THE PEREGRINE CENTRE

Working with LGBTQIA+SB Clients

A practice toolkit for mental health practitioners working in regional or rural areas

Who is this toolkit for?

The following toolkit is designed for any mental health practitioners working across remote, rural or regional NSW who wish to understand more about working with LGBTQIA+SB people and have not completed speciality training.

What does this toolkit include?

This is an introductory toolkit to working with individuals who are LGBTQIA+SB and is not exhaustive nor designed as a treatment manual. We encourage all practitioners who are working with LGBTQIA+SB individuals to seek specialised training and engage in supervision.

A note on language.

The Peregrine Centre recognises and values the diversity of LGBTQIA+SB communities. While this toolkit contains information on how to navigate language, individuals may have their own preferences. In practice, listen and reflect the language of the person. If in doubt, ask their preferences.

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NSW GOVERNMENT

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LGBTQIA+SB ...

What do those letters all stand for?

The acronym LGBTQIA+SB encompasses a broad range of identities. Identities are not mutually exclusive; People may identify with one or multiple identities.

It is important to recognise the breadth of unique experiences, identity, and health needs within this population. As our understanding of sexuality and gender grows, people are finding better descriptions and labels for themselves.

SB for sistergirl and brotherboy are specific to some First Nations communities and their longstanding concepts of gender and identity.

LGBTQIA+SB people have always and will always exist. As societal attitudes have changed over the years, people may feel more comfortable being open about who they are. However, discrimination, stigma, and fear are still factors in people feeling able to be their authentic selves.

A note on 'queer': Though it is contained in the acronym, and can be used as an umbrella term, some people have experienced harmful and derogatory use of queer. It is generally a good idea to only use this word when someone has first self-described with it.

Lesbian
A woman who is attracted to women

Gay
A man who is attracted to men

Bisexual
Attraction to more than one gender

Transgender
Identifies with different gender than that assigned at birth

Queer
Encompasses a range of non-normative genders and sexualities. Also includes resistance to hetero-cis norms.

Intersex
People born with physical, chromosomal, or hormonal characteristics that differ from conventional understanding of female or male bodies

Asexual
People who do not or rarely experience sexual attraction

+
acknowledges the diversity of identities

Sistergirl
Gender diverse First Nations people that have a female spirit and take on female roles within the community

Brotherboy
Gender diverse First Nations people that have a male spirit and take on male roles within the community

Sexual Identity and Gender Identity

It is important to understand the difference between sexual and gender identity. The Gender and Sexuality Galaxy is a handy tool that captures the breadth of identity and includes some prompts for self-reflection and learning.

Sexuality encompasses orientations such as lesbian, gay, heterosexual, bisexual, asexual, pansexual. This is to whom we are romantically, emotionally, spiritually, and sexually attracted.

Gender identity covers transgender, cisgender, gender non-conforming, bigender, agender and so on. This covers the gender a person is, including how they choose to present themselves. There is no 'correct' way to present within the gender spectrum and this is incredibly individual.

Intersex is not considered a sexual or gender identity, and people with intersex variations will have their own sexual and gender identities. It is included within the LGBTQIA+SB acronym in recognition of the stigma, medical violence, and societal barriers that people with intersex variations face. There is more about people with intersex variations on the next page.

A brief glossary

Below is a non-exhaustive list of terms that are helpful to be aware of. A more comprehensive list can be found here, and in the NSW Health LGBTIQ+ Strategy.

Sexuality terms

Pansexual: A person who experiences attraction regardless of gender

Aromantic/Aro: Someone who does not or rarely experiences romantic attraction

Gender terms

AFAB/AMAB: Assumed fe/male at birth. Note: It is good to understand this term, however, consider if always knowing someone's assigned gender at birth is clinically relevant.

Binary: Binary genders refer to male and female. Some people are non-binary. Non-binary identities include agender, bigender, gender fluid, trans masculine, and trans feminine.

Cisgender: Someone who identifies with the gender assumed at their birth

Transgender: Someone whose gender is different to that assumed at birth.

Pronouns: Words used to refer to people (e.g., she, he, they). Some people use neo-pronouns (e.g., ze, zir, xe).

