Chapter 4

Lesbian, Gay, Bisexual, and Transgender Cultural Competency for Public Health Practitioners

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INTRODUCTION AND BACKGROUND

Public health services rendered to LGBT people are negatively impacted by practitioners' lack of knowledge about or sensitivity to sexual or gender orientation, ignorance about specific health concerns, and real or perceived homophobia and heterosexism. Ignorance, fear, and aversion by both practitioners and LGBT clients can lead to suboptimal care or a lack of provisions of public health services (Gay and Lesbian Medical Association and LGBT Health Experts, 2001; Lee, 2000). LGBT cultural competency training can help practitioners overcome these barriers, resulting in improved public health services for LGBT people.

Beyond the individual practitioner level exists a growing body of work designed to create a public health environment that is more accessible and services that are appropriate for LGBT individuals. To achieve this, LGBT individuals should be included in public health research, interventions, and policy development. Public health practice standards and guidelines on culturally appropriate health care services for LGBT people are also needed at the national, state, and local level.

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In the absence of national or state policy standards and a coordinated effort to implement them, individual organizations have developed guidelines, training curricula, and materials to prepare public health practitioners in LGBT cultural competency. These could serve as a foundation for the development of future standards. In Massachusetts, the Gay, Lesbian, Bisexual, and Transgender Health Access Project created a set of community standards of practice and indicators for the provision of quality health care for LGBT clients (see Exhibit 4.1.) (GLBT Health Access Project, 1999).

The Society for Public Health Education (SOPHE) passed a resolution, based on the United States Department of Health and Human Services document for Healthy People 2010, that measures should be taken to eliminate health disparities based on sexual orientation.

The Society for Public Health Education (SOPHE) is an independent, international professional association organized to promote healthy behaviors, healthy communities, and healthy environments through its membership, its network of local chapters, and its numerous partnerships with other organizations. With its primary focus on public health education, SOPHE provides leadership through a code of ethics, standards for professional preparation, research, and practice; professional development; and public outreach.

Among other actions, this resolution calls for professional training to increase LGBT cultural competency of public health and health care professionals (SOPHE, 2001). Likewise, the American Public Health Association (APHA) has passed two resolutions that, respectively, supported increased inclusion of LGBT people in research efforts (APHA, 1998) and specifically acknowledged transgendered individuals in research and clinical practice (APHA, 1999). A milestone in LGBT health care guidance was achieved with the coordinated effort of the Gay and Lesbian Medical Association and LGBT health researchers to develop the *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender Health* (Gay and Lesbian Medical Association and LGBT Health Experts, 2001).

LGBT competency is one of many aspects of cultural competency. To date, much of the work and literature on cultural competency has focused on racial and ethnic minorities. The U.S. Office of Minority Health (OMH) has created guidelines and culturally and linguistically appropriate standards for cultural, racial, and ethnic competency in health care (OMH, 2003). Many individuals belong to multiple cultures; for example, they may be racial/ethnic minorities as well as LGBT. Care must be taken when developing cultural competency standards not to infuse biases, such as a heterosexual bias in racial/ethnic competency standards or a white bias in LGBT competency standards. Although some similarities exist regarding

EXHIBIT 4.1. Massachusetts GLBT Health Project Standards Example

The community standards of practice and quality indicators identified were designed to guide and assist providers in achieving specific goals of eliminating bias and prejudice while supporting a safe health care environment for LGBT people.

The standards address both agency administrative practices and service delivery components, including the following areas:

Personnel
Client's Rights
Intake and Assessment
Service Planning and Delivery
Confidentiality
Community Outreach and Health Promotion

Following is an example of a standard and indicators in the area of service planning and delivery:

Standard: All agency staff shall have a basic familiarity with gay, lesbian, bisexual, and transgender issues as they pertain to services provided by the agency.

Indicator: Development and implementation or revision of agency training and programs on diversity, harassment, and antidiscrimination to assure explicit inclusion of gay, lesbian, bisexual, and transgender issues.

Indicator: Development and implementation of training for all intake, assessment, supervisory, human resource, case management, and direct care staff on basic gay, lesbian, bisexual, and transgender issues.

how to approach cultural competence in racial/ethnic and LGBT populations, each community's characteristics and histories of stigma and discrimination require that specific competency standards be established to address their unique concerns. Advocating for one type of cultural competency does not diminish the importance or need for other types.

The goal of this chapter is to provide a framework for understanding, assessing, and developing training to enable public health practitioners to provide competent and sensitive services to LGBT people. The LGBT Cultural Competency Framework for Public Health Practitioners introduced in this chapter, organized by topic areas and including specific objectives, covers each progressive stage leading to cultural competency. The framework is designed to aid the development of LGBT cultural competency training for public health practitioners and, ultimately, lead to consistently equitable and high-quality public health services for LGBT people.

