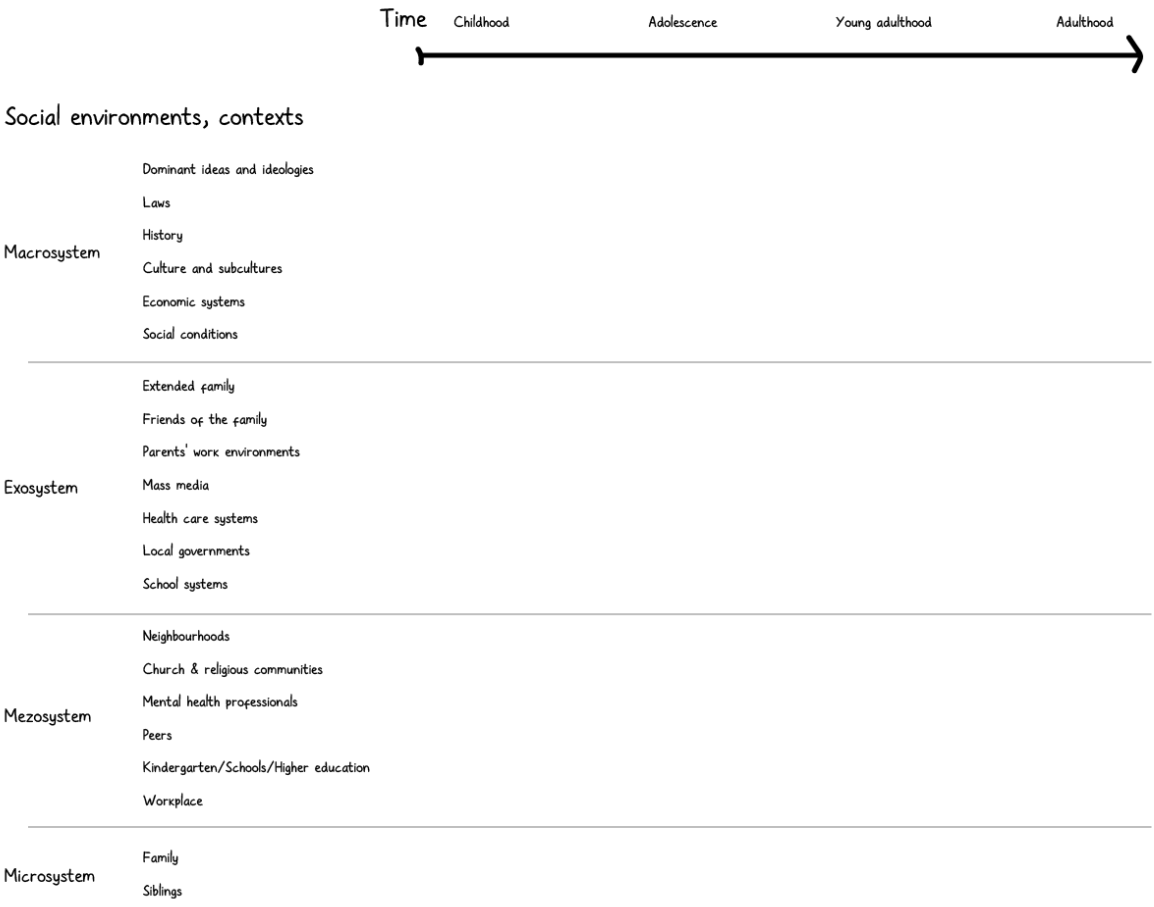
Requirements:

- Group size:
  - Big group with all participants (max. 14 participants); or
  - Smaller groups with 3-4 participants
- Materials:
  - A big poster with the structure outlined below on it
  - Small prints or drawings of the structure (for small group work)
  - Post-it notes
  - Markers, writing utensils

Description

In this activity participants will map the many influences they've had on their knowledge, attitudes and skills around sexuality and gender. Sexuality and gender are present in our lives in many ways and in many situations, although a lot of the times we don't notice it, especially if our identities are priviledged in some way or comform to the heteronormative ideal. Exploring where and what we've learnt about sexuality and gender, how we've come to the knowledge we hold today is a powerful exercise and a great foundation to professional development.

Participants will have a flipchart paper with the following structure in front of them:



The structure has two dimensions: one is a timeline on which different life stages are marked, the other is a list of different social environments and contexts based on Bronfenbrenner's Ecological Systems Theory. According to this theory we live and navigate in multiple social systems that are different in their sizes, distances from us, direct or indirect availability.

Ecological systems theory. (2021). *In Wikipedia.* https://en.wikipedia.org/w/index.php?title=Ecological_systems_theory&oldid=1038677351

Participants' task will be to come up with different messages, memories, things that happened to them or they've heard during their life about sexuality and gender. You can work with all participants in a big group, having participants put their thoughts on post-its and stick the post-its on the flipchart. Or participants can work in small groups or individually, just make sure you have smaller versions/prints of the structure above that you can hand out to them. They can use post-its, or they can write directly on the paper they have. For small group work it is advised to have 3-4 participants in a group, as this is a somewhat sensitive activity with a lot of personal storytelling. You can also provide the following questions to participants to guide their ideation, or you can facilitate the conversation along these questions if you work in one big group.

- Think about the first time you became aware of your gender: when was it? Where and how did you express it? How did you know you were a "boy" or a "girl"?
- Do you have a memory of first love or first feeling attraction towards someone? What expectations were communicated toward you regarding love and relationships?
- Do you know when you first became aware of your sexuality? When and how did you get information on romantic and sexual orientation?
- Was it allowed to talk about sexuality in your family? With your peers at school?
- Did you have sex education in kindergarten, elementary and secondary school?
- Where did you learn about sexuality, orientation, sexual health, gender identity?
- What do you think about the quality of education on sexual orientation and gender identity during your undergraduate, graduate and postgraduate education?
- Were sexuality and special aspects of work with LGBTQI+ persons included in the curriculum of your professional education and to which extent? Do you feel competent enough to work with LGBTQI+ clients?

- Did you ever watch a movie or a TV series that brings up LGBTQI+ themes? Do you know an actor or an actress who identifies as LGBTQI+ (abroad and in your country)? Can you name movies or TV serials that have LGBTQI+ persons as main characters or portray LGBTQI+ topics? What would you say about stereotypes on different LGBTQI+ (lesbian, gay, bisexual, trans, etc.) identities in movies?
- Is your society liberal toward diversities or homophobic and heterosexist? Do you feel safe in your society? Have your clients ever experienced violence due to their LGBTQI+ identity?

Questions for debriefing:

- We hear a lot in our society that sexuality is a private matter which only belongs to our bedrooms. Based on these post-its and stories does this sound true to you?
- How do you feel about your current knowledge, concepts and attitudes around sexuality and gender?
- What stories and examples stood out most for you? Why?

Notes for trainers

You can use this activity to introduce participants to the concept of "Content Diet". Content Diet refers to the types of information we choose to consume on a daily, weekly basis. In this activity it became clear that surrounding information and content is really powerful in shaping our knowledge and attitudes, and as adults we have the opportunity to seek out more diverse content to consume. Participants can make a map of the different platforms and types of content that is in their lives, and can brainstorm together how to make it more diverse (for example following LGTBQI+ organisations and activists online).

Introductory Activity 2. - "Comfort Zones"

Time: 30 mins

Sensitivity: Low level

Purpose:

- Assessing attitudes and levels of comfort with professional situations regarding LGBTQI+ persons

Requirements:

- Group size:
  - Max. 25 participant
- Materials:
  - Flipchart paper with the Learning Zone Model
  - Post-its

Description

Participants will assess their own comfort levels with different situations they might come across in their practice as a mental health professional regarding gender and sexuality. For this we advise to use the Learning Zone Model (or you might also come across this tool named "Comfort Zone Model").

Before introducing participants to the Learning Zone Model, get them each to list a few situations that could happen in their practices which have some relevance to sexuality and gender. Might an LGBTQI+ person come out to them? Might a gender questioning person ask them to call them a different name than the one they used to? Might a person unsure about their sexual orientation ask explicit questions about sexuality or sexual acts? You can come up with an initial list of situations yourself, and get participants to complete that list with new elements, or you can brainstorm with your participants from scratch.

After you've collected several ideas, introduce the Learning Zone Model to your participants. For this, have three concentric circles drawn on a flipchart paper: the innermost circle will symbolise the Comfort Zone, the second circle will be the Learning Zone, and the outer circle will be the Discomfort or Panic Zone.

The Learning Zone Model: Moving Beyond Your Comfort Zone. (n.d.). Retrieved 26 October 2021, from http://www.mindtools.com/pages/article/learning-zone-model.htm

You will read out the situations you've collected one by one, and participants will have to stand in the circle they feel is suited to their comfort level with the situation. For this you will need to "draw" out the three circles in the room, you can use chairs or post-its stuck to the floor to implicate where each circle starts and ends.

After reading out a situation and once participants have chosen their circles, you can ask some participants to share their reasons for choosing which circle they stood in. Ask participants from every circle, and if no one is standing in one of the circles, ask participants to imagine what a person who chooses that circle to stand in might know or feel.

Questions for debriefing

- How do you recognise that you are at this comfort level? What makes it different from other situations?
- What can you do to make yourself feel more competent in this case or increase the ability to cope with situations like this? What helps you to feel safer in situations like this?
- What resources do you need?

Introductory Activity 3. - "Fears and concerns around LGBTQI+ clients"

Time: 30 mins	**Sensitivity:** High level

Purpose:

- To assess the current attitudes of participants
- To help participants verbalise the concerns they might have around LGBTQI+ persons or topics as a professional

Requirements:

- Group size:
  - Max. 14 participants
  - For groups of more participants read the notes
- Materials:
  - Post-it notes
  - Markers

Description

Participants write down their professional concerns about working with LGBTQI+ persons on post-it notes. These post-it notes will be collected, shuffled and then participants will get a random post-it they will read out loud. Thus the concerns that participants write down will be read out loud, but the writer of the post-it will remain anonymous. The trainer should tell the participants in advance that what they write will be read out loud, so write accordingly.

After shuffling and picking a random note everyone reads their note out loud as if it is their own problem, and then tries to think about how they would assess the issue. After the participants tell their initial ideas, you can open up the circle and let others reflect on the concern. After everyone has read their notes, the group discusses the activity.

Questions to help reflect:

- How did it feel to hear your concerns read out loud?
- Did it help to hear your concern from another perspective?
- Did you get closer to resolving the concern?
- How can you utilise other people's perspectives?
- How did it feel to read someone else's concerns?
- Did you notice anything common among the notes? Did any common theme emerge for you?

Notes for trainers

If you have more than 14 participants, we suggest splitting the group into smaller groups of 3-6 participants after collecting and redistributing the post-its. The smaller groups can read out and discuss the concerns and they can bring the most difficult or most common concerns back to the whole group. This way the big group needs to discuss only a selected range of concerns, and you can save time.

A tip: to help participants open up their thinking and find new solutions to their concerns, try to frame the questions as a How Might We question. These questions are used in Design Thinking trainings. An example: the shared concern might be that one doesn't know how to respond to a client's coming out, and in this case the How Might We question would be something like "How might we respond in a way that the client feels safe?" or "How might we respond in a way that the client feels heard and seen?"

How Might We | Design Kit. (n.d.). Retrieved 2 November 2021, from https://www.designkit.org/methods/how-might-we

You can also open up the brainstorm by a method called Opposite Thinking. Ask the participants to come up with ideas that are the opposite of what you look for. They can come up with the worst examples or a list of signs that shows they are failing. For example: "What would be the worst way to respond to a client's coming out?" or "How would you know that you have not responded in the best way?"

You can use the post-its written during the activity in a closing activity at the end of the training. You can revisit the most pressing or common concerns, and see how participants feel about them at the end of the training. They can talk about whether and how the training has helped them to feel calmer about these challenges.

Introductory Activity 4. - "The tree exercise"

Time: 30 mins	**Sensitivity:** Moderate level

Purpose:

- To assess current skills and competencies
- To outline professionals goals, improvement plans

Requirements:

- Group size:
  - Max. 30 participants
- Materials:
  - Flipchart papers
  - Markers

Description

This activity is adapted from the book: *Becoming a Trainer in Adult Abuse Work: A Practical Guide* by the author Jacki Pritchard. The goal of the activity is to outline participants' skills and competencies that can aid them in their work and practices with LGBTQI+ persons. They map the skills and competencies they currently have as branches of a tree (a little similar to the Mind Mapping technique), and they can also map the skills and competencies they lack or would like to acquire during the training. You can use these tree drawings through the training, and participants can add new branches to it as they learn.

Hand out flipchart papers to participants, and ask them to draw a tree trunk on them with a few branches on the left and on the right, but leave a lot of spaces for new branches at the top. On the branches on the left they will draw leaves and write different skills and competencies they have

into the leaves. These skills and competencies are the ones they currently have and that can help them with LGBTQI+ clients and with creating inclusive practices.

After the participants are ready, ask them to stick the drawings on the wall. They will have some time to look at each other's drawings, then you can facilitate a discussion about the skills and competencies outlined. Ask the group to comment on the skills they possess, then to identify the skills that are missing.

Notes for trainers

You can also use the drawings in one of the closing activities, as it can help the participants reflect on where they were at the beginning of the training, how they have grown and what they have learnt. If you use this activity as a closure to another activity or to the training itself, ask participants to draw leaves on the right side of the tree with the new skills and competencies they acquired during the activity or the training. At the top of the tree where they've left some place to new branches, participants can list further skills and competencies they may need, they can identify their weaknesses, concerns and gaps in knowledge they will need to work on further. As a closing exercise, have every participant talk for a few minutes about their own tree in front of the group.

You can also complement this activity with introducing the concept of Fixed and Growth Mindset. See, trees can grow new branches with time, professionals can become competent in new fields and situations. Your participants might need some encouragement like this.

- Popova, M. (2014, January 29). Fixed vs. Growth: The Two Basic Mindsets That Shape Our Lives. *The Marginalian*. https://www.brainpickings.org/2014/01/29/carol-dweck-mindset/
- Pritchard, J. (2001). *Becoming a Trainer in Adult Abuse Work: A Practical Guide|Paperback*. Barnes & Noble

Introductory Activity 5. - "99 challenges of an LGBTQI+ person"

Time: 15-30 mins	**Sensitivity:** Low level

Purpose:

- To explore experiences and stories participants have with clients of different sexual orientation, gender identity and sex characteristics
- To explore participants' thinking regarding mental health and LGBTQI+ identities

Requirements:

- Group size:
  - Any group size
- Materials:
  - Post-it notes
  - Markers

Description

This activity is for getting a general idea of what participants think of working with LGBTQI+ clients, what their ideas are of the issues their clients might seek help with, and how they think these challenges and problems are connected to sexual and/or romantic orientation and gender. The activity might reveal that participants focus mainly on problems related to LGBTQI+ identities, and don't take into account "regular" problems people can seek help for.

Ask the participants to write on post-its topics and problems with which LGBTQI+ persons might seek the help of a mental health professional. Ask them to make the description very short, try to stick to one word, if possible. After everyone is finished, each participant sticks their post-its on a wall or flipchart, and reads their ideas out loud. When all of the post-its are visible, the trainers

facilitate a conversation on why these ideas were selected and what aspects of these problems are related to sexuality and gender.

Notes for trainers

You can use this activity at various points in the training. You can use it at the beginning as a general exploration activity, or as a warm-up activity at the beginning of different modules and specific topics.

Closing activities

Closing Activity 1. - "Developing action plans"

Time: 10-15 mins	**Sensitivity:** Low level

Purpose:

- To help participants to develop a personal action plan and to improve the inclusivity of their practice

Requirements:

- Group size:
  - Max. 25-30 participants
- Materials:
  - Sheets of paper
  - Stationery
  - Envelopes

Description

This activity is adapted from the book: *Becoming a Trainer in Adult Abuse Work: A Practical Guide* by the author Jacki Pritchard. The goal of the activity is to help participants to sustain their learning after the training and to make them think about ways they can apply their new knowledge. Participants may be very enthusiastic about the course and what they have learnt but as soon as they go back to the workplace, much of the information may go to the back of their minds. They need to go away with a simple action plan which will act as a trigger to remind them about what they need to do in the following three months.

Participants will at first work individually. Ask them to think about what they need to develop in their practices (these can be subject areas, skills, attitudes, etc.), and to brainstorm five tasks they

can do in the next three months to achieve these developments. After they have drafted their plans, they can share these plans in small groups (3-4 participants) to get inspiration and ideas from each other. They will be asked to put their final action plan into an envelope, and write "LGBTQI+ inclusive practice" on the envelope. They can also write encouraging or important thoughts on the envelope. Then ask the participants to put a reminder in their online or offline calendars three months from the training date called: "Open LGBTQI+ inclusive practice envelope!". They will revisit their stated goals and actions then, and make adjustments where needed.

You can also help participants to brainstorm about other accountability practices they can implement to sustain their learning. For example, they can choose one of their colleagues to be their accountability buddy.

SECTION 2
LGBTQI+ 101

Section 2 - LGBTQI+ 101 outlines the most important knowledge on LGBTQI+ persons lives, identities and challenges, complemented with suggested activities that can deepen participants' learning, shape their attitudes and enhance specific skills. Section 2 consists of 6 modules that provide an introduction to the most important LGBTQI+ topics: *Terminology; Trans and gender-diverse persons; Coming out; Human rights and systems of oppression; Mental health risk and minority stress; Personal and professional prejudices.*

The knowledge and activities in Section 2 target mental health professionals generally - thus these sections can be used with all four of the specific target groups.

How to use these modules

Familiarise yourself with the theoretical concepts described in the module. If you feel the need for further information, use the suggested resources collected at the end of the Handbook. You can create a presentation and handouts from the texts in this module. Make sure you tailor the theoretical content to your audience considering the professional background your participants might have in LGBTQI+ terminology.

Note on the terminology

Through the handbook we will use the LGBTQI+ acronym most of the time. A lot of variations exist in this acronym that refer to sexual/romantic orientation and gender identity, and there can be different ideas and ideologies around what identities the acronym should contain and exclude. We decided that we will use a form of the acronym in which the biggest groups of persons of different sexual orientation and gender identity are signalled explicitly with a letter, and the plus stands for further groups. We have decided to involve the letter Q most of the time, despite queer being a broad umbrella term that includes a lot of individuals with varying levels of "passing" or conformity. Queer persons can live with very different levels of challenges and exclusion, some of them might experience much fewer difficulties and less oppression from the dominant culture than other oppressed groups. However, passing and apparent conformity can be a part of gay, lesbian, bisexual and trans identities and expressions too. As you can see, this is a very complex topic tucked into a compact acronym. That is also why we will refer to sexually and gender diverse individuals with the term LGBTQI+ persons - we would like to signify the heterogeneity and complexities of these groups. The LGBTQI+ "community" consists of individuals with very different experiences and identities.

Module 1 - Terminology

Topics in this module: Basic termonology; Foundational concepts of sex, gender identity and gender expression; Terminology; Sexual orientation and gender identity; Thinking outside the box and non-binary thinking

Relevance

It is important for professionals to be familiar with LGBTQI+ concepts and terminology; to be able to grasp the complex ways gender identity/experience, and sexual and/or romantic orientation can be related; to be able to use the terminology in a flexible way.

Aims

This module serves to broaden participants knowledge of LGBTQI+ terminology and the key differences between gender identity and sexual orientation, and explains the importance of unboxing and non-binary thinking.

After this module, the participants will be able to:

- Understand the key differences between gender identity and sexual orientation;
- Feel more comfortable discussing LGBTQI+ issues;
- Be able to correctly and inclusively use the relevant LGBTQI+ terminology.

Knowledge base for trainers

Statistically speaking, at some point in their careers, counsellors, social workers, hotline/chat operators, psychologists, therapists will almost surely come across clients who identify as LGBTQI+, so they need to be prepared to work with this population. When working with sexual and gender diversity it is important for professionals to be able to use LGBTQI+ concepts comfortably and inclusively. Talking to the client is one of the most extensively used tools in counselling and every professional must be aware of the importance of the words that are used.

Also, it is important to keep in mind that the language and terminology are also changing and evolving. The terms that were a part of everyday language before (for example, the term "homosexual") now carry negative connotations and should not be used. The language can be more challenging when working with trans persons (or persons who are questioning their gender identity). Besides knowing the basic terminology, it is also important for the professional to be open to the client's own definitions. LGBTQI+ clients don't necessarily know the terminology and concepts outlined in this chapter, they can have ideas and knowledge about gender and sexuality that are in line with societal binary thinking. You can guide them through these concepts if you feel that it could help the client in their identity exploration or in understanding themselves better, but you should restrain from correcting the labels they are identifying with.

During this section it is recommended to give time and space for questions to clear up any confusion participants might have. It may be useful to use a presentation or flipchart or other forms of visualisation to enhance understanding. This section is particularly important as it lays down the basic definitions and the mindset that we will use throughout the training.

Basic terminology

Terminology listed: Lesbian, Gay, Bi(sexual) person, Trans person, Queer, Intersex

Even though participants might have already heard the LGBTQI+ acronym before, there might be confusion regarding the different letters and other acronyms used, therefore it is important as a trainer to explain each letter and clear up confusion.

Note: The appropriate use of terminology might vary across countries, regions and communities. As a trainer you should check what is used and accepted in your country before the training.

The letters LGBTQI+ stand for lesbian, gay, bisexual, trans, queer and intersex people. This acronym or the LGBTQI+ acronym is commonly used by the community as well. Throughout this material we will use the LGBTQI+ acronym, where the + stands for all further groups of sexually and gender diverse persons not included in the acronym. Sometimes we refer only to one group within the LGBTQI+ spectrum. The acronym refers to a great variety of people, so emphasise to

the participants that it is also important to recognise the diversity among LGBTQI+ persons and that different persons can have very different challenges.

Lesbian
Refers to a woman who has a romantic and/or sexual orientation towards women.

Gay
Refers to a man who has a romantic and/or sexual orientation towards men. Also this is a generic term for lesbian and gay sexuality and romance, as some women define themselves as gay rather than lesbian. Some non-binary people may also identify with this term.

Bi(sexual) person
Bi is an umbrella term used to describe a romantic and/or sexual orientation towards more than one gender.

Bi people may describe themselves using one or more of a wide variety of terms, including, but not limited to, bisexual, pansexual, queer, and some other non-monosexual and non-monoromantic identities. Sometimes they identify their attractions with the word lesbian or gay.

Cisgender
Denoting or relating to a person whose sense of personal identity and gender corresponds with their sex assigned at birth.

Heterosexism
Discrimination in favor of heterosexual and against homosexual people.

Trans person
An umbrella term for people who 'transgress' gender boundaries: whose gender identity, experience of gender and/or gender expression differs from what is typically associated with the sex they were assigned at birth. People under the trans umbrella may describe themselves using one or more of a wide variety of terms - including trans, non-binary, gender fluid, etc.. It is important to underline that a trans identity is first and foremost an experience, thus it is not dependent upon physical appearance or medical procedures.

Queer

Queer is a term used by those wanting to reject specific labels of romantic orientation, sexual orientation and/or gender identity. The term conveys the fluidity of the human experience contrary to the notion of fixed identities. Also used as an umbrella term to describe individuals who don't identify as straight, and to describe people who have a non-normative gender identity.

Intersex

Individuals born with any sex characteristics that can not be clearly categorised as 'male' or 'female', or can be categorized as both. These sex characteristics may be chromosomes, gonads, sex hormones or genitals. The differences in these characteristics might be revealed at birth, later in life or some intersex people might never find out about them.

For more definitions see the Glossary at the end of the Handbook.

For more detailed information on trans and intersex identities see Module 2.

Foundational Concepts

Conceps listed: Sex, Gender, Gender identity, Sexual orientation, Gender expression

After introducing the LGBTQI+ terms, the most important is to help participant familiarise themselves with the four fundamental concepts: sex / sex assigned at birth, gender identity, gender expression and sexual and romantic orientation. The design of later modules expects the participants to be familiar with these concepts, so make sure you have time to thoroughly discuss these topics. You should remind participants that these terms concern everyone, not just LGBTQI+ people.

Sex

Sex, also known as sex assigned at birth, describes the physiological makeup of a human being, meaning the combination of one's genes, hormones, biochemistry, internal and external anatomy, affecting the physical body (Denton, 2016). We have all heard of the binary male and female sex assignments at birth. The sex assigned at birth means that medical personnel make a decision about whether the person was born male or female based on certain sets of physical features (genitalia, chromosomes, gonads, hormones, etc.) when the baby is delivered. There are people who fall outside the sex binary, for example intersex people, who are born with a reproductive or sexual anatomy that does not fit into the typical binary categories.

Gender

Gender refers to the construct of socio-historical and cultural roles given to people usually based on their sex assigned at birth. Gender roles are how a society thinks an individual should behave, based on the labels of either being born male or female, including personality traits, mannerisms, duties, and cultural expectations (Jourian, 2015). Gender is also a socially constructed definition of the relationship between the sexes, which contains an unequal relationship of power with male domination and female subordination in most areas of life. For example, starting from a very young age, girls are encouraged to behave in certain ways – to be gentle, to be caring, to be soft, to play with certain toys (dolls and not cars), to sign up for certain sports – like ballet, skating etc. rather than to play football. Boys are expected to be strong, aggressive, assertive, not to show emotions, they are expected to not be sensitive, to not talk about their fears, to play with

gender-specific toys – guns, cars etc.

Gender identity

Gender identity is a person's own self-conception and experience of gender, the individual's internal sense of being either male or female or an identity between or outside these two categories. Individuals do not choose their gender identity; rather they explore what already is there. Our gender identity is a core and integral part of our identity, and it is not something we really make decisions about. How and when we use the different gendered labels is a decision, but the inner sense and experience of our gender is not. One's gender identity can be the same as (cisgender) or different from (including trans) their sex assigned at birth. One's external appearance usually through behaviour, clothing, hairstyle, which may or may not conform to socially defined behaviours, is described as gender expression. Expectations regarding gender are communicated through every aspect of our lives, including family, culture, peers, schools, community, media coverage. Pressures to conform to these expectations at home, bullying by peers in school, and social isolation are just some of the struggles facing a person whose gender expression does not follow the rigid binary gender system. We cannot and should not presume someone's gender identity by their gender expression: how we interpret someone's behaviour and what we assign to that is all about our own belief system, not about who the other person is.

Romantic and sexual orientation

Romantic and sexual orientation encompasses one's romantic, sexual, and/or emotional attractions to others, which might also include sexual behaviours and fantasies. The labels people use to describe their sexual orientation, also known as sexual identity or sexuality, are vast: heterosexual, gay, lesbian, bisexual, queer, asexual (please refer to the glossary). The Kinsey scale developed by Dr Alfred Kinsey, Wardell Pomeroy and Clyde Martin in 1948 demonstrated that people cannot all be described as either homosexual or heterosexual exclusively. Thanks to developments since then, we view sexuality and gender on a spectrum.

Having the perspective of these four concepts of sex, gender identity, gender expression, and sexual orientation as four fluid and non-binary continua gives us the space to discuss gender and sexuality in complex ways. Furthermore, it allows the freedom for agency and self-identification

by the client. A person born with a penis was probably assigned male at birth (sex), may self-identify as female (gender identity) and present to the world in feminine ways (gender expression). This individual might be sexually and romantically attracted to females, males, or both (sexual and romantic orientation). This person may or may not be interested in gender affirming surgery. Gender expression is very fluid: a person born with male characteristics can have a non-binary gender expression; a person born with male characteristics and identifying as gay might demonstrate a very masculine gender expression, or the opposite: a man who is heterosexual could be very feminine or metrosexual in their presentation. Furthermore, regardless of their sex assigned at birth, gender identity and romantic orientation a person can identify as asexual – having no sexual attraction towards other people. Sometimes gender non-conformity and gender-fluidity is a statement of not accepting the binary model of gender identities, an action of exploring how a person feels best in his gender identity, gender roles and gender expression.

To better grasp these concepts, we encourage you to use "The Genderbread Person" educational material. You can find it at www.genderbread.org

Thinking outside the box and non-binary thinking

It is very important for your participants to understand is that professionals providing psychosocial and psychotherapeutic support or operators should not pathologize, not label the client, not assume the sexual orientation and gender identity and minimize heterosexual bias (instead of using "wife" and "husband", "boyfriend" or "girlfriend", try using "partner" when exploring relationships, for example). One advantage of a stereotype or fitting people into boxes is that it enables us to respond rapidly to situations because of the generalised experiences. On the other hand it makes us ignore differences between individuals. The use of presumptions is a major way in which we simplify and make sense of our environment and social world; since they reduce

the amount of processing (i.e. thinking) we have to do when we meet a new person or find ourselves in a new situation. So, the need for trying to fit other people into categories, is the natural default process, being aware of this helps rethink automatisms.

However, if a professional asks questions that lead to the client's self-identification, this would allow them to learn the language which the client uses (as language evolves, terms describing sexuality and gender change, influenced by context, culture and people), the pronouns which they prefer and to meet them where they are. By not imposing our interpretation of the client's gender identity and/or sexual orientation, we are creating affirming, respectful, and safe spaces. Names, labels, and language communicate about our knowledge, assumptions, intentions, and interpretations of LGBTQI+ terms and experiences. Having in mind the complex context in which LGBTQI+ clients live, the psychosocial professional should provide space for them to safely explore who they are at whatever age.

Activities for Module 1

Activity 1.1. - "Vocabulary Extravaganza"

Time: 40 mins	**Sensitivity:** Low level

Purpose:

- To provide an opportunity for participants to increase their breadth and depth of LGBTQI+ vocabulary
- To increase participants exposure and knowledge of a variety of terminology
- To emphasise how powerful language is
- To clear up any misconceptions or questions about terminology or common phrases

Requirements:

- Group size:
  - At least 5 participants
- Materials:
  - Stationery

Description

Start the activity by instructing the participants to what the activity will entail. Let them know they're going to have a few minutes to read through a list of terms. During reading, they should put a check mark next to words they'd like to talk more about and a star next to any new term. Encourage participants to resist reading the definitions and to simply read through the terms. After a few minutes, have participants flip back to the first page and ask what stars or checks people had on that page. Invite a person to read out a word they have marked with a star or a check mark and its definition out loud (or someone else if they don't want to). Ask if the person has questions and then open up the discussion to the group for additional questions and dilemmas. Move to the next term and repeat.

As the participants can be overwhelmed with the amount of vocabulary and information in this activity, it is important to reassure them at the wrap-up of the activity that the goal is not to memorise these words and definitions, but to be familiar with the variety of terminology and concepts so that they can better start and join in on conversations.

Notes for trainers

This activity can easily take 40 minutes, but if you notice that the energy is fading or people are losing interest, consider adding more dynamic to the discussion. For example, you can state: "We're going to do 3 more terms, anyone have one they want to make sure we get to?"

It is also important that these words do not describe the whole of a person's identity, thus using the terms queer, gay, transgender as nouns is limiting rather than affirming. As a general rule, when in doubt, adjectives are always safer. They add on an aspect of someone's identity rather than reducing them to a single identity. For example, it feels different when you say, "Meg is a blonde," vs. "Meg is blonde." With identity terminology, no definition is absolute, or applicable to 100% of the people who use that term to describe themselves. That's okay! Someone can use a word to mean something different from the definition here, and you can provide a definition as an "in other cases" context. These definitions and terms change (sometimes quite rapidly), so don't be alarmed if you haven't seen a term before or have heard a different definition.

Activity 1.2. - "F(earfully) Asked Questions"

Time: 30 mins	**Sensitivity:** Medium level

Purpose:

- To help participants to separate myth from fact, and accurate information from hearsay regarding popular misconceptions about LGBTQI+ persons

Requirements:

- Group size:
  - Large Group
- Materials:
  - Markers
  - Sticky flip-chart paper

Description

Prior to the training, prepare a flipchart (or powerpoint slide) with 5 - 7 common questions you believe your group might have regarding LGBTQI+ persons, but would be afraid to ask (e.g., because they are worried about appearing ignorant or offending someone). Number the questions and write them in a large size and legibly, allowing for people to easily identify them. The numbers allow participants to simply call out a number (instead of having to actually ask the question themselves).

When you begin this activity, hang the flipchart where participants can see them. Provide context for the questions. For example, "These are common questions that folks have regarding LGBTQI+ people and we wanted to provide an opportunity to answer any questions that you have on this sheet. What is the number of one of the questions you would like us to answer?"

Answer each question a participant chooses. Continue until all questions are answered, the group stops choosing numbers, or you are out of time.

Sample "Fearfully Asked" Questions

1. What bathroom does a trans person use?
2. How do lesbians have sex?
3. Are all trans people gay?
4. Is bisexuality real?
5. Why is there a LGBTQI+ community, but not a straight community?
6. Why are gay men more promiscuous?
7. Don't all these labels actually make it worse, not better?
8. In a gay relationship, who is the man?
9. Can I ask someone how they identify?
10. Is a man who dates a trans woman actually gay?

Short Answers

1. Trans male would go to the Male bathroom. A trans female would go to the Female bathroom. In an ideal situation, there would be a gender-neutral bathroom where a non-binary would go to.
2. Sex aims to give and receive certain physical and emotional pleasure. Sexual behavior and preferences do vary from person to person, which also apply in a heterosexual and non-heterosexual context.
3. Sexual orientation and gender identity might be interrelated or completely independent concepts. What that means - a trans man might be attracted to cis

and/or trans men/women. A trans person might have a homosexual/bisexual/heterosexual orientation.

4. It is possible to have a physical and emotional attraction to different gender characteristics at the same time.
5. We live in a heteronormative society with predominantly heterosexual people. It would make sense to have an LGBTQI+ minority community with shared experiences, difficulties, and issues.
6. The core issue in this myth is the prejudice that gay men are having trouble being in a monogamous relationship. There is no statistical data to support this assumption. The variety of sexual partners a person might have in a certain period in their life does not mean that they cannot form a meaningful relationship with only one partner.
7. It is important to respect the definition a person uses about themself - it might be an umbrella term (queer) or a more specific label. It is up to the person to state how they identify, not for others to put a certain label on them.
8. The role of a "woman" and a "man" is strictly connected to heterosexual relationship concepts. In gay relationships, these terms do not apply.
9. Depending on the conversation and the context, it might be suitable to ask someone how they identify in order to have more clarity and to avoid misunderstandings.
10. A man who dates a transgender woman is heterosexual.

Notes for trainers

This format gives you total control to only answer questions you're comfortable answering, and to prepare (or even script out) your answers beforehand. Take advantage of this difference! Practice answering the questions with a co-facilitator or peer. Ask them to challenge you in particular ways you're nervous about encountering in the room. Come up with several distinct ways to

answer every question (e.g., in a really direct, short way; using an anecdote or statistic; situating your answer within a larger picture; using humour) and you'll be able to choose the one, in the moment, that best matches the tone of the room and group you're with.

None of the questions in our sample list are "easy" to answer, nor do they have one correct answer.

Just asking some of these questions, or creating space for questions like this, is potentially opening a can of worms. Be ready for this when you choose your questions, or decide to use this activity.

Activity 1.3. - "This is what an LGBTQI+ person should look like"

Time: 30 mins	**Sensitivity:** Moderate level

Purpose:

- Open up discussion about common myths and stereotypes which LGBTQI+ people live with.
- Enabling the group to grasp the four fundamental concepts – sex assigned at birth, gender identity, gender expression and sexual orientation - and their interrelated but separate nature

Requirements:

- Group size:
  - Max. 25-30
- Materials:
  - YouTube video – LGBTQ+ stereotypes which need to die
  - Genderbread person drawn on the whiteboard for reference
  - Genderbread person handout

Description

The group is positioned in a circle. The trainer plays the video and then opens the discussion. The trainer is leading the discussion by questions, reflecting and pointing out relevant parts of the Genderbread person.

- What can you tell by *looking* and *listening* to the people in the video? Can you tell their sexual orientation, gender identity, sex assigned at birth or gender expression?
- How do we make sense of what we see? Are labels helpful, or do they limit our perceptions? What would be more helpful (eg. continuum or scale model)?

- Why is it problematic to try to guess what someone's sex assigned at birth might be based on their identity and expression? (Because it is based on an assumption; assumptions are usually flawed; these three things need not be connected.)

Notes for trainers

Most misconceptions come from lack of knowledge or the presence of misleading theories. Thus this activity is better executed if it follows the explanation of foundational concepts.