Societal Issues

Passing: Being perceived as cisgender

Heterosexism: Discrimination against same-sex attracted people based in belief that everyone is heterosexual *(Also known as homophobia)*

Misgendering: Referring to someone as the incorrect gender, either intentionally or unintentionally

Biphobia: Stigma and discrimination faced by people who are multi-gender attracted

Cissexism/Cisgenderism: Stigma and discrimination based in binary gender norms and belief in fixed (i.e., from birth) identity *(Also includes transphobia)*

Dead name: Birth name (when a person goes by another name)

Drag: A performance of gender, not a gender identity

While ideal, it is not necessary to have a comprehensive working knowledge of all terminology. At a minimum, doing your own learning and reflection, holding a curious standpoint, avoiding assumptions, and reflecting the language the person uses is a good path forward.

Intersex People and Communities

Intersex is not a gender or sexual identity.

Someone is intersex when their innate anatomical, chromosomal or hormonal sex characteristics are outside conventional medical standards for male or female bodies. What makes a person intersex is incredibly diverse, with at least 40 known potential traits. Intersex variations can be identified through the life span, not just at birth. Sometimes, the variation won't be identified at all. The term for people who are not intersex is endosex.

While exact numbers are unknown, it is generally estimated that people with intersex variations make up about 1.7% of the population. This is roughly the same prevalence as people with red hair, or green eyes. That is, it is not so rare.

It is important to know and understand that people with an intersex variation face discrimination, stigma, and medical violence. People with an intersex variation report invasive, often irrelevant, questions from people around them. People with an intersex variation have had their human rights violated by governments and health and medical systems. Still today, there can be pressure from medical professionals for the person with the intersex variation, or their parent/guardian, to consent to deferrable surgeries or other medical interventions related to the intersex variation.

People with intersex variations have long been campaigning and advocating for their human right to not be subjected to forced medical intervention, and to have the right to bodily autonomy, amongst other rights (see The Darlington Statement below). While gains have been made, there are many systemic barriers still being fought against.
It is the duty of health practitioners to understand the stigma and violence people with an intersex variation face, and work to not repeat the pattern. Seeking education, including lived experience stories, and examining our own beliefs and biases of what life for people with an intersex variation can be are starting points for working with people with an intersex variation to create a better, more inclusive healthcare system.

Further reading:

Hegarty, P., Smith, A. Public understanding of intersex: an update on recent findings. *Int J Impot Res* **35**, 72–77 (2023). https://doi.org/10.1038/s41443-021-00485-w

Hegarty, P. (2022). The Psychology of People With Variable Sex Characteristics/Intersex. *Current Opinion in Psychology*, 101539. https://doi.org/10.1016/j.copsyc.2022.101539

Jones, Tiffany. (2016). The needs of students with intersex variations. Sex Education. 16. 1-17. (Access here)

Extra resources:

Intersex Human Rights Australia has a wealth of information, including information for inclusive practice and further reading

The Darlington Statement is a joint consensus statement between Australia and Aotearoa/New Zealand intersex organisations to promote the rights of people with an intersex variation. Your organisation can sign the statement to show your support for people with an intersex variation

Kids Helpline has produced an easy-to-read explainer on intersex variations that may be helpful if working with young people and their families

Intersex Peer Support Australia is a peer support and advocacy group for people with intersex variations and their families

Considering Stress and Marginalisation

LGBTQIA+SB people will access mental health care for a myriad of reasons, not always related to stigma and discrimination.

However, as mentioned previously, LGBTQIA+SB people are more vulnerable to poor mental health and wellbeing due to their marginalization in society. This can lead to feelings of isolation, loneliness, and have perceived or actual reduction in social supports. Having knowledge of the Minority Stress Model helps understand these impacts.

Particularly in rural settings, LGBTQIA+SB people can feel isolated and alone, with little exposure to other LGBTQIA+SB identifying people. They may feel it is safer to keep their identity a secret, which compounds feelings of isolation. For young people, this isolation can have ongoing developmental effects, such as impacting opportunities for social connection, and developing psychological resiliency. It is important to identify appropriate supports to create community and inclusion, a key predictor of improved wellbeing. Family support, in particular, results in better physical health, self-esteem and social support, but a supportive family is also protective against mental ill-health, and suicidality.

There are specific traumas that affect people who grow up as LGBTQIA+SB. These unique set of traumas are referred to as "queer trauma."