CONTEXT FOR TERMINOLOGY AND DEFINITIONS

In discussions on LGBT cultural competency, consistent and common terminology is needed, including the terms culture, cultural competency, awareness, sensitivity, competency, and mastery. *Culture* can be defined as a specific set of social, educational, religious, or professional behaviors, practices, and values that individuals learn and adhere to while participating in or out of groups with which they usually interact (DiversityRX, 1997). Cultural competency has been extensively discussed and defined in the literature (DiversityRX, 1997; Goldsmith, 2000; Messina, 1994; OMH, 2003; Sullivan, 1995). For the purposes of this chapter, *cultural competency* will be discussed as an evolution through a series of stages, from awareness of the culture, to sensitivity to cultural issues, to competent practice within the culture, and ultimately, to mastery as a trainer of cultural competence. *Cultural awareness* is understood as knowledge about a particular group and about oneself in relation to that group. Awareness is gained primarily through reading, studying, observing, or training. *Cultural sensitivity* is defined as having a deeper understanding, appropriate attitudes, and a commitment to addressing disparities in a particular group in relation to other groups (Messina, 1994). *Cultural competency* is defined as a set of knowledge, attitudes, and skills that can be demonstrated by an individual under specific conditions and evaluated on predetermined standards based on the premise of respect for individuals and differences and the implementation of a trust-promoting method of practice (DiversityRX, 1997; Sullivan, 1995) (see Figure 4.1). Usually, a tandem process of personal and professional transformation occurs during the journey toward cultural competency and mastery. Even when one has attained mastery, learning and evolving one's cultural skills should be an ongoing process.

RATIONALE

LGBT individuals deserve health care services that are appropriately and competently provided at the same level of access and quality as they are to all other members of the larger society. Practitioners need to realize that LGBT individuals are accessing services as well as working as their peers

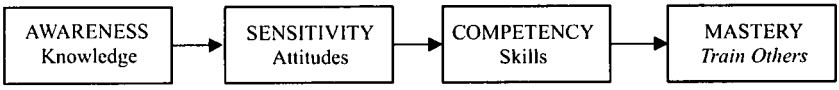

FIGURE 4.1. Stages of Cultural Competency

and colleagues. Two of the biggest barriers to culturally competent care are practitioners' lack of awareness that LGBT individuals have specific health service needs and, even if they are aware of specific needs, their inability to provide services competently. Once practitioners are sensitized to LGBT needs, they can begin developing appropriate attitudes and skills to attain LGBT cultural competence.

"When I asked if they had seen any other gay people, she said, 'We treat all our patients the same,' and my first thought was, 'Uh-oh . . . warning sign.' " — Gay man (Turner, Wilson, & Shirah, 2003)

Because of ignorance about the diversity within the LGBT community, a lesbian, gay, bisexual, or transgender person who does not fit a stereotype may not be recognized or identified as LGBT. For example, if practitioners only recognize effeminate, white, gay men as LGBT, the needs of the remaining members of the LGBT community are ignored or inadequately served. This limited view of LGBT individuals continues to perpetuate service and health disparities among LGBT people.

In some instances, LGBT people may face similar barriers to health care access as in the general population, for example, because of low income or lack of health insurance. However, certain barriers are unique to LGBT people. Transgender people have in some instances been refused service specifically because of their gender orientation or appearance. Lesbians and bisexual women on average may have reduced means to afford services because of lower earnings than their male counterparts (Perry & O'Hanlan, 1997). Inequitable quality of care for LGBT people has been documented (Bowen, 2001; Perry & O'Hanlan, 1997); specific examples include

- Overt prejudice, discrimination, disdain, or denial within health systems that leads to LGBT people feeling unsafe or uncomfortable with disclosure of sexual or gender orientation and intimate relationships and can result in avoidance of care;
- Overt homophobia, subtler heterosexism, or denial of LGBT-specific norms and needs that impairs practitioners' interactions with clients and decreases effectiveness of service delivery;
- Ignorance regarding issues of sexual and gender orientation and the health needs of LGBT people by practitioners;
- Assumption of risk factors based on sexual or gender orientation rather than individual behaviors and health history, resulting in inappropriate services;

- Inadequate protection of individual and same-gendered couples' rights in health policies and a lack of recognition of LGBT people's intimate relationships and families; and
- Inadequate research on LGBT health issues, exclusion of LGBT people or means of identifying them in general research, and general reluctance of LGBT participants to participate or disclose their identity in research.

"It's kind of Russian roulette because you don't know how a doctor is going to react when you come out to them and there have definitely been times when I haven't because already from the doctor's manner or things he or she has said, I just feel like it's not safe." — Lesbian (Shirah, 2002)

Many public health practitioners do not recognize how their assumptions and biases affect their interactions with LGBT peers and clients as well as the quality of services they deliver, even when those biases are unconscious or communicated nonverbally (Cranton & King, 2003; Duffy, 2001). For example, practitioners may avoid eye contact, maintain more distance, place a physical barrier such as a desk between themselves and their clients, or put on more physical barriers (such as two pairs of latex gloves) before making contact with clients. Practitioners can also convey assumptions or discomfort through spoken language, such as using words or asking questions that assume heterosexuality, ignoring or not responding to clients' comments about their sexual or gender orientation, or even using blunt or abrasive language with LGBT clients (Dean et al., 2000; Matthews, Peterman, Delaney, Menard, & Brandenburg, 2002; Shirah, 2002). Nonverbal and verbal communication speaks volumes to clients about the practitioners' receptivity to them and, in turn, clients may be less likely to seek or return for health care services or provide adequate information for the practitioner to provide quality services (Clark, Landers, Linde, & Sperber, 2001).