Some helpful thoughts on the questions:

- How do we make sense of what we see? Are labels helpful, or do they limit our perceptions? What would be more helpful (eg. continuum or scale model)? *There are a lot of labels for different configurations on these scales, which are empowering to some individuals and offensive/stigmatising for others. Gender is more complex than what was previously thought.*
- Why is it problematic to try to guess what someone's sex assigned at birth might be based on their identity and expression? *Because it is based on an assumption; assumptions are usually flawed; assumptions are a bad way to think we know someone. The four fundamental concepts – sex, gender identity, gender expression and sexual orientation are interrelated but separate.*

Further reading material:
"The struggles of rejecting the gender binary" – New York Times Magazine article

Activity 1.4. - "Act like a lady"

Time: 50 mins	**Sensitivity:** High level

Purpose:

- To grasp the connection between sexism, heterosexism and transphobia
- To inspire thinking about the cultural variations of gender(s) and contextualise the dominant narrative about gender

Requirements:

- Group size:
  - 15 participants
- Materials:
  - Pieces of paper, pens, pencils, magazines
  - Whiteboard (or large sized paper)
  - Youtube video: https://www.youtube.com/watch?v=jvgvaFFZlZ0 – "Be a lady they said"

Description

Seat the participants in a circle, and let them know that in this exercise there will be some sensitive topics evoking a mixture of emotions, you are going to ask them to say words that are offensive to some people. Hand out pieces of paper and stationery to participants, and make sure to have some magazine pictures lying around in the centre of the circle.

Draw two boxes on the whiteboard or large sized paper that all participants can see. Make sure there is enough space to write and draw both inside of the boxes and outside the boxes. Ask the participants to draw the same boxes on the paper in front of them. Label the first box as "Masculinity", and facilitate discussion about the masculine ideals known to the participants.

- Have any of you been told to "act like a man"?

- How are men supposed to be different from women? (stronger, tougher, in control)
- What feelings is a "real man" supposed to have? (anger, superiority, confidence)
- How do "real men" express their feelings? (yelling, fighting, silence)
- How are "real men" supposed to act sexually? (aggressive, dominant, expected to be sexually attracted to women)

Also ask the participants to look at the magazines in front of them, and choose pictures depicting the "masculinity" ideal. Put the words, phrases and pictures that came up inside the "Masculinity" box.

Now turn the discussion towards men who (can) not fit into the ideal box.

- How is a man who is perceived to be outside this box *called* and *seen*?

Also ask the participants to look at the magazines in front of them, and choose pictures depicting these nuances outside the box. Put the words, phrases and pictures that come up outside of the "Masculinity" box.

Steer the discussion towards the lived experiences to those living or being seen outside the box.

- What things happen to people outside the box? (Harassment, bullying, verbal and physical abuse, ignorance, social exclusion, relational aggression, stigmatisation etc.)

Close the discussion on masculinity and let the participant know you will go through the same questions and process related to the feminine ideal. Label the second box "Femininity". To provide a starting point to the discussion you can play the video "Be a Lady They Said" featuring Cynthia Nixon.

After watching the video facilitate discussion about thefeminine ideals known to the participants:

- How are women supposed to be different from men? (nicer, weaker, more sensitive etc)
- What feelings and attributes is a "real woman" supposed to have? (kind, caring, conforming, organised, etc.)
- How do "real women" express their feelings? (crying, screaming, hysteria, tenderness)

- How are "real women" supposed to act sexually? (follow the man, don't sleep around and the opposite)
- How is a woman who is perceived to be outside this box *called* and *seen*? What do they get called?

Also ask the participants to look at the magazines in front of them, and choose pictures depicting the "femininity" ideal. Put the words, phrases and pictures that came up inside the "Femininity" box.

- What things happen to people outside the box? (Harassment, bullying, verbal and physical abuse, ignorance, social exclusion, relational aggression, stigmatisation etc.)

Also it is very important to explain that while we are looking at the dominant mainstream ideas of gender, we are acknowledging that gender roles may vary depending on ethnicity, culture, class, ability and family etc.

Notes for trainers

These are sensitive topics, people will have anger, sadness, a complex set of emotions around these stigmatising words and behaviours. It is important to create a safe space if they need to talk and explore more. Be ready for some disputes and try to remind them that only respectful behaviours are accepted.

This exercise can be a lead-in for discussions around multiple issues. For example, after the initial questions you can steer the discussion towards the topics of sexism, heterosexism and transphobia and their connections to each other.

Reflection questions for a discussion on homophobia, transphobia:

- What do you notice about the influence of male and female stereotypes on sexism, heterosexism, and transphobia? (You may want to break this into three separate questions.)
- How do the stereotypes listed from the boxes relate to stereotypes for straight and queer people?
- What is the implication of the names that men get called?

- Can men be in the box all the time?
- Which box has more power?
- How do these boxes contribute to the existence of homophobic, transphobic and biphobic behaviors?
- How do we change these societal expectations?

Activity 1.5. - "Circles of Human Sexuality"

Time: 45 mins	**Sensitivity:** Medium level

Purpose:

- To show participants that sexuality is a very broad concept.
- To explore sexuality and its different components.
- To identify issues of sexuality which are important to the group

Requirements:

- Group size:
  - small or large group (between 5 and 15 people)
- Materials
  - Chart papers and markers
  - White board
  - Copies of the Circles of Sexuality handout, pens or pencils.

Description

First, it is very important to review the Circles of Sexuality handout and read the explanation of Circles of Sexuality in here.

After you've done all that, here are the following steps.

First, draw a large version of the Circles of Sexuality on the chart paper or the board. Write 'Sexuality' on the board. Ask participants to brainstorm on the word sexuality, sharing the words that come into their mind. Write these around the word 'sexuality'.

Explain to participants that when they see the words 'sex' or sexuality', many people think of sexual intercourse. Some also think of other kinds of physical sexual activities. However, sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who each person is. It includes all the feelings, thoughts, and behaviors of being female or male, being

attracted and attractive to others, and being in love, as well as being in relationships that include sexual intimacy and physical sexual activity.

Draw a box around the letters s-e-x. Point out that s, e, and x are only three of the letters in the word sexuality. Then, display the five circles of sexuality. Explain that this way of looking at human sexuality breaks sexuality down into five different components: sensuality, intimacy, sexual identity, sexual health and reproduction, and sexualization. Most things related to human sexuality will fit into one of these circles.

After showing the five components, explain each circle briefly beginning with the circle labelled sensuality. Take five minutes to read the definition of the circle aloud, point out its elements, and ask for other examples that would fit in the circle. Write within that circle any words from the initial brainstorming exercise too that would fit into that circle's definition. Continue with each circle until you have explained each component of sexuality.

After finishing the fifth circle and its components, ask if anyone has any questions. Then conclude the activity using the following discussion questions:

- Which of the five sexuality circles feels most familiar?
- Which of them is less familiar?
- What do you think is the reason for this?
- Is there any part of these five circles that you never thought of as sexual? Please explain.
- Which circle is important for young people to know?
- Which ones are not important? Why?
- Which circle would you feel interested in discussing with your partner?How would you bring it up?
- How are rights connected to different circles of sexuality?

Module 2 - Transgender, gender-diverse and sex-diverse persons

Topics in this module: Transgender and gender-diverse persons; Transitioning and gender recognition; Affirmative practices and creating affirming spaces; Transphobia

Introduction

This module introduces the most common challenges transgender and gender-diverse persons face, provides basic facts about transition and legal gender recognition, and gives insights on how to talk to trans people without being embarrassing or impolite.

Relevance

As showed in Module 1 the first three letters in LGBTI+ refer to sexuality, while T and I are connected to gender identity and sex characteristics. "T" stands for the term 'trans' and it can be understood as an umbrella term for different situations. The letter I stands for the term 'intersex'.

Aims

This module serves to broaden participants knowledge of transgender and gender-diverse people's life experiences and the obstacles they face in society. Participants will learn about those specific topics a trans or gender-diverse client might need help with.

After this module, the participants will be able to:

- Empathise with trans and gender-diverse persons' lives and what they may face practically on a daily basis;
- Be familiar with basic facts about transition and legal gender recognition in Europe;
- React supportively when trans or gender-diverse persons come out to them;
- Know how to approach trans and gender-diverse persons with openness and respect.

Knowledge base for trainers

Gender can be described as a combination of the sex assigned at birth, gender identity, and gender expression. Sex assigned at birth, gender identity and gender expression *can* be "correlated" with each other: for example the term cisgender woman means a person who identifies as woman, dresses and behaves in a way considered feminine, and was assigned a female sex at birth. In the dominant narrative this correlation is framed as a necessary and natural causation (biological sex as the causal determinant of our gender identity and expression), but in reality these three aspects of gender exist in a lot of variations in different persons. For example, the cisgender woman described above could have a masculine gender expression - as gender expression is very fluid, thus she could present herself in a way that is considered manly, and can identify herself as a "butch woman". A lot of other variations exist, all of which "transgress" the dominant idea of gender; this transgression is signalled in the term *trans person*. One variaton (and one identity under the trans person umbrella) is transgender. Transgender man means a person who identifies as man and was assigned female sex at birth, and transgender woman means a person who identifies as a woman and was assigned male sex at birth.

In the examples above we are still talking about gender identity, gender expression and sex assigned at birth in binaries, along the common man-woman dichotomy. But there is also a wide spectrum of people who disrupt these binary concepts, as they simply do not fit into these two "boxes".

- Sex assigned at birth: The biological reality of a person might not fit into the male-female binary. This "outlier" category is covered by the term intersex.
- Gender identity: There are persons who do not identify either as a man or as a woman, they identify as both or neither. They are gender diverse persons.
- Gender expression: This is the most fluid aspect of gender, and a lot of persons don't present themselves in an exclusively feminine or manly way. They are gender nonconforming persons.

The common theme here is the insufficiency of binary categories. These binary categories are not something that nature "decided", rather nature presents us quite a few variations of "penises", "sex" chromosomes and other "sex" characteristics. Nature also presents us with variations of

lived experiences of our bodies, motivations, inclinations and desires. Nature doesn't decide where the category of "male" ends, and where the category of "female" begins; or where the category of "normal" sexuality starts and ends. Nature also doesn't give any clues about what clothing and movements are "healthy" or "matching" expressions to our biological bodies. One of the basic characteristics of nature is diversity and humans decide these categories.

Intersex persons

Intersex is also a category containing very diverse biological realities and experiences, thus it is not logical to call it the "third gender". Intersex is not a gender identity, but a biological reality, thus intersex persons could have different challenges and journey than other identities from the LGBTQ+ mosaic. Intersex persons can have various gender identities: they can identify as a woman or as a man, as any non-intersex person; or they can consider themselves to be gender diverse or having an alternative gender. All in all, identity is not the central problem for intersex persons: the Intersex Society of North America states: "Intersexuality is primarily a problem of stigma and trauma, not gender". Due to the great distress of parents and the limiting beliefs of medical professionals, many intersex persons undergo repeated, unnecessary and traumatising medical processes and surgeries without their consent or without considering their own self-identification. In these situations healthcare providers forget who the client is: they mainly treat the immediate distress of parents, and they are unable to give parents thorough information about comprehensive intersex needs that considers all aspects of gender and mental health. Both parents and intersex persons can suffer greatly when at a later stage the consequences of early trauma and a forced decision might come to the surface.

However, the challenges of intersex persons can also have some similarities to the ones persons identifying as LGBT+ face, as both LGBT+ identities and intersex biological characteristics are stigmatised and challenge the binary norms of our society. You can find many resources online about the cross-section of intersex and LGBT+ identities. To get a perspective on the experience of transitioning for an intersex person, listen to the episode 70 of the "Gender Reveal" podcast.

Frequently Asked Questions | Intersex Society of North America. (n.d.). Retrieved 27 October 2021, from https://isna.org/faq/

Gender Reveal: Episode 70: Mari Wrobi. (n.d.). Retrieved 27 October 2021, from https://gender.libsyn.com/episode-70-mari-wrobi

Thisisintersex.org. (n.d.). Retrieved 27 October 2021, from https://thisisintersex.org/

Gender dysphoria

Trans persons can experience gender dysphoria. It is a distressed and/or dissociated physical and/or mental state arising from the conflict a person feels between their gender identity and their sex assigned at birth. Dysphoria can arise from the social aspects of our gender and the gendered way people react to us (discomfort with one's name, pronouns, social role). It can also arise from bodily aspects (e.g. trans men may feel discomfort with their chest, trans women with their neck because of their Adam's apple etc.). The severity of this feeling can range from mild discomfort to very serious distress. The first signs of this dissonance could appear from early childhood when the person's experiences and the impression of their gender do not match with their physical bodies. Puberty can be an upsetting experience, where the bodily changes can lead to negative feelings towards one's body, especially when it comes to the changes of the female body with the development of secondary sex characteristics and the onset of menstruation.

It is important to note that not everyone who identifies as transgender feels discomfort related to their body, some trans persons are happy with their bodies as they are. Gender dysphoria isn't an illness, but unadressed and unappreciated distress may be linked to mental health problems, such as anxiety disorders, schizophrenia, depression, substance abuse disorder, eating disorders, and

suicide attempts.

You can use videos and short films to explore trans persons' experiences with the group. You can use the video from the CommonPoint e-learning course, or you can choose some freely available films, for example:

- Break free Short Film (2014) written by Isabella Seedorff, directed by Ramses Schwaner Sjøholm
- Masked Short Film (2019) written by Lachlan McKeown; directed by Jay Beckerleg and Michael Hardinge

Transitioning

When someone identifies as trans, they may want to undergo the process of gender affirmation/transition, which means acquiring the visual characteristics, physical features and the social role that is in accordance with a person's gender identity. Transition thus has three main aspects:

- Social – change of name and pronouns; adjusting visual expression; performing the desired gender role
- Physical/medical – hormone replacement therapy (HRT), surgical changes (gender affirmation surgery – GAS)
- Legal – change of legal gender marker and legal name

There is no right way to transition, transitioning in all three aspects doesn't mean someone is a "real trans" or "better trans". There is a lot of variation in trans persons' desires and needs regarding transition, a lot of them desire/need social and legal transition, but no or very little medical procedures (such as hormone therapy and gender affirmation surgeries). This can be the case for trans persons feeling comfortable in their bodies with very little dysphoria, but the transition process has many other factors besides one's gender identity: while some undergo medical transitions for psychological or health reasons, many won't because of some obstacle (fear of surgery, health problems, legal restrictions, etc.).

The three aspects are not independent, they inform the decision to transition in highly complex ways. The reasons for physical changes are different and very individual: while some want to address physical discomfort, for others it is more important that other people perceive them and react to them in accordance with their gender identity - thus physical transition helps them with the social aspect. Unfortunately in some countries, those who want to change their gender legally have to undergo surgical sterilisation.

Everyone's journey is different. Transitioning can be an overwhelming process with many dilemmas and even grief: these difficulties do not mean someone made a wrong decision about transitioning, but are natural parts of the process, in which proper psychological and emotional support makes a big difference. It is worthwhile to note that transitioning can be - or can be helped to become - a joyful and freeing experience too.

Physical and bodily aspects

Physical changes are the most visible parts of the transition process, and for many trans persons it is the most important and needed aspect of transitioning, however, as mentioned above, there are many variations in the expectations to transition. Some trans or gender diverse persons do not consider the bodily aspects important, they are more or less satisfied with their body.

In most countries, when a person opts for a transition, the first step is usually to contact a doctor/sexologist to obtain a psychiatric diagnosis. Obtaining such a diagnosis can involve passing various examinations, both physical and mental. Fortunately, in ICD-11 (the eleventh revision of the International Classification of Diseases) ICD-10's "transsexualism" and "gender identity disorder of children" are replaced with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood". Gender incongruence has thus been moved out of the "Mental and behavioural disorders" chapter and into the new "Conditions related to sexual health" chapter. This reflects evidence that trans and gender diverse identities are not conditions of ill mental health, and classifying them as such can cause enormous stigma according to the WHO. We recommend that you find out about the specifics of the transition process in your country.

The first step of physical transition is usually changes made in one's self-expression (clothing, hairstyle, stc.), and Hormone Replacement Therapy, which starts to change the gender

characteristics of one's body. The changes induced by HRT can be visible and thus can lead to the person needing to disclose their trans identity in a bigger circle of acquaintances. Coming out can take place before the diagnosis or the first visible changes, a person may come out to their close family and friends when first finding out about their trans identity, but visible physical changes can also lead the coming out process. These first changes can cause a lot of distress: personal relationships, work situations and many other things can be up in the air and changing.

There are a lot of additional steps and possibilities of physical transitioning, from facial plastic surgery to removing one's breasts and Gender Affirmation Surgery (GAS) concerning the genitals. The World Professional Association for Transgender Health (WPATH) have created Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People based on the best available science and expert professional consensus. The overall goal of the SOC is to provide clinical guidance for health professionals to assist transgender and gender diverse persons with safe and effective pathways to achieve lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. While this is primarily a document for health professionals, the SOC may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

You can learn more about the transition process from Volume 7 of the Standards of Care, available in 18 different languages.

Social aspects

Social change means making changes in the social roles a person fills in society. Today the upbringing of children is heavily gendered (from gender reveal parties to the colours of bedrooms), also society and communities lay different expectations on the child according to their gender assigned at birth. Social norms dictate very different life paths, relationship roles

and opportunities based on gender. Shifting one's social role is the most difficult aspect of the transition process to many trans persons. Their social status could change – for example trans women may earn less money in their jobs, or can experience misogyny after transitioning. The expectations of others could change as well. The older a person is and the more social roles they have already acquired, the more difficult transitioning is for them. In extreme cases, a person can find themselves in social isolation.

Part of our social role is our name and preferred pronouns. The name and pronouns with which a person is comfortable are important because they are part of their identity or can signal their identity in a conversation. Therefore it is very important that the trans person's environment and community respects their preferred pronoun.

Another aspect of the reality of some trans and gender diverse persons is the so-called "bathroom problem" - people who are in transition or do not pass on the outside as "clearly male" or "clearly female" are thrown out of both men's and women's restrooms on a daily basis. Some places provide "unisex" or "family" restrooms, but the majority do not. If a trans person wants to go out and enjoy a concert, sporting event, or simply a day outside the home, he or she must make concessions that most people never have to think about. The bathroom problem is usually sensationalised and infantilised in the media, and used a lot of time as a topic in order to make fun of the needs of gender diverse persons. In reality the "bathroom problem" is not the most important challenge of trans persons, but it is a good example for conveying some of the complexities and difficulties they face.

Legal aspects

Transition is dealt with differently in the legislation of each country, so we recommend that you familiarise yourself with the practice used in your country. In any case, the process must begin with a personal decision to transition, prompted by the feeling that one's gender identity does not match one's sex assigned at birth. In some countries, a diagnosis and a number of medical examinations (endocrinological, internal, psychological, etc.) must be made prior to HRT or GAS. Part of the diagnosis can be the so-called Real Life Test, i.e. a person should start to live in the gender role with which they identify before the gender affirmation surgery.

Regarding the legal aspects, The Council of Europe demands that its member states provide for legal gender recognition, but 30 countries in Europe have robust legal procedures, and currently only 7 do not demand that trans people undergo sterilisation, or medical interventions, divorce, or a psychological diagnosis or assessment. These abusive requirements, or the lack of legislation altogether, mean that most trans people have to live with documents that do not match their gender identity. Gender recognition goes beyond an administrative act: it is essential in order for many trans people to be able to live a life of dignity and respect.

Many countries in Europe still require trans persons to undergo sterilisation before their gender identity is recognised. The Human Rights Commissioner has critically remarked that "Transgender people appear to be the only group in Europe subject to legally prescribed, state-enforced sterilisation". Other requirements may include diagnosis of a mental disorder, medical treatment, invasive surgery, assessment of time lived in the new gender identity, and being single or divorced. Such requirements violate a person's dignity, physical integrity, right to form a family, and right to be free from degrading and inhumane treatment.

How can you create affirming spaces for trans persons?

Make these values your guiding stars:

- Believe – every identity is valid.
- Respect - do not only tolerate but respect gender variance and expression.
- Support, empower – create safe spaces, communicate, befriend.
- Protect – stand up for trans people even when they aren't around.

How to use affirmative language?

- Never assume someone's gender based on the ways they dress or express themselves. Unless you know for certain, it is better to use gender-neutral language. Activity 1.4. is good for exploring these assumptions.
- Use the language trans persons prefer. If they wish to keep their gender identity a secret, do not discuss it with other people.

- Respect the name that the person prefers to be addressed by, even if it's different from the name in their legal documents. Ensure that their preferred name is the one used wherever possible. For some transgender people, being associated with their birth name is a tremendous source of anxiety, or it is simply a part of their life they wish to leave behind. If you happen to know a transgender person's birth name (the name given to them when they were born, but which they no longer use), don't share it without that person's explicit permission.
- Use their preferred pronouns or gendered language, and try your best to encourage others to use them too, even if the person isn't present. If you aren't sure about their preference, ask, for example you can start with your own: "Hi, I'm Alex and I use the pronouns he and him. What about you?" If you accidently use the wrong pronoun for someone, apologise, then move forward with intention.
- Don't ask about a transgender person's genitals, surgical status, or sex life – it would be inappropriate to ask a non-transgender, or cisgender person about the appearance or status of their genitals. If a trans person wants to talk to you about such matters, they will bring it up.
- Know your own limits – don't be afraid to admit when you don't know something. It is better than to make assumptions or say something that may be incorrect or hurtful. Seek out the appropriate resources that will help you learn more.

The best-case scenario is probably to:

1. ask what questions, if any, are appropriate; and
2. give the trans person an out if he or she feels like you are overstepping your bounds (even though your questions may be born out of innocent curiosity).

This makes it easier for a trans person to maintain privacy and integrity.

A short list of affirming sentences:

- *"Thank you!"* – let them know that you're grateful for getting to know them on a different, deeper level and that they trust you.
- *"If/when you're ready, let's talk more."* – maybe they aren't quite ready to go into details. Make sure that they know you're open to hearing more about their journey.
- *"What can I do to help?"* – helping can come in many forms, for example: listening, remaining non-judgmental or aiding them in reaching out to others with the news.
- *"I support you."* – express your desire/ability to encourage them to be themselves.
- *"What can I do to improve?"* – understand that you may have said or done things that could have confused them or made them question their identity, even if you didn't mean to.

Transphobia

Transphobia is intolerance of gender diversity. It is based on strict binary thinking and the idea that only two, very distinct biological sexes exist – male or female, which are assigned and fixed from birth, and which must also inherently cause us to prefer interests, expression, clothes and behaviours associated with the corresponding gender role. Those who fit in with the strict binary gender norms and ideals are considered to be morally better, even smarter or somehow just more "worthy". Like any other prejudices, transphobia involves cognitive, affective and behavioural aspects, thus transphobia can manifest itself in people's thoughts, feelings and in what they do or say. It can be present in an active, very noticeable way, for example intentionally acting against gender diverse people; but also in a passive, more invisible way, for example not recognising or allowing for the fact that gender variance exists.

Violence against trans and gender-diverse people frequently overlaps with other axes of oppression prevalent in society, such as racism, sexism, misogyny, xenophobia, and anti-sex worker sentiment and discrimination. In the United States, the majority of the trans people reported murdered are trans women of colour and/or Native American trans women (90%), and in France, Italy, Portugal, and Spain, which are the countries to which most trans and

gender-diverse people from Africa and Central and South America migrate, 65% of the reported murder victims were migrant trans women.

Trans and gender diverse persons face high rates of rape and death in custody while in prison. The level of cyberbullying towards trans people and suicide is also very high. Many trans children face prejudice from their own parents. Besides the increased risk of violence and other threats, the stress created by transphobia causes negative emotional and distressed states, which may lead to substance abuse, running away from home (in the case of minors), and a higher rate of suicide.

Misgendering people

For example, calling a trans man ‘she’ or even ‘it’ even though the speaker knows that they are a man. It can take a while to get used to using new pronouns and people might make mistakes, but if they do it deliberately knowing what the right pronouns are and knowing that using the wrong ones will hurt somebody, then that’s transphobia. It can also include discrimination, like not allowing a trans man to use the men’s changing rooms.

Gatekeeping

This happens most commonly in the medical field where transgender people can be denied the right to transition. Arguments by medical gatekeepers center around the belief that transgender people are wrong about their identity (which notion is transphobic in itself), and they need to undergo months or even years of therapy before they can be allowed to transition. Worse, some gatekeepers say that any psychological problem should exclude being "allowed" to transition, which puts transgender people in a stalemate situation, as their psychological problems are often caused by dysphoria from living in the wrong gender.

The notion of gatekeeping as a "protection" against "wrongly transitioning" is a bogus shield for transphobia because cis people don't transition. Feminine men, butch lesbians, and people who think that their lives might be easier if they were born as "the other" gender don't transition. When someone comes out as wanting to transition, it's because they need to do it.

Trans Panic

It is being used as a defence by some assailants of trans women. The defendant states that he was meeting a woman for sex, but upon discovering at the crucial moment that the woman is trans, his shock and outrage was such that he could not help but attack her. The "trans panic" defence was used in the murder case of trans women Gwen Araujo and Angie Zapata.

Selective Transphobia

A growing number of transphobic people make exceptions for those deemed ‘good enough’. They make a distinction between “true trans” people and "transtrenders", who are supposedly only pretending to be trans. They may not have an issue with straight trans people but take issue with gay trans men and trans lesbians. They question the identity of people who do not meet the stereotypical narrative of "wanting to play with dolls/trucks since the age of 2, and hating your genitals since the age of 5". Even talking the wrong way can get a trans person deemed a "transtrender". This kind of transphobia even exists within the trans community.

Activities for Module 2

Activity 2.1. - "Gender Confusion"

Time: 90 mins	**Sensitivity:** Medium level

Purpose:

- To make participants reflect upon their approach to gender as such and their own gender in particular;
- To demonstrate that gender is not a static and not limited to the dichotomy male-female or man-woman;
- To foster critical thinking about gender-based terms in language, and their impact on society and people within gender diversity in particular.

Requirements:

- Group size:
  - 10 to 30 participants
- Materials:
  - Pens
  - Papers

Description

This exercise is a combination of an analytical exploration of concepts used in the 'gender debate' and a critical and personal reflection on one's own gender. It also addresses sexuality and sexual orientation.

First, ask the participants to write down, individually, the first thing that comes into their minds when hearing the word 'gender'. Tell them to keep this piece of paper by them for a later stage in the activity.

Then help participants form smaller groups (maximum 5 people in a group), and give them instructions to start a discussion. They will have 25 minutes reflecting on what each of their concepts means to them. You can provide them with the question prompts from below, or advise them to go in a circle to make sure everyone's thoughts are heard. Inform them that after the discussion they will need to make a short report with the results of their discussion, which is to be presented to the whole group by one selected member of the smaller group. After the 20 minutes discussion they will have 5 minutes for preparing the report.

- What feelings do I have when I encounter this term?
- How do I see myself in relation to those concepts and the definitions presented?
- Do I agree with the definitions presented? Why or why not?
- Can I identify with any of the definitions? How or why not?

Bring the groups back into plenary and invite them to present their report. Make sure to allow each group an equal amount of time for presenting, and to ask if there are any questions of clarification needed after each presentation.

After the presentation, ask participants to write down, again, the first thing that comes to their mind when hearing the word 'gender'. Ask them to compare the initial and the current answers. Initiate a debriefing discussion to explore participants' reactions to any difference there may have been between what they wrote the first time and the second time. For the debriefing ask participants to sit in a circle on the floor or on chairs. The following could be the guiding questions for the discussion:

- Could you share with us what you wrote the first and second time about the first thing that comes to your mind when seeing the word 'gender'?
- Why do you think there was a difference between the first and second response?
- Are you surprised by the difference if there was one? Why?
- Why do you think people have such different understandings of the terms relating to gender?
- How are those terms presented in the public?
- How can language contribute to gender-based violence?
- Does gender-related language and the way in which it is used contribute to discrimination?

- To what extent is there space for debating the definition of terms relating to gender where you live? To what extent do you think young people are involved in those debates?
- How can young people get involved in those debates if they want to?

Notes for trainers

Be aware that the participants will have different approaches to and knowledge of the topic. There may be confusion about the different terminology and linguistic differences, especially with regards to gender identity. Try to explain and clarify without giving the impression that what you are telling the participants is 'the truth'.

Consider inviting a guest speaker from a local LGBTQI+ or gender organisation to come and talk to the group further on gender and related definitions. Participants can prepare questions before they come and the invited speaker can talk about what role gender definitions and common understandings of terms have within their organisation and the work that they do.

Activity 2.2. - "Gender Roles"

Time: 60 mins	**Sensitivity:** Moderate level

Purpose:

- To identify common gender role expectations;
- To understand how people are pressured to conform to gender roles.

Requirements:

- Group size:
  - 15 to 30 participants
- Materials:
  - 5 sheets of flipchart paper
  - post-it notes
  - a big wall
  - masking tape
  - marker for each participant

Description

Hang five flip chart papers on the wall, or spread them on the floor where each participant can see them. Write on the top of each paper one of the following words: school, family, friends, society, partner. Each of the papers will show the typical relational and social contexts in which people face gendered expectations. Divide each flip chart into two columns; one column will have the title 'men', and the other will have the title 'women'.

Tell participants they will have a few minutes to think about what they believe is expected or demanded of men and women in the different settings identified on the posters. For this they can walk around or sit down and think, but they should do this part of the activity individually. Once they have ideas, they should write them in the relevant column of the flip charts. You can hand out post-it notes on which they can write their thoughts and then stick them onto the posters.

After the brainstorming, divide participants into five smaller groups. Each group will select one of the posters and discuss its content. Inform the groups about the time they will have for the discussion, and how they will be expected to present their conclusions. The following guiding questions may help participants in the discussion:

- What differences can you identify between the expectations and demands put on men and women?
- What would you like to change?
- How do you think it can be changed?

After the discussion, bring back the group to the circle, and let each group report the results of their discussion briefly to the whole group. Ask participants about their initial reactions to the results, how they feel about them, if anything surprised them and, if so, why. Continue the discussion using the following guiding questions:

- Where do these expectations come from?
- Is it possible to fulfil these expectations?
- Who promotes these expectations?
- How do we ourselves promote them (whether consciously or unconsciously)?
- What are the effects of these expectations on young people?

Notes for trainers

You can encourage the group to discuss what they would like to change about these expectations and their manifestations, and provide them with the opportunity to brainstorm and prepare projects or actions to create the desired change. Make sure that participants of every gender are involved in this process and find an equal voice for their ideas.

This activity is a little similar to activity 1.4. - "Act like a lady": you can transfer facilitation ideas from one to another or you can better decide which activity is most suited to your participants.

Activity 2.3. - "Gender Identification"

Time: 30 mins	**Sensitivity:** Moderate level

Purpose:

- To identify gender stereotypes and the ways of thinking that could lead to stereotyping;
- To be aware of the difference between sex assigned at birth and gender expression

Requirements:

- Group size:
  - 20-30 participants
- Materials:
  - Printed list of the individuals for each participant

Description

This exercise asks participants to guess the gender of unspecified people from the descriptions below. Each person has a mix of masculine-coded, feminine-coded, and neutral characteristics.
List of the individuals:

- Architect, 32 years old, married with two children. Likes skiing and skating, spends occasional weekends in the Alps. Reads extensively about mysteries and psychic phenomena.
- 23-year-old college student planning to go to law school. Gay, involved in an ongoing relationship. Is on the college debate team, likes dancing and old movies, works out at the gym.
- 67-year-old elementary school English teacher, retired, married with three children and five grandchildren. Likes gardening, reading, and musicals.

- 54-year-old real estate agent, divorced with one child. Heterosexual, actively dating but no steady relationship. Likes to travel; goes to France or Spain every year. Likes to watch crime stories.
- High school volleyball coach, age twenty-six. Married, no children. Played volleyball in high school and college, majored in physical education. Also likes to play the piano and paint.
- 8 years old and in the third grade. Wants to be an archaeologist. Takes dancing lessons on weekends.
- Doctor, age 42. Heterosexual, involved in an ongoing relationship. Favourite movie is Notting Hill. Lives with three cats.
- Accountant, age 34. Heterosexual, no steady relationship. Likes hunting, fishing, and rock climbing. Likes science fiction movies.
- Car mechanic, age 22. Heterosexual, no steady relationship. Likes to play tennis. Favourite movie is Gone with the Wind.
- 19-year-old psychology student, plans to become a psychologist. Gay, not sexually active. Doesn't smoke or drink. Favourite television series is In Treatment.

Help the participants to form small groups of 4, and pass out copies of the list to them. Give them about ten minutes to discuss the people on the list and make guesses about their genders. After they have made their guesses, bring participants back into a circle for a ten-fifteen minutes discussion. See if there was any consensus about people's genders among different groups. Which individual is the easiest to identify, and which is the hardest? Which clues are the most salient? Where there is no consensus, ask which clues could be changed to make the person easier to identify. Would additional clues help?

At the end of the exercise, inform the students that there is no correct answer; both men and women can and do exhibit these characteristics. There can be some difference shown on an average level, but statistical averages are abstractions and are not describing everyone's experiences.

Notes for trainers

One of the basic misconceptions is that men and women are polar opposites, with instantly recognizable differences in personality traits, interests, and activities.

You can also set up some kind of an experiment: change some words in the descriptions for some of the small groups (for example write aerobics instead of working out; single or unmarried instead of married, etc.) and see whether the groups will have different experiences along these changes.

Module 3 - Coming out

Topics in this module: Coming out: the process; Identity development models; Factors affecting the coming out process; People surrounding the LGBTQI+ person; Safety during coming out

Relevance

Coming out is one of the most important processes in the life of every LGBTQI+ person, thus a professional working with LGBTQI+ persons needs to comprehend it thoroughly, with all the specificities that go along with it. Also, it is important to be aware of its main components (intersectionality for instance), to learn how to support someone in the process of coming out, as well as to bear in mind the most common "mistakes" that professionals usually make, and how to avoid them.

Aims

The theoretical frame is aimed at providing an overview of coming out, its specificities and all the relevant aspects, identity development models, what to do and what to avoid while providing psychosocial support to LGBTQI+ persons in the matter of coming out. The activities aim to sensitise the participants about the most common situations that LGBTQI+ persons generally face in their everyday life, to gain insights on the coming out process and prepare them for the needs of LGBTQI+ persons regarding their processes.

Knowledge base for trainers

Note that coming out is a lifelong process and every individual goes through it in a unique way.

Coming out as a process of coming home to one's true self

Coming out is a process of understanding, accepting and valuing one's personal romantic and sexual orientation and/or gender identity. It involves exploring the personal identity of sexuality, romantic and sexual orientation and/or gender identity, arriving at a definition that is

comfortable and true to one's self, and also sharing and expressing these identities and feelings. People can come out as any identity the LGBTQI+ mosaic contains: as gay, lesbian, bisexual, trans, etc. (Note: trans is an umbrella term covering the whole spectrum of gender identities: gender variant, gender fluid, pangender, queergender, bigender, etc.). One can also come out as an intersex person - but remember: intersexuality is not an identity in the same sense as LGBT identities, but rather a biological reality that might need recognition and acknowledgement (see more in Module 2). The topic of coming out can also be the various forms of sexual desires and relationship formats people experience or commit to, that are not in line with the heteronormative narratives. Thus, persons of any sexual orientation or gender identities can come out as asexual, or as someone interested in BDSM or committed to non-monogamous relational settings.

Coming out isn't simply a matter of finding self-acceptance — it's a choice that's often wrapped up in issues surrounding one's race, age, career, and community, and one's ability to deal with the potential consequences (mental health, supporting relationships, etc). There can also be many factors enforcing outness, for example the bodies of intersex person's can start to look different from the "norm" once puberty hits, thus their "otherness" becomes visible.

The first stept usually involves personal coming out (coming out to oneself), often with a realization that the feelings one has had for some time make sense if one can define oneself as gay, lesbian, bisexual, transgender or queer. These emotions may appear confusing, terrifying for most LGBTQI+ persons, mostly due to the stigma that is attached to these identities. Coming out also involves facing societal responses to their coming out: they may feel ashamed, isolated, and afraid. The main focus for mental health professionals should be to deal with the emotions that arise during the process, especially those saturated with shame. Mental health professionals should also be competent in finding out whether their client represses their sexuality or gender identity due to social oppression.