Queer trauma is:

Distinct: LGBTQIA+SB people are at higher risk of being isolated from their families and communities. This means no shelter within the family, school, or work environments, and no community to instil positive messages growing up

Intersectional: Intersects with other types of trauma e.g., misogyny, Indigeneity, disability, and racial trauma. Intersectionality is not "one plus one equals two" - identities combine to form specific types of oppression

Transgenerational: To be a LGBTQIA+SB person is to exist with a cultural history that differs from your cis-het peers. Two such examples are the AIDS epidemic and police brutality - even if an LGBTQIA+SB person wasn't born during these times, the impacts echo through generations

Repetitive: Queer trauma is experienced repeatedly, in all sorts of situations. While there has been societal progress, LGBTQIA+SB people still experience traumas, stressors and microaggressions in their families, schools, service settings, and workplaces

Present: Most, if not all, LGBTQIA+SB people have an experience of trauma related to their identity, an experience of hate crime or hateful comments, or an experience of microaggressions. People may not readily identify this as trauma.

Population and MH statistics

Population level surveys have not always been inclusive, making it difficult to estimate the prevalence of people who identify as LGBTQIA+SB. There is ongoing development of how to collect this data in the most inclusive way, and the ABS released new standards in 2020. Additionally, shame and stigma unfortunately might also prohibit people from responding authentically.

Best estimates place LGB people at 3-4% of the population, transgender people at 1%, and intersex people at 1.7%. There is data missing for people who identify outside of these terms, including asexual, pansexual, non-binary peoples. This is reflected in the statistics below, where not all identities have been included in these studies.

It is estimated that between 20-30% of LGBTQIA+ people live in regional, rural or remote Australia.

What we do know is that people who are LGBTQIA+SB disproportionally experience mental health distress, including higher rates of self harm and suicide.

Still today, there is ongoing stigma and discrimination that LGBTQIA+SB people face. It is this stigma, discrimination, and isolation that contribute to the high rates of psychological distress and mental illness within LGBTQIA+SB communities, discussed more on the next page.

Compared to the general population:

LGBTI young people aged 16 to 27 are **five times** more likely to have made a suicide attempt in their lifetime.

Transgender young people aged 14 to 25 are **fifteen times** more likely to have made a suicide attempt in their lifetime.

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Over their lifetime, **73.2%** of LGBTQI people have been diagnosed or treated for a mental health condition, compared to 45.5% in the general population

Coming out... And out... and out.

Coming out is not a single time event.

LGBTQIA+SB people have to navigate sharing their identity nearly daily. Just because someone has shared their identity to you does not mean they want other people to know. They have chosen to invite you in. Discussing who has already been invited in, and who they do and don't want to invite in is a powerful way to reframe this process, rather than 'coming out' which may suggest hiding or being dishonest.

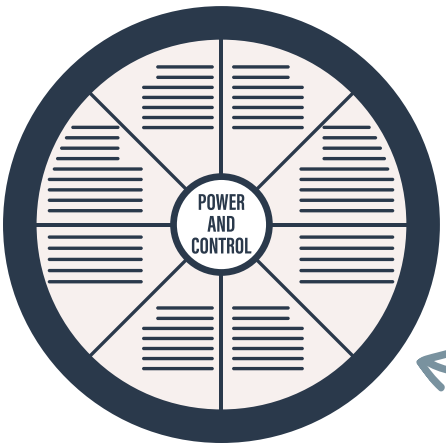
Inviting in also carries over to other health professionals, especially if referring. Consider if the information is relevant and discuss with clients if they are comfortable with this information being shared.

Domestic and Family Violence

Domestic and family violence can be frequently overlooked when working with LGBTQIA+SB people.

Yet, LGBTQIA+ people experience domestic and family violence at rates comparable to cisgender women in different-sex relationships. Bisexual, transgender and gender diverse people may experience higher rates of domestic or family violence than other population.

Despite experiencing violence at the same rates, LGBTQIA+SB people are even less likely to disclose or report due to fear, shame, and stigma.



The COHSAR Wheel can be a helpful tool to explore the domains in which domestic violence can occur. This tool updates the Duluth Power and Control wheel to be inclusive of many relationships, not just heterosexual ones with the man as perpetrator and woman as victim.