"Even when they're nice, I don't like seeing doctors. It's like going to a judge or priest: They're authorities, they always know and you don't. My sexual choices are suspect and I'm supposed to believe them." — Bisexual man (Turner, Wilson, & Shirah, 2003)

Some specific examples of how anti-LGBT bias can negatively impact health services include defining gay men's health needs only in the context of HIV and ignoring broader health needs; missing the importance of cervical cancer or sexually transmitted infection screening in sexually active les-

bian clients; or failing to understand why a female-to-male transgender person who still has breasts would need a clinical breast exam, even if he does not relate comfortably to his female body parts.

LGBT individuals often make rational assumptions about health services and practitioners due to the social stigma they have faced in their broader life experiences. Fear or hatred (homophobia or transphobia) and denial (heterosexism or strict gender roles) of LGBT people in our society creates an environment in which LGBT people may rightly be wary when accessing new health services or seeing a practitioner for the first time. Health systems and practitioners have often perpetuated discrimination and homophobia with LGBT clients. Some health practitioners continue to maintain biases against LGBT people, fail to recognize LGBT health concerns, or make heterosexist assumptions (Perry & O'Hanlan, 1997; Ryan, Brotman, & Rowe, 2000). Service and organizational polices need to address potential presumptions by LGBT people that they may need to hide their sexual or gender orientation in order to receive adequate and equitable care. Taking steps to reduce biases and create an environment that is supportive to appropriate self-disclosure can increase service quality.

"He [the doctor] said, 'You're an aberration. You should expect this kind of treatment.' There have been others, but that stands out particularly in my mind . . . he did absolutely nothing to make me want to stay on this plane of existence." — Male-to-female transgender (Turner, Wilson, & Shirah, 2003)

That the previously mentioned biases continue to be experienced and documented indicates a need to establish standards for LGBT cultural competency for all public health practitioners that can be implemented in all health services. Establishing standards for working with LGBT communities provides a structure for public health practitioners and institutions to follow. As part of their evolution from awareness to sensitivity, practitioners need to learn about the characteristics of LGBT cultures. As with every culture, unique norms of behavior and communication impact the quality of interactions. The diversity within the LGBT community creates unique variations in language that need to be explored and understood. Once an initial awareness and sensitivity toward LGBT culture and needs are addressed for individuals, the process can then move to the service-delivery level to create a more welcoming environment for LGBT people. This progression would include institutionalizing policies to address LGBT competency and making commitments to provide training in core preservice educational curricula as well as in-service training for established public health practitioners.

Practitioners may be concerned that providing culturally competent care for LGBT people might be unacceptable to their non-LGBT clients and that they could be perceived as promoting homosexuality and transgenderism. It is helpful to understand the difference between affirming LGBT communities and promoting homosexuality. To "affirm" LGBT communities is to communicate positively about their existence and value; to "promote" LGBT communities would be to advance or put LGBT people in a higher position than another group (Hedgepeth, 2000). A practitioner would be promoting homosexuality and transgenderism if the messages stated they are preferable to or better than being heterosexual or nontransgendered. Affirming the LGBT community in health services builds on the awareness that LGBT people exist and deserve fair treatment and that LGBT people represent a valuable part of the community as a whole.

Every public health practitioner has an ethical and professional responsibility to provide the best care and services possible to every person who needs them. Public health practitioners may have difficulty reconciling professional standards while remaining true to personal values. Because some of their clients will be LGBT, practitioners may need to assess their attitudes and beliefs and then explore how they impact individual practice and the health services environment as a whole. Support and training for providers through LGBT cultural competency curricula would provide them with the opportunity for this necessary reflection and evolution.

Public health institutions and individual practitioners must take the initiative to assess the state of their intentions and readiness to provide LGBT-positive health services to diverse LGBT individuals and communities. Given the persistent biases keeping individuals from providing competent care, there is a clear need to create standards and training curricula that support LGBT competency. In doing so, these standards and training curricula will help to eliminate systemic, institutional, and individual barriers to appropriate and sensitive services and create culturally competent public health environments for LGBT individuals.

AN LGBT CULTURAL COMPETENCY FRAMEWORK

Based on rationales already outlined in this chapter, public health institutions of higher learning and professional organizations must effectively prepare public health practitioners to address LGBT health disparities and thus institutionalize LGBT cultural competency training into the core curriculum and ongoing certification requirements. To date, no widely accepted LGBT cultural competency framework for training public health practitioners has been developed. However, identifying and defining the core public

health competencies needed for practitioners to effectively conduct research, deliver services in a practice, and advocate for policies concerning LGBT individuals and communities is a crucial step in developing such a framework.