Although coming out can be difficult, it can also be a very liberating process. LGBTQI+ persons may feel like they can finally be their authentic selves. After coming out one can start living freely with their full identity and true self. They may find a community, and feel supported and inspired. Even if it is scary to think about coming out to others, sometimes the reward can be worth the challenge. During the process, it is of great importance for mental health professionals to

carefully examine the potential risks of timing and the decision to whom and in which context coming out takes place.

How to think about the models

There are many theoretical models about LGBTQI+ identity development and the stages of the coming out process. These can inform mental health professionals' practices and help them understand the process LGBTQI+ persons go through, become aware of the normative challenges and crises of the process and also recognise the moments where special support and intervention might be needed. It is important for mental health professionals to be acquainted with these theoretical concepts and be able to use them. Also, the model can be helpful in pointing out for clients that they are not alone and not "freaks": the experiences they have are completely common and many others have had similar experiences.

However, it is crucial that these models should not be used for prediction, or understood as a "guide" that each individual has to follow in their processes, rather as an aid to better understand the client's current situation. **Always keep in mind that sexual and gender identity development is a complex, multidimensional, individual and often fluid process. One must consider cognitive, social, emotional, cultural, social and familial complexities of the individual's experience to contextualize the narrative of sexual identity development and coming out.**

Also, people do not move through the process at the same speed or in the same sequence. Some people are aware of their identity at an early age while some are not, and the process can be gradual or very sudden. Coming out is also not an end point, but a continuing process – in each new circumstance (for example when meeting new people, starting at a new job, enrolling in a new course etc.), one decides whether and how to express their identity, whether they would like to come out or not. Coming out can mean more than one process: some people have more than one LGBTQI+ identities (e.g. as a trans woman who also identifies as a lesbian), that are not necessarily processed at the same time, thus the person may come out with them separately. There are others who go through the process more than once in their lives, as their identities might be shifting or they might find and inhabit a new identity that is more true to them.

Every stage can have a different meaning, rhythm and reality to each individual. For example, being "out" most often doesn't mean that a person is out in every important social context and relationship. Rather, "being out" and "coming out" mean various things to different persons. It is only the person themselves who can decide when and how safe it is to come out for them, and whether to come out in one part of their life and not in another. For example, one may be out in the family and not at school, among friends or at work.

There is a risk that mental health professionals might pressure their LGBTQI+ clients to come out as a part of their process of self-acceptance. One may think that being out is "good", "healthy" and generally a happy place to be, and being in the closet must be "unhealthy" and "bad" for the individual. The assumption can be that LGBTQI+ persons feel bad until they reach the "final" stage, where they are completely and comfortably out. In reality, there is no "final" stage and being out looks different to everyone. Coming out is certainly a journey with challenges, but it is unhelpful to think about it in this black and white way. Earlier stages in the process are not inherently bad or horrible, there can be a lot of joy, freedom and meaningful transformation found in them. LGBTQI+ persons don't need to be saved from the early stages of the process. A mental health professional must try to avoid the role of the saviour, which they can easily pick up based on the outlined binary ideas about coming out.

Models of LGBT identity development and coming out

Over the years, researchers have developed various theoretical models regarding sexual orientation and gender identity development, including:

- **Stage models** (for example Cass, Fassinger, Savin-Williams, Troiden) that assume linear progression from lack of awareness of sexual orientation, through immersion in identity, to integration of identity;
- **Life span and other nonlinear models** (D'Augelli, Fox, Klein, Rhoads) that focus on specific processes of identity development within sociocultural and life span context;
- **Diverse perspectives on sexual orientation and gender identity development** (Boykin, L. S. Brown, Clare, Diaz, Raffo, Wilson) that describe LGBT identity and development in relation to other psychosocial identities (gender, race, culture, class, ability, and so on).

Sexual orientation

One of the first models of sexual orientation identity development was developed by Vivian Cass (1979). It is a six-stage model that describes the developmental process that individuals go through as they consider and then acquire their identity as a lesbian, gay or bisexual person.

- Stage 1 – Identity Confusion: The person begins to wonder whether they might be LGB. With many different thoughts and feelings, one may experience denial and confusion.
- Stage 2 – Identity Comparison: The person accepts the possibility that they might be LGB, and face the social isolation that can occur with this new identity.
- Stage 3 – Identity Tolerance: The person experiences increased acceptance of the probability of their LGB identity, and comes to tolerate this identity a little bit more. Although confusion and distress might decrease at this stage, the person may feel isolation and alienation as their self-concept becomes increasingly different from societal expectations and norms. In this stage, the person often begins to make contacts with other LGB persons.
- Stage 4 – Identity Acceptance: The person has managed to resolve most questions concerning their sexual identity, to accepts themselves as a lesbian, gay, bisexual person, and they are increasing their contact with the LGB community.
- Stage 5 – Identity Pride: The person begins to feel proud of being part of the LGB community and immerses themselves into LGB culture. In turn, they have less contact with the heterosexual groups: sometimes they may feel angry toward these people or even reject them.
- Stage 6 – Identity Synthesis: The person integrates their sexual identity with other aspects of it, and sexual orientation becomes only an aspect of their sense of self. The intensity of emotions that have emerged through the process (anger, pride, etc.) may decrease, and they can be their true selves in both LGB and heterosexual communities. The person feels more congruence between their public and private self.

The main issue with Cass's model is its description of the stages as fixed, but today we understand sexual identity development as a more dynamic and fluid process. Therefore the other model to introduce to your participants can be Dillon's more recent (Dillon et. al., 2011)

multidimensional model, which includes individual and social aspects as well. He describes 5 phases that are non-linear and flexible:

- Compulsory heterosexuality
- Active exploration
- Diffusion
- Deepening and commitment
- Synthesis

Gender Identity

Coming to recognize oneself as gender-variant or trans person involves stages of exploration and analysis on both interpersonal and intrapersonal levels over the course of many years. Considering the usually multiple minority statuses of trans persons and their special challenges due to the transition process, Aaron Devor (2004) has worked out a model of transgender identity development that encompasses 14 possible identity stages until complete medical transition. It is important to emphasize constantly that not all transgender people want or have access to the entire transition process due to various reasons: their place of residence, financial reasons, medical conditions etc.

Pinto and Moleiro's model of transgender identity (2015) does not pathologize trans identities and defines five stages of transitioning, regardless of age-related experiences. This model starts with the stage of confusion, followed by the need to define one's self, seeking for an explanation. The second stage is exploring, realising that one's sex assigned at birth does not match one's experience of gender. The third is the revision of transition options, fourth is embracing their identity and the chosen way of transitioning. The last stage is to integrate trans identity to be a part of the self.

In general, one's experience of mind-body dissonance is the starting element: the realisation that one's experiences and impression of their gender do not match one's physical body comes early in childhood. Puberty can be an upsetting experience, when the bodily changes can lead to negative feelings towards one's body, especially when the changes of the female body with the development of secondary sex characteristics and the onset of menstruation. The feeling of

dissonance, moreover, may manifest itself in feelings towards dressing expectations (dressing is an explicit way of gender expression), and also regarding activities. In the absence of support, the feelings of dissonance are repressed or at least hidden, even until early adulthood. Starting the process of transition - which can mean any form of transition that is found suitable by the individual - is considered the breaking point in this model, when the individuals start to accept and live by their gender identity.

The coming out process here is even more complex due to the process of transition; you can read more about this in Module 2.

Factors affecting the coming out process

Age

The experiences of lesbian, gay, bisexual, trans and gender-variant individuals may differ substantially based on their age. The time in which one has lived and/or came out can profoundly shape one's journey: claiming certain identity labels, disclosing and expressing identities, parenting, and political involvement. Mental health professionals should be mindful of the social and cultural environment in which their clients came of age.

Youth

Navigating the cognitive, emotional, and social developmental changes of adolescence while simultaneously integrating the emergence of a LGBTQI+ identity can be challenging for youth. LGBTQI+ youth often face problems in their school due to their sexual orientation, gender identity and/or gender expression, such as social alienation and bullying because of the prejudices of their peers, teachers, parents and the wider society. These factors increase the risk of substance abuse or have long term consequences such as posttraumatic stress. The social stigma associated with being LGBTQI+ may create pressure on youth to conform to heterosexual dating behaviors, to hide their sexual orientation - practices that can lead to "passing" - or to avoid social interactions. Attempts to mask or deny their sexual identity may put them at higher risk for unwanted pregnancy, engaging in unsafe sex, general health risk behaviors, interpersonal violence, mental health risks and suicide attempts.

LGBTQI+ youth often experience negative parental reactions to their sexual orientation and gender identity expressions. Supportive family may be a protective factor against the effects of minority stress for LGBTQI+ youth; however, well-intentioned heterosexual parents may not have the insight needed to protect their LGBTQI+ children from heterosexism, cisgenderism, and the internalization of heterosexist beliefs within traditional patriarchal societies. Close relationships with supportive friends can serve as a buffer against the pain of familial rejection and/or societal heterosexism, thus a strong friendship network is pivotal in sexual identity exploration and development.

Elderly

For people who grew up during the 20th century, when the human rights of LGBTQI+ people were out of professional, political and institutional sight, coming out may have seemed dangerous, especially in less accepting regions. Only a small number of trans persons had undergone a transitioning process before 2000. Older LGBTQI+ persons are often reluctant to come out because of these past traumas. Some of them were forced to participate in sexual orientation change practices (so-called conversion or reparative therapy).

Mental health professionals and services tend to not take into account the sexuality and gender experiences of older adults, they are usually considered to be asexual. However, sexuality and gender continue to be important parts of one's identity, sense of self and relationships well into older ages. For example, many social service providers think that sexuality does not matter to the elderly, that it is a private matter everybody should keep for themselves, or that only young people identify themselves as LGBTQI+, thus this minority simply can not be found among older adults (Novotná, 2016).

In addition to simply being invisible, LGBTQI+ older people often face social isolation, as most of them do not have children, and unfortunately the idolisation of youth and beauty is present among LGBTQI+ persons too. The mental health professional needs to carefully address the special challenges of the LGBTQI+ elderly: lack of social support, lack of family members, poverty, economic difficulties, elevated shame, trauma, depression, loneliness and isolation.

Religion

Many clients come from religious surroundings in which LGBTQI+ identities, transition or gender affirmation are considered to be a sin. While therapists should absolutely work to help clients embrace their sexual orientation, gender identity and/or gender expression and to overcome internalized homophobia/transphobia, it's also important to consider that some families may never come to that same acceptance. Sometimes religious LGBTQI+ persons find acceptance in progressive religious settings, but other times the person decides to stay in the closet or chooses an alternative lifestyle of which sexuality and gender expression are less important.

Intersections

Cultural, ethnic, racial and political background

Different communities view homosexuality and non-traditional gender identities differently — in some, it is a "quirk", in others, there is a "don't ask, don't tell" policy. Elsewhere, it is a sin and is to be punished (even with a death sentence) by the law. Therapists should consider where their client comes from — will coming out result in exclusion from their community or threaten their physical safety?

The intersectional identities of the client must be also considered. It is a very different experience to be out in various racial/ethnic groups. For example, decisions about coming out may pose even greater difficulties for LGBTQI+ youth of colour for whom family and community may be a vital source of support for dealing with racism (for example LGBTQI+ youth in Roma communities). It is also highly important to consider cultural diversities in the contemporary fast-changing societal background due to migrations. For trans persons there is high risk of discrimination in crossing borders if their bodies do not match the gender in their documents. Sometimes they are denied health protection, hormonal therapy or are criminalised.

Physical, sensory and cognitive-emotional disabilities

LGBTQI+ persons with disabilities encounter a wide range of challenges related to social stigma associated with disability and sexual orientation, gender identity/expression. They experience a

sense of invisibility due to prevailing societal views of people with disabilities as non-sexual and alone. One's self-concept may be negatively affected by these, which further compromises one's sense of autonomy, personal agency, sexuality and self-confidence. They may experience a pressure to be "normal" at least in their sexualities and genders, thus may try to adhere to societal ideals and expectations about gender. For example men are expected to be strong and independent, which can be difficult to live up to for a person living with disabilities; and women are expected to be weak and adaptable, which is hard to avoid for disabled LGBTQI+ persons.

Trauma

Psychological trauma from the childhood or adolescence of LGBTQI+ persons (physical abuse, emotional violence, sexual abuse, e.g.) damages all the aspects of human functioning: trauma is often the result of an overwhelming amount of stress so one is unable to cope or integrate the emotions involved with that experience. Trauma may result from a single experience or recurring events that can precipitate weeks, years, or even decades later as the person struggles to cope with their immediate circumstances, eventually leading to serious, long-term negative consequences. Thus, it is very important to bear in mind how trauma can impact the decision to come out or not.

People surrounding the LGBTQI+ person

Parents of LGBTQI+ children

Many parents feel uncertain when they learn of the LGBTQI+ identity of their children: how to react and how to support their child. They love and want to help their child, yet they may not understand or may not want to "encourage" their LGBTQI+ identity. Parents and caregivers often fear that others may hurt their LGBTQI+ child, so many react negatively to these identities or expressions of nonconformity. Torn between their beliefs, cultural norms, fear, shame, guilt and love for their offspring, they may say: "Keep a low profile. Don't tell anybody else." "Do you have to wear those clothes/this haircut?" "Wait until you graduate to tell others you're gay". Youth interpret these sentences as a rejection, but often parents use them to mask their anxiety and fear of a hostile world. Some parents hold very discriminatory attitudes toward sexual orientations and gender identities different from the norm. They become hostile and violent: there are many

cases of LGBTQI+ children physically punished, tortured, emotionally/sexually abused, forced to reparative therapy and even killed by their parents or caregivers. It is necessary in these cases that institutions such as social services, police, mental health professionals, organisations and shelters react promptly to protect the health, dignity and human rights of LGBTQI+ children.

Apart from situations when family members react violently toward their LGBTQI+ child, families are motivated to learn how to support their gay or transgender children when they realize that their words and actions have a powerful impact on their children's survival and well-being. Parents are shocked to learn that their reaction can increase their children's risk of depression, self-harm, suicide, HIV infection and STDs, and other health problems (eg. anorexia, bulimia, drug, tobacco and alcohol abuse). Also, parents are often relieved to learn that talking with their children about their identity and expressing affection for their gay or trans children helps protect them against these risks and improves their well-being.

Spouses and partners

One important situation to write about is an LGBTQI+ person coming out when being in a heterosexual, normative relationship or marriage. This is a very challenging and emotionally intense situation for both parties, there may be children and extended family who are involved in the process too. It is important to note that amongst LGBTQI+ persons, the patterns and rules of relationships can differ from the hetenormative and monogamist ideals. Relationship dynamics can be quite similar to any other romantic relationship, but a lot of the time LGBTQI+ persons reconsider their previous ideas about relationships and normative rules along with their identities. They may experiment and pursue relationship settings that feel more free to them (for example ethical non-monogamy) - thus LGBTQI+ persons who disclose their identity in a heteronormative relationship may not feel that the relatinship needs to end, but rather prefer to create new arrangements that can be unusal for the mental health professional. Or due to their minority status, LGBTQI+ persons can experience a narrowing in their opportunities for romantic relationship partners, thus may stay in relationships that are abusive or not in line with their values.

The other topic to address is how LGBTQI+ persons navigate their coming out processes when they are in a queer relationship. The preferences and meanings attached to being out may differ greatly among the individuals in the LGBTQI+ couple, and this may pose challenges to their

individual coming out processes. While in a relationship the coming out process is formed by the emotions and preferences of the other person too.

Children of LGBTQI+ persons

The question whether the quality of parenting differs when a child is reared by a heterosexual or same-sex couple has been addressed since the 1970s, particulary in connection with child custody after divorce. There are dozens of studies confirming that sexual orientation has no influence on the ability to be a good parent. (To read more on this topic go to Module D).

"It can signify a big change in the family, especially when accompanied by all of the transitions that come with a divorce or break-up."

Family Equality | Coming Out to Your Child. (n.d.). Family Equality. Retrieved 14 October 2021, from https://www.familyequality.org/resources/coming-out-to-your-child/

The mental health professional

When a mental health professional understands factors at play in a client's personal and professional life, it's their job to help them find tools and acquire skills for coming out. This also includes preparing them for the worst-case-scenario. For many clients, coming out may simply be the first step in a series of challenging conversations with friends, family, colleagues and acquaintances. It is an obligation of mental health professionals to prepare them to address different reactions and create a plan of action if they at any point feel unsafe.

The role of the mental health professional

- The most important is not to presume the client's sexual orientation or gender identity, but to ask how they identify and which terms they use.

- For mental health professionals working with LGBTQI+ person for the first time, it is good to find support and supervision from LGBTQI+ informed colleagues.
- Carefully examine potential risks of timing and the decision to whom and in which context coming out takes place.
- Get familiar with current models of identity development and coming out - these can help understand clients better, and can also be helpful in pointing out to them that they are not alone with their experiences.
- Mental health professionals should also be competent in finding out whether their client represses their sexuality or gender identity due to social oppression.
- Also take these theoretical models with a grain of salt and know that every journey of coming out is very different.
- Take into account the client's age, religion, intersectional identities, the cultural, racial/ethnical and political context.
- Restrain from pushing the client out of the closet if they're not ready: you can only support clients along the process and decision to eventually self-disclose.

Crucial questions to consider around LGBTQI+ persons' coming out decision

1. Do they want to come out?
2. What fears and dilemmas surround the coming out process for them?
3. How can you help to relieve the pressure of being a "perfect" LGBTQI+ person and being "perfectly" and "bravely" out? How can you help them identify their own wants and needs around coming out?
4. What does being out mean to them?
5. What skills can you develop to support them through this process?

Self-disclosure as a mental health professional

Disclosing our LGBTQI+ identities as mental health professionals is a highly complex decision depending on many factors and the professional setting we work in. Coming out to a client can have various consequences, both positive and negative, even if the client themselves have an LGBTQI+ identity. Generally, being able to help and empathise with LGBTQI+ persons does not require disclosing our identity. Here are a few questions to consider:

- What is your comfort level with sharing personal information (sexual orientation, gender identity, partnership status, etc.) with clients? Have you disclosed personal information with them previously? If so, how comfortable was it for you to share that? Reflecting on your comfort level and the clinical and ethical rationale for self-disclosure can help you be better prepared to handle these situations with confidence. Discussing it with other professionals may also be useful.
- How would you answer a client asking you if you are lesbian, gay, bisexual, or transgender? Thinking ahead may reduce anxiety and increase your comfort level if it actually happens.
- Do certain clients present concerns that make you feel compelled or reluctant to disclose? Consider what these feelings are based on. Do they stem from your theoretical orientation or the personal characteristics of the client? Examining your own biases can be helpful in determining if your decision to disclose is truly in the service of the client.
- You may also consider: How might your perspective on this differ based on your development as a therapist? Where and how discussions of disclosure fit in the curriculum of a training program? How can educators and supervisors help trainees make good decisions regarding self-disclosure to clients? How might self-disclosure of sexual orientation or gender identity be similar or different from disclosing other stigmatized identities?

You can also read more about coming out as a psychologist in Module C.

Handout 2 - Pocket book on coming out for LGBTQI+ clients

1. Coming out is a personal decision: there's no right or wrong way to do it, it's completely up to you and your relationship with who you might come out to. There are lots of different ways: talk in person, phone call, an email, text, a letter etc.

- What is your preferred way of coming out to relevant others?
- Does it differ depending on the person you want to come out to?
- What would you expect from the person to whom you come out?
- What would you like to say to someone you want to come out to?
- Who do you feel safe and comfortable sharing about my life with? Who is always by your side?

2. Remember if you have ever tested someone to whom you wanted to come out about their attitudes about LGBTQI+ people.

- What was the way you tested someone's opinion about LGBTQI+ people?
- Did you present them LGBTQI+ celebrities or watch Pride on TV with them?
- Did you find out how they feel about LGBTQI+ people adopting or having children? Did you probe their attitudes about marriage equality? Have you ever paid attention to their stereotypes about LGBTQI+ people and the words they use when talking about LGBTQI+ people?

3. There is no perfect time or place to come out. Coming out is a lifelong process and it depends on whom you want to tell. Sometimes it takes more time to talk in person. Sometimes it happens spontaneously. Sometimes you have to feel confident and secure to do it: it is important to do it whenever it feels right for you.

- Think about what time and place works best for you to come out. Would you rather be in a public or a private space during that? Is your home a safe place to come out?
- Are there some confidentiality and safety preconditions to think about before coming out?
- What time works best for the person you want to come out to? Are you both comfortable talking in public places or at home? Is there some special location for coming out to someone close to you?

Activities for Module 3

Activity 3.1. - "Coming out in a reversed world"

Time: 20-60* mins	**Sensitivity:** Moderate level

Purpose:

- to experience some stereotypical reactions of society to coming out
- to experience how it feels to come out in a non-affirmative environment
- to reflect on the privileges of heterosexuality

Requirements:

- Group size:
  - 2 groups for 6 participants
  - 6-7 groups for 30 participants
- Materials:
  - One paper containing coming out statements (the number of papers must match the number of groups you are planning to have)
  - Several papers containing different questions/reactions to coming out statements (the number of papers must match the number of groups you are planning to have)

*depends on group size and duration of discussion

Materials

Examples for papers with coming out statements (names can be adapted to domestic culture)

ROBIN

You must be wondering why I invited you... (silence) I have to tell you something ... I'm not like most of you... I'm straight ☹

Examples for papers with questions/reactions to coming out statements (names can be adapted to domestic culture)

LUCY

- If you have never slept with the person of same sex, how do you know that this wouldn't attract you? Maybe you just haven't yet found the right person?
- Don't you think it is just a phase that you're going through?
- Why do you straight people always have such a need to emphasize it (your sexual orientation)? You talk about your boyfriend/husband or wife/girlfriend, you mention them in a private conversation, at work, everywhere ... Wherever, in the street or in a restaurant, people can see that you are in a relationship/marriage. Turns out you are imposing it to the others?

JACKIE

- Can you tell me when you decided to be straight?
- Will the children growing up in a heterosexual family become heterosexual? What if you pass it on to them?
- Why are straight people so promiscuous and give so much importance to sex? Why is it so important that you have sex with a person of a different sex?

CHRIS

- There are so many examples in the Bible that heterosexuals are abnormal and sick, isn't it hypocritical of you to believe in God considering you are straight?
- Given that there is so much hunger and poverty in the world, and resources are rapidly decreasing (water, food, etc.) if everyone would be straight, how will the human race survive?
- Will heterosexual marriage destroy the family we know?

This is the example where each person asks 3 questions. In larger groups, questions can be shared so each person asks 2 questions.

Description

The exercise is useful as an introduction to the education on coming out process: participants become more aware of the complexity and comprehensiveness of coming out, learn about obstacles that LGBTQI+ persons face and that coming out is an intimate experience related to different life dimensions simultaneously.

Participants are divided into groups of 4-5 and told to imagine a "reverse world" - most people are LGB, heterosexual persons (straight) are marginalized and discriminated against. Each pulls out one paper (turned upside down so the text is not visible): papers are arranged so that each group has one person who comes out and 3-4 people who receive a paper with questions.

Instructions (to the participants):

The person with the “coming out statement” has to come out to the group using the statement on the paper. The others, who got papers with questions, ask them questions and the person answers. Participants have about 10-15 minutes after which a discussion will follow.

Suggested questions for discussion:

- The persons who had the role to "come out" should be invited to share their experiences of the exercise. What did they think when the questions started? Were they surprised with some questions? Was it easy or difficult to give all the answers? How did they feel while answering? Did they feel attacked or supported?
- The persons who had the role to ask the questions can be asked to share their experience. How was it for them to ask those questions? Were they satisfied with the answers? How did they feel? Were they comfortable or uncomfortable during this exercise/workshop?
- All participants can be asked: what does this experience tell them about the coming out act?

Notes for trainers

This activity can be quite sensitive, especially for the persons that get the "coming out" role, so make sure to debrief them and check if they are feeling OK at the end of the exercise. A fun activity where everyone stands up, then shakes their legs, and their arms and then the whole body (to completely get them out of their roles) is advisable after the discussion, before moving on to the next activity.

Activity 3.2. - "Icebergs and snowflakes of our identity"

Time: 30 mins	**Sensitivity:** High level

Purpose:

- to get participants to think about the construct of identity in a more dynamic and contextualised way
- to show participants that none of our identities are restricted to just one social context
- to tackle the myth of "sexuality is a private matter"

Requirements:

- Group size:
  - Max. 12 participants
- Materials:
  - Sheets of papers outlining identities
  - Blu Tack or tape

Description

This activity is adapted from the Identity Signs activity outlined by Meg Bolger in The Social Justice Toolbox. This activity is about our identities and showing participants experientially how our identities are complex and dynamic constructs that constantly change and adapt to social contexts. In every social context (family, work, etc.) different part(s) of our identities come to the forefront (the tip of the iceberg), but the identities in the background (the underwater part of the iceberg) do not disappear either, they are just less visible at the time. There are many identities or identity elements that are constantly forming our sense of self and our points of contact with others: for example, at work we are not just workers, but also social beings, every workplace culture enhances a certain aspect of workers' identities, and turns these aspects into possibilities for connection and disconnection between the workers.

To prepare for this activity, first make the identity signs: print or write every identity onto a sheet of paper (we recommend A/4 size), and stick these identity signs onto the wall around the training room, or put them on the floor in a big circle.

Identitites for the identity signs: Race; Ethnicity; Socio-economic status; Gender; Sex; Sexual orientation; National origin; First language; Physical, emotional, developmental (dis)ability; Age; Religious and spiritual affiliaton

Ask participants to prepare themselves to move around the room: stand up and familiarise themselves with the identity signs. Tell them that these signs represent different aspects of their identities. After they are ready, introduce the activity and say that you will read a series of sentences, each sentence will be about their identities, but instead of the identity there will be a blank space in each sentence. To fill these blank spaces they will choose an identity sign that is most relevant for them based on that sentence. They are asked to stand next to the identity sign that they choose. Everyone can pass, thus if needed, they can choose not to stand next to any sign. The passing option is advised to be used only if someone does not want to answer the sentence for some reason; if a participant is just indecisive about where to stand, they should still try to choose an option and stand next to that sign. That might not be the most obvious option for them, but they can discuss their dilemmas during the short discussion after every sentence.

Sentences for the activity "Icebergs and snowflakes of our identity"

- The part of my identity that I am most aware of on a daily basis is_____.
- The part of my identity that I am the least aware of on a daily basis is_____.
- The part of my identity that was most emphasised or important in my family as I was growing up was _____.
- The part of my identity that has the greatest effect on how others perceive me is _____.
- The part of my identity that I most often use to connect with others is _____.
- The part of my identity that most often comes up directly or indirectly when talking with colleagues is _____.
- The part of my identity that almost or almost never comes up when talking with colleagues is _____.
- The part of my identity that I wish I knew more about is _____.
- The part of my identity that provides me the most privilege is _____.
- The part of my identity that I believe is the most misunderstood by others is _____.
- The part of my identity that I feel is difficult to discuss with others who identify differently is _____.

After participants have chosen their identity sign for the first sentence, ask them to look around, and share their thoughts and feelings about the sentence, about the identity sign they have chosen, about where they see the most people standing, about their decision process or the reason they stand next to their chosen sign. After a few minutes of sharing and processing, read the next sentence and repeat the previous process. By the third or fourth sentence you can start to ask participants about how it feels to see many others moving around and choosing a new identity sign for each sentence. There might be participants who do not move or choose new signs at all – if you see this is the case, tell the participants that it is completely okay not to move, having the same or different element(s) of your identity emphasised in different social contexts are both normal.

After the last sentence get the participants back into a big circle, and ask them about their experiences.

- Why do you think this activity is called "Icebergs and snowflakes of our identities"?
- Was it difficult to choose just one identity sign, or was it easy? Why? Did you have a different experience with each sentence?
- Do you think any identity sign was missing? What identity sign would you add to the ones on the wall/on the floor?
- Were there any identity signs that you almost never considered in your choosing process? Something you almost never felt to be important when thinking about the sentences? Which one and why?
- Do you think there is an identity element that is only relevant in certain social contexts, situations, and not in others?
- Were there any sentences, or are there any social contexts in your life where you felt that sex, sexual orientation or gender are not at all important?
- How do you think this activity is relevant for the topic of coming out?

Notes to trainers

This activity is a highly sensitive activity. Participants have all kinds of feelings and life experiences regarding their identities, and memories can come back suddenly - even if the participants don't share them. If you think your participants are very trusting of each other and feel that the group is safe enough for them to share about their identities, this activity can be a valuable companion to delivering the knowledge on coming out. Before this activity we advise you to remind participants about the group rules you have set up at the beginning of the training, or do an activity that enhances group cohesion and trust even more.

If you see that the group is not a safe space for sharing participants' own identities, you can modify this activity, and have each participant think about not their own, but an imagined person's identity. You can ask them to imagine a person - this can also be someone they know but is currently not present, or you can hand out role descriptions to them (similar to the activity "Privilege Walk").

Module 4 - Human rights and the systems of oppression

Topics in this module: Human rights; Violence experienced by LGBTQI+ persons, Systems of oppression

Introduction

This module introduces the negative attitudes towards LGBTQI+ people and the characteristics of oppression and violence they experience in different societal settings.

This module looks at the different types of violence experienced by LGBTQI+ people, including their most common experiences. It raises fundamental questions on how society treats their LGBTQI+ members and what professionals' competences are in the subject.

Relevance

You may find that participants bring in their own beliefs and biases, for example victim blaming attitudes. We are providing a variety of activities to help participants gain a better understanding of the nature of violence, which may help participants work on their views as professionals.

Aims

This module serves to broaden participants' knowledge of the experiences of LGBTQI+ people in society and with violence.

After this module, the participants will:

- Be familiar with the concept of basic rights and their violation
- Know more about the impact oppression has on LGBTQI+ people
- Have gained knowledge on the types of discrimination and violence LGBTQI+ people experience

- Be able to recognise the negative effects of oppression and violence
- Have worked on their understanding of victimisation

Knowledge base for trainers

Human rights of LGBTQI+ persons, laws and legislation

In order to work successfully with LGBTQI+ persons, it is very important to be well informed and aware of all aspects concerning their everyday life, including legislation. This does not mean that a professional working with LGBTQI+ persons must be a legal expert on human rights, yet it is helpful to have an overview of the state of rights of LGBTQI+ persons globally – how it is on one's continent and over the world.

The reason for this is that each professional working with LGBTQI+ persons, regardless of their field of expertise and/or work, essentially informs and sensitizes both LGBTQI+ persons and the general public regarding various topics: the state of human rights, the history of LGBTQI+ movement, queer culture etc. For instance, a professional may be working with a lesbian/gay/bisexual or transgender person who has no knowledge about any of these topics, perhaps has no one to ask, so learning about them may be of great importance for that persons and their personal growth. Also, in terms of informing the public, a professional working with LGBTQI+ persons will sooner or later be asked about a variety of topics connected to the LGBTQI+ spectrum, while human rights are somewhat most commonly known and it is expected from a professional to provide valid information.

The legislative frame of the human rights of LGBTQI+ persons varies drastically in different regions: only 9 UN states contain constitutional provisions that specify sexual orientation (not necessarily gender identity/expression) in their discrimination protections while in 72 countries being gay or being accused of being gay leads to criminal penalties (prison) and in 9 countries there is a death penalty for it. A professional working with LGBTQI+ persons can learn about these topics either from local LGBTQI+ organisations or international bodies – for instance, the European Union Agency for Fundamental Rights has conducted extensive research about the state of the human rights of LGBTQI+ persons in Europe (in 2012 and 2019). ILGA-Europe (an independent, international non-governmental umbrella organisation) publishes annually

Rainbow Europe, which ranks 49 European countries on their LGBTQI+ equality laws and policies. All the data is available on their web pages.

Also, it is very important for a professional to be aware of the myth of 'requesting special rights'. It is a rather common general idea that LGBTQI+ persons ask for some 'special' or 'additional' rights when talking about their human rights, even though the overall aim is merely to achieve complete equality before the law for all people, regardless of their sexual orientation, gender identity and/or gender expression. In that sense, most people are astonished once they hear about the real condition of human rights around the globe, and also about the legal inequalities in their own country.

Violence and abuse experienced by LGBTQI+ people

Violence and abuse can take many forms, can occur regularly or intermittently but is always focused on one thing: power and control over the victim. LGBTQI+ persons often experience harassment or abuse based on SOGIE (sexual orientation, gender identity, gender expression), but they can also be the targets of domestic and dating violence. Here we list the most common forms of violence and abuse that professionals might meet when working with LGBTQI+ clients.

Discrimination

Discrimination may occur directly, when a person is treated less favourably than another person because of their sexual orientation or gender identity, or indirectly, when a general criterion or practise disadvantages a person based on their sexual orientation or gender identity. LGBTQI+ people face discrimination in various aspects in their life. The scenes of discrimination can vary for each individual, but the most prominent are the following:

- Education (e.g. not being able to attend a given school)
- Workplace (e.g. job application being rejected)
- Healthcare (e.g. services being denied)
- Public spaces (e.g. being excluded)
- Media (e.g. not being properly addressed)
- Religious communities (e.g. being shunned)

In most countries, discrimination is prohibited by the law. Check for the legislation in your country to provide your participants with valid and up-to-date information and also create a list of services that provide legal aid.

Microaggressions

Microaggressions are behaviours that subtly or indirectly communicate a derogatory or otherwise hostile message to the recipient. Microaggressions are defined as "brief and commonplace daily verbal, behavioural, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups" (Nadal, 2008, p. 23, as cited in Nadal et.al.,.2011).

Types of microaggressions	
Un-affirming attitudes	• assumption of universal LGB or trans experience (e.g. stereotyping; assuming all LGBTQI+ individuals share characteristics with an LGBTQI+ individual one personally knows) • assumption of abnormality • discomfort with or disapproval of LGBTQI+ experience • denial of the reality and consequences of heterosexism and/or transphobia
Un-affirming behaviours	• heterosexist or transphobic terminology • endorsement of heteronormative and/or gender normative culture and behaviors (only being heterosexual and cisgender is treated as normal) • exoticization (the life of an LGBTQI+ individual is used as entertainment or objectified) • denial of bodily privacy (e.g., asking probing questions of trans individuals)

Bullying in school environment

This is a short introduction to bullying, for more see Module B for School Psychologists.

Sexuality is an important topic among teenagers, and schools are a place where children learn what's acceptable regarding sexual orientation and gender roles, expression, and gender identity. Schools are also the primary place for youths to socialise, form friendships, and from the age of 7 to 19 this is the place where they spend most of their days. If someone is harassed or abused at school, they must face that day after day. It is visible that for LGBTQI+ youth, school can be experienced as an unsafe place for a variety of reasons.

Plenty of LGBTQI+ youths report feeling uncomfortable or unsafe in their schools, this may lead to avoiding particular areas (i.e bathrooms, lockers), not taking part in particular activities where they might have bad experiences, or in extreme cases they might even avoid attending school, which can cause failure at classes or even being kicked out, resulting in worse options for their academic success. An unwelcoming or hostile school environment can cut back LGBTQI+ students from accessing all academic possibilities, from socialising or from engaging with the school community.

When talking about the negative effects of bullying we don't solely mean harsh verbal or physical harassment, but every manifestation of non-acceptance, starting from LGBT-phobic remarks. Anti-LGBTQI+ remarks contribute to hostile school climates. Any negative remark about sexual orientation, gender, or gender expression may signal to LGBTQI+ students that they are unwelcome or unaccepted, even if these negative remarks are not directly aligned to the particular sexual orientation, gender identity, and gender expression of the LGBTQI+ student who hears it, or they are not particularly directed at given student, but appear in the form of jokes or stereotypes. Especially if these remarks come from a teacher or other adult, as this normalises these types of behaviours.

Domestic violence

According to the definition, domestic violence is the aggressive and abusive behaviour that appears between family members or intimate partners, regardless of gender, sexual orientation, gender identity, age, social background, race etc. A lot of people fail to recognise the signs of domestic abuse as most people consider only physical aggression as violence. In reality, in an intimate relationship or in family situations, violence can take many forms other than physical: psychological, emotional, economic, social and sexual. The abusive behaviour moves on a very wide scale in severity, starting from belittling comments to excessive physical violence, even murder. It is common that in the beginning there are isolated and rare manifestations of violent acts on the other person's side followed by apologies and regrets, the violent party comes up with excuses (stress, alcohol etc.) and promises it won't happen again.

There are three main myths regarding domestic violence within lesbian and gay couples: the first one is that it is non-existent, the second is that the violence is reciprocal, the third is that the

abuse is less severe. The truth is that the prevalence of domestic abuse is the same amongst heterosexual couples and LGB couples, there is existing power difference between the parties, and the severity of the abuse isn't connected with sexual orientation.