As with many aspects pertaining to the LGTBQIA+SB communities, exact prevalence statistics are unknown due to a combination of lack of asking, and reluctance in reporting. Private Lives surveys the lives of LGBTQIA+ people in Australia. With regard to DFV, the 2020 survey found:

- 41.7% of LGBTQIA+ people reported ever experiencing violence in a relationship
- When asked about specific acts of violence, rather than experience of violence, 60.7% of people had experienced intimate partner violence.
- 65% of LGBTQIA+SB people will have at least one experience of family violence, most commonly from parents (75%)
- Yet, 72% of people who had experienced DFV did not report the violence to anyone. In regional, rural and remote communities, reporting rates are lower again.

How and what should I ask about?

Practitioners can:

- Understand the dynamics of domestic, family and sexual violence, and elements of coercive control and other types of non-physical abuse
- Screen for DFSV, with open-ended questions. Remember, identification of behaviour as violence or abuse is challenging for LGBTQIA+SB people, as clients tend to dismiss it as "not that bad".
- Be mindful of your biases. If the behaviours would be unacceptable in a male-female relationship, or with a child who was cisgender and heterosexual (e.g. refusing them access to bathrooms, forcing them to wear clothes of the wrong gender, verbal abuse, extensive criticism and shame), they are unacceptable behaviours.
- It is important to frame this conversation in the correct terms. People who are LGBTQIA+SB are not abused as a result of their identities - they are abused due to the choices that people around them make. Anyone who uses abusive behaviour has other choices available to them.
- Recognise and discuss that abuse is about power and control, and mutual abuse is widely debunked as a myth. Too often, in LGBTQIA+SB communities, the presumption is that both parties share equal responsibility for bilateral violence. This stops victims disclosing and seeking help.

What are the support options?

ACON have a list of useful resources for practitioners and consumers.

Rainbow Sexual, Domestic and Family Violence Helpline available 24/7 on 1800 487 292

1800 Respect have a list of DFV services including those specific to LGBTQIA+ people

Say It Out Loud contains information and resources for LGBTQIA+SB people experiencing DFV, as well as for professionals working with the community.

Newcastle Domestic Violence Committee has a number of helpful resources, including a poster on coercive control available in 9 languages

How do I make my therapy space safe for LGBTQIA+SB clients?

Practitioners can take small steps to make their practice safe and be an ally to LGBTQIA+SB people.

These steps are helpful to take regardless of if you are aware if you have LGBTQIA+SB clients.

Welcome Here is a good resource to explore how you can create a safe clinical space, as well as consider the following:

- Review intake forms.
  - Is gender limited tick boxes? Consider having an open response instead.
  - Are there separate spaces for name and legal/Medicare name?
  - Is there space for pronouns?
- Are clients called the correct name by all staff? (Including admin and clinical staff)
- Introducing yourself to all clients with your name and pronouns
- Display of pride flags
- All gender bathrooms
- Consider your language and gender assumptions. When in doubt, use 'they' pronouns, use 'partner' rather than 'husband/wife' or 'boyfriend/girlfriend', and 'parent' rather than 'Mum/Dad'.

The choice to invite you in lies with the client. Clients may not want to discuss gender or sexuality. It is important to respect this.

Minor adjustments can have major impact

You do not need to learn entirely new therapies when working with LGBTQIA+SB people.

What is important is reflecting on your own internal biases or beliefs when it comes to the LGBTQIA+SB community to ensure these do not influence your treatment.

Standard therapies are just as when working with LGBTQIA+SB people. However, some tweaks to address factors such as isolation, stigma, and discrimination are often critical. You may consider looking into specific training, such as Affirm CBT. This article demonstrates how the therapeutic relationship can be part of the affirming process.

Do not underestimate the power of **just listening**. It is likely your client has been considering whether to invite you in, whether it is the first time ever, or just the first time to you. Receiving this invitation with compassion, and openness can go a long way to building a trusting relationship that allows for the client to show up authentically, just as with any client.

A qualitative study examining helpful and unhelpful aspects of therapy for LGBT clients found the following *helpful* aspects:

- Respecting clients choice to come out, or not, and to whom
- Did not focus on sexual or gender identity if it was not clinically relevant (i.e., being aware of 'trans broken arm syndrome')
- Knowledgeable of LGBT issues
- Knowledgeable of transgender issues, including affirmation support
- Instilled hope, optimism and positive expectations

Unhelpful aspects included:

- Imposing own values or judgement on clients, particularly negative bias towards sexual or gender identity
- Pushing to discuss or disclose on topics the client did not want to
- Ignoring side effects of medication
- Discouraging client from coming out
- Encouraging client to not be LGBTQIA+SB

Culturally safe and trauma informed care for LGBTQIA+SB people

Cultural safety is described as *"as the creation and provision of an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need."***

It is about understanding the unique experiences of an individual based on the interactions of their identities. It's important to apply principles of culturally safe care intersectionally - the experiences of an Aboriginal LGBTQIA+SB person will be different to an Irish or Vietnamese LGBTQIA+ person, different to the experiences of an LGBTQIA+SB person with disability, and so forth.