The LGBT Cultural Competency Framework for Public Health Practitioners is outlined in Table 4.1. This framework identifies topic areas necessary to achieving LGBT cultural competency with related learning objec-

TABLE 4.1. LGBT Cultural Competency Framework for Public Health Practitioners

	Objectives by Stage		
Topic Area	**Awareness**	**Sensitivity**	**Competency**
Inclusion	Recognize the presence of LGBT people in every community and culture, encountered in both personal and professional lives	Demonstrate understanding of the importance of designing and delivering health services inclusive of LGBT people	Provide services that are inclusive of LGBT people
Sex and gender	Differentiate between sexual and gender orientation and identity	Demonstrate sensitivity toward the diversity of sexual and gender orientations and identities	Deliver services that are appropriate to people's self-identification of gender and sexual orientation
Terminology	Define key terminology and concepts used by LGBT individuals and communities	Demonstrate understanding of the importance of terminology to LGBT identity and community	Use LGBT terminology appropriately in practice
Roles and family structures	Identify partnership and family structures and individuals' roles within them	Respect individual roles and partnership and family structures	Provide services that respect individual roles and appropriately include LGBT people's partners and families
Diversity	Recognize the diversity within LGBT communities	Appreciate the diversity within LGBT communities	Design and provide services that meet LGBT people's diverse health needs
Stigma	Describe heterosexism, homophobia, and transphobia, their institutionalization in the public health systems, and impact on LGBT people's health	Accept responsibility for addressing stigma at the individual and organizational level	Institute policies and practice norms that create a safe and welcoming environment for LGBT practitioners and clients within public health organizations and services

TABLE 4.1 *(continued)*

	Objectives by Stage		
Topic Area	**Awareness**	**Sensitivity**	**Competency**
Sociopolitical factors	Discuss sociopolitical factors that impact the health and quality of life of LGBT individuals	Demonstrate concern about the social and political environment for LGBT individuals	Advocate for legal and civil policies and laws that promote LGBT health and quality of life
Health status	Describe current demographics and health status of LGBT populations	Demonstrate concern for LGBT people's health status and means of improving it	Design and provide public health services that improve LGBT people's health
Access to care	Identify unique factors affecting LGBT individuals' access to health care	Accept responsibility for reducing barriers to health care access for LGBT individuals	Proactively reach out to LGBT clients and implement strategies to facilitate access to services
Quality of care	Identify factors affecting quality of health services provided to LGBT individuals	Demonstrate commitment to improving health services for LGBT individuals	Design and deliver consistently high-quality public health services for LGBT people
Personal values	Recognize personal beliefs and biases related to LGBT individuals and communities	Accept responsibility for personal beliefs and biases related to LGBT individuals and communities and how they impact service delivery	Practice effective, respectful, and trust-building interaction and communication with LGBT people

tives for each topic area. Each topic area's learning objectives are listed as a progression through the cultural competency stages identified earlier in this chapter: awareness, sensitivity, and competency. (The mastery stage mentioned previously will not be addressed here, as it lies beyond the scope of this chapter.)

The framework serves as a basis for achieving general LGBT cultural competency and can be used as a guide for developing LGBT cultural competency training materials and curricula. For individual public health and related disciplines, additional topic areas or more specific learning objectives may need to be developed to address particular practice areas and guidelines (e.g., gynecological screening standards for transgender patients).

The first topic area addressed, inclusion, illustrates the first step in achieving LGBT cultural competency: acknowledgement of the presence

of LGBT people in the world and, hence, the need to provide services that are inclusive of LGBT people. The next topic areas—sex and gender, terminology, roles and family structures, and diversity—consist of internal factors of LGBT (and heterosexual) communities and individuals. The existence of external factors that affect LGBT communities shapes the next two topic areas: stigma and sociopolitical factors. Stigma refers to heterosexism, homophobia, and transphobia on an individual and organizational level. Sociopolitical factors include laws, policies, and social structures that affect, intentionally and unintentionally, the lives of LGBT people.

Health status, access to care, and quality of care describe the health of LGBT individuals as well as what and how internal and external factors affect LGBT individuals' health status, access to care, and the quality of care they receive. For public health practitioners, these topic areas illustrate the particular health needs of LGBT people and what factors may help or hinder the ability to address those needs. The last topic area, personal values, focuses on the individual public health practitioner's own beliefs and biases related to LGBT communities and individuals.

Awareness

Basic awareness (Figure 4.2) begins through the acknowledgement that LGBT people exist in every family, organization, community, and culture whether these individuals are recognized or identify as LGBT or not. Differentiating sex and gender, both sexual and gender orientation, as well as sexual and gender identities, shapes the understanding of continuums of sex, gender, and sexual orientation identification. Learning essential terminology and concepts that are used to describe LGBT subcommunities, family structures, and other defining characteristics provides a context for understanding the beliefs and practices of LGBT people.

Multiple factors affect access to quality health care and general quality of life issues for LGBT individuals and communities. Perhaps the most significant of these is stigma, both actual and perceived, which plays out in not only the individual lives of LGBT people but also in the social and political environment in which individuals function (Dean et al., 2000). Therefore, practitioners should be able to identify forms of stigma, sociopolitical factors

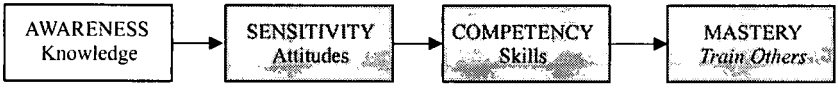

FIGURE 4.2. Stages of Cultural Competency: Awareness

that perpetuate prejudice and discrimination, and other factors that influence health status, access to care, and quality of care.