As LGBTQI+ people often experience peer and family rejection, they are the subject of increased isolation, making it harder to reach out for help and support in an abusive situation. In LGBTQI+ relationships the sexual orientation/gender identity can function as a "tool" in the partner's hand, there are cases when they threaten their partners with sharing their SOGIE or withhold them from coming out.

The LGBTQI+ identity makes it harder for the victims to reach out as they fear being judged and rejected. A disturbing piece of data: trans women, especially sex workers, are at a high risk of suffering violence from partners or clients and reports are still very rare, only an estimated 4% percent of the victims have reported to the police or looked for help from other sources. Another high-risk group are those LGBTQI+ children and teens whose family abuses them on the basis of their sexual orientation and gender identity.

Hate crimes

In many countries of the European Union, acts of violence against a social group are legally classified as hate crimes, which entail harsher sentences if convicted. In some countries, this form of legislation extends to verbal abuse as well as physical violence. The base offence could be anything prohibited by the criminal law, the act becomes a hate crime when the victim is selected based on a personal characteristic ie. sexual orientation or gender identity. For perpetrators, these kinds of acts serve as a message to the whole group that they are unwelcome and unsafe in the society, thus decreasing feelings of safety and security, which leads to making LGBTQI+ people hide their identities in fear for their safety.

There exists conclusive evidence that anti-LGBTQI+ hate crimes persist across Europe. The FRA European LGBT Survey (2019) found that 11% of LGBTI people experienced physical or sexual attacks due to being LGBTI+ in the five years preceding the survey, and 38% had experiences of harassment due to being LGBTI+ just in the 12 months preceding the survey.

People victimised by violent physical hate crimes are likely to experience more psychological distress than victims of other violent crimes. Specifically, victims of crimes that are bias-motivated are more likely to experience post-traumatic stress, safety concerns, depression, anxiety and anger. Furthermore, even just witnessing discrimination against one's own group can lead to an amount of psychological distress , a feeling of being in danger, and lower self-esteem.

Hate crimes have the potential to cause injury and distress both at the individual and community level.

Hate speech

By FRA's definition "Hate speech refers to the incitement and encouragement of hatred, discrimination or hostility towards an individual that is motivated by prejudice against that person because of a particular characteristic, for example, their sexual orientation or gender identity. '' Hate speech tries to promote and justify hatred and hostility towards the group of LGBTQI+ people, it can also contribute to the general societal atmosphere: in communities where hate speech is accepted or tolerated, actual attacks are more probable against the members of a given group. Hate speech is hard to tackle, as cases are underreported and they can also appear on any given platform.

For more information on online hate speech you can visit Galop's website.

Relevant legislation

Trainers should prepare and give information on the most important national legislation regarding discrimination (equal rights legislation), hate crimes and domestic violence as it can

vary even between EU countries. As a handout, give a list of local victim support services to which your participants might refer their clients if needed.

Systems of oppression and their impact on LGBTQI+ people

When talking about the complex context in which LGBTQI+ people live, it is important to identify the systems of oppression which have an impact on their external and internal experiences, sense of self and quality of life.

Heteronormative society

Heterosexism refers to the belief that everyone is heterosexual, which develops a steady systemic institutionalization of attitudes and biases that privilege those who identify as heterosexual and/or are in heterosexual relationships. The heteronormative society which we all live in is based on the (un)questionable truth that heterosexual identities and relationships are the norm.

- Homophobia and biphobia derive from this powerful and superior social reality and have in their core the imbedded fear of being physically near homosexual people, viewing them as contagious or the fear of someone thinking you are gay. It is now a term describing not only fear but also extreme hatred and disgust toward people with homosexual orientation and other non-heterosexual orientations, viewing them stereotypically as wrong, mentally sick, perverts, sinners (more on homosexuality and mental diagnostic manuals, page 11) and also perceiving heterosexual people as superior and ideal. It is also a description of everyday emotional and psychological tensions related to non-heterosexual orientations among straight people. Although not all people who are homophobic will act upon their beliefs, the widespread stigma contributes to high levels of intolerance, experienced by LGBTQI+ people.
- Monosexism is the notion that we can only be attracted to one sex. We could be either heterosexual or homosexual. Deriving from this belief is of course the hatred towards people who are bisexual within the community because they are viewed as indecisive, promiscuous or just trendy (biphobia).

Similarly, the notion that there are only two genders based on one's sex assigned at birth is described as genderism. These beliefs are enforced in various contexts and institutionalised in many ways. The most simple examples are the ones with the labels "Male" and "Female" we see on the signs of toilets in private, public, corporate, administrative and recreational places, or the boxes that we tick every time when applying for a job, to a university etc. So, imagine someone who identifies as transgender in a daily situation where they constantly have to make a decision to compromise with their genuine gender identity. For someone coming from a privileged position of being a heterosexual cisgender professional, these elements of reality might not sound like a big thing. But they, along many others, shape a constant sense of shame, feeling a misfit, being wrong, not belonging, being invisible in someone who identifies as genderqueer (as an umbrella term for all who don't fall in the cisgender category).

- Transphobia derives from genderism and includes a wide range of negative attitudes directed at devaluing trans people. For more information on transphobia see Module 2.
- Interphobia - Intersex people were mentioned earlier in the chapter, when describing the notion of sex assigned at birth. Based on the binary notion of gender, many nonconsensual genital surgeries (intersex genital mutilation) are performed on intersex newborns everyday around the world. Intersex people are facing interphobia via violence, mutilation, undesirable hormonal treatment, physical interventions, and severe discrimination in many forms. All these actions against intersex people have been recognized as tortures and crimes against humanity by the UN in 2015.

Professionals working with LGBTQI+ persons, in order to be successful at their job, need to obtain a certain level of knowledge in terms of the legislative framework of the human rights of LGBTQI+ persons. Besides that aim, it is also important to continuously break the myth of 'requesting special rights' that is quite common among the general population.

Handout 1 - Some of the basic human rights of LGBTQI+ persons that are threatened across the globe:

- Right to Life: the only right not threatened directly in Europe, but it is in other regions;
- Right to Equality and Non-discrimination: LGBTQI+ persons are discriminated in many areas: in access to social and health care, in protection from violence, in housing, public spaces etc;
- Right to liberty and personal safety;
- Right to work: LGBTQI+ persons often experience insults, harassment in the workplace, denial of promotion, poorer working conditions, and poorer pay;
- Right to education: Textbooks and learning materials with discriminatory statements against LGBTQI+ people, non-existent human rights education, LGBTQI+ students exposed to insults and abuse from other students (but also teaching staff), hiding their sexual orientation or gender identity, etc.
- The right to marry and the right to found a family: unavailable for LGBTQI+ persons in most countries;
- Freedom of assembly: for instance, Gay Pride but also other forms of protesting are not possible or receive negative reactions from the public.

Handout 2 - The most common transphobic reactions

"There are only two sexes."

"Trans women are not 'real' women, and trans men are not 'real' men."

"People should use toilets according to their biological sex."

"Being trans is a new phenomenon, it's a fashion these days."

"There are real trans people and fake trans people who just want to be interesting."

"Trans people are mentally ill."

"Children aren't old enough to know their gender identity."

"You can tell if someone is transgender just by looking at them."

Activities for Module 4

Activity 4.1. - Quiz: How much do you know about the human rights of LGBTQI+ persons?

Time: 15+ mins	**Sensitivity:** Low level

Purpose:

- To raise awareness and self-awareness on one's knowledge on human rights of LGBTQI+ persons and the relevant legislative framework in general

Requirements:

- Group size:
  - Max. 25 participants in groups of 2-4
- Materials:
  - Index cards or small sheets of paper for each participant with the offered responses A, B, C, D

Description

A trainer prepares a short quiz with several questions (at least 5) on various topics: the state of human rights, history of the LGBTQI+ movement, queer culture. The questions are best if they are rather general and not too demanding in terms of having legal expertise, for instance:

- Do you know why is Pride usually in June?
- Do you know what happened during the Stonewall riots? When did they occur?

The responses may be offered so participants would be able to choose A, B, C or D. Participants can simply raise their hand to respond, or they can respond in teams (2-4 person/team). After getting the answers, the trainer tells a bit more about the topic of the question. After the quiz, a brief discussion on the group's knowledge on the subject may also be good for better comprehension and sensitisation.

Activity 4.2. - "The privilege walk"

Time: 40 mins	**Sensitivity:** High level

Purpose:

- To foster participants' understanding regarding the intricacies of privilege
- To help participants' explore their own privileges
- To gain insight into the many ways that being members of recognized groups provides people with security and advantages

Requirements:

- Group size:
  - At least 10 participants
- Materials:
  - List of statements related to privilege or obstacle
  - Sticky notes outlining different "roles" (folded)
  - Hat, bowl or similar item
  - Space to move around

Description

Arrange the space so that participants can stand next to each other in one line - ideally with an arm's length between them. This activity involves moving around: participants will need to take some steps forwards and backwards - ideally they have enough space to take 10 steps forward. You can mark these 10 steps for them with items (post-its, chairs, etc.), or you can show them how big a step they should take. If you don't have enough space for the amount of participants you have, you can also use a big flipchart paper, on which participants can move post-its back and forth.

Before giving the roles, instruct participants to forget themselves and imagine a bit the life of the person they are about to "become". Then pass a hat around with the sticky notes folded inside it

so that everyone can draw a sticky note with a "role" on it. Give participants 3-5 minutes to prepare and get into the role.

Roles for the activity "The privilege walk"	
36 year old gay man	Lesbian woman, teacher
Bisexual man, father of 2	Trans woman
Trans man	Crossdresser
Drag queen	White male, lawyer
60 years old gay man in the closet, married to a woman	26 years old woman in college
35 years old father of three	45 years old, recently divorced
Pansexual male	Bisexual woman
16 years old. boy from a religious family, who wants to come out of the closet	.. you can add more roles

When participants are ready, ask them to make a line with an arm's length between themselves and the person on their left. When the line is ready, give the following instruction:

I am going to read you some statements. Every time you can answer with a YES – make a step forward, every time the answer is No – take 1 step backwards. Please, stay completely silent through the process and pay attention to your journey.

After giving the instruction, start reading **The Privilege Walk Statements** slowly. After the fifth statement, ask participants to look around them for a second. Continue with the statements and do the same thing after the 10th and last statement. After you are all done with the statements, politely ask participants not to start talking just yet, to return to their seats and prepare for the discussion.

Statements for the activity "The privilege walk"

1. You can walk on the streets holding hands with your loved one freely.
2. You can get married.
3. You can have as many kids as you want easily.
4. You can tell the person you like how you feel.
5. You can dress however you like at work.
6. You can easily find work.
7. Your friends and family really know who you are.
8. You are not afraid to share your feelings.
9. You can show affection for your romantic partner in public without fear.
10. You find partners easily.
11. You can confide in your coworkers.
12. You are not embarrassed of your clothes and the way you look.
13. You've never been bullied about something you can't change about yourself.
14. You were able to speak to your parents freely about everything.

You can add more statements.

Ideally participants sit in a circle for the discussion. Start the discussion by going around the room, and have each participant share one word that captures how they are feeling at the moment. If they do not want to share, they can say, "pass".

Questions for discussion:

- Would anyone like to share more about their feelings?
- How did it feel to be one of the students at the "back"?

- How did it feel to be one of the students at the “front”?
- Did anyone think they had experienced an average amount of privilege, but it turned out to be more or less than they thought?
- If anyone was alone on one side, how did that feel?
- Was anyone always on one side? If yes, how did that feel?
- Were there certain sentences that were more impactful than others?

Activity 4.3. - "Everyday violence"

Time: 15 mins	**Sensitivity:** Moderate level

Purpose:

- To facilitate participants' thinking about everyday forms violence that LGBTQI+ people might experience;
- To help participants understand how even "simple", everyday acts can serve as a tool for communicating hatred towards an oppressed group and its members;
- To help participants understand and categorise different acts of prejudice.

Requirements:

- Group size:
  - At least 5 participants
- Materials:
  - Pieces of paper with the names of the categories from the module
  - Small slips of paper for the participants to write on
  - Markers
  - Adhesives to stick the notes on a wall or on a flip-chart paper

Description

The trainers introduce the categories used for this activity, the labels can be spread on the floor or put up on walls, flip chart papers etc. The participants are handed small slips of paper and they are asked to think of particular examples of harassment, discrimination, violence LGBTQI+ people might experience. Everyone works individually, and after everyone has written at least one example, the participants go and stick their slips under the label of the category it belongs to. After everyone has finished, the group discusses the examples and corrects miscategorised acts.

Make sure to have the participants look at all the examples and during the discussion raise the topic of how these acts can affect the everyday life of individuals, and how it makes them feel as

group members and as individuals.

Notes for trainers

Categories used in this activity: biased language, homophobic remarks, negative remarks on gender expression, verbal harassment, physical harassment, physical assault, relational aggression, cyberbullying, sexual harassment, property theft or damage.

Module 5 - Mental health risk and minority stress

Topics in this module: Minority stress, Internalised homo/bi/transphobia, Mental health risks of LGBTQI+ persons

Introduction

This module talks about minority stress, internalised homo/bi/transphobia, as well as the most basic mental health considerations and mental health risks of LGBTQI+ people. The concept of minority stress is defined and the Meyers model of minority stress is presented. Internalised homophobia, biphobia and transphobia are explained, as well as their manifestations and relation to negative health outcomes. The module also provides tips on how one can overcome internalised homo/bi/transphobia. At the end of the module, some mental health risks that LGBTQI+ persons often face are presented.

Aims

This module aims to raise awareness and improve knowledge regarding the topics of minority stress, internalised homo/bi/transphobia and the mental health risks of LGBTQI+ persons.

After this module, the participants will be able to:

- understand the concept of minority stress and its negative effects on health outcomes
- describe internalised homo/bi/transphobia and its effect on health outcomes
- list the most common mental health risks of LGBTQI+ persons

Knowledge base for trainers

Research shows that when LGBTQI+ populations and cisgender heterosexual populations are compared regarding mental health, certain psychological disorders are more prevalent in

LGBTQI+ persons. It is important to note that being LGBTQI+ does not increase the risk of mental health issues, but rather the experiences LGBTQI+ persons have because of belonging to a sexual or gender minority group. As explained in module 4, the environment that LGBTQI+ persons live in can often be discriminative, prejudicial or even hostile; it is visible that there are many stressors that can affect mental health. So, for a better understanding of some of the stressors, it is very important to take into account the social environment.

Minority stress

Stress is a normal occurrence for everyone, whether it's from a major event (e.g. death of a close person) or just our daily lives (e.g. traffic jam). Generally, stress can be defined as a state of disrupted psycho-physical balance that the individual is experiencing because of a form of threat (physical, psychological, or social) to themselves or a loved one (Havelka, 1998). In addition to the general stressful situations that all people are expose to, LGBTQI+ persons also face everyday stigma, prejudice, and discrimination, which creates a chronic stressful environment. According to Meyer (2003) LGBTQI+ persons experience minority stress, which is defined as chronic level of stress caused by prejudice, discrimination, lack of social support, and other factors that minority individuals experience. The inferior status of LGBTQI+ persons leads to an increased number of stressful events such as violence, discrimination, or harassment, which are associated with lower self-esteem, insecurity, and physiological and psychological experience of stress.

Minority stress model for LGB persons

Minority stress model, developed by Meyer (2003), is an attempt to clarify the process through which social stress brings about poorer mental health in LGB persons. The model is based on two assumptions:

1. Stress is social; there are objective external stressful events and conditions, which appear a consequence of heterosexism and which create a hostile environment for LGB people.
2. The existence of these conditions leads to poorer mental health outcomes.

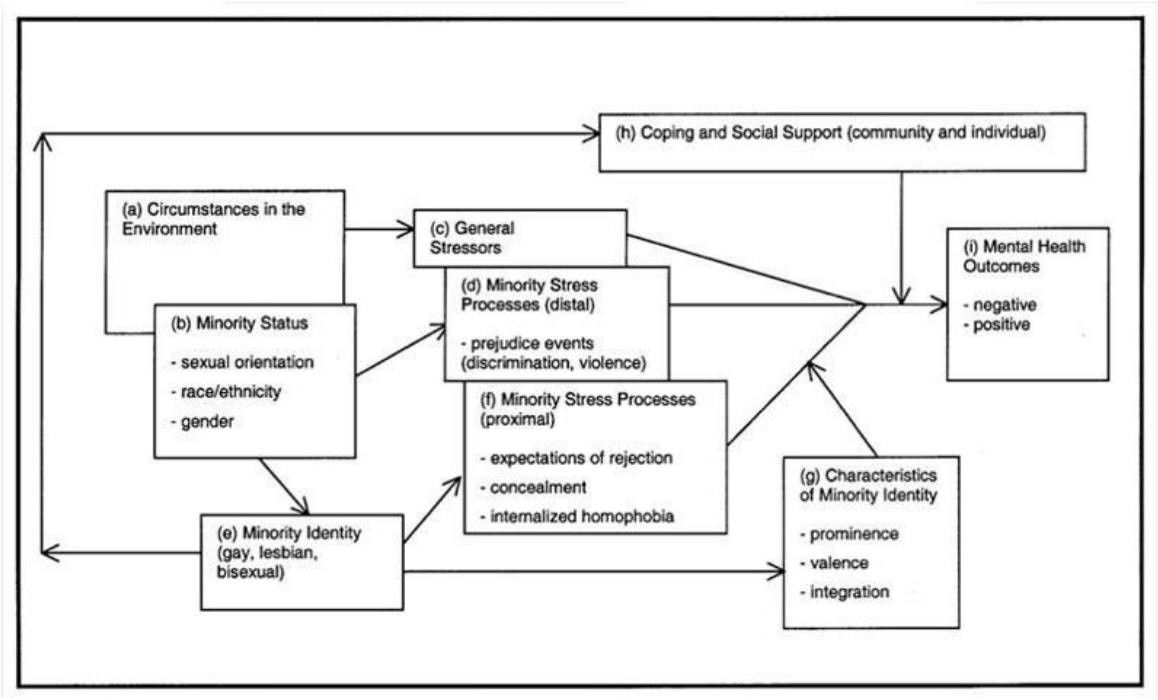


Figure 1. Meyer's minority stress model (Meyer, 2003, pp. 253)

The circumstances in the environment (box a) refers to the social context that the person with a minority status (box b) lives and develops in. This context affects the LGB person's positive and negative mental health outcomes (box i) by means of distal and proximal minority stress processes (box d and f). We must not forget the impact of general stressors (box c) present for all individuals. Characteristics for minority identity (box g) and the individual and community ways of coping and social support (box h) represent the mediators in the relationship between distal and proximal stressors on mental health. Social support and social identity are often theorised as buffers which reduce the negative effects of stress on health. Minority identity (box e) has multiple effects. It determines whether the individual living in a particular social context would be exposed to the distal and proximal stressors. It also mediates the impact of these stressors on mental health.

The central elements of the model are distal and proximal stressors which can be acute and chronic sources of stress. Objective stressors that are brought in from the outside and do not

depend on the individual`s subjective assessment represent the distal stressors (e.g. the experience of discrimination, violence, abuse). The proximal stressors are more subjective in nature and related to the identity of LGB persons themselves. Some of the more relevant proximal stressors are the expectation of rejection by other people, the concealment of one's identity, and internalised homophobia.

The minority stress model was developed specifically for cisgender individuals with diverse sexualities (i.e., lesbian, gay and bisexual individuals), yet recently it has been empirically applied to the transgender population (Bockting et al., 2013; Scandurra et al., 2017). It has been widely demonstrated that experiencing violence and discrimination in high rates leads transgender individuals to direct negative societal attitudes towards themselves and that, at the same time, resilience is exercised to contrast societal stigma nested within a society which discriminates on the basis of gender identity.

Internalised homophobia/biphobia/transphobia

Negative social attitudes affect the lives of LGBTQI+ persons on a daily basis, which can result in an internalization process of stigma associated with sexual orientation. When lesbians, gay men, bisexuals, and gender diverse people internalise[1] the negative attitudes of society and develop negative feelings and attitudes toward their own identity, we speak of internalised homophobia, biphobia, or transphobia. Adopted (internalized) homophobia, biphobia or transphobia are manifested through feelings of guilt and shame, discomfort with the disclosure of sexual orientation / gender identity, low self-esteem, belief that a person is inferior to others, moral and religious condemnation etc. Internalized homo/bi/transphobia includes: disturbing, uncomfortable and negative feelings about oneself as a homo / bisexual or non-binary person, self-devaluation, distorted notions and negative attitudes towards homo / bisexuality and trans persons, negative moral attitudes towards LGBTQI+ people, lack of connection with LGBTQI+ communities, tolerance of discriminatory treatment of others, irrational undermining of one's own intimate relationships, denying one's sexual orientation etc.

[1] It is the process of adopting social norms, standards of behaviour and experience.

Religion

Internalised homo/bi/transphobia can also be closely related to religious environment and beliefs, especially in the context of religions that are not affirming towards LGBTI+ individuals or condemn LGBTI+ individuals. Some research suggests that the level of internalised homophobia is higher for persons who are religious than for persons who are not.

In the context of Eastern Europe, where mostly Christianity is the dominant religion, LGBTQI+ persons of faith often grow up being taught that their different sexual/gender identity is a sin, abomination, against God's original plan, and a threat to having eternal life. Therefore, same-sex attraction and/or gender incongruence is perceived as problematic and unacceptable. Some religious groups will be affirming of non-heterosexual identity itself but will condemn people living a "gay lifestyle". For most religious conservatives, gender reassignment or living in a different gender than one's sex assigned at birth is discouraged.

LGBTQI+ persons of faith internalise the shame, the image of sinfulness and unworthiness that is imposed upon them. They can perceive themselves as "lesser humans." Self-hatred can manifest itself in deep emotional conflict and lead towards physical self-harming.

Religious LGBTQI+ clients differ in dealing with acceptance of their sexual/gender identity. The more conservative the affiliated religious group is, the more drastic the decision can be. A number of them decide to stay closeted and supress their sexuality or decide to enter a so-called "reparative therapy". (We would encourage the reader to look further into the topic of "reparative therapy" as it still presents a danger, though illegal in many countries and soon in the European Union).

Others will make a decision to lead a double life. It seems that it gives them some kind of relief, but it soon creates cognitive dissonance. The pressure of keeping their identity secret, living two lives, and keeping people apart can result in depression, anxiety and other forms of emotional and physical distress.

A part of religious LGBTQI+ clients can go into a denial of their religious identity or even feel animosity against religion. Even when they make this decision, the above-mentioned feelings of

guilt and shame may still stay with them on a conscious or subconscious level because the person has internalised the received messages.

For the processes of self-acceptance, coming out and dealing with internalised homo/bi/transphobia, an integration of religious and sexual identity can be seen as an ideal outcome. This, however, excludes change of religious affiliations, as the group the person belongs to often cannot accommodate a different opinion on homosexuality and/or gender identity. Also, it is necessary for the client to recognise that a reinterpretation of the holy texts is possible and available, although they may view this as threatening in the beginning. When talking about Eastern European countries, it must be mentioned that finding an affirming church can be a challenge because very few exist in these countries or none at all. There is also generally a limited availability of content about revisionist theology or queer theology in their language. In this case, the counsellor can either reach out to religious LGBTQI+ organisations/groups to get more information or refer the client to such an organisation/group.

Negative health outcomes

IH[2] is one of the main risk factors of the LG population leading to negative physical, mental, and well-being health outcomes (e.g., Berg et al., 2016). Studies have shown, for example, that internalised homophobia is positively associated with depression and anxiety (e.g., Mereish & Poteat, 2015), suicidal thoughts and behaviors, especially in LGB adolescents and the elderly (e.g., Livingston et al., 2015), substance abuse and risky sexual behavior (e.g., Herrick et al., 2013), as well as interpersonal challenges such as reduced social connectivity, lack of sexual desire, and difficulty in conjugal intimacy (Meyer & Dean, 1998; Wight et.al., 2013).

Although the studies reviewed thus far focused largely on the experiences of lesbian and gay individuals, recent data of bisexual persons suggest that internalized biphobia is correlated positively and uniquely with psychological distress (Brewster & Moradi, 2010; Brewster et al., 2013). There is also evidence that expectations of stigma and internalized biphobia are negatively connected with psychological wellbeing for bisexual people (Balsam & Mohr, 2007; Sheets & Mohr, 2009).

[2] Refers to internalised homophobia.

Transgender people are a highly-stigmatized population. For this reason, they might internalise society's normative gender attitudes and develop negative mental health outcomes. Also, transgender persons can also be lesbians, gays or bisexual, and thus experience additional stigmatization and internalized homo/bi/transphobia. Bockting et al. (2013) found a positive association between social stigma and depression, anxiety, and somatization at transgender people. Internalized transphobia increases the likelihood of suicide attempts (Perez-Brumer et. al., 2015). Specifically, shame about one's own transgender identity was found to be positively associated with perceived stress, depressive symptoms, and social anxiety symptoms (Testa et al., 2015), while alienation from other transgender people was found to be positively associated with perceived stress, depressive symptoms, and anxiety (Scandurra et al., 2017).

Research also suggest that the presence of protective factors (such as coping strategies, community connection, disclosure of sexual orientation to friends, and social support) can ameliorate the effects of IH on the psychological suffering of LGBTQI+ persons.

Internalised homophobia/biphobia/transphobia is not a disease, or a personality trait, much less a condition of a single individual. It is a response to the social circumstances of external oppression and marginalisation of LGBTQI+ persons. Indeed, overcoming internalized homophobia is an important developmental task in the coming out process that lesbian, gay, and bisexual individuals undergo and is seen by clinicians as a necessary step toward achieving good mental health and well-being.

Counselling or individual psychotherapy could alleviate the negative effects of internalised homo/bi/transphobia on self-perception. Counsellors and therapists should work on feelings of shame about one's own sexual orientation or identity, helping clients to reshape negative emotions associated with stigmatizing experiences and assist them in developing a self-image freer from binary notions of gender. They should also consider group approach as a valid alternative to individual work. Indeed, by its nature, the group encourages mirroring processes that facilitate reshaping one's self-image in an innovative and potentially creative way (Amodeo et al., 2017), increasing self-empowerment processes and resilience strategies (Amodeo et al., 2018).

Mental health risks for LGBTQI+ persons

Lesbian, gay, bisexual and/or trans persons may be more susceptible to mental health problems than heterosexual people due to a range of factors, including discrimination and the inequalities they face in everyday life. As the participants might have different depths of knowledge on the following topics, the trainer has to adjust their presentation of this part of the module. Here are some of the most important areas that should be addressed when talking about the mental health of LGBTIQ+ persons. A trainer can add local and up-to-date data on the prevalence of these mental health issues when presenting this section to the participants.

Impact of societal oppression on the mental health of LGBTQI+ persons

LGBTQI+ persons experience various forms of oppression and discrimination on a daily basis, costing them their quality of life, healthy sense of self, the good state of their interpersonal relationships at home, school or work. So, in view of this context in which LGBTQI+ people live, it is important to realise one crucial aspect when we talk about mental health related issues. When a client with a different sexual orientation and/or gender identity seeks psychological and/or emotional support, one should not look for the reason of the client's struggles in their sexuality or gender. To assume that diverse sexuality and gender identity imply psychopathology is simply untrue and utterly damaging. It is not because someone is gay, lesbian, trans or non-conforming that they are experiencing psychological struggles but, in many cases, because of all the prejudices and unpleasant events that they experience due to the systems of oppression in which they live (as described in Module 4).

Shame, due to all these systems of oppression, is at the core of many psychological issues and most people at some point in their lives will feel this intense emotion. But LGBTQI+ persons experience shame in isolation and they feel it systemically. Imagine feeling ashamed of who you are, who you love. Imagine feeling the agonising fear of anybody else knowing about you. Imagine feeling like this every day. Our beliefs are shaped from a very early age by the context we are living in, it is the messages we hear on a daily basis from our family, media, our teachers and friends about LGBTQI+ people that shape our views. So when there is a negative perception and rejection of one's sexual orientation and/or gender identity, especially by the closest people, relatives, loved ones, it could result in many psychological issues. It is not uncommon that LGBTIQ+

persons are reduced to one aspect of their personality in a way that being a lesbian/gay/trans/queer/etc. suddenly becomes the only important thing, like a lense that their environment looks at them through, and leaving out all the other positive and negative characteristics of the LGBTIQ+ person's identity, the history they have together, the memories etc. So, it may take years and years until a person is ready to move on to accepting their diverse identity.

Self-acceptance and integrating the sexual orientation aspect in one's identity is a very individual and complex process, but what research has indicated is that the greatest predictor of LGBTQI+ people's mental well-being and quality of life is the support of their family. The more supported a person feels, the higher the levels of well-being, the better the general health, and there is a significantly decreased risk for suicide, depression, and substance abuse (Ryan, 2009). Research (The Trevor Project's National Survey on LGBTQ+ Youth Mental Health, 2019) also shows it might only take one accepting adult in the life of the LGBTQI+ adolescent for the chance of suicide attempt to be reduced by 40%. Supporting clients in building their own support network of people is a crucial task, and it can also mean finding relevant supporters (teacher, guidance counsellor, mentor, instructor, trainer. Also, being the one or one of the accepting person(s) makes a world of positive change to LGBTQI+ persons and definitely serves as an essential protective factor, improving their mental health.

The most common mental health consequences for LGBTQI+ persons

Research consistently shows that LGBTQI+ persons have more mental health problems than cis normative, heterosexual persons, mostly due to the reasons explained in the previous text. Here are some of the most common problems:

Depression - Research has consistently shown higher rates of major depression and depressive symptoms (that do not meet the diagnostic criteria) for LGBTQI+ persons in comparison to cis normative heterosexual persons.

Anxiety - Psychological disorders or statuses linked to anxiety range from social anxiety, general anxiety disorders to panic attacks and specific phobias. Similar to depression, increased levels of anxiety and anxiety-related psychological disorders can be found amongst LGBTQI+ persons.

Researchers have found links between internalised homo/transphobia, minority stress and anxiety disorders in the LGBTQI+ population.

Self-harm and suicide - LGBTQI+ persons are at high risk of self harm and suicide. These are not diagnosable conditions but are associated with many mental health conditions, and are a great concern when it comes to mental health. A research from 2011 (Grant et. al., 2011) suggests that approximately 41% of gender diverse individuals have had at least one suicide attempt. LGBTQI+ youth are in particular a very high risk population regarding this matter. Risk factors for suicidal behaviour are: depression, substance use, traumatic experiences, peer rejection, feeling unsafe at school, lack of social support, family rejection, victimisation. If there is appropriate social and family support available for LGBTQI+ individuals, it can be a protective factor.

Substance abuse - Research suggests higher rates of alcohol and substance use and abuse among LGBTQI+ persons. Substance use can be a means of coping with the experienced minority stress, emotional pain and/or self-medicalisation of undiagnosed psychological states.

Trauma - Experiencing any kind of traumatic event can have a negative effect on mental health. LGBTQI+ persons are often at risk of being exposed to traumatic events and victimisation, such as experiencing rejection, being bullied, being assaulted because of their sexual orientation, gender identity or gender expression. Experiencing traumatic events can lead to post-traumatic stress disorder (PTSD), and are linked to attachment problems, depression, anxiety, self harm, suicide, substance abuse and risky behaviour. When talking about traumatic experiences, not only single events are meant, but also longer and constant exposure to harmful or abusive situations.

Activities for Module 5

Activity 5.1. - "The sound of silence"

Time: 15 mins	**Sensitivity:** Moderate level

Purpose:

- To help participants empathise with closeted LGBTQI+ people who are unsure if it is safe to come out

Requirements:

- Group size:
  - At least 5 participants
- Materials:
  - Index cards or small sheets of paper for each participant
  - Pens/pencils for each participants
  - Time cards
  - Time keeper

Description

This interactive exercise allows participants to experience what it is like for many closeted LGBTQI+ people who are unsure if it is safe to come out. When LGBTQI+ people are not out, fear being found out, or are scared of the repercussions of coming out, they may refrain from sharing important details about their lives when having conversations with others. Some may even talk about these details in a "roundabout-way" or discuss them within heteronormative or gender-normative language. In this experiential exercise, the participants are challenged to engage in a *conversation without discussing something that is most important to them.*

You can separate the participants in pairs (ideally they should not know each other). Each person should be given about two minutes to complete their index card with the information below.

Inform all participants that their partners should not see what they are writing on the cards. The first thing that comes to mind is important.

Index card for the activity "The sound of silence"	
What is your job? What do you do?	
Who are the most important people for you in your life?	
What are the 3 most important events that have occured in your life?	
What are 3 things that you enjoy most in your free time?	

When everyone has filled in their index cards, tell the participants:

You have just met the person with whom you are paired and can't wait to tell them all about yourself. Each partner in the pair has two minutes to tell her or his partner all about her- or himself, but you cannot discuss anything you wrote on your index cards. Participants in pairs have to decide who will introduce themselves first.

At the two-minute mark, tell the participants to switch, and the person who was listening now does the talking. After they are done, some of the couples might want to share what they have learnt about the other person. But it is very important for you to lead the discussion towards the following important points:

- How much energy and conscious attention did it take to talk about yourself without mentioning the items on your index card?
- What was it like to do this exercise?

- How did it feel?
- Can you imagine how many LGBTQI+ can't share some of the most important parts of their lives with people? Can you imagine how isolating this could be?

You can end the activity by allowing the participants to go back in their pairs and this time share what they wrote on the index cards. Maybe there will be people who will feel comfortable to come out as LGBTQI+? This would definitely be a sign of a job well done.

Notes for trainers

Main message to come across: LGBTQI+ people who are closeted or unsure if it is safe to come out can feel overly limited in what they share with people. When you have cisheterosexual privilege, you can speak openly and comfortably about your romantic partner, social interests and personal preferences.

Activity 5.2. - "The Body Keeps The Score"

Time: 15 mins	**Sensitivity:** Moderate level

Purpose:

- To help participants to understand the symptoms following trauma and traumatic life circumstances

Requirements:

- Group size:
  - Any number of participants ideally in 4 small groups
- Materials:
  - Papers
  - Writing utensils (pens or pencils)

Description

The participants are working in 4 small groups. Each group has to collect different ways of functioning, behaviours, emotions and other experiences that people can have after traumatic events, but each group works with a different category.

The four categories are: emotional reactions, physical reactions, behavioural reactions, cognitive reactions.

The participants have 10 minutes to work and discuss, and after that each group presents what symptoms they've collected.

Correct or add items if they are wrongly listed/missing, clear confusions. For the group discussion here are some suggestions for reflective questions:

- Have you ever worked with trauma? What have you learned from that experience?
- Which are the most important signs mental health professionals should be aware of?

- How do you know if a person is in a crisis?
- What do you think are the basic principles when you work with traumatised clients?

Notes for the trainers

List of symptoms for the activity "The Body Keeps The Score"	
Emotional reactions	fear, shame, anxiety, helplessness, insecurity, sadness, depression, a feeling of losing control, panic attacks, feeling guilty, distrust in other people, oversensitivity, constant changes of mood, and other intense emotional reactions
Physical reactions	dizziness, body tremors, muscle tensions, psychomotoric disturbances, sweating (particularly palms), headaches, high sensitivity to light exposure, feeling cold in lower body (particularly in feet), heart palpitations, high blood pressure, low blood sugar, digestive problems, hyperarousal, difficulty speaking, difficulty breathing, various stages of shock
Behavioural reactions	reticence: refusing communication, isolation, crying, aggression, verbal outbursts, impatience, drug or alcohol abuse, self-harm, suicide attempt
Cognitive reactions	disorientation, confusion, difficulty with concentration, difficulty speaking, forgetfulness, distraction

Module 6 - Personal and professional prejudices

Topics in this module: Personal and professional prejudices – awareness and consequences; Implicit bias; Harmful professional practises towards LGBTQI+ people

Introduction

This module introduces one of the most important aspects a professional should work on: their own prejudices. When working with LGBTQI+ clients, even unconscious biases can affect the client-mental health professional relationship. That's why we suggest revisiting personal and professional prejudice from time to time.

Relevance

Looking at one's own prejudices and biases can be a good lesson but also a very personal experience. During this module, make sure to create an accepting space that can be the basis of safe self-development.

This topic can be sensitive for some people, so it is good to pay attention to your participants. There should be enough time during the activities to work through personal reactions, and to reflect on these reactions and feelings, and the participants should have the opportunity to share their feelings either with the group or with you privately afterwards.

Aims

This module serves to broaden participants' understanding of their own functioning and their (unconscious) prejudices and biases.

After this module, the participants will be able to:

- Gain a better understanding of their own personal and professional biases
- Overcome them with the help of the tools provided

Knowledge base for trainers

Personal and professional prejudice – awareness and consequences

The main objective of mental health care providers is to build rapport with the people who seek their professional help. It is only through establishing a relationship of trust that one can provide meaningful and long-term support. Having in mind that the people who reach out for psychosocial services might have already experienced stigmatization, discrimination, and/or exclusion by other health care professionals or institutions, it makes it even more important to counteract to these previous harmful life experiences by showing acceptance, tolerance and providing safe space for LGBTQI+ clients. They will sense if the psychologist, social worker or hotline operator has a prejudice against them and this will lead to numerous painful and distressing consequences – accepting the prejudice as a truth which might lead to severe psychological damage, or refusing to accept it but feeling betrayed by one more potential figure of support.

Prejudice and implicit bias

The word prejudice basically means a preformed negative, unreasonable stereotype towards a group of people. It can be suppressed: "I know I have a prejudice towards LGBTQI people but will not show it because I am aware it is not accepted." Mostly, it is rationalized: "Gay people are mentally sick, and I know this because I have heard it many times. That's the way it is." What makes implicit bias so difficult to detect is that we are not aware of it. The first step towards gaining such awareness is accepting one's personal and professional obligation to study one's own bias in order to effectively provide psychological and emotional support to LGBTQI+ clients. Once we become aware of it, we might instinctively deny it and it takes courage to try to transform our personal and interpersonal beliefs. Understanding the messages we received and having in mind the heteronormative social norms around us can help us identify our own beliefs and biases that we can then challenge, helping to make us stronger allies.

Once aware of our own bias, we could try to implement the following techniques to transform it. Individuation is the process of focusing on specific information about the person, and avoiding

their categorisation based on stereotypes around various elements of their identity. "How can I set my assumptions aside in order to get to know the person who is seeking help?" "Do I only perceive the person as trans without taking into consideration all other aspects of their personal history, development, experiences, relationships?" Perspective taking is the process of putting ourselves in the shoes of the person seeking support – "If I was gay, how would I feel in this moment, meeting this new mental health practitioner? What would I be worried about? What would be my thoughts?"

NB! If even after realising your own implicit bias towards LGBTQI+ people you still cannot overcome it, following the ethical principles and standards of care you should refer clients to a colleague who provides LGBTQI+-affirming care. Professionals who strongly believe that diverse sexuality/gender identity is a mental disorder, an illness, caused by past trauma or dysfunctional family structures and relationships, infectious, a sin and still provide services for LGBTQI+ people in order to "treat" them, do not only violate professional and administrative principles, guidelines and standards of care, but most importantly they harm and damage a person's mental and physical health, social standing, personal relationships, and overall quality of life.

Harmful professional practises towards LGBTQI+ people

It would be impossible to start this section without taking into consideration the historical perception of homosexuality and diverse gender identity by psychologists, psychiatrists, other medical professionals and policy makers with the help of the official classification manuals – DSM (standard classification of mental disorders) and ICD (international classification of disorders):

DSM	ICD
DSM 1st edition (1952) – homosexuality is categorized as "sociopathic personality disturbance" DSM 2nd edition (1968) – homosexuality is described as a "sexual deviation" DSM 3rd edition (1973) - it is concluded that sexual orientation cannot be changed, same-sex attraction is part of the normal spectrum of human sexuality DSM 5th edition (2018) – "gender identity disorder" is replaced by "gender dysphoria"	ICD 6th edition (1948) – homosexuality is described as a "sexual deviation" ICD 10th edition (1992) – "sexual deviation" replaced by "ego-dystonic sexual orientation", keeping the notion that one's sexual orientation or gender identity is subject to change. ICD 11th edition (2018) – homosexuality is completely removed, gender identity is replaced by "gender incongruence"

Even though homosexual orientation and trans identity are officially not pathological diagnoses, LGBTQI+ persons still experience harmful practices directed towards "healing", "changing" or "repairing" their sexualities and identities (Bishop, 2019). The World Psychiatric Association states in this regard: "Any intervention purporting to 'treat' something that is not a disorder is wholly unethical." Still, based on heteronormative norms, as well as personal, social and institutional bias towards LGBTQI+ persons, there are still some (if not many) mental health care professionals who provide therapies aiming to convert and treat non-heterosexual people and/or non-cisgender people.

"Conversion therapies" or "reparative therapies" is an umbrella term describing these harmful, shameful, degrading practises provided by parents (home-based), mental health professionals, religious activists/gurus and institutions (external, usually initiated by parents or caregivers).

International official data regarding conversion therapies is scarce, but according to a UCLA Williams institute, more than 700,000 LGBTQI+ persons in the US have been subjected to them, with 80,000 youth to experience harmful unprofessional practice in the coming years (Mallory et. al., 2018). Currently, talk therapy in disguise (difficult to pinpoint) and many other forms of shaming, guilt-tripping and blaming are used by mental health providers in order to alter associations related to a person's desires and sense of self. Historically, "conversion" practises include:

- aversion treatment, inducing nausea, physically intolerable conditions or vomiting when the person is shown visual stimuli with sexual content;
- electric shocks, chemical castration;
- chemical castration;
- forced medical examinations, including forced anal examinations;
- forced or coerced psychiatric assessment;
- forced surgeries, including female mutilation;
- collective beatings for public display;
- corporal, institutional, religious punishment, arrests;
- isolation
- rape, humiliation
- forced marriages; forced impregnation

Even though the most widely used practice nowadays is talk therapy used by professionals, parental rejection and attempts to change their LGBTQI+ child is perceived as harmful as the most outrageous practises described above.

The long-term effects on LGBTQI+ people of conversion therapies in all their forms, whether or not they are torturous, include:

- decreased self-esteem; increased self-hatred and self-blame; confusion, depression, helplessness; social withdrawal; suicidality;
- anger, sense of betrayal; feeling of being dehumanised and untrue to one's self;
- hostility toward and blame of parents (believing their parents "caused" their sexuality)
- intrusive images of sexual stimuli and sexual, romantic and intimate dysfunction with future sex partners (same-sex or other)

An experience of identity crisis and a potential loss of family, close people and social support can cause an LGBTQI+ person to feel on the verge of giving up. Not being able to change who they are might lead to feelings of failure and further isolation. The psychologist or other mental health care professional might not state that the aim of "therapy" would be to amend the core personality elements – sexuality or gender identity – disguising the support as affirmative. This approach is one of the most harmful ones, as the client forms a relationship of trust with an authority figure only to be betrayed at a later stage.

Handout 1 - How do we provide affirmative care to LGBTQI+ people in the aftermath of conversion practises?

Usually at the initial meeting or online chat it becomes clear whether the LGBTQI+ person has experienced negative "interventions", and if so, they will most probably declare their mistrust towards helping professionals.

Operators – online chat/hotline

The provision of emotional support through active listening, clear boundaries and the creation of a safe space where the LGBTQI+ person can feel accepted are the most important aspects of the operator's work. If the client states that they have had a negative experience with a psychologist, psychiatrist or any other mental health practitioner, they should not be directed towards similar care. Talking online and the presence of someone who hears them and understands them without wanting to alter them or label them, will be of huge importance to this person.

Psychologists and mental health practitioners

Bear in mind that a psychologist may remind the LGBTQI+ client of a previous figure of trust and betrayal will set the steps towards a very slow process of building rapport. It will take a lot of time to normalise the sense of same-sex attraction or the transgender identity through affirmative language, away from terminology. It will be a journey for LGBTQI+ persons to accept that there is nothing wrong with them, that they can lead normal lives,

that it is not true that they will "die lonely" or will never experience love, that they can have healthy relationships, that they deserve to be loved.

Working on the fears, shame and internalised homophobia is essential, as this will help the client regain some level of self-esteem. Exploring all aspects of identity will widen the perception of who they are. Directing the person towards dreams, perceived future and aspirations will help them see that they could lead a normal life being LGBTQI+ (Glassgold et. al., 2009). If possible, it is recommended to work with the family members on destigmatizing and building awareness, bursting existing myths and meeting them where they are.

Some formal directions for psychosocial support include:

- unconditional and positive regard for and empathy with the client;
- openness to the client's perspective
- encouragement for the client's positive self-concept
- identity exploration and development
- identifying positive coping mechanisms and protective factors
- reducing self-stigma and shame;
- awareness of personal beliefs, values, motivations

Given the existence of mental health care professionals who act on their prejudices against LGBTQI+ people, extra focus should be directed towards further adequate training for affirming practises and enforcing policies to diminish the tolerance and execution of conversion therapies.

Handout 2 - Some questions we could ask ourselves when working with LGBTQI+ people (GLSEN Safe Space Kit, 2016):

- What were the earliest messages you received about LGBT people and where did they come from?
- Were they positive, negative or neutral?
- If someone were to come out to you as LGBT, what would your first thought be?
- How would you feel if your child came out to you as LGBT? How would you feel if your mother, father or sibling came out to you as LGBT?
- Would you go to a physician whom you thought was LGBT if they were of a different gender than you? What if they were the same gender as you?
- Have you ever been to an LGBT social event, pride or support group? Why or why not?
- Can you think of three historical figures who were lesbian, gay or bisexual?
- Can you think of three historical figures who were transgender?
- Have you ever laughed at or made a joke at the expense of LGBT people?
- Have you ever stood up for an LGBT person being harassed? Why or why not?
- If you do not identify as LGBT, how would you feel if people thought you were LGBT?

Activities for Module 6

Activity 6.1. - "First thoughts"

Time: 60 mins	**Sensitivity:** High level

Purpose:

- To provide a safe and non-judgemental environment to participants for exploring inner implicit bias
- To foster commitment to continuous self-reflection regarding bias

Requirements:

- Group size:
  - 20-25 participants
- Materials:
  - Pieces of paper
  - Pens, pencils
  - List of words
  - Implicit bias personal self-assessment handout

Description

This exercise consists of two parts.

The first part is about associations for specific words.

Instruct the participants to look at each of the words below (the words can be edited) and write down the first two or three adjectives, which come to mind (their thoughts or traditional ideas). Positive or negative, make sure to tell them that they need to be as spontaneous as they can – just to write down their first thoughts.

List of words for the activity "First thoughts"	
Disabled:	Elderly:
Doctors:	Women:
Balkan people:	Trans girl:
Teachers:	Cis man:
Parents:	Taxi drivers:
Gays:	Police officers:
Teenagers:	Covid-19:
The Pope:	Managers:
Manhood:	Same-sex couple:
Child:	

After the participants are done, you start picking the words randomly and whoever wishes can share which adjectives they put in the space provided. Beware that you will come across many socially acceptable answers. In order to set the stage for more honest answers, you can share your own personal story with implicit bias. Ask participants whether there were some surprises in their

answers, which words were the most difficult for them to categorise, and explore some negative experiences they might have had.

Part two is about personal reflections.

Tell the participants to think of a time in their life when they were discriminated against or treated unfairly because of who they are. Instruct them to pair up and describe the situation to each other. As this is a quite sensitive activity, instruct them to only share experiences which are not too emotional for them and happened some time ago. Do not bring in the most traumatic ones, but those with which they can already deal safely. Some questions to be discussed:

- What did they feel?
- How did they cope?
- What did they learn?

After the paired discussion, bring participants back to the circle, and start a discussion. They can reflect on their discussion without sharing the stories they told, or if they are comfortable they can share their stories too.

After the activity the scene is set for delivering the knowledge outlined in this module about implicit bias.

You can also encourage participants to continue reflecting on their experiences and bias in the form of self-assessment. They can work on **Handout 2 - Some questions we could ask ourselves when working with LGBTQI+ people** on the spot or take it home.

Additional materials:

Provide the participants with this link to a behavioural measurement by researchers from Harvard where they can further explore their biases.

Notes for trainers

We all have implicit biases, but we are not aware of some (or most) of them. If we allow our biases to surface and to accept that we need to work on them, then we can be effective helpers.

We advise the trainers to deliver this activity right before explaining what implicit bias is.

Depending on the group dynamics and on how comfortable people will feel sharing, it might be easier or more difficult for the participants to talk. You should support them and make sure you remind them that in order for them to be able to effectively provide emotional support, they need to dig into their own biases. If they have some resistance to work with associations around a specific group of people, this should be acknowledged.

Activity 6.2. - "The stereotypes game"

Time: 15-20 mins	**Sensitivity:** Medium level

Purpose:

- To make participants more aware of how their childhood experiences have affected their current beliefs about gender roles
- To open up participants to think about their own biases

Requirements:

- Group size:
  - 30 participants
- Materials:
  - Printed questions
  - Devices with internet access

Description

This activity is based on an activity of the same name outlined by Mary E. Kite and their colleagues.

Have people shop online at a website such as amazon.com or toysrus.com for a gift to a child who is celebrating her or his 5th birthday. Half the class should look up something for a girl, and half for a boy. Ask the students to search for specific toys they come up with themselves (and not just to search for boys' or girls' toys). In 5-7 minutes, they should choose a toy in the $10-20 range. After they have chosen the toy, each student should individually answer the **Gender Stereotypes Discussion Questions.** The entire class can then discuss their answers.

Gender Stereotypes Discussion Questions for the activity "The stereotypes game"

- Describe the process you used to select the toy you decided on. What factors influenced your decision?
- As a child, what toys did you play with? Were these toy selections at all influenced by your parents, the media, or friends? Why or why not? Were these toys similar to or different from the toy you selected?
- Name your favourite movie from elementary school. Describe the main character of that movie. Was it a male or a female? Were there toys available based on this character?
- Do you think the movies targeting today's children are more or less gender stereotypical than the movies you watched as a child? Why or why not?
- Do you believe that the choices parents make about their children's toys or movies influence the child's beliefs about the appropriate roles for women and men or boys and girls? Why or why not?
- Do you think children who play with toys designed for the other sex are treated differently from children who play with gender-typical toys? Why or why not?

Notes for trainers

Some background research for the trainer to consider:

The process by which children learn stereotypes is dynamic; it is a combination of biological influences, the children's development of socio-cognitive abilities, and the way in which their environment is socially constructed (Blakemore et. al., 2009). Parents, the media, and peers convey stereotypical beliefs and children learn which behaviours are viewed as gender appropriate and which are not (see Matlin, 2012, for a review). By around age 3, for example, most children can accurately identify another child's sex

and about half can correctly label toys by gender (Campbell et.al., 2004); by age 5, most children can do so (Ruble & Martin, 1998). Children's toy preferences reflect these beliefs; research shows that girls are more likely to list dolls, stuffed animals and educational activities as their favourite toys whereas boys are more likely to list manipulative toys, vehicles, and action figures as their favourites (e.g., Cherney & London, 2006). Cherney and London also found that boys' preference for masculine television programs and girls' preference for feminine television programs increased with age. Gender-associated beliefs also can affect the roles children expect to fulfil. Levy et.al. (2000), for example, found that children's predictions about their happiness in future occupations reflected gender stereotypic beliefs; more boys expected to be happy in a masculine occupation and more girls expected to be happy in a feminine occupation.

This activity is ideal as an icebreaker or to be implemented during the section of "Personal and professional prejudice" as a demonstration that we all have stereotypes formed during our childhood development.

This activity works best with a group size of 30 or fewer, but it could be modified for larger classes by having the instructor rotate between the groups while they discuss the topic or by having teaching assistants facilitate discussion in the smaller groups.

Activity 6.3. - "Your Stereotypical Life Story"

Time: 10 mins	**Sensitivity:** High level

Purpose:

- To help participants understand the ways they live or do not live according to the stereotypes of their gender
- To clarify participants' understanding of the gendered stereotypes they've internalised, as well as the stereotypes others have internalised about gender
- To raise awareness of the limiting (and often problematic) depictions of themselves and others that stereotypes encourage.
- To provide a concrete counter-narratives that challenge these stereotypes (internally, when they see themselves doing so; and externally, when discussing identities with others)

Requirements:

- Group size:
  - Large Group
- Materials:
  - Timer (cell phone timers work great!)

Description

Instruct everyone to find a partner, and determine who is "Partner A" and "Partner B" among themselves. (If you have triads, have two people play "Partner B"'s role). Explain further instructions.

Part 1

"Partner A" and "Partner B" will share some things about themselves that are compliant with stereotypes of their gender. They need to think of features, characteristics, hobbies, etc. that they

identify with or that describe them, and that are also stereotypical features, characteristics, hobbies etc. of their gender. "Partner A" and "Partner B" will take turns in sharing, starting with "Partner A", they will have 1 minute each. Instruction for the exercise: For the next minute, you're going to tell your partner your life story. There are only three rules: 1) only one person talks at a time -- Partner A will go first, Partner B, your job is to nod or say "Tell me more"; 2) you must talk for the entire minute; and 3) you may only tell the other person things about yourself that are true and are also stereotypes of people of your gender. For example, if you identify as a woman and you would also describe yourself as someone who is sensitive, you can say "I'm sensitive." Do you have any questions about the instructions?

After the two minutes take a few minutes to check in with the group before moving on, and help them reflecting on their experience:

- What was this exercise like for you? Let them just yell out answers "popcorn style". They'll say "Hard!" or "Fun!" (often both). Echo both and any others. If you want to process this more, ask folks to expand on their one word responses. If someone wants to give a longer response, let them.
- Why was it hard? People often say: "I don't know that many stereotypes"; or "I don't often describe myself in that way"; or "It's hard to think on the spot." These are all helpful responses to call back on during the final discussion.
- Why was it fun? You'll hear variations on the responses from "why hard?" and get a sense of how people react to challenges. The people who give this response were likely experiencing the same things as those who thought it was fun, they just react differently.

Part 2

For 1 minutes each, "Partner A" and "Partner B" will share some things about themselves that are NOT compliant with stereotypes of their gender. They need to think of features, characteristics, hobbies, etc. that they identify with or that describe them, and that are ways they break gender stereotypes. This time "Parner B" starts sharing in 1 minute, then "Partner A" shares their part.

Instruction: Now, we're going to change things. Partner B is going to talk first, and you're going to tell Partner A about your life, but only describing yourself by saying things that are true for you, but NOT stereotypical of your gender. Or, another way of thinking about it, describing yourself

using stereotypes of another gender. For example, if you identify as a woman, and you would describe yourself as someone who is "courageous" (a common stereotype of trans* or genderqueer people), you may say "I'm courageous."

Final discussion

- What did you think of that activity? Why? By a show of hands (or claps), who thought the first half was easier? Who thought the second half was easier?
- Ask for a few people from both groups to explain why. "What made the first part easier for you?" "Why was the second part easier?"
- What was challenging about describing yourself in this way?
- What's stereotypical (and gender in general) changes over time, and within our life cycles (e.g., how's the "little girl" stereotype is different from the "mom" stereotype)?
- Why do you think I asked you to do this activity?
- What lessons did you learn that you might be able to apply in the future?

Notes for trainers

Make sure people understand the task (get nods, or verbal yes's from the group) before you start the timer for Part 1. The instructions are hard to verbalise, but easy to follow if communicated correctly.

Sometimes it's helpful to provide more examples (e.g., "If you identify as a man and you would describe yourself as 'a strong leader', you may say 'I'm a strong leader.'" or "If you identify as trans* or genderqueer and you would describe yourself as 'courageous' you may say 'I'm courageous."). But be wary of giving too many different examples, because much of this activity comes from the participants exploring what stereotypes and previous knowledge they are bringing into the conversation. As you are timing, you can walk around the room, or, if in a bigger group, just stay up front and give them time updates ("30 seconds left! Keep talking, Partner A!") or just encouragement ("Tell me more!").

People don't think of themselves as stereotypes, as expressed by the saying "Stereotypes are for other people, I'm a snowflake." We often think of others as stereotypes, but do not generally do so

of ourselves; but we're also innately aware (and sometimes uncomfortable) of how well we do or do not fit into the boxes of our genders (and other identities). Also, we often don't realise how many stereotypes we know, or how hard it can be to think of them on the spot, but they pop into our minds a lot without us noticing. It is similar to how we use our mother tongue: we don't necessarily use grammar consciously, we just know as we talk what the next correct sentence part is. Stereotypes work in similar ways: they are so widespread and almost never questioned, thus we are not always aware of them.

Activity 6.4. - "The road to hell is paved with good intentions" (role play)

Time: 60 mins	**Sensitivity:** High level

Purpose:

- To help participants dig deeper into the specific ways conversion/reparative therapies harm LGBTQI+ persons
- To have participants develop personal insights and gain personal experience on the effect of these practises

Requirements:

- Group size:
  - 25-30 participants
- Materials:
  - Index cards, pieces of paper outlining different roles
  - Stationery: pen, pencil

Description

In this role-playing activity participants will be divided into groups, depending on the total number of people. Ideally, one group should have 6 participants.

Distribute index cards in every group. Each group should get 6 index cards outlining different roles: The suggested roles are: Teenager (Peter), Friend of the teenager, Mother, Father, Conversion therapist, Teacher. Have every participant draw an index card from the ones provided to their group and see what their role will be in the scenario to be played.

Set the scene for the role-play. The overall socio-cultural context is the following:

"Homosexuality is the norm. Being heterosexual is considered abnormal by some health-care practitioners and many people worldwide. Heterosexuality is perceived by professionals as sin, as an

illness, and they deal with it in the framework of diagnosing and treating. They believe that these individuals who identify themselves as heterosexual should be cured.

They apply these conversion therapy methods:

- *Psychotherapy performed by licensed therapists*
- *Recovering repressed childhood memories*
- *Identifying the root causes ranging from bad parenting, childhood trauma or abuse, delayed development, etc.*
- *Religious counselling, laying of hands, exorcism, prayer, meditation, etc.*
- *One-on-one counselling by licensed professionals*
- *Group counselling and accountability groups*
- *Seminars and weekend retreats*
- *Inpatient and outpatient treatment programs*
- *Sexual celibacy including abstinence from masturbation and restricted thought life*
- *Aversion therapy including electric shocks or other negative stimuli*
- *Exposure to homosexual pornography*
- *Submitting to a positive homosexual role model or mentor"*

One of you will play Peter, who is a straight, 18 years old boy. He recently came out to his parents and they threatened to throw him away if he doesn't change. The situation at home is very abusive. Peter has only one friend he can trust. His parents have planned a meeting with a conversion therapist.

Your role-play will take place at this moment, at the therapist office. At this session the whole family and the therapist are present. Peter's friend receives text messages from Peter during the session.

The trainer should give 20 minutes for the participants to discuss their roles and to play out the scenarios. After each group is done practising, there will be time for maybe one or two groups to role-play in front of the whole audience.

Debriefing is highly important after this role-play. It is important for the participants to share

- How did they feel in their particular role?
- How can they relate to that particular role?
- Did playing this role provoke physical sensations (headache, stomachache, tension)?
- How has this role play added to their understanding of the effects of conversion therapies?

At the end of this activity, participants should be asked whether they feel they are back in their usual self. Some of them might still carry a part of the role they were playing out.

Notes for trainers

This experiential activity should be done after the trainer has already explained to the audience that "conversion therapies" or "reparative therapies" are the umbrella term describing these harmful, shameful, degrading practises provided by parents (home-based), mental health professionals, religious activists/gurus, institutions (external, usually initiated by parents or caregivers).

Role-play is a technique that allows participants to explore realistic situations by interacting with other people in a controlled way in order to develop experience in a supporting environment. Depending on the intention of the activity, participants might be playing a role similar to their own (or their likely one in the future) or could play the opposite part of the conversation or interaction.

It may be very difficult for the participants to believe this socio-cultural context. Some people feel threatened or nervous when asked to role-play, because it involves acting. This can make them feel silly, or that they've been put on the spot. Assure them that this is not about their acting skills, but about putting themselves in the shoes of the particular character.

Additional Materials

Video: "What Gay Conversion Therapy Is Really Like", an interview with Gerrard Connelly about what it's really like to be in a conversion therapy center Video: "'Gay conversion therapist' comes out: Exclusive interview"

Section 3
Field-specific guides for training mental health professionals

This section consists of four modules which provide knowledge and activities curated for mental health professionals working in specific fields. These fields are crisis lines, school counselling, clinical psychology and social work. Each module curates specific background knowledge, guidelines and sample activities for one of the four target groups.

How to use these modules

The modules in this section are more diverse in their structures than in the previous section. This is because each module is dedicated to a different mental health field with varying needs for knowledge, attitudes and skills training. However, the modules in this section have both theoretical and practical, interactive parts similar to previous modules. The theory in these modules might be more advanced and deeper, thus we advise you to consult with professionals about your presentation and delivery of ideas before implementing the training. We also recommend refreshing the advice we gave in Section 1 - and read the part entitled 'Structure and content of the training course'.

Module A – Hotline/Chat Operators

Topics in this module: Active listening/ models of support; Boundaries; How to handle difficult questions and aggressive behaviour; How to handle frequent callers/users; Critical situations

Introduction

This module introduces the specifics of working with LGBTQI+ people via chat or a hotline. Counselling and handling clients on a hotline or chat is very different than doing it in person. Here you will find examples of chats/ calls with different scenarios and using different approaches to the situation. In the first part of the module is the basic knowledge for a call or chat, presenting the key stages and steps in this process. The second part of the module concentrates on more specific types of clients and situations, going deeper into the different models of support, critical situations and types of users.

How to use this module

Module A gives a general view of what it means to be a hotline/chat operator for LGBTQI+ clients, how to handle a conversation/chat, possible scenarios and different approaches to use in certain situations.
After every theoretical part there is an example to help you understand the matter better. At the end of this module you will find some activities to choose from for interactivity and experience-based learning. Pick the ones you think are best for satisfying the learning goals for your participants or according to the professional focus of the participants.

Aims

This module aims to give examples of possible situations for a hotline/chat operator and to clarify how to react and reflect on people seeking support.

After this module the participants will:

- Be familiar with the principles of being a hotline/chat operator

- Be familiar with the different models of support
- be able to handle difficult clients
- be able to actively listen

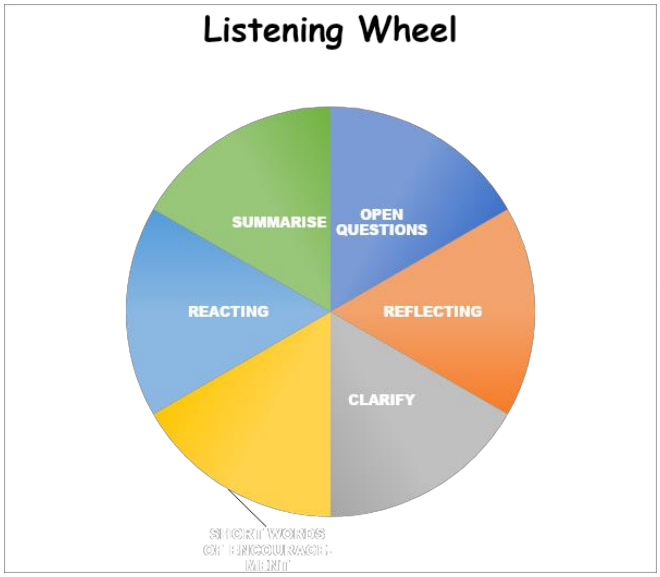
Knowledge base for trainers

Models of emotional support

Active listening

The chat/hotline operator builds rapport with the LGBTQI+ person/client by listening, reflecting, summarising, showing understanding, support and empathy. The role of the operator is to explore the client's story by clarifying questions and navigate the current situation through stimulating/provoking the client's own sources to solve problems or seek solutions.

In order for the operator to be able to provide effective client-oriented emotional support, we will explore an existing model of counselling:



The listening wheel

Open questions

Hotline operators should ask questions which give the possibility for a more open answer. The question "Why" should be avoided as it may invoke guilt and sound judgmental. It might lead to the person shutting down emotionally. We explore the emotional state, the current situation and

the future prospects by asking "How?" – "What?" – "Where?" – "Who?" The hotline operator does not assume, but seeks to ask and clarify if something is not understood. You should not be judgmental, avoid projecting your own feelings about the situation; this is especially important when working with LGBTQI+ callers.
Examples of open questions:

- How did you experience it [the event or thing that is the current topic]?
- Can you tell me more about that?
- What is that relationship like?
- How was that experience for you?
- How does that feel?
- What are your thoughts about that?

Reflecting

This might sound a bit counterintuitive but paraphrasing or repeating a word or phrase back to the person will not only encourage them to continue talking, but will also give them the feeling that they are listened to. Especially when we talk about a chat line, it is very important for the person to feel heard (in every meaning of the word). So you are reflecting their emotion back to them and you are paraphrasing what they have said.

Example:

Client *I just lost my best friend. I have known him for as long as I can remember! It feels awful!*

I am sorry to hear that. You have just lost your best friend, whom you have known your whole life. It sounds like you are having a really hard time. **Operator**

Clarify

After reflecting back to the person, the role of the operator is to explore the situation further, to broaden the context. It might be that the person just mentions something and then jumps to

another point. Don't be afraid to ask for clarification. "Correct me if I am wrong, I understood that...." "Can you help me understand more about...?" Do not assume and clarify the situation yourself. You should let the person clarify it for themselves!

Reacting

Communication in a chat format is giving a space for reacting just like when you are talking to the person on the phone. Demonstrate empathy by acknowledging that you have heard what has been said and repeat back in an empathic manner e.g. use phrases such as 'it sounds like you have been having a tough time lately', 'I'm sorry to hear that...', 'from what you have said...' And 'I'm here to support you.' You should make sure that the person feels your commitment to supporting them by saying 'we all need reassurance sometimes' and 'it's ok to have these feelings'. Tell them that they only need to share what they feel comfortable with. When communicating via chat, always re-read your response before you hit 'send'. It is useful to ensure no text has been omitted and to double check spelling. Remember, online/hotline support is not therapy. Even if you have a mental health qualification, the task of 'active listener' is one of support and not professional expertise.

Summarise

Summarising is a key part of the conversation. It shows that you are actively involved and emotionally engaged. Having the psychological distance will help you to summarise the situation with all the steps that you have undertaken and points that you have touched upon during the conversation. It will make the client feel understood, listened to and appreciated.

Key Stages of a Call or Chat	
Stage of the Call/Chat	**Key skills**
Beginning	• Be ready for the call/chat • Allow phone to ring/chat to be initiated • Use the set hotline greeting • Small encouraging words • Explain confidentiality if appropriate
Exploration	• Ask open questions • Acknowledge feelings – empathic responses • Hypothetical questions • Reflect back
Clarification	• Paraphrase • Ask questions to check you've understood correctly
Identifying next steps	• Establish options • Provide appropriate information • Signpost if appropriate
Ending	• Summarise • Encourage the person to contact us again • Inform the person of any action you'll be taking (e.g. posting information)

After the call	• Undertake any follow-up work required • Discuss call/chat with operator on shift with you, if you'd like to • Note anything you'd like to raise at collective meetings • Debrief if you want to

Boundaries

Hotline/chat communication implies intimacy (the person is communicating from their comfort zone or personal space) and immediacy (the communication is fast, immediate). A close rapport seems to be created; the conversation goes very quickly "to the point" in most cases. The feeling of presence is physical, and the rhythm of the conversation validates the connection between the operator and the seeker of support. There is this common space where the person can find support every day. The person who is seeking help needs to know that they are talking to a real person. They will often ask that, and it is understandable in this vulnerable situation. The style of communication of the hotline operator will be the means to make the person feel that they are communicating with a real person. When we talk about hotline counselling, the tone of voice, the verbal language will be making it easy to identify that it is a real person, maybe identify the gender of the operator, maybe their age. The client will project their expectations towards the operator and will try to get some sense of who they are. It is of utmost importance for the operator to keep their personal boundary intact as best as they can.

Another reason why operators should be keeping their boundary is in order to prevent burnout. If they are emotionally involved and taking things too personally after every single chat or conversation, they will not be able to keep their ability to feel mentally safe in order to help. We should not forget that operators may encounter aggressive, rude clients, or suicidal people, deeply depressed people, whom they should redirect to the psychologists/ therapists in their network of support. Having this safe distance will make it possible for the operators to ventilate all the different nuances of emotions in a much healthier way.

Example: Pushing boundaries

	Hey, would you like to tell me what it is that you wish to talk about today?	**Operator**
Client	*Well, I dunno, I just want to communicate with someone who is more "open". I was just curious to visit your chat.*	
	Oh, I see. Are there "closed" people around you?	**Operator**
Client	*Well, yeah, to some extent I feel like in real life I am surrounded by people who won't understand my sexuality. They are morons. I don't have anyone to talk to freely.*	
	I have the feeling by what you are saying that you don't feel comfortable discussing things which are important to you?	**Operator**
Client	*Yes, I don't feel authentic and real. I am always wearing a mask. It is easier!*	
	Would you like to tell more more about who is behind the mask? What is it that people can't see in you?	**Operator**
Client	*Yes, sure. Before that though, I would like to know more about the person I am communicating with.*	
	It is a policy of our online chat not to disclose personal details. What would be important for you to know about me?	**Operator**
Client	*Well, are you a professional? Do you have the knowledge and competence to help?*	
	All operators have gone through the same training, covering all the necessary topics related to online counselling. You can read some stories about our operators in our blog.	**Operator**

Client	*What about you personally – do you have experience with some issues that LGBTQI+ people have?*	
	This is something of a concern I hear a lot. I do feel your worry that only a person who has gone through these issues can go deep into the experience. However, I choose to keep my sexuality to myself. I can assure you that I can be of help to you. Would you be ok to continue the conversation without you knowing something about me?	**Operator**
Client	*Yes, no worries.*	

Difficult conversations

There are many reasons a conversation online or over the hotline can be difficult to handle. Maybe the topic or the way the conversation is going is a sensitive trigger for the operators themselves. Sometimes it is all about the meta-communication (what is the context of the talk) and the "background" of the talk which makes it hard – may be the connection is not ok, or the person leaves and comes back to the conversation repetitively, or the rhythm of collaboration between the operator and the person seeking help is not smooth.

Resistant clients

There are sometimes people who respond only with a "yes" or "no", "I don't know", "You tell me..." answers no matter how hard the operator tries to explore or stimulate the conversation. More often than not, the operator will encounter people seeking help who have tunnel vision (looking only in one direction) and who cannot see any new possibilities. You would hear these clients state: "There is NOBODY who wants to help me," or "I have already tried that..."

These type of difficult conversations might trigger a few reactions in the operator:

- A feeling of helplessness which turns into self-criticism – "I can't help this person no matter how hard I try." "I haven't done my job of supporting this person." "I am a failure".
- A feeling of helplessness which triggers a defence mechanism – In this case the operator might be willing to break all boundaries only to feel like they have done all needed to help. This is the most unhealthy way to deal with the chat/talk as it results in the operator, for example, stepping out of anonymity and crossing ethical guidelines (for example, giving their personal phone number so that the seeker of support might call them to continue the conversation privately).
- A feeling of anger, which turns into blaming the person seeking support – "I try so hard, I do everything I can and this person still doesn't accept what I am saying."
- All of the above are understandable, but need to be worked through supervision (we will talk about that in the following pages). If the operator does not share all these feelings with the supervisor, the risk of burning out, not helping but hurting the person seeking support (unintentionally, for example by promising them something that is not achievable) is going to be high.

So, let us remind ourselves how (in the best-case scenario) the person looking for support should be feeling after a chat or a call. The person does not necessarily need to have a clear solution to their problem but they should feel listened to and able to move forward in dealing with the problem that was the initial reason for the chat or call.

People usually contact the chat/helpline in order to:

- To manage a crisis situation (e.g. they feel down, sad, suicidal).
- To be reassured, to vent, to find out that they are not the only ones, to find out that they are normal, and to gain perspective.
- To develop strategies to gain control of the situation, to clear the mind and get focus.
- To think of some directions.
- To get information or to be referred.
- Simply to be in contact with another person

People would usually not feel ok after a chat or a call if:

- They needed some information and didn't find it.
- They feel pressured into a solution or a referral.
- They don't feel understood or taken seriously.
- They feel like the operator writes very slowly or is not engaged.
- They feel that the operator becomes "hopeless" or runs out of ideas.

