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GLBTI affirmative practice

Caroline Bowen

Cool and collectable, Royal Worcester Gaiety Girl Arabella is a fine bone china figurine, pretty in a soft blue gown with pink accents and a matching feathered hat. The real Gaiety Girls first appeared in *haute couture* fashions and modest swimming costumes in the 1890s at London's Gaiety Theatre. As the chorus girls in Edwardian musical comedies, they were beautiful, respectable, elegant magnets for well-heeled Stage Door Johnnies, and many married into society and wealth, pursuing significant acting careers.

In Australia a theatrical organisation founded in 1881, known as Williamson, Garner, and Musgrove, and from 1905 as J.C. Williamson Ltd. (McPherson, 2008), or JCW's, continued the gaiety girl tradition with troupes of talented female singers, dancers, and accompanists. By the end of the 1920s there were ten major theatres operating in Sydney, with JCW's imported productions and home-grown melodrama, vaudeville, and revue dominating the business. But theatrical entrepreneurship was a risky affair and this vibrant scene was devastated by the Great Depression, foreign cinema, and entertainment taxes, so that by 1935 there were only two commercial theatres left, no major drama touring companies, and few European style little theatres. But the Gaiety Girls kept performing in reviews during and after World War II, weathering sporadic and erratic attempts to revive live theatre until the whole scene changed again in the 1950s – a period of post-war reconstruction and the **darkest decade**[1] of homophobia in Australia.

Several other Gaiety theatres had sprung up around Australia. Sydney's, with two shows daily at "dinkum prices", opened its doors in 1880, but in March 1904, the Melbourne *Argus* quoted a Public Health Board enquiry into the safety of Sydney theatres as saying:

> *This theatre is in most unsatisfactory condition, especially so as regards its position relative to hotel and steam boilers under the building, general arrangement, means of egress, and the details of construction. Radical structural alteration is required to render the building safe for public use.*

Pride and prejudice

Inaugurated in 2008, its twenty-first century **namesake**[2] has nothing to fear from the health inspector, but its mission statement reflects the fearsome prejudice that continues to blight the lives of many GLBTI (Gay, Lesbian, Bisexual, Transgender, Intersex) people. Its stated aim is to champion "theatre that is inclusive of gay and lesbian characters" adding, "visibility through performance can be a powerful tool to counteract prejudice and to reinforce pride within the GLBTI community."

The **Victorian Gay and Lesbian Rights Lobby**[3] believes that 84 per cent of gay men, lesbians, and bisexual Victorians have been discriminated against because of their sexuality, noting that in a **study**[4] of 5500 GLBTI Australian people nearly 70 per cent said they modify their daily activities, fearing prejudice and discrimination (Pitts, Smith, 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).

Arabella

Lenses

Heterosexism is a system of attitudes, bias and discrimination favouring opposite-sex sexuality and

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, heterosexist and homophobic lenses 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**)[5] 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 Ethics**[6] 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)**[7], 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

Bowen, C. (2009). Multiculturalism in communication sciences and disorders. *ACQuiring Knowledge in Speech, Language and Hearing*, *11*(1), 29–30.

Bowers, R., Plummer, D. & Minichiello, V. (2005). Homophobia and the everyday mechanisms of prejudice: Findings from a qualitative study, *Counselling, Psychotherapy, and Health*, *1*(1), 31–51.

Crisp, C. (2006). The gay affirmative practice scale (GAP): A new measure for assessing cultural competence with gay and lesbian clients. *Social Work*, *51*(2): 115–126.

Frazier, A. M. (2009). Culturally and linguistically diverse populations: Serving GLBT families in our schools. *Perspectives on Communication Disorders and Sciences in Culturally and Linguistically Diverse Populations*, *16*, 11–19.

Jung, P. B. & Smith, R. F. (1993). *Heterosexism: An ethical challenge*, Albany, NY: SUNY Press.

Lee, J. (2002, April). Culture and sexual orientation : How to create more sensitive environments for gay, lesbian, bisexual, and transgendered clients. *The ASHA Leader*.

McPherson, A. (2008). *History of Sydney: Theatre*. Retrieved 10 August 2011 from www.dictionaryofsydney.org/entry/theatre

Pitts, M., Smith, A., Mitchell, A., Patel, S. (2006) *Private lives: A report on the health and wellbeing of GLBTI Australians*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

Links

1. http://connection.ebscohost.com/c/articles/359027/darkest-decade-homophobia-1950s-australia
2. http://www.gaietytheatre.com.au
3. http://www.vglrl.org.au/index.php
4. http://www.glhv.org.au/files/private_lives_report_1_0.pdf
5. http://www.speech-language-therapy.com/webwords32.htm
6. http://www.speechpathologyaustralia.org.au/about-spa/code-of-ethics
7. http://www.asha.org/Publications/leader/2002/020402/020402f.htm

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