One of the more difficult steps in achieving cultural competency is becoming aware of one's own personal biases and stereotypes (Dedier, Penson, Williams, & Lynch, 1999). In order to effectively work with LGBT individuals and communities, public health practitioners must acknowledge the assumptions and stereotypes that color their interactions with clients (Welch, 2002).

Sensitivity

Although public health practitioners may have an awareness of the issues surrounding professional interactions with LGBT individuals and communities, they must also become sensitive (Figure 4.3) to the norms that shape their clients' lives. Resnicow, Baranowski, Ahluwalia, and Braithwaite (1999) suggest that culturally competent practice begins with the ability to incorporate awareness of experiences, beliefs, and practices within a historical, social, and political context. The sensitivity stage, therefore, should guide practitioners to distance themselves from a heteronormative perspective, in which the existence of LGBT people, clients, and peers is not recognized or valued, through developing respect and appreciation for the culture of LGBT communities and individuals.

With movement toward cultural sensitivity, public health practitioners should foster appreciation for and validation of diversity in sex and gender orientations and identities; respect for family structures, functions, and roles within LGBT culture; and appreciation of the diversity within and among LGBT communities and individuals. They must also begin to understand and acknowledge the relationship between the social environment and the lives of LGBT individuals (e.g., how lack of same-sex marriage rights prevents automatic visitation privileges and health care decision making of same-sex partners).

Public health practitioners can become more culturally flexible and sensitive by identifying crucial sociopolitical factors and particular cultural beliefs and practices and then incorporating and validating these factors in their practice (Welch, 2002). Similarly, it is important for practitioners to

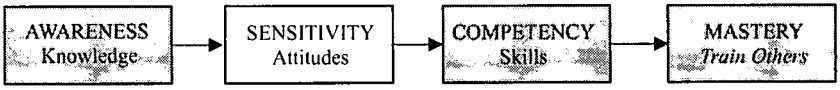

FIGURE 4.3. Stages of Cultural Competency: Sensitivity

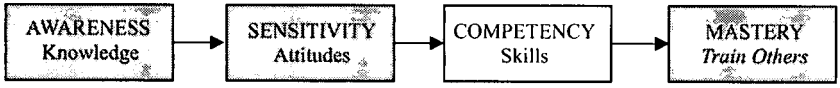

FIGURE 4.4. Stages of Cultural Competency: Competency

accept responsibility for their personal beliefs and biases, and respect when others' beliefs and practices may be different from their own.

Competency

Achieving cultural competency (Figure 4.4) among all public health practitioners should be the goal of both preservice and in-service curricula. Although achieving LGBT cultural awareness and sensitivity learning objectives signifies good intentions, competency combines both the desire and ability to effectively serve the public health needs of LGBT individuals and communities (Welch, 2002). Cultural competency entails modifying one's own practice as well as working to create a supportive organizational and sociopolitical environment in partnership with LGBT individuals and the community (OMH, 2001; GLMA & LGBT Health Experts, 2001).

Culturally competent practitioners are able to effectively assess and provide services in an inclusive and respectful manner. They are able to advocate for policies and practice norms within their organizations and communities that create a safe and welcoming environment for LGBT people. Further, public health practitioners should be able to design and implement health services and programs that are inclusive and respectful of LGBT individuals, as well as attempt to overcome the barriers that prevent LGBT individuals from accessing those services. This can be achieved by practicing trust building and effective interaction and communication skills, as well as suspending personal beliefs and practices in order to maintain a perspective of LGBT individuals' beliefs and practices.

LGBT AWARENESS, SENSITIVITY, AND COMPETENCY TRAINING

This section will address both preservice and in-service training for public health students and current practitioners on the continuum from awareness to sensitivity to competency. Students and in-service trainees will be described as participants, while faculty and facilitators conducting the training will be referred to as instructors.

LGBT and allied faculty, students, staff, and practitioners may be the individuals to initially advocate with school and organization administrators

for the inclusion of LGBT competency training in the core curriculum and ongoing certification requirements or staff development (see Exhibit 4.2 for tips on advocating). However, it is important that the burden does not fall on only LGBT people to ensure LGBT competency training. It has been the authors' experience that if LGBT issues are only or mostly addressed when certain people raise them, this can lead to LGBT training becoming inconsistent and sporadic, with varying levels of quality.

LGBT training cannot be a one-time occurrence. It takes time and experience under varied circumstances to attain sensitivity and competency. Rather than only offering one discrete course, LGBT training is more effective when it is interwoven in all public health courses (Garcia, Wright, & Corey, 1991; Stephenson, Peloquin, Richmond, Hinman, & Christiansen, 2002). Courses can include case studies, essay questions, field practicums, and other learning exercises that include diverse scenarios of LGBT people and their health concerns. LGBT and allied faculty, students, staff, alumni, practitioners, and community groups can be excellent resources to schools and organizations that need assistance in developing appropriate training policies and materials.