It is very important to stress the fact that sometimes people seeking help have unrealistic expectations of what the role of the operator is. They should be constantly reminded that the online chat/hotline is not therapy or psychological support, but a source of emotional support. The competencies of the operators, no matter whether they are psychologists or not, should stay in the realm of providing emotional guidance and support, not giving direct advice, refraining from bluntly stating what the person should or should not do. It might be challenging for the operator to leave the decision-making in the hands of the support seeker. It is always easier to hand them the solution ourselves. But the goal of the online/hotline support is to empower the person, finding their own resources of coping, with our guidance.

Aggressive chats/ calls

After being challenged in the previously outlined ways, sometimes the operator might feel an urge to react to the client with a more aggressive communication style. The operator can also be challenged by aggressive communication and behaviour coming from the caller. It is not easy to handle these types of calls but we should remind ourselves what our role is in providing support. The most important advice would be for the operator not to get into the same mode of communication, stay emotionally distant and repeat what the purpose of the chat/hotline platform is, be slow with their answers and stay polite. If the client does not stop the aggressive behaviour, the operator is allowed to end the chat/call and if they see a systematic attempt of this client to engage in aggressive talks, to block them from using this service.

People who are not truthful

During a chat, it is difficult to verify whether a person is representing themselves honestly. As operators it is important to remind ourselves that honesty sometimes is not so crucial. The

operator should focus on the responses they provide. Playing with different identities in cyberspace can even be used constructively in the chat. Having a conversation with a stranger about something that is difficult and personal is not easy for anyone. For young people who may have lived socially isolated for years, possibly because of bullying, neglect or abuse in the home, it is certainly not easy. For others, the mistrust in the confidentiality policies might trigger the need to present themselves and their story as different from the real one. Operators are not detectives and they should not be focusing on the fact-checking of the stories told, but mostly on the emotional background of these narratives. Eventually, the person seeking support might open up to them and start sharing the situation as it is. A frequent concern for the people seeking support might be whether whatever they say will be shown to anyone else. Depending on the policies of the company, the operator might say that the chats are stored in an online database and if they return to the chat another time, another operator might ask for permission to see the previous chats. This information should not be withheld from the person.

Repeated contacts/frequent users

There will often be people who will seek support about the same issue several/many times. It usually becomes a difficult conversation if the chat sessions don't contribute to an improvement in the person's situation. There are people for whom contacting the chat/helpline again and again is not about the improvement of their life situation, but a desire for immediate contact, attention or other things. They can become burdensome. Again, we should remind ourselves of the purpose of the chat/helpline support – to contribute to the positive development of the person's situation. If that is not possible, we should refer the person to a more relevant and useful source of help. If the operator suspects that the person is masturbating (this can be more achievable over the phone by the tone of their voice), then they are allowed to end the conversation politely. If the conversation is held over chat and the operator feels like there is sensitive sexual information, then they can slow down their responses and go back to the main question *"What is it that you need help with at the moment?"*

Critical situations

Often, we might have LGBTQI+ people who are contacting the chat/hotline when they are confronted with acute and immediate problems. It is very important in these critical situations for the operator to be directive. The immediate crisis requires action, less focus on the emotions, more concentration on the next steps and available options. The goal of crisis intervention is solving the immediate problem by developing an action plan and also alleviating the accumulated stress and anxiety. It is important to emphasize that not all conversations about suicidal thoughts, violence, abuse or self-harm are immediate.

If the situation is critical, the operator steps away from the more passive role and takes charge of the conversation. Sometimes individuals confront situations they have never encountered in the past. As a result, they have not developed adequate coping mechanisms to deal with them. These crises leave individuals feeling overwhelmed and powerless. For many people, these crises cause their heightened emotions to impair their ability to think rationally. During critical situations, people spontaneously turn to others for comfort, support, understanding, and protection. If the person is chatting or talking to you, then there is hope. They need your help.

The assessment of the situation is crucial. Acute and immediate situations can be:

- The LGBTQI+ person has specific plans for suicide or are in the process of a suicide attempt.
- The LGBTQI+ person is subject to domestic violence or will be subject to violence or other kinds of abuse if no help is provided for them.
- The LGBTQI+ person is severely mentally ill.

Plans for suidice or suicide attempt

On important critical situation to discuss is when the LGBTQI+ person has specific plans for suicide or is in the process of a suicide attempt. The operator should be able to identify whether the situation is immediate and acute. If the person says that they have suicidal thoughts, the operator should assess how specific these thoughts are, whether the person has specific suicide plans, and how far the person is in these considerations. Another important task is to explore how

much the person is currently experiencing tunnel vision, and trying to broaden the view they currently have in a gentle and consensual way as possible.

Example:

	Ok. I have to ask if you have considered harming yourself?	**Operator**
Client	*Lately, all the time. I am so tired of feeling the way I do.*	
	On a scale of o to 5 where would you rate your intention to harm yourself now?	**Operator**
Client	*4.*	
	Have you considered how you will harm yourself?	**Operator**
Client	*My parents will never accept who I am. Every time I think of it, I think about pills.*	
	Have you got pills now?	**Operator**
Client	*None which I think will be able to harm me.*	
	Ok. It is important that you understand that if you are thinking of harming yourself, then there are several options with which we can proceed. The chat can be of limited help.	**Operator**
Client	*But I don't know who I should ask for help.*	
	Ok – that's important – let's look at that together – ok? You can give me your permission to call the Emergency services on your behalf or you should do it yourself.	**Operator**

The conversation proceeds in listing the possible options and building rapport.

It is important to be able to assess the immediacy of the situation based on the information you have. The factors that may increase a person's risk for suicide include:

- Current ideation, intent, plan, access to means
- Previous suicide attempt or attempts
- Alcohol / Substance abuse
- Current or previous history of psychiatric diagnosis
- Impulsivity and poor self control
- Hopelessness – presence, duration, severity
- Recent losses – physical, financial, personal
- Recent discharge from an inpatient psychiatric unit
- Family history of suicide
- History of abuse (physical, sexual or emotional)
- Comorbidities, especially a newly diagnosed problem or worsening symptoms
- Age, gender, race (elderly or young adult, unmarried, white, male, living alone)
- Being LGBTQI+ and a subject of homophobia, bullying, abuse

Factors that may decrease the risk for suicide are also called protective factors. These include:

- Positive social support
- Spirituality
- Sense of responsibility to family
- Children in the home, pregnancy
- Life satisfaction
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Positive therapeutic relationship

Asking questions about suicidal ideation, intent, plan, and attempts is not easy. Sometimes the person will start a chat or a conversation directly with the topic of suicide, but in most cases the topic does not readily flow from the beginning. Asking about suicidal ideation and intent does not increase the likelihood of someone thinking about suicide for the first time or engaging in such behaviours. In fact, most people feel a sense of relief and support when a caring, concerned operator or professional non-judgmentally expresses interest in exploring and understanding the

person's current psychological pain and distress that leads them to consider suicide or other self-injurious behaviours.

All suicidal ideations and suicidal threats need to be taken seriously.

If the operator has some suspicion that the person might have suicidal thoughts, they might ask:

Are you feeling hopeless about the present or future? Hopelessness – about the present and the future – has been found to be a very strong predictor of suicidal ideation and self-destructive behaviours. Associated with hopelessness are feelings of helplessness, worthlessness, and despair.

If yes, ask.....

Have you had thoughts about taking your life? In most cases, suicidal ideation is believed to precede the onset of suicidal planning and action. Suicidal ideation can be associated with a desire or wish to die (intent) and a reason or rationale for wanting to die (motivation). Hence, it is essential to explore the presence or absence of ideation – currently, in the recent past, and concurrent with any change in physical health or other major psychosocial life stress.

If yes, ask.....

When did you have these thoughts and do you have a plan to take your life? Most people become suicidal in response to negative life events or psychosocial stressors that overwhelm their capacity to cope and maintain control. Hence it is important to understand what elicits suicidal thoughts and the context of these thoughts.

Have you ever had a suicide attempt? Most people who attempt suicide do not attempt again. However, about 16% repeat within one year and 21% repeat within 1-4 years. The majority of repeat attempters will use more lethal means at subsequent attempts – increasing the likelihood of increased morbidity or mortality. Approximately 2% of attempters die by suicide within 1 year

of their attempt. The history of a prior suicide attempt is the best known predictor for future suicidal behaviors, including death by suicide. Approximately 8-10% of attempters will eventually die by suicide.

Are you planning to hurt yourself now?

If yes, ask.....

On a scale of 0 to 5, how would you rate your intent now?

If the answer is 3 or above.....

Do you have the means to harm yourself now? It is important to know whether the individual has begun to enact the plan by engaging in such behaviors as rehearsals, hoarding of medications, gaining access to lethal means, writing a suicide note, etc.

As one of the aims of the chat/helpline is to prevent suicide and provide the most effective support, the operator may express concern that the persons' life is in danger and explore immediate support options available to them (country specific).

The operator may ask the person about contacting the emergency services on their behalf. If the person says they do not want the emergency services to be contacted, then the operator will attempt again to explore the persons' reasons why they are actively suicidal.

If the person continues to be actively suicidal, the operator then will make another attempt to direct the person to receive emergency help. If the support seeker agrees to action being taken to prevent their suicide, the operator will explore two options with the person:

Option A

Get the support seekers' agreement that the individual will take emergency action themselves.

The operator can inform the support seeker of the range of emergency options available to suicidal people, as follows:

- Contact the emergency services by calling 112.
- Contact suicide helplines (if available)

Option B

Get the support seekers' agreement that the Operator will take emergency action on their behalf.

If the person would like action to be taken to prevent their suicide but does not feel able to take one of the actions identified in option A, then the Operator can offer to do the following:

- Stay on the phone/chat with the person and continue to listen to them.
- Offer to contact the emergency services on behalf of the person.

If the support seeker agrees to the Operator contacting the emergency services on their behalf, then the Operator will ask the individual the following questions and write down their responses:

- "Can you tell me where you are now?" or "Can you tell me where the emergency services can find you?".
- "What's the name of the last town/place you were in?" - Get address, street name, landmarks and/or specific location.
- "Can you give me your phone number to pass on to the emergency services?" - Preferably get a mobile number but any contact number is better than none as this will assist the emergency services in finding the person, particularly if they are in a remote or secluded area.
- "Can you give me your name to pass on to the emergency services? It doesn't have to be your real name" - This will assist the emergency services in finding the individual when they get to the location.
- "Can you tell me how and where you were planning to kill yourself?" - Important to ask so that you can find out if the person is planning to kill themselves in a manner that could be harmful to others or to the emergency services and to be able to identify the location of the person.

If sufficient details identifying the support seekers' location are given by the person, then the Operator will agree with the support seeker to contact the emergency services on their behalf.

The operator will do the following:

1. Dial 112.
2. Inform the emergency services about the reason for calling.
3. Give your name and your contact number.
4. Give any details that the support seeker gave including their location, contact number, name and/or planned method of suicide.
5. Ask the Emergency contact to follow up immediately on your call because you are very concerned for the safety of the support seekers' life.
6. Contact your Supervisor or Operator Leader and inform them of what has happened. It is very important for the operator to have the chance to debrief after such a stressful situation.

Threat or presence of violence

Another critical situation can be when the LGBTQI+ person is subject to domestic violence or there is a threat that they will experience some kind of abuse or violence.

Acute conversations where help is needed immediately will typically begin with an assessment of what the issue is, what the person's exact situation is, what the risk is, and who is involved, etc. This should be followed by

- Support: "It is good that you contacted us"
- Clear feedback on what is going to happen
- Help and exploration of options: "You need help right now." "Let us think of different options together..."

The focus can be shifted to supporting the person in assessing more specific action plans for the future.

If a support seeker expresses that they are in danger because of domestic violence or the threat of domestic violence, the operator may ask the support seeker about their ways of managing this danger.

- The Operator may express concern about the support seeker's safety.
- The operator may ask the person about contacting 112 or the relevant organisation supporting victims of domestic violence (country specific) on their behalf.
- If the support seeker says they do not want anyone to be contacted this must be respected by the Operator. The operator in this case continues to provide support and to build rapport with the person.

If the support seeker agrees to action being taken to ensure their safety, the Operator will explore one of the following two options with them:

Option A

Option A is to get the support seekers' agreement that they themselves will take emergency action.

The operator will inform the support seeker of the range of emergency options available to a person in danger because of domestic violence, including:

- Contact the emergency services by calling 112.
- The relevant organisation supporting victims of domestic violence

Option B

Option B is to get the support seekers' agreement that the operator will take emergency action on their behalf:

If the support seeker agrees to the Operator contacting the emergency services on their behalf, the Operator will write down the support seekers' responses. If the support seeker will not provide any of this information then no follow-up action can be taken by the Operator.

If all support seeker personal details are answered by the person who contacted the chat/hotline, then the operator will agree with the person to contact the emergency services on their behalf.

The operator will do the following:

1. Dial 112.
2. Inform the Emergency Services where you are calling from.
3. Inform them that the support seeker asked that you to contact the emergency services on their behalf.
4. Give your name and your contact number.
5. Give any details that the support seeker gave including their location, contact number, name and/or details of any immediate risk/threat presented to the individual.
6. Contact the chat/hotline Supervisor or operator leader to inform them and to debrief.

Children who seek support

All children, without exception, have the right to protection from abuse.

The purpose of a child protection policy is to ensure that appropriate action is taken when a young person under the age of 18 years is suspected of either being abused or at risk from parents, guardians, carers, adult visitors, other responsible adults or other young people.

- Physical abuse of a child is that which results in actual or potential physical harm from an interaction, or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be single or repeated incidents.
- Sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others.
- Emotional abuse can usually be found in the relationship between a parent/caregiver and a child rather than in a specific event or pattern of events. It occurs when a child's developmental need for affection, approval, consistency and security are not met. Unless other forms of abuse are present, it is rarely manifested in terms of physical signs or symptoms
- Neglect can be defined in terms of an omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene,

intellectual stimulation, supervision and safety, attachment to and affection from adults, and/or medical care.

If the operator has any immediate concerns about the abuse or neglect of a child they must notify their Supervisor at the most immediate opportunity.

If the situation requires that the child has to give up their anonymity in order to get the necessary help, it is important to inform the child of this and to let them know what the consequences will be, as the child might have chosen to approach the chat helpline because they could remain anonymous. Therefore, it can make the contact very vulnerable if the operator insists that anonymity must be broken. It is important that the operator clearly informs the child so the child only breaks their anonymity with informed consent. This ensures that the child can continue to experience a certain degree of control over the situation. A lack of sensitivity to this could result in the child disconnecting or giving false information.

As an operator you should be aware that in most countries, when you know the child's identity and you assess that the child is in immediate danger, you are obliged to inform the local authorities ("duty of care"). There may be situations where the child's need for help is immediate, but the child does not want to get help, e.g., calling an ambulance, or being willing to provide the counsellor with the necessary information for the counsellor to get help. In such cases the counsellor must determine if there are other options for getting help that do not involve breaching the child's confidentiality.

In some situations, the operator has to accept that it will not be possible for them to provide the help the child needs. When the person does not want to be helped by referral, please assure them that they are welcome to the chat/hotline every time they need to talk.

Summary for critical situations

1. Assess the situation's seriousness. Is there a need for immediate intervention? Ask for facts rather than feelings.
2. Provide support.
3. Tell the person what is going to happen.

4. Wait together with the person until sufficient help has been established.
5. Contact your Supervisor immediately after such a stressful conversation to debrief.

LGBTQI+ callers with severe mental illness

Operators are not necessarily psychologists. Even if they are, the chat/hotline's purpose is not to provide therapy. The role of the operator is to provide emotional support, to inform and to empower the support seeker to find solutions in the current situation they are in. These platforms are not suitable for providing support for people with acute mental illness and they should be referred on following the same guidelines as in the case of a suicidal person (mentioned above). The operator will use active listening techniques, employing the listening wheel or the five-phase model. Usually the chat/hotline operator will support the person in telling their stories in a way that contributes to a feeling of "agency". The story is written in a way that shows the person as an authority in their own life rather than as a marginalised victim. In a narrative perspective, the chat can support the support seeker in "rewriting" the story in a more constructive way.

Referral

There will be cases when the chat and hotline framework has limitations. It is good to know our boundaries. The operator has a great opportunity to get to know the story of the support seeker, to navigate through the mental state they are describing and to make up their mind whether this person should be referred to a different service along with the chat/hotline option.

The pace of chat/hotline counselling can help to qualify the referral. The operator has good opportunities to obtain the necessary information and sometimes even consult with their supervisor before recommending a specific referral.

How should the operator proceed if they feel like a referral is necessary:

1. Explain why you think that a referral is relevant and ask if it is ok for the person to discuss this option.

2. Give the name of the person or the organisation you will refer the person to (this would be country specific)
3. Explain what the professional or place of referral can offer that is beyond the limits of the chat/hotline frame of support.
4. Ask what the person thinks and whether they understand the reasons of referral.
5. Provide contact information and web address (this would be country specific).
6. You can visit the website (if there is one) together and talk about the referral. Ask the person's thoughts about making contact. Ask the person if they find the service relevant.
7. Discuss consequences and develop strategies to deal with them.

Examples

- A young trans woman wishes to talk to another trans person. The organisation should have a network of support in which this young trans woman will have the chance to speak confidentially to another trans person and ask all the relevant questions they might have. The operator provides the trans woman with an email of the relevant trans person who can help her out.
- A non-binary person wishes to be a part of a support group and to meet other LGBTQI+ people, listen to their stories, find sources to cope and feel that they are not alone. The operator will provide information and link for the non-binary person and make it possible for them to sign up for a support group.
- A parent of an LGBTQI+ person wishes to meet other parents. The parent is struggling with accepting their kid and wishes to listen to the way other parents have dealt with these struggles. The operator provides the relevant contact and link for the parent to sign up.
- A person with a long history of clinical depression reaches out to the chat/hotline service. The operator provides active listening techniques and is empathetic but feels like the scope of the service is limited. After building rapport with the person, the operator suggests that they look for psychological help and provides a relevant contact.

A person who seeks information regarding his sexual health status should be referred to the relevant sexual health services within or outside of the organisation.

Every organisation should provide relevant and available resources of support outside the scope of the chat/hotline. The operators should have easy access to these resources. In the best-case scenario these resources should be free of charge. It is appropriate to make a list of the referral organisations' own updated websites to ensure that the information is as accurate and up-to-date as possible. A conversation with the person about a referral may also focus on how the LGBTQI+ person can look up and find a relevant organisation or project themselves. It can stimulate their own problem solving capacity.

It does not always have to be the operator who suggests a specific professional/ place/ group/ organisation for referral. At times it will be relevant to keep the chat/talk open while the person contacts the referral so that the operator supports the person until a new contact has been established. Waiting together with the person and supporting them through the process may help them feel less nervous about the referral. In some cases, if the client is already seeing a professional, they will benefit more from discussing how the relationship with the professional can be improved rather than being sent to a number of new places of referral.

Module B – School Counsellors

Topics in this module: Discrimination and bullying of LGBTQI+ students; Individual work with LGBTIQ+ students; Improving the climate at the school; General recommendations

Introduction

This module provides general information on the role of a school counsellors with regard to LGBTQI+ students. It provides information on the difficulties that young LGBTQI+ persons face in everyday school life, discusses the role of the school counsellor and provides concrete recommendations on how to work with LGBTQI+ students and on the school climate.

Aims

After this module, the participants will be able to:

- name the main difficulties that LGBTQI+ students face in everyday life,
- recognize the role of a school counsellors with regard to the needs of the LGBTQI+ students
- identify positive and affirmative practises when working individually with LGBTQI+ students
- use the knowledge to be an ally to LGBTQI+ students

Knowledge base

Discrimination and bullying of LGBTQI+ students

The turbulent period of adolescence usually brings various challenges, especially regarding identity development, and it can be very tough for some students. A growing body of evidence

shows that it can get especially tough for LGBTQI+ students. Since we live in a heteronormative and cisnormative society, when a young person realizes that he/she/they are attracted to persons of the same gender, the process of accepting themselves can be very challenging. Young LGBTQI+ persons go through the same "stress and anxiety of growing up" as their peers, but they also have to deal with the acceptance of the identity that carries strong stigmatisation, social exclusion and other negative consequences. Even the usual teenage behaviors like forming friendships, dating or developing an intimate relationship are not possible in the same manner as they are for their heterosexual and cisgender peers. When forming friendships, there is a constant struggle of having to hide a big part of one's self in order to avoid consequences like judgement, abandonment and social exclusion versus the need for being open and being able to share every aspect of their lives with a friend. Also, when forming intimate relationships, because of a general view on "immorality and abnormality" of same-sex attraction, LGBTQI+ adolescents are often forced to explore their sexuality secretly. This can cause them to develop a negative or "dirty" sense of themselves and their sexuality.

Besides the confusion and the struggle inside, for LGBTQI+ youth there is also an everyday "outside struggle" to survive. Research shows that LGBTQI+ students are at a disproportionate risk for stigmatizing and discriminatory experiences in schools, including alarmingly high rates of school-based bullying, harassment and biased language (Harris Interactive & GLSEN, 2005; Kosciw et al., 2014, as cited in Kull, Kosciw et. al. 2017). Evidence shows LGBT-identifying students are bullied three times more than the general population in schools. The most common is verbal violence in the form of teasing, name-calling, use of derogatory terms, inappropriate jokes, spreading rumours about one'ss sexual orientation and/or gender identity and gay-bashing. Other forms of homo/bi/transphobic violence include:

- Nonverbal violence such as offensive gestures, mimics and body language
- Social exclusion of the person because of their actual or perceived sexual orientation and/or gender identity
- Prohibiting a person from engaging in certain school activities
- Thefts, destruction of property
- Cyberbullying via email, social networks, chat groups, mobile technology etc.
- "outing" a person without their consent, or blackmails and threats that their LGBTQI+ identity will be revealed

- Unwanted physical contact (including sexual contact), attempted rape or rape
- Threats and physical abuse and assaults on a person (shoving, pushing, hitting, inflicting injuries etc).

In most cases such bullying and violence occurs on the basis of **perceived sexual orientation and/or gender identity**, and can be related to gender expression, especially when a person does not comply with traditional looks. Some of the typical "clues" that people use to label someone as a "lesbian", "gay" or "trans" are:

- short hair for females, especially "undercut"
- gestures (a man who is more "feminine", a girl who is more "masculine")
- wearing colourful clothes (especially rainbow colours – that are traditionally used as a symbol for LGBTQI+ persons) or non-standard clothes (for example – narrow jeans or pink shirt for men, wide pants or ties for women)
- wearing make-up (for men)
- wearing some symbols of LGBTQI+ associations or movements (badges, stickers, etc.)

It is important to recognize that a person does not have to be LGBTQI+, but it is enough to be perceived as LGBTQI+ in order to be bullied and exposed to homo/bi/transphobic violence. Also, for LGBTQI+ persons, it is not uncommon that their friends, family members and others who support them also get victimised. The story is similar also for children that come from "rainbow families" (families with same- sex parents) – they also experience these kinds of homophobic violence, despite the fact that they might be straight and cis gendered.

It is no wonder that LGBTQI+ students often feel unsafe in the school environment and skip school for safety issues. A hostile school climate affects students' mental health and academic success. The consequences of such bullying and victimization are serious and include psychological distress, lower self-esteem, higher levels of anxiety and depression, social isolation, poorer school performance, substance abuse, sexual risk-taking and suicidal behaviour. Also, this population is very vulnerable since, in most cases, they do not receive the necessary support in their families. Unfortunately, the situation is quite the opposite; the parents themselves are often perpetrators of violence. There are numerous examples where a young LGBTQI+ person is being punished or emotionally and physical abused by the member of their family in order "to correct" their sexual or gender identity.

Although the consequences are very serious, most of the LGBTQI+ students do not report bullying, harassment and other discriminatory experiences when they occur. The reasons for not reporting are different:

- fear of being "outed" as being LGBTQI+ to staff or family members by reporting it
- belief that the school staff will do nothing about it
- belief that the school staff's handling of the situation will not be effective
- belief that reporting will not change anything or that it will cause additional problems
- fear of being deprecated and rejected even more
- fear that the school staff is homo/bi/transphobic, not having "a person to go to"
- belief that the harassment was "not a big deal"
- concern for their safety (retaliation, violence from perpetrators/bullies)
- not wanting to be perceived as a "snitch" or a "tattle tale"
- feeling too embarrassed or ashamed to report it
- fear that they would be blamed or would get in trouble for the harassment

One of the important reasons for not reporting LGBTQI+ bullying could also be an unsupportive school environment. Research shows that school personnel often do not respond when the bullying occurs. For example, the results of the latest research on the experience of LGBTI+ students in Hungarian schools showed that in 52% of cases when a student reported victimisation to the school staff, school staff advised the student "to ignore it" (Háttér Society, 2019). These results are especially disturbing, because their silence supports discrimination and sends a wrong message to LGBTQI+ students that it is OK for them to be bullied. The reasons for not reacting are different and include:

- it happened so often that they got accustomed to hearing anti-gay remarks, so they let it slide
- they do not know how to react (what would be the appropriate way to react)
- they feel that they do not have support from the principal and other school staff to tackle the issue
- the fear of backlash from parents or school administrators.

On the other hand, research also shows that having supportive educators has positive impacts on LGBTQI+ students (they feel safer in their schools, they experience less victimisation, they report greater psychological wellbeing and have better academic outcomes (Singh & Kosciw, 2017).

Asplund (2018) summarises four major protective factors identified by previous studies: GSAs, supportive school staff, LGBTQ-inclusive curricula, and comprehensive bullying prevention policies that include enumerations for LGBTQ youth. The results of Kosciw, Palmer, Kull and Greytak (2013) showed that having supportive adults at school had the strongest positive influence on the school environment and LGBT students' well-being. Roe's qualitative research (2013) on the role of school counsellors in providing support to gay and bisexual youth concluded that most students believed that school counsellors are supposed to be supportive by virtue of their job title. Students believed that, for a school counsellor, being accepting of all students is one of the job responsibilities. However, in the same study, many LGBT students either did not disclose their sexual orientation to their school counsellor for fear of being judged or fear that their relationship would be negatively altered in some way.

How to become an LGBTQI+-aware counsellor

It is pretty clear that the role of a school counsellor gives a unique opportunity and position to help young LGBTQI+ students when facing everyday challenges. According to the American School Counselor Association (ASCA) Position "School counselors promote equal opportunity and respect for all individuals regardless of sexual orientation, gender identity or gender expression. School counselors recognize the school experience can be significantly more difficult for students with marginalized identities. School counselors work to eliminate barriers impeding LGBTQ student development and achievement." It is quite clear that school counsellors are in a position to promote and support the development of positive self-identities for all students.

There are two main directions of how a counsellor can offer support for LGBTQI+ students:

1. Individual work with LGBTQI+ students (in person or group work)
2. Working on the school climate

But before starting to work on the issues above, there are some important prerequisites that should be fulfilled.

Explore and know your own limitations

The first prerequisite for the counsellor is to know his/her own personal biases. In order to avoid the potential negative impact of one's own values, beliefs and biases (for example cultural influences, family upbringing, religion etc.) in the counselling process, it is very important for counsellors to honestly explore, question and evaluate themselves. Although mental health counsellors are, in most cases, more aware of these issues, bias against LGBTQI+ persons is very dispersed in our society and we often internalise and project stereotypes and prejudice without even realising it. Even if the counsellors think of themselves as and really are accepting and open minded, it is possible that there are some negative attitudes hidden in the unconscious mind. That is why it is so important to first explore yourself.

In some cases, counsellors' personal value and belief system (for example personal religious beliefs) will not be affirming towards LGBTQI+ persons. Keeping in mind the best interest of the student, if a counsellor recognizes that his/her own personal beliefs are affecting the counselling process in a non-supportive manner, the counsellor has to refer the student to another counsellor, according to the ethical principles of counselling.

Learn the terminology and use it appropriately

Talking to the client is "the main tool" in counselling and every counsellor should be aware of the importance of words that are used. It is important to learn and understand the LGBTQI+-specific terminology and to use it accurately and respectfully. Also, counsellors should keep in mind that language and terminology is also changing and evolving. The terms that were commonly used before (for example – the term "homosexual") now carry negative connotations and should not be used. Language can be more challenging when working with trans students (or students that are questioning their gender identity). A counsellor (as well as other persons) should always respect the name and pronouns that a student uses.

Besides knowing what the "L" or "T" and "Q" letters mean, a counsellor should understand the effect that "LGBTQI+" affiliation might have on identity formation. For most students, an important phase of the coming out process is identifying and accepting themselves as an LGBTQI+ person. This process is often related to the desire to meet other LGBTQI+ persons. When we are

confused and insecure regarding our identity, it can be helpful to find a niche "where we belong", and for some students it might be important to feel a part of a community. In those cases it will be important to support a student as "genderqueer" or "a lesbian". However in other cases the "T" or "L" will not matter and it will be important to avoid the "categorisation" trap and keep in mind that every student is an individual being. Some people deeply refuse to put themselves in any of the categories and that also should be respected. Keep in mind that an identity development process is a complex and individual journey for every student, and it should be respected and supported accordingly.

Educate yourself

Counsellors often lack the necessary knowledge and tools for working with LGBTQI+ persons. Formal higher educational curricula offer little or no knowledge on the LGBTQI+ topics so counsellors feel unprepared for working with that population.

In order to be able to work with LGBTQI+ clients efficiently, it is important for counsellors to educate themselves. There are various options for professional development in the area, including specific education and training, online resources, e-learning platforms and cooperation with local LGBTQI+ organisations.

Individual work with LGBTQI+ students

A counsellor can work with LGBTQI+ students on individual sessions, or in group settings. In both cases please keep in mind the following:

- create a safe space where LGBTQI+ students feel welcome and can be open about their problems. Always keep in mind that for LGBTQI+ students, opening up to anyone poses a great risk. Results of a study done by Roe (2013, page 158) showed that „*even though LGBT students believed that school counselors would be supportive because of their role, many LGBT students either did not disclose their sexual orientation to their school counselor for fear of being judged or fear that their relationship would be negatively altered in some way. LGBT youth used other cues such as political party affiliation, previous conversations with their counselor, and supportive symbols such as LGBT safe zone stickers to determine if their counselor would be supportive.*“
- respect confidentiality. This is an absolute imperative. “*Concerns about confidentiality between LGBT students and their school counsellor poses a potential barrier to a supportive relationship with school counsellors. LGBT students expressed confusion about the limits of confidentiality between them and their school counsellors. Specifically, students wondered if information they shared with their school counsellor would be shared with their parents or others.” (Roe 2013, page 158)*
- listen to the student, have a supportive role, without judgement. In one study in which the supportive role of counsellors was examined, “*Participants mentioned that they were not expecting that support would come in the form of complicated interventions, but rather having a school counsellor who would simply listen to their concerns was important.“(Roe, 2013, page 157).*
- remember that you are maybe the first person that a student is talking to about sexual orientation/gender identity. Respect the trust you were given.
- remember that gender identity is different from sexual orientation
- help to empower the student, help the student to accept him/her/themselves. Validate the person’s sexual orientation and gender identity or expression.
- Be careful with language. Use neutral language. (for example “Are you seeing anyone?” instead of “Do you have a boyfriend/girlfriend?” Respect the pronoun and name that the person uses.

- avoid unintentional microaggressions. Please see Module 4 for more information on microaggressions.
- be prepared to give a referral. If there are questions that you can not answer, be prepared to refer them to a more informed counsellor, hot lines, LGBTQI+ organisations etc.
- be aware of potential intersecting identities (religious, ethnic, disabilities etc) – see more information in module 3

One of the important topics that might arise in the counselling process is the question of coming out (*please read Module 3 on information regarding the coming out process*). Counsellors could help students to explore the risks and benefits of coming out as well as reasons for and against doing it. If a student decides to do it, it would be useful to make a plan.

Berzon (1988, at cited in Molnar, 2018) developed a set of questions that a counsellor can use to support the client in that process:

- Who? Who does the client want to come out to and what is their relationship like? Also, the therapist should explore together with his client the possible reactions after coming out and how that might influence the relationship.
- What? The therapist should help his client prepare what to say when they come out.
- Why? Before coming out, the client should be aware of their motivation and also, they should be prepared to answer different questions regarding being LGBTQI+ that the person to whom they intend to come out might ask.
- Where? The therapist should help the client decide where they want to disclose their sexual orientation or gender identity.
- When? The client should be supported by the therapist to choose the right moment to disclose, both for themselves and for the person to whom they come out.

If a student needs help regarding who to tell about their sexual orientation / gender identity, the counsellor can facilitate the process of decision-making by discussing the following topics:

- choosing the person that a student feels is most supportive
- considering the possible reactions of the person
- identifying potential problems
- identifying benefits of coming out to that person

Barret and Logan (2002, as cited in Molnar, 2018) offer some suggestions regarding coming out to parents for gays and lesbians, which include:

- feeling comfortable with being gay or lesbian and being clear about one's sexual identity before considering coming out;
- coming out in an adequate moment for the person to whom the disclosure is taking place. This means avoiding coming out in moments of major stress experienced by the parents, such as health problems, divorce or strong conflicts within the family relationships, work related problems and avoiding to come out during a conflict with the parents;
- being prepared to face a wide range of emotions that coming out might bring out in the person to whom the disclosure is being made. Many parents might feel embarrassed, shocked or angry at first, but in time, they can become more supportive and acceptant as they challenge and overcome their own prejudice and stereotypes.
- keeping an open and non-violent communication with parents after coming out and giving them time to adjust and understand the situation. It will probably take time, as it is a process for them too.
- encouraging parents to meet other gay and lesbian people and to get more information about what it means to have a gay or lesbian identity.

It is also good to keep in mind the following:

- do not assume that everyone in school are heterosexual and cisgender (including teachers and other school staff) or that every student that experienced homophobic, biphobic or transphobic bullying is LGBTQI+ (some students might be bullied because other students *perceive* them as beeing LGBTQI+, but they are not).
- do not try to change student's sexual orientation or gender identity. If a student is confused and not sure about thei sexual orientation, a counsellor should help the student to discover it in a gentle and supporting way (and not by "pushing" them in any direction, especially not in a cis and heteronormative direction)
- do not disclose a student's sexual orientation, gender identity or any other information that the student has shared with you to anyone (parents, colleagues, other school staff...)

Improving the climate at the school

There are many things that can be done to make schools more inclusive and safer for LGBTQI+ students. There are many different recommendations that have been tested in various schools and showed good results. Some of the recommendations are:

- implementation and enforcement of anti-homo/bi/transphobic bullying and harassment policies.
- addressing existing school policies to include more inclusive and non-discriminatory language
- implementing a plan for reducing homophobic language at school (education, raising awareness, reaction when it occurs)
- Advocating for LGBTQI+ topics to really be included in the curriculum
- using non-gender specific language
- organising various activities (education, workshops, commemorating important dates like IDAHOT for example, exhibitions etc.) where LGBTQI+ topics are discussed in a positive light
- helping students to organize a GSA group (gay straight alliance)
- creating support services for students, teachers, parents, and administrators including resource materials
- providing staff development/education on LGBTQI+ topics for faculty and administration

Asplund and Ordway (2018) recently provided a comprehensive model on how school counsellors can work toward an LGBTQI+ Inclusive school climate called The SCEARE (School Counselors: Educate, Affirm, Respond, and Empower) Model.

The model proposes 4 tiers that are mutually supportive and can lead to systematic changes in the school climate. The first tier is education and it is the foundation of the whole model. In order to be able to bring positive changes in their environment, school counsellors must firstly educate themselves on LGBTQI+ topics and then they can use the knowledge to educate other school staff, students and parents.

The second tier of the model is affirming adults. It has been proven that the presence of supportive adults at school serves as a protective factor for LGBTQI+ youth. In their model,

Asplund and Ordway (2018) propose an affirming adult spectrum that consists of affirming attitudes and behaviours at the top (like acceptance and advocacy), and unaffirming attitudes and behaviours at the bottom (heteronormativity and oppression). This spectrum is to be used as a reference tool and a major goal of Tier I of the SCEARE model is to educate staff so that their attitudes and behaviours can become more affirming.

The third tier implies a development of a LGBTQI+-responsive bullying prevention program. The model stipulates that school counsellors can and should advocate for the following additions as part of an LGBTQI+ responsive bullying prevention program: formal school policy, consistent staff intervention, an anonymous bullying report system, bathroom use and inclusive signs.

The fourth tier, and also the main goal of the SCEARE model is Student empowerment. The main goal of the empowerment is for LGBTQI+ students feel comfortable participating in all aspects of the school community without fear of discrimination or harassment. School counsellors can help students identify their personal strengths and weaknesses, facilitate opportunities for students to learn how to appropriately and effectively express their needs and desires, and help students learn how to use the resources available to them to create positive change for themselves. Although student empowerment is supported throughout the three preceding tiers, it can be endorsed by implementation of GSA group or fostering self-advocacy skills.