Practitioners can:

- Be aware of the context - historical, cultural, and current - in which clients exist and experience themselves
- Validate clients' experiences by acknowledging the impact of discrimination, prejudice, and violence. Be aware of a tendency to minimise the effects or impacts of trauma when working with people who have been marginalised.
- Recognize and address the intersectionality of identity, as clients may face multiple forms of discrimination or marginalization. Tailor treatment plans accordingly.
- Be prepared to advocate for your clients within healthcare systems, schools, or workplaces if discrimination or harassment is occurring. Refer clients to legal or advocacy services when needed.
- Focus on building resilience and coping strategies to help clients regain a sense of control and empowerment in their lives. Encourage self-acceptance and self-compassion.

(*Source: Binan Goonj as cited by Williams, 1999)

Six principles of working with LGBQ individuals

In the table below, six principles of working with LGBQ individuals are outlined. This was created specific to sexual minority individuals, however, provides a good underpinning of work with gender diverse people and people with an intersex variation. It is realistic to fear discrimination, and many LGBTQIA+SB people will have had discriminatory experiences, including exposure to negative societal attitudes and beliefs. Affirming the individual's strengths, highlighting examples of resilience, and understanding how the environment we have grown up in shapes our beliefs of self worth, which may be contributing to mental health difficulties, are all important elements to consider in conceptualization and treatment planning. Treatment is unlikely to result in a person no longer fearing discrimination, as this requires a shift in our culture. However, it can result in re-evaluating what these experiences mean – from a negative self-appraisal, to a more nuanced reflection on own values and being authentic.

LGBTQ Affirmative Principles

Principle 1	Highlight how symptoms of depression and anxiety can be normal responses to minority stress
Principle 2	Acknowledge how early and ongoing experiences with minority stress can teach individuals powerful, negative lessons about themselves
Principle 3	Empower individuals to effectively cope with the unfair consequences of minority stress
Principle 4	Help individuals build supportive, authentic relationships
Principle 5	Highlight individuals' unique strengths
Principle 6	Understand intersecting identities as a source of stress and resilience

Table adapted from: Pachankis, J. E., Soulliard, Z. A., Morris, F., & van Dyk, I. S. (2023). A model for adapting evidence-based interventions to be LGBQ-affirmative: Putting minority stress principles and case conceptualization into clinical research and practice. *Cognitive and Behavioral Practice*, *30*(1), 1-17. https://doi.org/10.1016/j.cbpra.2021.11.005

What is not treatment

Treatment that aims to convince the person that they are heterosexual, or cisgender is conversion therapy. This is illegal in Queensland, ACT, and Victoria, with upcoming legislation proposed in New South Wales, Western Australia, and Tasmania.

Unfortunately, conversion therapy is not yet a thing of the distant past. Research on this practice is limited, but it is estimated that about 10% of LGBTQIA+SB people will be vulnerable to these practices. While some organizations may have changed their stance from requiring reversal of sexual attraction or gender identity entirely, there remains a practice of encouraging suppression of self, which is also harmful.

Conversion therapy is not effective and causes a lot of harm. It instills shame. Many survivors of conversion therapy speak of trauma as a result of the practice. For LGBTQIA+SB people who are also religious, there can be a strong sense of loss, or conflicting identity about which parts of themselves they can hold on to.

When working with LGBTQIA+SB people it may be prudent to ask about their previous experiences of counselling, their involvement with faith or religion, and assess their support networks. When someone has been subjected to conversion therapy, they speak of loss of identity, confidence, and self-worth. Through the research, themes of support regarding trust, grief, appropriate information, and self-acceptance are repeated.

Working with people of faith and CALD backgrounds is discussed further later on.

(*Source: Binan Goonj as cited by Williams, 1999)

What does a clinician need to know?

People with an intersex variation and trans people often face questions about their genitals. These questions are invasive, and unwarranted.

As a mental health practitioner it is important to think about why you might be wanting to know that. