Arabella Mitchell & Patel, 2006). And yet, children of GLBTI parents, children and adolescents who are GLBTI, and GLBTI adults including colleagues are now more visible in our workplaces with the increased likelihood of coming out. With that improved visibility come tests of stereotypes, heterosexism, and homophobia (Bowers, Plummer & Minichiello, 2005).

Lenses
Heterosexism is a system of attitudes, bias and discrimination favouring opposite-sex sexuality and discrimination against gay men, lesbians, and bisexual individuals based on their sexual orientation. This can include negative attitudes, beliefs, and practices that are directed against individuals or groups based on their perceived sexual orientation. It often involves the portrayal of gay men, lesbians, and bisexual individuals as deviant, abnormal, or inferior, and can lead to discrimination in various areas of life, such as employment, housing, and healthcare.
relationships (Jung & Smith, 1993). It can include the view that everyone is "really" heterosexual and that homosexuality is a lifestyle choice or preference that is amenable to change, or a political statement, or that only opposite-sex attractions and relationships are "normal" and for that reason, superior. At one extreme, heterosexual and homophobically inclined people may tend to view GLBTI people only in sexual orientation and minority subculture terms, disregarding their other characteristics, attributes, and achievements. At the other extreme, heterosexism and homophobia can influence us subtly, like a habit that is so much a part of us that we hardly know it is there.

The chains of habit are generally too small to be felt until they are too strong to be broken. Samuel Johnson

Culturally effective health care policy, administration, practice and education see the development of mutually respectful dynamic relationships between providers (Bowen, 2009)3 and GLBTI consumers (Crisp, 2006) through consciously directed awareness, knowledge, skills and practice. Transcending the level of the "gay friendly" doctors’ surgery, all family structures are honoured and none are idealised. Sexual minorities are afforded comparable status to other minority groups in environments, actions, materials, routines and language that include unconditionally students, staff, clients, and family members who are GLBTI.

Through its lens marked "values", our Association’s Code of Ethics4 sees members who “do not discriminate on the basis of race, religion, gender, sexual preference, marital status, age, disability, beliefs, contribution to society, or socioeconomic status.” According to Frazier (2009) drawing on Lee (2002)5, such non-discriminatory practice includes creating alliances and fostering dialogue between professional colleagues irrespective of sexual orientation, providing safe environments for GLBTI youth, helping to raise awareness of the role of communication in achieving social justice in schools in particular, and promoting peaceable language and peer support in delivering services.

One step at a time

For our profession, culturally effective practice in GLBTI contexts can be achieved one step at a time with all of us promoting small changes that can help build appreciable improvements for clients and their families.

We can start with open, affirming, and inclusive intake forms and protocols that do away with Mother and Father in favour of Parent/Guardian 1 and Parent/Guardian 2, or Caregiver 1 and Caregiver 2 for all clients.

Case-history taking procedures can be modified with respect to privacy issues if necessary and to include gender/orientation-neutral language. The clinician can make sure to find out what the child calls each parent, how the parents refer to each other, the significance of the child’s surname, and how family identity has been constructed. We need to be aware and respectful of possible facilitators of and barriers to the construction of family identity in the particular family concerned, including the roles played by GLBTI parents’ parents, the child’s non-biological and biological parents, siblings and the wider community.

From the child’s perspective we need to appropriately acknowledge the contribution and standing of both, or all their parents, and respect the validity and significance of the couple relationship, and extended family relationships, in both nuclear and blended families. It is important too to ascertain who the family would like to be involved in intervention planning and to respond adaptively if initial decisions change.

It is a fact of case-history taking that the whole story does not always come out in the first encounter and parents, caregivers and clients often tell us crucial information following a period of learning to trust us. Given the negative experiences that many GLBTI people and their allies experience in health settings, it may be reasonable to review the history some time later and to ask whether they have anything they would like to add.

Assessment and therapy materials can be appraised by clinician and family for heterosexist terminology, language, and images.

In our professional and private lives, we can make it a habit to model inclusive and affirming conduct, being open in rejecting comments that sometimes pass for humour, that disparage, denigrate, demean, and devalue people’s heritage or identity.

Habit is habit, and not to be flung out of the window by any man, but coaxed downstairs a step at a time. Mark Twain

References


Links


Webwords 41 is at http://speech-language-therapy.com/webwords41.htm with live links to featured and additional resources.