Asplund and Ordway (2018) state that possible indicators of student empowerment within the school environment include the following: students feel physically and emotionally safe at school, students engage in self-advocacy and/or believe it would be safe and acceptable to self-advocate, students report heterosexist bullying and believe that doing so is beneficial, and the presence of a GSA and/or other LGBTQI+-affirming clubs or programs that provide community belonging for students.

General recommendations for school counsellors

Decide to be an ally

An ally is a person who supports and respects LGBTQI+ identities. It is very important that LGBTQI+ students know that you are there for them. Research shows that just knowing that there is a supportive educator at school can help LGBTQI+ students feel better about being in school, even if they don't come to you directly.

You can become visible as an ally by displaying LGBTQI+-supportive materials in your office (posters, leaflets, rainbow flag etc.) or wearing a visible marker (for example rainbow bracelet or a badge). Also, your visibility as an LGBTQI+ friendly person is best seen through your actions (responding to anti- LGBTQI+ behaviour, using inclusive language, making no assumptions regarding anyone's sexuality / gender identity etc.).

Respond to anti-LGBTQI+ language and behaviour

An active ally speaks up and stands up for a person or a group that is being discriminated against or treated unfairly. In school environments anti-LGBTQI+ behavior happens very often and comes in all shapes and sizes: biased and homophobic language, name-calling, bullying and harassment, and in extreme cases even physical assault. Learning how to respond and responding to anti-LGBTQI+ behaviour can be very challenging, especially if there is little or no support for doing so from the principal, teachers and other school staff. However, ignoring this behaviour sends a message that it is OK to bully and discriminate against students who are different and increases the fears for personal safety of LGBTQI+ youth. Although the task is difficult, it is imperative to address and respond to anti-LGBTQI+ language and behaviours.

Support student clubs, such as gay-straight alliances

Research shows that student support groups, clubs or Gay-Straight Alliances are a valuable resource that can help to make schools feel safer and more welcoming for LGBTQI+ students, as well as provide support for LGBTQI+ students to better cope with everyday challenges. These clubs

are usually student-led, but have a faculty advisor (from the school staff). Being an advisor provides an opportunity to be a more visible ally and to provide additional support to the students.

Recommended additional resources

The Safe Space Kit: Guide to Being an Ally to LGBT Students (2019) / Gay, Lesbian and Straight Education Network - GLSEN. Retrieved 9. November 2021 from: https://files.eric.ed.gov/fulltext/ED512337.pdf

Tackling homophobic language / Stonewall Education Guides. Retrieved 9. November 2021 from: https://www.stonewall.org.uk/sites/default/files/tackling_homophobic_language_-_teachers_guide.pdf

Suggested activities

Explore a few case studies with your participants

Here is an example for a case study that you can use for discussing the previously outlined topics. You can also search for country specific case studies in reports of research conducted in your country, or you can also ask participants to recall a few stories they know of LGBTQI+ students. These discussions should of course be in line with the obligation of confidentiality and professional secrecy.

"You work as a counsellor in a public high school. An adolescent girl comes to your office very worried. She tells you that one girl from her class to whom she is not close has found out that she had a girlfriend by spying on her FB profile. This girl is from a very traditional family and she holds quite a homophobic belief system. She is blackmailing your client that she will tell the client's parents about her sexual orientation if she does not give her 15 EUR each weekend. Your client's parents also hold patriarchal life views. What would you do as a counsellor in this case?

What would be your concerns? What do you perceive as a risk? What would you do with the information about your client's sexuality? What if your client happens to be forcefully outed in the classroom, in front of her parents? Would you ask for personal professional support and where?"

Use activities in Module C with a different lens

Activities in Module C are written for psychologists, and can provide relevant insights also for school counsellors as they touch upon development and developmental processes. You can modify the activities to fit more to school counselors' needs.

Module C - Clinical psychologists

Topics in this module: Treatment considerations; Affirmative practices; Overcoming heterosexism; Developmental models; Conflicts regarding sexual orientation; Clinical manifestations of internalised homo-bi-transphobia; Working with trans clients

Most of the resources on how to address the population of LGBTQI+ persons in general practice focus on the LGBTQI+-specific or nonspecific challenges of everyday life. In clinical practice the clients usually have more concerning problems that need therapy. LGBTQI+ persons might seek assistance concerning their sexual orientation and/or gender identity as well as other mental health concerns that may or may not be related to sexual orientation and/or gender identity.

In this module we use the words "therapy" and "therapist" for psychologists, clinicians and counsellors as well. In every region and country there are different names for practitioners, but here we assume that every psychologist can decide what competences they have in their field of work.

Introduction

This module provides a framework and point of reflection for clinicians that can complement their already existing diagnostic knowledge and tools. The module strengthens the social stance in therapeutic work, as it can be a valuable viewpoint when trying to develop a more inclusive practice. The module is also a good starting point for understanding the problems LGBTQI+ clients come to clinicians with.

Aims

After this module participants will be able:

- To reflect on the potential bias in their therapeutic practises
- To think about LGBTQI+ clients more open-mindedly and broadly

- To have a deeper understanding of the core concepts of gender that are more relevant to their field
- To understand internalised phobias and the coming out process better

Knowledge base for trainers

Systemic and critical lens

Psychology and clinical psychology is a field with great traditions and with many theoretical underpinnings that go back hundreds or thousands of years. Psychology has a great heritage from philosophy and other humanistic disciplines that started to form in ancient times. Questions like what a healthy and happy life means, or what the roles of people in society are have been on big thinkers' minds since antiquity. There are many "answers" to these questions hidden in our cultures and upbringing, and there are also many assumptions and ideas that are hidden in the literature and research of psychology. It is useful to help participants to take a hard look at their field and their professional studies: what does healthy development, healthy sexuality, healthy relationships and attachment, and healthy coping mechanisms entail? What does being an adult mean? What does family mean? What stigmas do the unhealthy vs. healthy, mad vs. sane binaries reinforce in people's lives? What social systems and systems of oppression do psychological theories uphold or leave untouched?

The focus of therapy is usually the individual, and oftentimes social systems and processes are neither addressed nor mitigated during therapy. If these systems are left unaddressed, the therapeutic relationship can end up enhancing the bias and oppressions that are the root cause of internalised phobias. Also, to really understand the mental health needs of diverse groups, professionals need to understand the cultural and social forces that have an impact on these groups and on the perceptions of them. It is very difficult to separate the mental health challenges of LGBTQI+ persons from social systems, culture and politics. So it is important to get clinical psychologists to think about the assumptions that saturate their practices and fields, to help them expand their thinking beyond the intrapersonal and interpersonal relationships, and also to help them learn and establish a reflective process they can implement continuously.

Here you can find a few of these deeply embedded assumptions, but you can help participants to come up with other ideas:

Core concepts and questions that are embedded in clinical psychology

- Conforming successfully to societal ideals and processes is often seen as the sign of healthy functioning.
- Healthy sexuality and attachment go hand in hand.
- There is a developmental process every human being goes through, which ideally ends in healthy functioning and relationships.
- The task of the psychologist is to help the client strengthen their adult sense of selves.
- Being married is a huge protective factor regarding physical and mental health issues.

You can use Activity C.1. - "Elephants in Your Field" to open up the discussion about these topics.

Overcoming heterosexism and cisgenderism

Heterosexism is the value system that prioritises heterosexuality and assumes it is the default, most appropriate and morally acceptable sexual orientation, labelling all other sexual orientations as not-normal, undesired and unhealthy. Heterosexism and cisgenderism are oppressive and they have a negative impact on LGBTQI+ persons. Many schools of psychology and traditions have underlying heterosexist beliefs, and many heterosexist concepts are considered to be the markers of mental health and flourishing, for example feminine and masculine expression, long-term relationships, marriage and the desire to have a child can be the standards of healthy functioning in many therapeutic schools and methods.

Heterosexism can appear in a psychologist's work even unintentionally, and could affect the therapist-client relationship and trust. Being an affirmative practitioner means being aware of one's biases, stereotypes and taking care of them in order to create a safe place for all clients. To overcome heterosexism it is important for practitioners to be aware of their own attitudes and beliefs regarding LGBTQI+ topics. It is an indicator of professional integrity to be aware of one's prejudices and value systems and therefore be aware of professional limitations in competency. It

is also expected that the psychologist be able to decide whether issues could be worked on in supervision or the client should be referred to another therapist.

The biopsychosocial framework: tackling the cause and effect thinking

This paragraph underlines the importance of the biopsychosocial model in providing effective help to LGBTQI+ persons. Your participants most probably are already familiar with this model and use it in their everyday practices, but this can depend a lot on the time when their studies took place. It is worthwhile to explore participants' knowledge of this topic before or during the training.

The diagnostic mode of clinical psychology can invite psychologists to think about human functioning along a cause and effect structure, which can be a fertile ground for biassed thinking. One of the biases is the imbalanced view of the "healthy" and "unhealthy" binary: "healthy" personality and functioning are considered to be the default, and they inevitably will be *formed* if the circumstances of the developmental process are average or "normal"; however, "unhealthy" personality and functioning are a deviation from the default, and are *caused* by various factors. In reality, both adaptive and maladaptive functioning are caused by many intertwined factors; all kinds of human functioning emerge from complex and intersecting biological, psychological and social mechanisms. Professionals should be aware of this bias and treat every aspect and variant of human functioning as the naturally diverse consequences of complex biopsychosocial processes.

Another bias that can form on the ground of cause and effect thinking is connecting trauma to sexual and gender identity: many psychololegist end up considering various elements of non-conformity and adverse circumstances in the client's past to be the *cause* of their non-normative sexuality and gender. In reality one can have a difficult relationship with their father figure, or can even be a sexual assault survivor, and at the same time can have non-normative sexual and gender experiences or identity independent of these expereiences. Even if some researchers can find correlation between adverse experiences and non-normative identities, professionals must be careful not to mix up correlation and causation.

Helping someone to heal after adverse experiences does not mean that their identity needs to or will become more conforming to the norm. Although trauma and and the challenges emerging from having stigmatized non-conforming identities can have some overlaps (for example trauma

can increase the effects of LGBTQI+ stigmatization on the person and vice versa); the two challenges are different sets of issues that need professional help. Dealing with one can alleviate the pain of the other, but healing trauma won't and need not change someone's core identity.

It is advised to talk to professionals about how they think about the relationship between mental health and LGBTQI+ identities. During the discussion the trainer is advised to call out the above mentioned biases, and try to tackle cause and effect thinking in professionals.

Affirmative practises

Affirmative counselling or therapy is a methodological framework in which the individual differences in sexual orientation and gender identity are considered to be healthy and deserving of support and even appreciation. It is not a separate method, rather an approach that can be cultivated regardless of what school one belongs to. It focuses on affirming the client's identity and self-discovery, realises the negative effects of homo-, bi- and transphobia and heterosexism on the client's life. It is about seeing the person and addressing the issues they bring into the process, not assuming them based on their LGBTQI+ identity. The counselor or therapist accepts that any sexual orientation is just as healthy as a heterosexual one, and that any gender experience, expression and identity is just as healthy as gender-comforming expressions, experiences or being cisgender. All the shades of sexual and gender diversity are considered to be natural variations of the wide spectrum of human sexuality.

Gay-affirmative therapy first developed after 1973, when the American Psychiatric Association removed homosexuality from its Association's Diagnostic and Statistical Manual of Mental Disorders. Soon after the concept of internalized homophobia - the inner shame that is produced by accepting society's negative view of gay people - was developed, and it was the biggest mental health problem LGBTQI+ persons had faced at the time. Since then there have been many changes in social structures and social acceptance, and we are currently living in the time of new changes - whether good or bad. As the trajectory of these changes unfolds, the mental health needs of clients also change. Clinical psychologists need to make an effort to follow these changes and consider the impact of past and current social states on the trust and well-being of LGBTQI+ persons.

APA guidelines

The American Psychological Association (APA) published its first guidelines for working with LGB clients in 2000. Since then the guideline has been updated and complemented with another guideline for psychological work with transgender and gender non-comforing clients. You can look for available translations into your native language, or you can use the original English version. Both guidelines are accessible from the site of APA, you can provide the participants with the links.

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. The American Psychologist, 70(9), 832–864. https://doi.org/10.1037/a0039906

Guidelines for psychological practice with lesbian, gay and bisexual clients. (n.d.). Https://Www.Apa.Org. Retrieved 1 December 2021, from https://www.apa.org/pi/lgbt/resources/guidelines

Activity C.2 .- "Guidelines" details how you can go through the guidelines with your participants in an interactive and meaningful way.

The mental health needs of LGBTQI+ persons

One of the principles of affirmative therapy is to see the client as a whole person instead of either focusing mainly on their sexuality and gender, or tracing back their mental health problems exclusively to their sexual and/or gender identity.

It can happen that a client's biggest challenge is not connected to their LGBTQI+ identity, as there are non-conforming persons who live in very accepting and supportive communities. In their case internalised homophobia might not be as robust, or they might already have the tools and support

to deal with minority stress in their lives. Also LGBTQI+ persons deal with a lot of other things: anxiety, depression, parenting issues, death of loved ones, having a bad boss, or existential threats like climate change. Thus LGBTQI+ clients come to treatment for the same reasons as other clients, they share the same human experiences as others, thus the focus of the therapeutic process should be flexible and follow the clients' wishes.

This can be tricky to balance, as sometimes a psychologist can sense that the client is in the state of denial or is trying to emotionally suppress the lived experiences and emotions of their own oppressed state. However, unless the client arrives with the intention to work on these specific topics, sexuality and gender should not be the main topic of therapy, rather the therapist should use their LGBTQI+ knowledge and systemic perspective as one lens of a multifocal glasses: sometimes this lens can add to the discussion about the client's life and to to their self-understanding, thus seeing the narratives and stories of the client through this lens serves the client and the process; but sometimes this lens is almost or fully irrelevant to the current therapeutic conversation, thus the therapist should use another lens of the multifocal glasses to look through.

The experiences of being and/or considered to be different, the feeling of risk that is attached to being open with others, the ways in which one's identity is not mirrored and validated in culture and everyday life - amongst other similar ones these are important interpersonal and intrapersonal experiences LGBTQI+ persons potentially face. As a therapist, these experiences are all important to think about and bear in mind. However, these experiences are not simply due to sexuality and gender, there are many other aspects and factors that contribute to forming these experiences, and they are in a complex relationship with the LGBTQI+ identity. Experiences that form the identity of "being different" can for example be adverse experiences with family and school relationships and social difficulties with other parts of their identities, e.g. being a "geek. These experiences and the way they are connected to LGBTQI+ identity are worth exploring with the client.

All in all, LGBTQI+ clients have many similar problems and challenges to other clients, so as a therapist it is suggested you use LGBTQI+ knowledge and topics not as a focus, but more as a lens that can be put on. Also, there are some challenges that are more commonly faced with by sexually and gender diverse clients. These challenges are mostly posed by the nature of these clients' relationships: LGBTQI+ persons' relationship with their family of origin, spouses and partners,

children and friends can be at odds with cultural norms, the patterns or arrangements of their relationships can be hard to navigate as their relationships are often not adherent to heterormative scripts. For example, ethical non-monogamy is present in more than half of gay male relationships (Nichols, 2020), or many diverse clients are estranged from their family of origin and create their own chosen families with friends and allies. Thus, being an LGBTQI+ affirmative therapist requires special knowledge and demonstrating the acceptive attitude in therapy should include the acceptance of alternative relationship forms and sexual desires (for example kink, BDSM) too.

The Introductory Activity 5. - "99 problems of an LGBTQI+ person" can be a good way to explore the assumptions participants have about the mental health needs of LGBTQI+ persons.

Building trust

Rapport and the client-psychologist relationship are essential in any type of therapy setting, but building trust is especially important when working with LGBTQI+ persons as they might have experienced damaging "helping" relationships. Thus at the first contact clients may have some - sometimes quite personal - questions for the therapist, or they try to assess the attitude of the psychologist with a different method. The psychologist should be open to answering questions about their professional stance, and be able to show their affirmative attitude and willingness to work with the client. This might be harder for those who have been trained not to answer questions, but rather than staying as a blank page for the client, by respecting and accepting the desires and choices of the client, the therapist can create a non-judgmental environment, which provides the feeling of safety for the client.

Therapists can also encourage LGBTQI+ clients to express their concerns openly about the therapeutic process, for example, if the therapist unwittingly uses an expression that is not comfortable for the client. This can deepen the therapeutic relationship and the client can learn how to give feedback in a safe environment.

The sexual orientation of the psychologist

Sexual orientation is relatively irrelevant when we talk about a competent therapist. The key values are the ability to empathise with and accept the client, and to properly do that, the psychologist needs to be able to assess and handle their own stereotypes and prejudices (not just in LGBTQI+ topics). For all psychologists working with LGBTQI+ clients it is also essential that they work on and overcome their own heterosexism.

Non-LGBTQI+ therapists however can represent the "out-group", help rewrite bad experiences of heterosexism and can facilitate other transference processes. Also, "out" LGBTQI+ psychologists may serve as role models. In both situations the therapist has to be careful about the disclosure of their orientation and they should think through the transference and countertransference processes. Even if clients wonder about the therapist's orientation, it's up to the therapist how they interpret the inquiry, and what are the implications of the given situation.

Also clients can withhold some information if they might presume that the therapist would be heterosexually biassed. To avoid this, therapists have to be able to actively demonstrate their affirmative and accepting attitude.

You can read about some more considerations regarding disclosing LGBTQI+ identity as a therapist in Module 3.

Things to keep in mind

- Being a member of the LGBTQI+ community is stigmatised
- Where the client is in the coming out process
- Don't let heterosexism take control - don't assume your clients' sexual orientation
- Use language that does not assume heterosexuality
- Remain open - LGBTQI+ identities are diverse and individuals have different experiences
- The client's current identity may not be a fixed point, but rather may be fluid over time
- When talking about sexual orientation and gender identity, be open to the clients' own definitions
- Familiarise yourself with the LGBTQI+ community and issues
- Communicate affirmation in your practice (small signs, books etc.)
- LGBTQI+ issues are unique to each group, and so there are specific competencies needed to work with each
- Be aware of your own competence, biases, stereotypes
- Clients are not there to teach you about LGBTQI+ communities
- Try to abstract from sexual orientation and gender when assessing the clients problem: sexual orientation can have an effect on other problems, but don't let it take away the focus
- Keep learning

Foundational concepts - a further exploration

Before going into more detail about identity development and other relevant knowledge, it is needed to strengthen and deepen the understanding of the foundational concepts (Module 1). We have previously discussed the concepts of sex, gender identity and gender expression, romantic and sexual orientation, and outlined the relationship between them: they mutually form our experiences in our everyday lives, but they are not in a causal or correlational relationship (in short: they are interrelated, but separate).

In the educational material 'Genderbread person', the word 'identity' is connected to gender, but in reality, identity is much more complicated: not only gender can be an element of one's identity, but sexual orientation can also be experienced as an identity. A person can *identify* as homosexual, lesbian, gay, asexual or with any other labels that describe sexuality and gender. Thus, identity is one of the measures when it comes to estimating the size of LGBTQI+ populations, or when conducting research. Besides identity there are two other factors regarding sexual orientation: *attraction* and *behavior*. Social science research mostly uses identity labels. The problem is that identity labels do not really capture the whole scale of feelings, attractions (who we are interested in) and sexual/romantic behaviours (what we actually do sexually/romantically), or even our fantasies and thoughts. Thus identity labels are not a "stand-in" for behaviour and attraction: two lesbians might share the same identity, but can have very different histories of sexual behaviour with and attraction to same-sex persons, or one of them migh even have some experience with opposite-sex persons. This is important information also for clients who identify as heterosexual: they might have desires and experiences that are not in line with the heterosexist norms, but they still identify as heterosexual. Thus it is crucial to stay open-minded and curious as a therapist, instead of using labels as boxes or in a definitive way.

Although a lot of people (for example older persons, see more in Module 3) unfortunately refrain from identifying with an LGBTQI+ identity for fear of the consequences, we must say that identity can not and need not be forced upon the client. One can have a happy and healthy life even if their chosen identity label might not capture the full scale of their experiences.

Another important thing is fluidity. Sexuality and gender can change through our lives - even the lived experiences of heterosexual cisgender persons change a lot from their adolescence to being an elderly citizen. These changes are multifaceted: one can just decide to change their *identity*

labels (for example due to living in a more accepting community, or due to legal or cultural changes), but also a person can experience sexual and romantic feelings (*attractions*) that are new to them, or the possibility of new sexual and romantic *behaviours* open up to them. Thus, sexual and gender *identity*, sexual *attraction* and *behaviour* can change in one's life, and these changes can go together (for example a new attraction might prompt a lesbian-identifying person to rather use the identity label 'bisexual'). These changes can be hard to navigate for everyone. LGBTQI+ persons can feel a lot of shame around these changes, which comes from the social pressure of "proving" their identites, "proving" they are "properly" gay, a trans "enough", etc. This shame can be even more robust if the changes are pointing towards the heterosexist norm: 'heterosexual panic' is as real for a person identifying as gay, as 'homosexual panic' is for some heterosexual persons. Changes can also mean an existential crisis for the LGBTQI+ client: for a lot of clients the argument that they were "born this way" has brought some peace and safety, and a change in their orientation or gender identity can throw a person into turmoil, one can "regress" to previous levels of internalised phobias. Changes are also risky because they can cause changes in one's chosen family.

Identity development

You can find most information on identity development and coming out in Module 3, but for participants who work as psychologists with LGBTQI+ persons, here is some complementary information.

There are many models of identity development, but Erikson's model of development is probably the most known one. According to this model of development, the formation of identity is a complex process and there are several tasks known as normative crisis along the way to be accomplished. Since sexual orientations are unique, researchers assumed that the development of a lesbian or gay identity is different from a heterosexual one, and so is the development of a bisexual or trans identity. Building up an identity of marginalised group membership can mean the integration of stigmatised aspects. Gay and lesbian identity development is different from bisexual identity development, as bisexuals can experience stigma in both the heterosexual and the LG communities. When we talk about trans identity, it is a different aspect as the individual is coming to terms with having a different body from what their identity would match with. Also

note that for trans individuals, developing their sexual orientation is a completely different process from developing a trans identity.

It is important for the practitioner to familiarise themselves with the sexual orientation identity models, as it can affect the interactions, the interventions and the focus of the therapy. Be aware of the coming out process as well, as the two can't be completely separated.

One of the first sexual identity development models was introduced by Cass in 1979, the 6 stages of which we have outlined in Module 3. Here we outline a few more points regarding the stages, which might be useful for psychologists. We suggest exploring with participants what emotions, thoughts, needs and coping mechanisms can be present at each stage - and don't forget to remind psychologists to also focus on positive feelings, as every stage contains something positive and liberating too.

- Stage 1 – Identity Confusion: Repression or denial is a usual occurrence at this stage.
- Stage 2 – Identity Comparison: The dilemma of redefining who one is comes up at this stage. At this point the previous assumptions about one's self and picture of the future can be challenged, and one has to rewrite or replace these. The feeling of alienation drives the individual to seek help either in a community or in therapy. However, the individual might still stick to presenting a heterosexual image of themselves. Another approach is when the individual somewhat accepts their sexual orientation but is not happy with it, or because of fear of rejection they don't act on their sexual orientation. Individuals can still experience strong negative feelings about homosexuality and they avoid anything in connection to that. This strategy in the long-run can result in depressive symptoms.
- Stage 3 – Identity Tolerance: Individuals seek opportunities to join the community, but it's still not full acceptance, rather toleration of one's identity. This can result in bad experiences, but positive contact can enhance the positive feeling about one's identity, provide role models, help finding a partner etc. Those who have affirming experiences can move easier towards self- acceptance.
- Stage 4 – Identity Acceptance: The individual has bigger access to the subculture at this stage as well as a greater number of supportive connections and friendships. At this point some still want to keep their gay identity private.
- Stage 5 – Identity Pride: The person starts to consider the rejection of the wider society as no good - instead of blaming themselves. The individual is now ready to explore the

whole of the LGBTQI+ subculture. They won't try to conceal their identity, this helps to balance the public and private identities that earlier were separated.

- Stage 6 – Identity Synthesis: Identity becomes more elaborate, giving space to acknowledging the existing differences and similarities between the self and both the LGBTQI+ and heterosexual communities.

Transgender development model

Most of the available models on gender identity development were written through a medical lens. In module 3 you can find Morgans and Stevens's and Pinto and Moleiro's models of transgender identity, which does not pathologise transgenderism.

Important note on "second puberty"

Mental health professionals should be prepared to understand the dynamics of coming out and the gender affirmation process correctly. Hormone Replacement Therapy and bodily changes can induce various emotional and cognitive processes that are a little bit similar to puberty. Also, LGBTQI+ persons - especially those identifying as trans - might have missed or didn't have the chance to fully experience several important milestones throughout their childhood and adolescent years. These are not developmental milestones, but important life events that help to construct our sense of selves. LGBTQI+ persons can feel the urge to reconstruct these experiences, and mental health professionals should recognize that this temporary regression or "craze" (impulsivity) is completely normal and expected, and should be very careful not to apply any diagnostic labels to it. It is also important to deal with this in the therapeutic context, as these changes can have an effect on the therapeutic relationship itself, and transference can occur.

Internal conflicts of specific clients

A special ethical issue can rise up when working with LGB clients is what to do when a client comes with the request of changing their sexual orientation. This raises the question of how

ethical principles meet the respect of the client's values and articulated needs. How can a psychologist contract to "change" someone's sexual orientation while respecting the client's integrity? Module 6 outlines that conversion therapy is a harmful method and scientific evidence suggests that one's sexual orientation can not be changed by efforts.

To deal with these dilemmas, therapists must familiarise themselves with the internal conflict LGB persons can experience. The conflicted feelings can manifest externally or internally, manifestations may include anxiety, depression, low self-esteem, emotional distress, feeling of loneliness.

The source of conflict can be

- the heterosexism of society and the negative associations with homosexuality it proposes,
- the individual's cultural context: it might explicitly condemn sexual orientations different from the heterosexual one, or in marginalised groups heterosexuality may be a source of privilege, or being part of one group means being excluded from another because of cultural differences
- religion: most religions are heterosexist and vocalise negative or hostile attitudes toward homosexuality and LGB individuals and relationships (although there are religious groups and communities with progressive views, and the mental health professional should be familiar with such groups)

One's cultural or religious background may be a central part to one's identity, or the only source of social support, and if these can't be aligned with one's sexual orientation, this can lead to intra-personal conflicts, and "getting rid of" the unwanted part seem to be the easier option for some.

Based on existing evindence of the significant harmfulness of conversion therapy and ideologies, it is unprofessional and unethical to offer such therapeutic outcomes. So what happens when a client seeks to change their sexual orientation? Suggestion is for psychologists is to embody a relatively neutral stance where they don't accept the request of changing one's sexual orientation but stays open and normalise the clients feelings towards their sexual orientation. The reason for this is that if the psychologist expresses their view on conversion too harshly, the client may feel violated and would seek conversion elsewhere. Before settling on a desired outcome, therapists

need to explore the client's biases about sexuality, the underlying intra- and interpersonal conflict, and the idea of an acceptable identity or lifestyle. In such situations the therapist has a psychoeducational role and they can provide information on conversion therapy, sexual orientation etc. It might be useful to keep the goal setting of the therapy as a dynamic process, and first contract for a deeper understanding of the clients self (not just regarding their sexual orientation). If the client is reluctant and certainly wants the therapist's help in changing their sexual orientation or gender identity, the therapist can ask for a follow-up session or ask the client to return to therapy when their wish to change becomes more uncertain, and their feelings and thoughts become more conflicted around this topic.

See more information on this topic on Module 5 - Internalised homophobia/biphobia/transphobia.

Manifestations of internalised homophobia

As Module 5 has discussed the topic of internalised homophobia, we are focusing on the clinical aspects of it. Internalised homophobia and transphobia can be a central clinical theme in a practice working with LGBTQI+ people. Its effects can range from lower self-esteem, self-doubt, disturbances in self-acceptance to a highly negative self-representation, self-hatred, depression or destructive behaviour such as substance abuse, self-harm or even suicide.

To map internalised homo- or transphobia, the therapist should ask about and give place for expression of negative thoughts on someone's sexual orientation or gender identity. Being affirmative is not only flowers and rainbows, it also means dealing with and accepting the client's negative feelings regarding their own gender and sexuality. However, providing space for the expression of such feelings doesn't mean you have to "push" them, as the client might interpret that as homophobia or heterosexism on the part of the therapist. The fact that it is hard to articulate negative feelings towards one's group which is already marginalised should be taken into consideration when approaching such topics.

As follows for the above mentioned reasons, clients usually don't arrive at therapy with the topic of internalised homo- or transphobia, but other issues such as problematic substance use. Therapists should also be aware of ego defence mechanisms that might be active because of the

internalised homophobia the person experiences. The most common ones are projection, rationalisation, identification with the aggressor, reaction formation, denial, repression.

Your clinical psychologist participants are most probably familiar with these defence mechanisms, but it is a good idea to enumerate them together and discuss how these mechanisms can work regarding LGBTQI+ identities.

Also, one of the most common fears which LGBTQI+ persons share are related to the negative future narratives – they feel like they will never have a "normal" family, they will always be alone, the option of having children is perceived to be impossible. The therapist's role here is to explore all these options with the client, to accept them as a reality, to respect these fears and to navigate through them. The role of the social context is of huge importance – what are the good role models we can use as examples of a positive alternative, what are the safe spaces where a person can meet up with other LGBTQI+ individuals. Going back to the level of self-acceptance – at what stage is the person with their own awareness and acceptance. The more we normalise their future, the better they will feel. But this also holds the tricky situation of sometimes promising them that everything will be ok – the therapist should refrain from such promises.

Working with trans clients

The reasons for transgender clients to visit a psychologist can be because they need a diagnosis for starting a desired treatment, need support in exploring their trans identity or with the process of transition, or they come with clinical issues or just in need for consultation or support regarding regular life issues that have nothing to do with their transgender status. Trans client are the most vulnerable in the LGBTQI+ population (more info in Module 2), and they can have more comorbidities (depression, anxiety, suicide ideation and BPD).

According to trans persons' experience, psychologists either lack knowledge and thus can't understand some aspects of the client's identity or they use the client as a source of information and tend to ignore the original goal the client came to therapy for.

With the high rate of individual uniqueness within the trans community, it is important for the therapist not to stick to labels, but rather let the client explain and use their own definitions. Sexual orientation and gender identity are two different issues, and need to be adressed separately. Sexual orientation may not be a concern for the trans client, but there are cases when it can be in focus, for example if sexual orientation is affected by the fact of transition, so the client has to work with a "new" heterosexual or LGB identity. While sexual orientation might not be a concern of the trans client, sexuality itself is often an inherent topic to one's gender identity. The feelings of attractiveness and sexual desires can - amongst many other factors - inform the gender identity of the client, and also a client can be on the search for sexual experiences that might affirm their sense of self. For example, there can be a self-identified trans woman who feels that they can only experience their gender to the fullest with a person who is relatively high in masculine presentation. Thus while sexual orientation is a separate issue from gender identity, sexuality should be adressed by the psychologist in the therapeutic process, and the therapist should demonstrate their openness to and comfort with the topic.

For trans clients, their body is a means of self expression and self representation. Gender expression and gender characteristics are twofold concepts: they are both the expression of someone's inner world, and also an interaction point between others and the self, or a "surface" based on which others form their impressions about the person. Being able to express oneself and being perceived in line with one's identity are both important. Thus there can be elements of the client's gender expression that are mainly for ensuring that others perceive them correctly, and

there can be elements that are more about their inner desires. It is difficult to find the right balance between the emphasis on others' perceptions and one's own bodily experiences, and there can be cases when perfectionism or the compulsion to conform can become a topic of discussion with the trans client.

Trans persons can experience a "pressure" that if they undergo more severe treatments to transition, the result has to be worth it, it has to conform to society's gender norms. The preponderance of these feelings can make the process heavier on the individual.

In every possible situation that a trans client might come into therapy with, it is essential that the psychologist validates and accepts the experiences of the individual, and affirms them in their ways of self expression and identity.

Important note: regarding treatment and diagnosis every country has different legal and healthcare protocols, so provide valid information for the participants. For example in Hungary neither clinical psychologists nor psychotherapists can give official diagnoses, only psychiatrists, even though evaluation is done by the psychologist.

Gender dysphoria

Being transgender is not an illness; however, it is important to recognise that experiencing gender-identity confusion often causes psychological distress. In most countries, gender dysphoria is the official DSM-V diagnosis that is needed for the individual to seek medical support for their transition. However, clinicians should be aware that in some cases, such severe distress can be experienced that it should be considered as a disorder and would need further help. (See more on gender dysphoria in Module 2.)

Safety during coming out

- Choose someone who the client feels to be supportive to be the first person to come out to.
- The client should plan what they want to say, choose the safest time and place.
- The client should be prepared for an initial negative reaction from some people. Some individuals need more time to adjust to what they have heard.
- The client should not give up if the initial reaction is not what they wanted. The client has the right to be who they are, open about all important aspects of their identity - someone's rejection does not prove the client's lack of worth.
- If a client has come out to others whom they trust, it is good to talk afterwards about how things went. A client should find trusted allies to help them cope with their experiences.
- A client should get support and use the resources available: the local LGBTQI+ community, events etc.

Activity C.1.- "Elephants in Your Field"

Time: 60-90 mins	**Sensitivity:** Moderate level

Purpose:

- To help participants see through what existing social systems are present in the therapeutic process, and how their practice can strengthen these systems both interpersonal and intrapersonal (in the client)
- To help participants to look at assumptions and ideas that are deeply embedded in their field

Requirements:

- Group size:
  - Small groups of 5 (depending on the number of participants)
- Materials:
  - Big sheets of papers/flipchart papers
  - Markers in two colours (black and red, or green or red)

Description

This activity is connected to the first part of the Knowledge base: Systemic and critical lens. The goal of this activity is to help participants to uncover deeply embedded ideas and assumptions that are relevant in their practices. The focus of therapy is usually the individual, and oftentimes social systems and processes are neither addressed nor mitigated during therapy. If these systems are left unaddressed, the therapeutic relationship can end up enhancing bias and oppressions.

During this activity participants will use the mind-map technique, so it is important for you to get familiar with this method.

For this activity form small groups of 5, and the groups will work on mind-maps for different concepts that are crucial for our understanding of humans and well-being. Here is a list of a few concept that you can give to each group to work on:

Core concepts:

- Development
- Adulthood
- Childhood
- Attachment (or love)
- Sexuality

You can also ask participants what are some core concepts that are important in their understanding of mental health and well-being. For brainstorming on this topic, ask for example: What does healthy functioning look like in human beings? Then pick the factors that are important for most participants, and these can be the core concepts that the small groups will work on.

After you have agreed on which core concepts to think through, form the small groups and give a big sheet of paper/flip chart paper and a black marker to each group, then assign a core concept to each group. Ask the groups to write the core concept they have been given in the middle of the paper. Tell them that during this small group activity they will think about this concept and what kind of behaviours, emotions, and internal mechanisms are important regarding that concept. They will have several things come up that are considered to be healthy and sane, and several things that are considered to be unhealthy, "mentally ill" or "mad". They will use the mind-map technique to document their ideas as a group, and for the first 10 minutes their task will be to come up with the most important factors that are inherently connected to the core concept. You can present or hand out the following questions to help their thinking:

- What are the most important behaviours, emotions and internal mechanisms connected to _____ [the core concept]?
- How do you know that a person has/had a healthy _____ [the core concept]?
- How do you know that a person has/had an unhealthy _____ [the core concept]?

They need to write down every idea that comes up around the core concept in the middle of the paper. After 10 minutes give a red marker to each group, and tell them to circle every idea that is about unhealthy functioning with the red marker, and every idea that is about healthy functioning with the black marker.

If you have time, you can do another 10 minutes round of brainstorming, but this time participants will need to write down things that are connected to the previously outlined ideas, not to the core concept itself. They need to write down these new ideas around the previous idea which they are connected to - like in the mind-map technique. Ask them again to circle everything that is unhealthy with a red marker, and everything that is healthy with a black marker.