Practitioners are raised, as all people are, with a wide range of beliefs about sex, gender, and human sexuality. The ultimate goal of LGBT competency training is to build upon the range of experiences and support the participants' personal transformation and attainment of professional skills. Public health practitioners cannot be blamed for not having been exposed to LGBT cultural competency training when standards and policies are not

EXHIBIT 4.2. Advocating for LGBT Cultural Competency in Training Curricula

- Identify public health curricula, courses, professional conferences, and other preservice or continuing education events that present an opportunity for introducing LGBT competency training.
- Identify the decision makers who have the authority to include LGBT competency training, such as faculty, administrators, instructors, conference organizers, and panel moderators.
- Identify key stakeholders who will actively support efforts to include LGBT competency training, such as faculty, alumni, administrators, professional organization officers, and LGBT advocates and leaders.
- Mobilize key stakeholders to gather support and precedence, advocate for inclusion, and work with decision makers to implement proposed policy or curriculum changes.
- Work with faculty, instructors, organizers, and LGBT advocates to develop or adapt appropriate training curricula and activities.

widely recognized, accepted, and instituted. However, once offered the opportunity, public health practitioners must be willing to work toward developing LGBT awareness, sensitivity, and competency to be able to provide competent care for everyone. Ultimately, if they are unwilling to work toward LGBT cultural competency, then they are not fulfilling the roles and responsibilities of a public health practitioner (Pew Health Professions Commission, 1995; Stephenson et al., 2002).

Creating a Productive Learning Environment

For effective public health training on LGBT awareness, sensitivity, and competency, the instructor creates a learning space that is both safe and challenging (Hutchinson, 2003; Newell, 1999). Instructors need to have participants create, agree upon, and remain aware of group guidelines, as well as ensuring enforcement when they are being violated. Group guidelines help establish safe parameters within which participants can take risks and still remain supported in their learning (Porter, 1984; Wegs, Turner, & Randall-David, 2003).

Perhaps because many are motivated by service to people, public health students and practitioners can be hesitant to explore or reveal their biases in front of their peers. Instructors may need to work diligently to create a nonjudgmental and supportive learning space that allows for open exploration and discussion without negative repercussions for those who express unpopular or minority opinions. Instructors can remind participants that a variety of viewpoints is common in every group and ask participants to take risks and voice their ideas or opinions, even if they are challenging for others. As long as participants are voicing their sincere opinions and are not intending to hurt anyone's feelings, instructors should continue to maintain an open space for a diversity of ideas and viewpoints. Instructors need to refrain from becoming defensive or taking comments personally when people voice opposing opinions. These differences of opinion can be channeled into important learning opportunities when instructors handle them effectively.

Awareness Training

LGBT Existence

LGBT awareness training can begin with a presentation that informs participants of the existence of LGBT people in every family, organization, community, and culture. This can be accomplished through the introduction of a trigger, or presentation, designed to stimulate thoughtful discussion, followed by a progression of questions and facilitated discussion. The trigger could be a quote, image, skit, panel of LGBT people, or clip from a

mainstream television show or film that deals with the invisibility of an LGBT character's sexual or gender orientation. Instructors can then split the participants up into pairs or small groups to discuss questions about their own experiences with LGBT people, relative LGBT invisibility in a heterosexist society, and reasons for this invisibility.

LGBT Terminology

Other important components of LGBT awareness training are desensitization to LGBT terms and images and the development of a common vocabulary to ensure clear communication throughout the training. This includes airing terms and images that are considered pejorative by some, neutral by others, and that may have been co-opted as positive language by some members of the LGBT community.

During a desensitization and vocabulary-building activity, instructors may ask participants to fill in the blanks for each of the following statements: "A lesbian is . . ." "A transgender person is . . ." Continue with "gay man," "bisexual woman," "bisexual man," "heterosexual woman," and "heterosexual man." Instructors can help participants overcome their hesitations to use words or images that may be considered stereotypical or demeaning by saying them first, thus demonstrating that this language is acceptable in that learning space. Instructors can encourage participants to call out their responses in a "stream of consciousness" manner without censoring their thoughts. The idea is to explore the words, images, and assumptions that first come to mind when people hear the words, "gay man," "lesbian," and so on and to become more comfortable using the terminology. Instructors can have participants brainstorm as many words and images as come to mind for each term, one at a time. Participants are then asked a series of discussion questions to provoke a deeper understanding of where these associations come from and what effects they may have on interactions with LGBT people.

These discussion questions could include the following:

- What are some ways you can overcome assumptions about LGBT and heterosexual people?
- What did you learn about the words and images you associate with LGBT and heterosexual people?
- What assumptions did you make?
- As public health practitioners, how might these associations and assumptions affect your interactions with LGBT and heterosexual coworkers and clients?

This exercise requires attentive facilitation and a healthy dose of humor to encourage a free-flowing group brainstorm and exploration without crossing the line to becoming a socially acceptable group bashing of LGBT or heterosexual people.