After the small group work you can invite participants back to the big circle, and ask them to talk about the ideas they have written down. After the short presentations open up the discussion and facilitate the thinking process with the following questions:

- Have you ever thought about these concepts in such detail?
- Was it difficult to differentiate between healthy and unhealthy, mentally well or ill? What was easy? What was difficult?
- Would these standards of mental health be the same in another culture?
- Do the same standards apply for everyone? Do these standards serve everyone, or mainly privileged groups?
- If society changed radically, would the standards of mental health change?
- Are healthy things really a sign of individual skills and features, or the consequence of lived privilege? Are unhealthy things really a sign of individual skills and features, or the consequence of a society that accommodates mainly to the needs of privileged groups?
- What stigmas the unhealthy vs. healthy, mad vs. sane binaries reinforce in people's lives?

- Which social systems and systems of oppression do psychological theories uphold or leave untouched?

Notes for trainers

Discussing and rethinking these core concepts and assumptions is just the first step. It is important to help professionals to establish a reflective practice they can use, and to come up with applicable ideas to change their practice.

For this end you can open up the following questions, or do a discussion world-cafe style about them:

- How do you address social and cultural systems in your practice? How can a systemic and critical lens to therapy serve the client?
- How do you ensure that you reflect on these core concepts and your assumptions? Do you have a reflective practice you use?

Activity C.2.- "Guidelines"

Time: 50 mins	**Sensitivity:** Low level

Purpose:

- To discuss and process the APA guidelines on psychological work with LGBTQ clients
- To get a picture about the necessary knowledge, attitudes and skills that participants need or already have

Requirements:

- Group size:
  - Small groups of 5 (depending on the number of participants)
- Materials:
  - Printed handouts of the APA guidelines for each participant (short or full version)

Description

The goal is to discussing the two APA guidelines that are relevant in psychological work with LGBTQI+ clients: Guidelines for psychological practice with lesbian, gay and bisexual clients; Guidelines for psychological practice with transgender and gender nonconforming people.

Divide the participants into small groups of a maximum of 5 persons. Try to group the participants randomly or ask them to choose partners they haven't worked with yet. Give them the handouts of the APA guidelines. Give 30 minutes for the groups to discuss the guidelines based on the following questions:

- How can you implement the guidelines in your current practice?
- What are the most important/useful parts of the guideline?
- Which of these are you already following?
- Which of these should you put more effort into to follow?

- Why is it important to have different guidelines for LGB and T? What are the differences/similarities in the guidelines?

After the 30 minutes are over, ask for a representative from each group to summarise their ideas to the rest of the group.

Notes for trainers

For this activity, participants need to be somewhat familiar with the guidelines already. You can give a presentation on the main points of the guidelines, or you can give them the printed handouts and provide some time to read through the guidelines before the discussion.

Activity C.3. - "Trust journey"

Time: 30 mins	**Sensitivity:** Low level

Purpose:

- To help participants to understand the processes of trust
- To get participants to think about how their onboarding practises are inclusive or not inclusive
- To help participants to prepare for answering difficult questions and demonstrating their affirmative stances

Requirements:

- Group size:
  - Max. 20 participants

Description

The goal of this activity is to spark participants' reflection on the rapport creation process and the first points of contact with the client. During the first phone call or first few sessions, LGBTQI+ persons need to gather more information about the viewpoint and openness of the therapist than other clients. For example, they might search for various signals that tell them about the psychologist's stance on gender and sexuality, or they might search for different signals of trust. Thus the first conversations are crucial, and mental health professionals should be prepared to provide information about their practices in a way that helps to form trust and rapport with LGBTQI+ persons.

For this activity assign participants in pairs, and give 10 minutes for the pairs to discuss the following:

- What signals might LGBTQI+ clients be sensitive to? What signals might they look out for?
- What questions would an LGBTQI+ person ask in order to map the therapist's attitudes?

To help the thinking process of the participants, you can suggest them to imagine that they are the client self-identifying as LGBTQI+, and advise them to think aloud in first person: "On the first session I would ask my new therapist the question..."

After the 10 minutes discussion, bring back the participants to the circle and ask them to share what came up for them. You can point out commonalities and open up the discussion for about a few signals and questions. For this you might ask the participants about what questions are hard to answer, or what signals are they most uncertain about? A good question to ask them would be: how would you react if the client asked an inappropriate question or a question that steps over your professional boundaries in a way that still reflects your affirmation and acceptance for them?

Further discussion questions for Activity 1.5. - "Circles of Human Sexuality"

Further discussion questions for clinicians for the activity "Circles of Human Sexuality"

- Do I conduct a thorough sexual history of my clients when this is relevant to the clinical conversation?
- How comfortable am I asking clients about their sexual history, orientation, or behaviours?
- Considering my own life, how did I come to define my own sexual identity or orientation? Is this an area that needs additional exploration?
- How do I conceptualise gender? What messages do I send to clients that reify the gender binary?
- What is my concept of "healthy" sexuality, and how might this bias my work with clients (e.g., bisexual, asexual, non-monogamous, kink)?
- Have I encountered clients with fluid or shifting sexualities, and, if so, what feelings did it bring up for me?
- What judgments or biases might I have about sexualities that are considered "alternative" to the dominant culture, including LGBQ identities or practises in consensual non-monogamy, polyamory, or kink/BDSM?

Activity C.4. - "Imagine alternative paths"

Time: 40 mins	Sensitivity: Moderate level

Purpose:

- To help participants to understand their knowledge and assumptions about development
- To help participants to deepen their knowledge about identity development and the coming out process

Requirements:

- Group Size:
  - Max. 16 participants
- Materials:
  - Flipchart papers/Big sheets of papers
  - Markers, writing utensils
  - Post-it notes

Description

The first ten minutes of this activity is for individual reflection time: ask participants to think about their lives, their journey and development, and come up with ideas about what would have been different through their childhood, adolescence and development, if they were a person identifying as LGBTQI+. Participants who are self-identifying as LGBTQI+ can also choose an LGBTQI+ identity that is alternative to theirs, so they do not have to disclose their personal path.

After ten minutes, form groups of 3 participants and ask them to discuss their ideas for 15 minutes. For this, give every group a flipchart paper and ask them to draw a horizontal line at the bottom of the paper that would symbolise the progress of time (similar to a Life Graph, a tool often used in therapy and counselling). They need to write every new idea on a post-it note and stick it on the flipchart paper along the timeline where it belongs.

After the small group discussion, bring back the participants to the circle and ask every group to present their ideas and the journey that unfolds on their flipchart paper. Point out commonalities and divergences between the groups, and open up the discussion about development processes.

Questions to think through for professionals:

- When thinking about your life path and development, what kind of models or theories informed your thinking? Was it easy or difficult to think alongside these? Were they inclusive enough to grasp the experiences of LGBTQI+ persons?
- What assumptions do these models hold about "normal" gender identity development or the development of other identities? What assumptions do you have due to being trained in these models/theories?
- What are your beliefs about the time in which a person comes to understand their gender identity and sexual orientation?
- In what ways do you explore a client's identity development during the onboarding process and ongoing care?
- What types of information do you need from my client that will help you to understand the challenges they have faced with regard to interruptions in their identity development?

Notes for trainers

This activity can be used before delivering the theoretical knowledge about the coming out process. After delivering the theoretical knowledge, you can go back to the flipcharts with the life graphs and try to map the different stages of LGBTQI+ identity development onto them.

Module D - Social Workers and Services

Topics in this module: Aspects of ethics in social work with LGBTQI+ users; Education, skills and qualities of social workers working with LGBTQI+ clients; The principles of the LGBTIQ+-friendly social service; Barriers for LGBTQI+ persons

Introduction

The following chapter studies the specificities of social work with LGBTQI+ persons. We assume that social workers will have the necessary qualifications and personal characteristics that are commonly required for performing social work.

Aims

This module explores principles of LGBTQI+ friendly social work and services. The first part of module D should give you a general view of what it means when a social worker or social service is LGBTQI+ friendly, how to recognize such service, or what you can do to improve your social work or a service to be more LGBTQI+ friendly. After the theoretical base, there are some activities to choose from for interactivity and experience-based learning. Pick the ones you think are best for satisfying the learning goals for your participants or according to the professional focus of the participants.

After this module, the participants will:

- Know about ethical principles in social work with LGBTQI+ persons
- Know recommended education, skills and attitudes of social workers when working with LGBTQI+ clients
- Be able to identify LGBTQI+ friendly social services
- Be able to create a safe environment for LGBTQI+ clients

Knowledge base for trainers

The aspect of ethics in social work

The requirement that social workers should support social justice for, amongst other groups, also LGBTQI+ people is part of the code of ethics jointly created by the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW) in 2004. The latest version of the Global Social Work Statement of Ethical Principles developed by the IASSW was adopted in Dublin on 5 July 2018. Among other things, the above-mentioned ethical principles oblige social workers to promote justice not only with respect to the people they work with, but also within society in general:

"*Social workers challenge discrimination, which includes but is not limited to age, capacity, civil status, class, culture, ethnicity, gender, gender identity, language, nationality (or lack thereof), opinions, other physical characteristics, physical or mental abilities, political beliefs, poverty, race, relationship status, religion, sex, sexual orientation, socioeconomic status, spiritual beliefs, or family structure.*"

You can read more at the IFSW website.

Translated to practice, this means in particular that social workers should act according to their best knowledge and beliefs, and treat all users of social services regardless of any characteristics attributable to them. They should also actively challenge any incidence of discriminatory practice that they witness around them. They should try their best at not succumbing to common myths about sexual orientation and gender identity, but they should also know their personal boundaries, be conscious of their attitudes, opinions and relationship to LGBTQI+ clients. For example if they know they are currently not able to give the best service to certain types of clients, they should inform their superiors or supervisors about it, and find a solution: this can be further education, training or referring the client to another social worker who is more suited to their needs.

It goes without saying that social workers are supposed to maintain confidentiality about the sexual orientation and gender identity of social services users and not to disclose such information to third parties.

Perhaps the best approach to vulnerable groups, including LGBTQI+ persons, which has proved to be successful in practice is based on the human rights perspective. Among other things, this human rights-based approach puts emphasis on active participation of clients in establishing their contracts. It is also taken into account how clients are treated. Then, it names values that form the sum and substance of social work and education.

The human rights based approach has been a source of inspiration for both education in social work (respect to people and their rights, knowledge of applicable legal regulations, approaches to various ethical dilemmas) and, for example, the Social Work Code of Ethics.

As regards the human rights of LGBTQI+ persons, countries throughout the world have adopted differing approaches. There are countries where same-sex couples are allowed to enter marriage, trans people are not forced to undergo mandatory sterilization and any discrimination of LGBTQI+ people is sanctioned. On the other hand, there are countries that have made sex between men punishable by death. The Yogyakarta Principles from 2006, created in response to abuse and discrimination of LGBTQI+ people, are considered to be the global charter on human rights in the areas of sexual orientation and gender identity.

Education, skills and qualities of social workers working with LGBTQI+ clients

The education of social workers should include LGBTQI+ specific issues because it is more than likely they will come across them in their practice. The educational programmes focused on LGBTQI+ topics should include at least the following:

- Basic terminology;
- Basic statistics and demographic data;
- LGBTQI+ history and traditions, customs;
- The topic of discrimination of LGBTQI+ persons and communities;
- The topic of legislation and social policies focused on LGBTQI+ persons;
- A map of LGBTQI+ organisations operating at local, national, and even international level.

The skills that a social worker should have are as follows:

- They are able to create respectful environments forLGBTQI+ clients;
- Does not assume a client's sexual orientation or gender identity but is able to ask about it;
- Understands a client's contract holistically, that is in the context of their life, personal history, family, community, etc.;
- are able to recognize the signs of internalised LGBTQI+-phobias and uses supervision sessions where they could resolve anything that may arise when working with LGBTQI+ persons;
- In planning a social service, they also take into account a client's family of choice or whom a client has already come out to and whom they have not come out to yet;
- As part of social counselling, they are able to refer clients to LGBTIQ+ organisations or LGBTQI+-friendly organisations;
- They regularly educate themselves on LGBTQI+ topics.

The most important qualities of the social worker working with LGBTQI+ clients are as follows:

- Empathy - the ability to identify with and understand another person's situation and the emotions that they are going through, in order to provide comfort and support;
- Social perceptiveness - good listening skills, being able to read between the lines to help clients talk about the issues that are not so easy to discuss, interpreting body language, etc.;
- Patience - especially with complex cases that involve various people and differing goals, it also takes time to build up trust between social worker and their clients;
- Dependability - a key indicator of trust;
- Objectiveness - personal feelings can't get in the way of what's best for the client;
- Flexibility - respond to emergencies and be there as much as they can for their clients, but know and guard their boundaries as well;
- Resilience - clients may be dealing with insufficient care, abuse, bereavement, and poverty among other issues, and though it can be heartbreaking, it is important to realise that helping them is the only way the situation will get better.

The principles of the LGBTIQ+-friendly social service

If a social service identifies itself, or is interested in identifying itself, as LGBTIQ+-friendly, it should comply with the following principles:

The area of communication:

- A social service provider listens to how a client describes their identity, gender, partners and relationships, and responds to the the client's choice of language;
- They avoid assumptions about the sexual orientation or gender identity of the client – uses gender neutral terms; if they are unsure, asks about the preferred gender; the gender sensitive language is used also with regard to employees;
- A social service provider avoids using words and phrases that are perceived as negative or hurftul ("homosexual" or "transsexual", but these are very dependend on differenc cultures, nations and languages)

Care for clients:

- The offer of leisure activities should be accessible to all clients regardless of their gender identity (e.g. baking should be accessible to men if they are interested in it, etc.);
- Clients can choose a person who will care for them with respect to the care of intimate body areas, and when a method of care is being selected, their requests are taken into account;
- As part of a social service, LGBTQI+ clients are encouraged to establish support groups;
- The LGBTQI+ topic is included in user satisfaction surveys;
- A social service monitors the sexual orientation of its users who are willing to provide such information and does so in compliance with the legislation on the protection of data and privacy. Such a procedure will enable a social service to identify the unused reserves it may have in providing services. However, a social service always clearly states what the information is used for. Without such data, the potential exclusion of LGBTQI+ persons in social services will continue to be ignored.

Personnel matter:

- A social service regularly trains all (paid and unpaid) employees on LGBTQI+ issues;
- More than two gender categories are provided in recruitment and staff questionnaires;
- The respectful approach to, among others, LGBTQI+ individuals and culturally sensitive care for them are also reflected in the advertisements placed to recruit new staff and in

recruitment interviews with potential employees; they also make part of employees' job contracts;
- Any information disclosed about the sexual orientation and gender identity of recruits and employees is confidential and accessible only to HR departments;
- A social service seeks to integrate LGBTQI+ topics into job duties instead of avoiding them or considering them to be complementary to other duties.

Social service rules:

- The social service has a declaration of its accessibility to all, including LGBTQI+ people, prominently displayed. Its wording may be for example as follows: "Our organisation provides care to all people regardless of their age, disability, gender, gender identity, faith or sexual orientation." At the same time, they also make sure that their employees really know what this means;
- Respectful approach to LGBTQI+ persons is an integral part of the social service's code of ethics, standards of quality and, in the case of residential social services, house rules. Provisions are also made to ensure that any homo/transphobic incidents will be addressed, whether they concern clients or employees.
- The social service encourages its employees to challenge negative comments and jokes about LGBTQI+ persons, while urging them to report any homo/transphobic incident, whether it occurs at the workplace and outside of it. The social service has information about where and how such incidents can be reported (to a manager, the police, a third party, etc.) prominently displayed.

Cooperation with other organisations:

- The social service regularly exchanges experience regarding the care for LGBTQI+ persons with other facilities;
- It establishes cooperation with local LGBTQI+ organisations, assists them in offering and implementing leisure and educational activities for clients and employees.

Other:

- Clients and employees have access to information materials about LGBTQI+ topics;

- The social service sensitively responses to the needs of trans people as regards the sex-segregated facilities located within its premises (toilets, changing rooms, etc.). Gender-neutral toilets are a standard. In case this raises concerns in some people, the concerns must be taken into account and discussed with the individuals, and addressed where relevant.

For more information and inspiration on LGBTQI+ friendly social services you can check out these booklets:
"Providing Inclusive Services and Care for LGBT People: A Guide for Health Care Staff" by National LGBT Health Education Center

"How to be LGBT friendly: 30 Practical Ways to Create a Welcoming Environment for Lesbian, Gay, Bisexual and Transgender People" by the University of Warwick

Barriers that hinder LGBTQI+ persons from accessing social services

LGBTQI+ clients may feel there are some barriers on the part of social services that may discourage them from using such a service. The most common claims or facts that may pose such barriers for LGBTQI+ persons (Fish, 2012) may be:

"*We do not want to offend the other users of social services.*"

A frequent remark in discussions about the need to provide services to LGBTQI+ persons is that the other service users will feel uncomfortable. Out of concern about the reactions of other clients, for example, some retirement homes are unwilling to offer a shared couple's room to elderly same-sex partners.

"*We are open to everybody, treating everyone the same. Differences are beside the point here.*"

When providing social services, various needs and experiences of their users have to be taken into account. Treating everyone the same, regardless of diversity, suggests that a social service disregards individual differences, needs and experiences.

"*There is no discrimination based on sexual orientation or gender identity here.*"

Some social service providers claim that LGBTQI+ persons are not subject to any discrimination because the legislation offers protection against it. However, that is not exactly true. Open or covert forms of homophobia and transphobia persist in society. For example, situations may still arise where an employer finds out that their employee is a gay (lesbian, trans) and so starts seeking ways to get rid of the employee. The only problem is that the employer cannot admit frankly that the reason for dismissing an employee is their sexual orientation or gender identity.

Lack of experience with LGBTQI+ persons

In some cases social service providers are also hindered from accessing LGBTQI+ people because they are unfamiliar with, and have little experience with, the specific needs of this community in the social area. In addition to this low level of awareness, there are many myths and falsehoods circulating among the general public about people with a non-conforming sexual orientation or gender identity. To increase the accessibility of social services for LGBTQI+ clients, it is necessary to raise awareness of these issues among social service providers.

Activities for Module D

Activity D.1. - "Reflecting on one's own values"

Time: 60 mins	**Sensitivity:** Low level

Purpose:

- To identify values and attitudes towards LGBTQI+ persons and how they can affect the relationship and work with LGBTQI+ clients.

Requirements:

- Group size:
  - Max. 30 participants
- Materials:
  - Pens
  - Papers
  - LGBTQI+ glossary (optional)

Description

The activity uses brainstorming techniques to help participants understand their own values and attitudes towards LGBTQI+ persons, and also leads to reflection on creating LGBTQI+ friendly social services.

Participants in several smaller groups discuss the following issues with each other and take notes, which could be later used to reflect on the activity in a large group:

- What were the values you were brought up with relating to LGBTQI+ persons?
- What were the attitudes of your friends and schoolmates?
- How do you think your values might affect the way you work with LGBTQI+ service users?

- Do you know LGBTQI+ persons in your personal life?
- Do you think it is important for social service providers to know the sexual orientation or gender identity of their clients?
- What conditions should LGBTQI+-friendly social services meet?

After some time (cca 30 minutes), the activity should continue by brainstorming in a large group and in the end participants could together determine what an LGBTQI+-friendly social service should look like.

The following could be guiding questions for a debriefing discussion:

- What did you learn during this activity?
- How did you feel during the activity?
- How do you feel now at the end of the activity?

You can also think about inviting a guest speaker from the LGBTQI+ community with some experience with social services where their sexual orientation or gender identity played a role.

Notes for the trainers

Before the activity there could be debate within the whole group if participants already have some experience with LGBTQI+ clients. You can prepare and distribute to participants a glossary with basic terms related to the issue of sexual orientation or gender identity.

Activity D.2. - "Resources"

Time: 60 mins	**Sensitivity:** Low level

Purpose:

- To identify and locate LGBTQI+-friendly social services and other resources (crisis intervention services, counselling centres, websites, etc.) which the participants know or should know about.

Requirements:

- Group size:
  - Max 50 participants
- Materials:
  - Pens
  - Papers
  - Flip chart
  - Marker

Description

In five smaller groups, participants write down on paper as many resources (social services, crisis intervention services, counselling centres, websites, etc.) as they can come up with. Each group will address one of the following areas:

- Health (mental health, emotional well-being, sexual health);
- Family and relationships;
- Children and young people;
- Substance abuse;
- Lack of money or lack of housing.

In the meantime, the trainer writes down on the flip chart the names of the five areas. After the discussion in smaller groups, the trainer will write each resource under the name of the relevant area according to how the representatives of the groups will describe it.

Then a brainstorming should follow focusing on the following issues:

- Would you add another resource to any area?
- Should any resource be mentioned outside of the areas mentioned?

The following could be guiding questions for a debriefing discussion:

- What did you learn during this activity?
- How did you feel during the activity?
- How do you feel now at the end of the activity?

Notes for trainers

It is recommended you find out the most important services from each area and create a map or other type of aid for the participants.

Activity D.3. - "Key questions"

Time: 60 mins	**Sensitivity:** Low level

Purpose:

- To think about possible answers for the key questions according to the most common groups of LGBTQI+ clients in social work.
- Activity should give participants some leads to a better knowledge of how to approach LGBTQI+ clients within specific groups of users of social services.

Requirements:

- Group size:
  - Max 50 participants
- Materials:
  - Pens
  - Papers
  - Flip chart
  - Marker

Description

Firstly, ask the whole group of participants if they have any experience with LGBTQI+ clients and if they could share it with others. If any questions arise from this discussion, you can add them to the prepared list of key questions.

Then the participants should be divided into smaller groups and think about answers to the key questions according to the chosen target group of clients.

LGBTQI+ substance users:

- How do LGBTQI+ persons access information and services relating to alcohol and drug misuse in your country/local community?

- What are the risk factors for LGBTQI+ persons that may increase susceptibility to alcohol and drug misuse?
- What are the effective interventions and treatment programmes in alcohol or drug misuse with LGBTQI+ persons?
- What knowledge, skills and values underpin social work practice with LGBTQI+ substance users?
- What resources, organisations and people can support your work with LGBTQI+ substance misusers in your country/local community?

LGBTQI+ children and young people:

- Is there a space in your country/local community which helps LGBTQI+ children and young people deal with stigma and discrimination?
- How do you think LGBTQI+ children and young people in your country/local community feel about their self-presentation to the world? Do they feel a pressure to 'look gay' or to pass as heterosexual or neither of these? Are they supported in exploring their feelings about themselves?
- Do you think LGBTQI+ children and young people in your country/local community have enough opportunities to develop a positive identity through meeting others?
- Do you think LGBTQI+ children and young people have positive images of LGBTQI+ young people around them?
- What knowledge, skills and values underpin social work practice with LGBTQI+ children and young people?
- What resources, organisations and people can support your work with LGBTQI+ children and young people in your country/local community?

Older LGBTQI+ people:

- How do you ensure that older LGBTQI+ people are treated with dignity and respect?
- Do you show that you value the positive contribution made by older LGBTQI+ people in service provision and in society more generally?
- Have you considered how confidentiality impacts on the lives of LGBTQI+ service users?
- How does your service welcome older LGBTQI+ people?

- In your opinion, what are some aspects of care that contribute towards the best possible care in the final days of life?
- What knowledge, skills and values underpin social work practice with LGBTQI+ older people?
- How do you engage with LGBTQI+ communities locally and are they aware of your services?

Same-sex couples:

- Is it possible for same-sex couples to enter into some form of legally recognized partnership in your country?
- How do you perceive current legislation with regard to LGBTQI+ persons and their families in your country/? If it was up to you, would you make any changes?
- What do you think is the prevailing view of your country/local community regarding the care of children by same-sex couples? In your opinion, could there be any risks or any benefits compared to the care of children in heterosexual couples?
- What knowledge, skills and values underpin social work practice with gay or lesbians couples or families?
- What resources, organisations and people can support your work with gay or lesbians couples or families in your country/local community?

Trans clients:

- What legal protections are afforded to trans people as users of public services in your country?
- Identify potential discrimination on the grounds of gender identity in social work and other public services.
- How do you ensure that trans people are treated with dignity and respect?
- How do your social services monitor gender identity?
- How do you engage with trans communities/users locally and are they aware of your services?

After discussion in small groups, the key questions should be debated with the whole group of participants and there should be agreement on some conclusion. The conclusion should be written on the flip chart in some form, for example a mind map.

The following could be guiding questions for a debriefing discussion:

- What did you learn during this activity?
- How did you feel during the activity?
- How do you feel now at the end of the activity?

Notes for trainers

It is good to target the activity according to the professional orientation of the participants. If social workers are not professionally focused on one target group, then select two or three groups of clients of your choice.

The presented questions are just for your inspiration, you could use them or leave them and think about more suitable options, or you can add more questions to the ones we present here.

Activity D.4. - "Social situations"

Time: 60 mins	**Sensitivity:** Medium level

Purpose:

- To think about some of the situations LGBTQI+ persons may face.
- Activity should give participants some leads on how to react in different situations with their clients.
- Participants have the opportunity to try different ways of dealing with different situations with their LGBTQI+ clients through role playing.

Requirements:

- Group size:
  - 15 participants
- Materials:
  - Pens
  - Papers

Description

The situation shall be described to the participants. Then they have the opportunity to ask for details. After some time, the educator should invite the participants to take on the role of social worker or a client.

Possible situations:

- A bisexual man addicted to alcohol and a social worker who does not take his sexual orientation seriously.
- A lesbian couple asks for child custody (you can consider different types of partnerships of the two women here).

- A trans senior in a retirement home wants to change their room because a roommate has made inappropriate comments on their gender identity.
- A boy in an orphanage confides to a social worker that he is gay, the social worker says it is just a phase from which he will grow up.

The trainer and one of the participants sit on the chairs in front of the others. The trainer leads the situation so that it won't end well at first.

Then the participants are asked to play one of the roles if they are interested or have some idea what they could do to try to change the situation to make it better.

There should be a reflection of how the participants who played the roles felt in them.

Everyone should have an opportunity to tell how satisfied they are with the solution of the situation and how they felt during the activity.

Reflection on emotions can be done, for example, through the technique of "one word", i.e. each participant describes in one word how they feel now.

Notes for trainers

The presented questions are just for your inspiration, you could think about other situations, for example those that you encounter more often in your social practice.

Choose just one of the situations you want to focus on during the activity. Think carefully about the situation and the different ways of behaviour as a social worker and as the client in the chosen situation. Write down some basic scenarios. Be well prepared to play the role of both, a social worker and a client as well.

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Section 2 - LGBTQI+ 101

Module 1 - Terminology

Module 2 - Transgender, gender-diverse and sex-diverse persons

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Further resources

European Professional Association for Transgender Health - http://epath.eu/

Examples of laws, proposals and court decisions regarding legal gender recognition - https://tgeu.org/gender_recognition_laws/

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Video: Gerrard Connelly – interview about what it's really like to be in a conversion therapy center
Video: https://www.youtube.com/watch?v=pDME5MhRKyM – "Conversion therapist" comes out as gay

Section 3 - Field-specific guides for training mental health professionals

Module A – Hot-line/Chat Operators

Module B – School Counsellors

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Module C - Clinical psychologists

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Further Resources

https://www.ifsw.org/global-social-work-statement-of-ethical-principles/.

Glossary

Ally

A (typically straight and/or cisgender) person who supports and respects members of the LGBTI community. We consider people to be active allies when they act in support and show public respect.

Androgynous

Referring to a person whose sex cannot easily be determined by gender expression and/or physical characteristics.

Aromantic

A person who experiences little or no romantic attraction to others. Not to be confused with asexual.

Asexual

A person who has limited or no sexual feelings or desires.

Biological sex

Often referred to as simply "sex," "physical sex," "anatomical sex," or specifically as "sex assigned at birth." In other words, this is the anatomy of an individual's reproductive system, and secondary sex characteristics.

Biphobia

Prejudice or discrimination against bisexual people.

Bisexual

A person who is not sexually attracted exclusively to people of one particular gender; attracted to both men and women.

Cis(gender) person

Describes a person whose gender identity aligns with the sex they were assigned at birth – e.g. a person who was assigned male at birth, was raised as a man and considers himself a man.

Cissexism

The belief or assumption that cis people's gender identities, expressions, and embodiments are more natural and legitimate than those of trans people.

Closeted

An individual who is not open to themselves or others about their sexuality or gender identity. This may be by choice and/or for other reasons such as fear for one's safety, peer or family rejection or disapproval and/or loss of housing, job, etc. Also known as being "in the closet." When someone chooses to break this silence they "come out" of the closet. (See coming out)

Coming out

1. The process by which one accepts and/or comes to identify one's own sexuality or gender identity (to "come out" to oneself).
2. The process by which one shares one's sexuality or gender identity with others (to "come out" to friends, etc.). This is a continual, life-long process. Everyday, all the time, one has to evaluate and reevaluate who they are comfortable coming out to, if it is safe, and what the consequences might be. Not to be confused with *outing*.

Conversion therapy

Attempts to change people's sexual orientation or gender identity in order to make them *heterosexual* or *cisgender*. Disavowed and considered an abusive practice by every global medical authority, but still often practiced by faith groups and dubious therapists. Also known as reparative therapy.

Cross-dressing

Wearing clothes, accessories, or make-up typically associated with another gender, for many different reasons.

Demisexual

A person who isn't sexually attracted to anyone unless they have formed a deep emotional or romantic connection with them.

Drag culture

In drag culture people are using drag clothing and makeup to imitate and often exaggerate female

gender signifiers and gender roles for entertainment purposes. Historically, most drag queens have been men dressing as women.

Drag Queen

A person, usually male, who dresses in clothing more conventionally worn by women and acts with exaggerated femininity and in feminine gender roles for entertainment or fashion.

Drag King

A person who dresses in clothing more conventionally worn by men acts with exaggerated masculinity and in masculine gender roles for entertainment or fashion. Less common than *Drag Queens.*

Femininity

A set of attributes, behaviors, and roles generally associated with girls and women, which is socially constructed, and is not the same as female sex assigned at birth.

Fluid(ity)

Generally with another term attached, like gender-fluid or fluid-sexuality, fluid(ity) describes an identity that may change or shift over time between or within the mix of the options available (e.g., man and woman, bi and straight).

Gay

An individual who is emotionally, physically, and/or sexually attracted primarily to members of the same sex and/or gender. More commonly used when referring to men who are attracted to other men, but can be applied to women as well. 2. An umbrella term used to refer to the queer community as a whole, or as an individual identity label for anyone who does not identify as heterosexual.

Gender

Gender is the state of being male or female in relation to the social and cultural roles that are considered appropriate for men and women. You can use gender to refer to one of a range of identities that includes female, male, a combination of both, and neither.

Gender dysphoria

The discomfort felt when a person's *assigned sex* does not match with their *gender identity*.

According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), the term "...is intended to better characterise the experiences of affected children, adolescents, and adults." A diagnosis of gender dysphoria is often required before a trans person can access any form of medical transition.

Gender expression

The external display of one's gender, through a combination of dress, demeanor, social behavior, and other factors, generally made sense on scales of masculinity and femininity. Also referred to as "gender presentation."

Gender fluid

Describes a person who does not consistently adhere to one fixed gender and who may move among genders over time or according to different social situations.

Gender identity

A person's deeply held core sense of self in relation to gender. Gender identity does not always correspond to biological sex. People become aware of their gender identity at many different stages of life, from as early as 18 months and into adulthood.

Gender non-conforming

1. A gender expression descriptor that indicates a non-traditional gender presentation (for example, masculine woman or feminine man);
2. a gender identity label that indicates a person who identifies outside of the gender binary.

Heteronormativity

The assumption, in individuals or in society at large, that everyone is heterosexual (e.g. asking a woman if she has a boyfriend) and that heterosexuality is superior to all other sexualities. Leads to invisibility and stigmatizing of other sexualities. Heteronormativity also leads us to assume that only masculine men and feminine women are straight.

Heterosexism

Behavior that grants preferential treatment to heterosexual people, reinforces the idea that heterosexuality is somehow better or more "right" than queerness, and/or makes other sexualities invisible.

Heterosexual

A person emotionally, physically, and/or sexually attracted primarily to members of the opposite sex/gender. Also known as straight.

Homophobia

An umbrella term for a range of negative attitudes (e.g., fear, anger, intolerance, resentment, erasure, or discomfort) that one may have towards LGBTQI+ persons. The term can also connote a fear, disgust, or dislike of being perceived as LGBTQI+. Homophobic is a word used to describe an individual who harbors some elements of this range of negative attitudes towards gay people. May be experienced inwardly by someone who identifies as queer (internalized homophobia).

Homosexual

A person emotionally, physically, and/or sexually attracted primarily to members of the same sex/gender. This rather medical term is considered stigmatizing (particularly as a noun) due to its history as a category of mental illness, and is discouraged for common use (use gay or lesbian instead). Until 1973 "Homosexuality" was classified as a mental disorder in the DSM Diagnostic and Statistical Manual of Mental Disorders. This is just one of the reasons that there are such heavy negative and clinical connotations with this term.

Intersex

Term for a combination of chromosomes, gonads, hormones, internal sex organs, and genitals that differs from the two expected patterns of male or female.

LGBTQIA

Lesbian, Gay, Bisexual, Trans, Queer, Intersex and Asexual. Sometimes the sign plus is used at the end of this abbreviation to show that there are a lot of other identities in the spectrum.

Lesbian

Women who are attracted romantically, sexually, and/or emotionally to other women.

Masculinity

A set of attributes, behaviors, and roles generally associated with boys and men, which is socially constructed, and is not the same as male sex assigned at birth.

Metrosexual

A man with a strong aesthetic sense who spends more time, energy, and/or money on his appearance and grooming than is considered gender normative.

Minority stress

Minority stress is a term that encompasses stressful situations and experiences in the form of prejudice and discrimination due to one's race, ethnicity, sexual orientation, and/or gender identity.

Misgendering

Refer to (someone, especially a transgender person) using a word, especially a pronoun or form of address, that does not correctly reflect their gender identity.

MSM

Men who have sex with men, who may not necessarily identify as gay or bisexual.

Non-binary

Refers to people who do not subscribe to the gender binary. They might exist between or beyond the man-woman binary. Some use the term exclusively, while others may use it interchangeably with terms like genderqueer, genderfluid, gender nonconforming, gender diverse, or gender expansive.

Outing

Involuntary or unwanted disclosure of another person's sexual orientation, gender identity, or intersex status.

Pansexual

A person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions. Often shortened to "pan."

Polyamorous

A person who has open sexual or romantic relationships with more than one person at a time.

Queer

Used as an umbrella term to describe individuals who don't identify as straight. Also used to describe people who have a non-normative gender identity.

Questioning

An individual who is unsure about or exploring their own sexual orientation or gender identity.

Sexual orientation

The type of sexual, romantic, emotional/spiritual attraction one has the capacity to feel for others, generally labeled based on the gender relationship between the person and the people they are attracted to.

Trans

An umbrella term covering a range of identities that transgress socially defined gender norms.

Trans(gender) person

An umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth. People under the transgender umbrella may describe themselves using one or more of a wide variety of terms - including transgender. It is important to underline that a transgender identity is not dependent upon physical appearance or medical procedures.

Trans(gender) Man

A man who was assigned-female-at-birth, but has a male gender identity. Trans men are sometimes referred to as FtM (female-to-male).

Trans(gender) Woman

A woman who was assigned male at birth, but has a female gender identity. Trans women are sometimes also referred to as MtF (male-to-female).

Transition

The process of being affirmed in one's gender identity. It is a complex process that can take

different lengths of time according to individual needs of a trans person. It contains several dimensions, for example: social gender affirmation (preferred name and pronouns, gender role), psychological gender affirmation (one's gender is respected and validated), medical gender affirmation (hormone therapy, surgery), legal gender affirmation (name and gender marker change) etc." The exact steps involved in transition vary from person to person. Avoid the phrase "sex change".

Transphobia

The fear or hatred of trans persons, often in the form of verbal or physical attacks (assault, insults, confrontation, misgendering, deadnaming etc.).

Transsexual

A term which refers to people who consider or use medical interventions such as hormone therapy or gender-affirming surgeries, also called sex reassignment surgery (SRS) or pursue medical interventions as part of the process of expressing their gender. A less frequently used—and sometimes misunderstood—term (considered by some to be outdated or possibly offensive, and others to be uniquely applicable to them). Some transsexual people do not identify as transgender and vice versa. Like the term queer, due to its varying meanings, use this term only when self-identifying or quoting someone who self-identifies as transsexual.

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