Awareness of One's Own Biases

Public health practitioners must learn how their assumptions and biases affect the quality of their interactions with LGBT clients and peers and, ultimately, the quality of the services provided. Instructors can have participants reflect on situations they have experienced personally. For example, a time when the participants knew without being told that someone else was making an assumption about them, or a time when someone held a bias against a participant because of a characteristic that was out of their control. For example, a participant may share her experiences with people assuming she was dumb because she was blonde and attractive. Some may have experienced bias because of their appearance or accent. Instructors can then ask participants how being the recipient of bias made them feel about themselves and about that person, and how the bias affected their interaction with and trust of the person. This type of reflection may help participants gain a better understanding of how assumptions and biases can have profound negative effects on people's interactions and the outcomes of those interactions (Cranton & King, 2003).

Sensitivity Training

Values Clarification

A necessary element of LGBT sensitivity training is the opportunity for participants to reflect on their values and attitudes in such a way that leads to personal and professional transformation. Most people, including many LGBT people, are unaware of the extent of their own homophobia and heterosexism. Personal relationships with LGBT people are key to this process. It can be helpful for instructors to have participants reflect on LGBT people in their lives or characters on television or in film to whom they can relate. Then the instructor can facilitate a process in which participants experience an LGBT person's pain and see themselves as part of the source of that pain. Again, this can be accomplished through the presentation of a trigger followed by a series of discussion questions that elicit participants' learned heterosexism and homophobia in order to make them more con-

scious of the ways they may unwittingly feed into those biases and assist them in identifying the ways they can alleviate the suffering they cause.

Values clarification is an important element in sensitivity training. It helps participants become more aware of their values and attitudes, gain a deeper understanding of others, question their personal beliefs, and gain empathy for LGBT people by demonstrating the stigma that they face. One extremely effective values clarification activity is "Four Corners." In advance, the instructor posts a sign in each of the four courners of the room that reads "strongly agree," "agree," "disagree," or "strongly disagree." The instructor distributes worksheets to participants, who anonymously indicate their responses (strongly agree, agree, disagree, or strongly disagree) to a series of statements about LGBT people, policies, and civil rights. The instructor collects and redistributes the worksheets so every participant has one that is most likely not their own. The instructor then reads one of the statements and asks participants to go to the corner of the room with the sign that corresponds with the response on their worksheet. A group is now in each of the four corners. All four groups are given a few minutes to develop the strongest arguments they can think of in support of the response on their worksheet, regardless of whether it aligns with their own beliefs. A reporter for each group then presents their group's arguments to the other three groups. This is repeated two to three times using different statements on the worksheet. Participants then sit back down and debrief the activity. By having to construct arguments for opinions they may or may not hold, this activity serves to help participants clarify their values and gain empathy for others. Participants will identify their own attitudes about LGBT issues and have the opportunity to better understand other people's opinions, hear additional or different arguments about their own opinions, and hear discussion and questions about their beliefs.

Empathy Development

Another important process in sensitivity training is empathy development. A variety of empathy exercises help participants better understand life as an LGBT person, the unique challenges and stigmas they face, and what actions could make life less stressful and more enjoyable for LGBT people. A visualization activity is often very effective in accomplishing this process by having people imagine what their everyday lives would be like if they were members of a sexual or gender minority in an intolerant world. Participants close their eyes and the instructor leads them through a number of scenarios in which they imagine their lives as part of a sexual or gender minority. This is usually a sobering experience for people who have taken

their sexual and gender orientation, and the privileges they are accorded because of them, for granted. One example of an experiential empathy activity is the LGBT homework assignment. Participants are given a list of activities and asked to do at least one of them in the two weeks following the LGBT sensitivity training. They are paired with a buddy, with whom they will debrief their action once they have completed the assignment. Examples of empathy-building activities include trying to keep their romantic relationship closeted for a week; raising LGBT issues or concerns to a group of peers; or buying, carrying, and reading an LGBT publication in public.

Competency Training

Building upon the attainment of awareness and sensitivity, participants need to acquire and apply skills in both simulated and actual settings in order to reach competency. Competency training needs to be skill based and provide opportunities for participants to practice their skills with LGBT people. The skills practiced by participants need to be relevant and applicable to their work as public health practitioners. The instructor also needs to provide opportunities for participants to anticipate barriers they will face in advocating for LGBT inclusion and how they will overcome those challenges. The goal of competency training is for participants to practice and get feedback on addressing LGBT competency issues with their standard public health skills until they have reached an acceptable established standard.

Critical Analysis

Skill activities may include practice with critical analysis on public health case scenarios to determine the potential implications for LGBT people. Participants read case studies and answer questions about how the particular scenario could potentially impact LGBT people and their health.

Development of LGBT-Inclusive Interventions

Another skill activity is for participants to develop public health programs, research, and policies that are LGBT inclusive. Small groups can work on designing LGBT-inclusive health education or health-promotion materials and programs, research designs and measures, and public health policies. In addition to identifying the language, images, outreach, promotion strategies, and definitions they would employ, groups would identify potential barriers they could face in advocating for LGBT inclusion and methods for overcoming them (see Exhibits 4.3 and 4.4).

EXHIBIT 4.3. Case Example Preservice Training: Introduction to LGBT Competency Workshop for Public Health Education Master's Students

At the UNC–Chapel Hill School of Public Health, public health education master's students and alumni advocated for the inclusion of LGBT training for all first-year master's-level students. One faculty member was supportive and set aside a class for this training.

The faculty member allowed the instructors autonomy with workshop design and facilitation and had well-defined participation in the workshop. The instructors designed and conducted a needs assessment with the students to determine their levels of experience with LGBT issues, attitudes about working with LGBT people, and potential training needs. Evaluations from a previously conducted antiracism workshop the students had participated in were also analyzed. The instructors formed a committee with students to help plan and prepare for the workshop. They tailored the agenda and activities to the unique needs, experiences, group dynamics, and range of experiences with LGBT people and topics. Based on the needs assessment and other workshop evaluations, instructors knew the workshop needed to be relevant, practical, and skills focused. Due to the relatively short time allotted for the workshop, instructors also maximized group learning time by assigning independent readings and LGBT-awareness homework assignments before and after the workshop and then a follow-up LGBT homework assignment with a planned debriefing in pairs. Despite this level of planning, instructors remained flexible to make changes throughout the workshop if the planned activities or discussions weren't having the desired effect or students expressed other expectations of the workshop. They conducted an evaluation to determine if students' needs were met and facilitate planning for the next year's workshop.

Note: Due to continued support by subsequent faculty, this workshop is now an annual part of first-year student training.

Recommendations

- LGBT cultural competency needs to be included in national public health standards and guidelines.
- LGBT cultural competency training needs to be integrated into public health and in-service curricula for public health practitioners.
- LGBT training cannot be a one-time occurrence. It is more effective when it is interwoven in all public health courses.
- Every practitioner, whether LGBT or not, needs to raise issues of increasing LGBT competency so the burden does not fall solely on LGBT communities.

- LGBT competencies need to be further developed and tailored for specific public health disciplines.
- Training curricula need to be developed to train practitioners to competency within their public health discipline.
- LGBT and LGBT-allied faculty, students, staff, alumni, practitioners, and community groups can be consulted as resources to schools and organizations that need assistance developing appropriate training policies and materials.

EXHIBIT 4.4. Case Example In-Service Training: Culturally Competent Care Training Curriculum

A preliminary needs assessment conducted by the Lesbian Resource Center (LRC), a nonprofit organization in Durham, North Carolina, highlighted the overwhelming need for additional services to address lesbian health care service delivery needs. In addition to increased national attention on the health issues affecting women who partner with women (WPW), the organization received a vast number of requests for recommendations for friendly and knowledgeable health care providers and detailed information about those providers' qualifications. The organization identified the need to develop a standardized training curriculum for health care providers that would be implemented by volunteer trainers.

Utilizing a cultural competency framework, the development of the curriculum involved three key elements: an extensive review of existing LGBT training guides and manuals; interviews with health care providers to determine the most appropriate format, delivery, and content of a training on the health issues of WPW; and interviews and focus groups with community members to identify particular health care needs of local WPW.

The goal of the training curriculum is to educate clinical health care providers on the health care concerns, issues, and needs of WPW living in the North Carolina Triangle area (Durham, Orange, and Wake Counties). The curriculum covers information, skills, and resources health care providers need to create a WPW-friendly health care practice. Based on providers' identified need for flexibility in training, the core components of the curriculum, two ready-to-go training modules and several mix-and-match modules, allow for variety in training length, design, and setting.

"Culturally Competent Care for Women Who Partner with Women in the North Carolina Triangle Area" serves as an excellent resource for the LRC in offering trainings to Triangle health care providers. In addition, it may be used as a starting point for other individuals and agencies to offer health care provider trainings in their own communities (Shirah, 2002). More information on the curriculum can be found at www.trianglelrc.org.

CONCLUSION

LGBT people are in every family, community, workplace, and client population and are deserving of the same high-quality public health services as all other members of society. Health disparities experienced by lesbian, gay, bisexual, and transgender individuals and the LGBT community are sufficiently documented and must be eliminated. This chapter has begun charting LGBT cultural competency objectives, and additional work must be done to complete, standardize, and institutionalize these competencies in public health standards, guidelines, and curricula. It is the duty of public health practitioners to serve the public, and LGBT people are part of that public. Public health practitioners, in order to fulfill their roles and responsibilities, must be trained to competently serve LGBT people.

"I liked that we're all leaving assumptions behind. We need constant reminders. We needed more time to discuss, unpack our stereotypes." — Health education master's student/training participant (Turner, Wilson, & Shirah, 2003)

QUESTIONS TO CONSIDER

1. What are some specific examples of how public health practitioners' biases can affect services provided to LGBT people?
2. How can cultural competency training for public health practitioners improve health services for LGBT people?
3. If differences were to exist, how can health care practitioners reconcile their personal beliefs about LGBT people with their professional responsibility to provide high-quality care to all clients?
4. As they progress through each stage of the LGBT Cultural Competency Framework, what are some examples of the knowledge and skills public health practitioners should possess concerning LGBT people at the
   - Awareness stage?
   - Sensitivity stage?
   - Competency stage?
5. What are some training activities that can help public health practitioners improve their LGBT cultural competency?
6. What are some steps individuals can take to advocate for the inclusion of LGBT cultural competency in preservice or in-service training for public health practitioners?
7. Has your academic institutional review board (IRB) been educated about LGBT cultural competency issues and LGBT health issues?

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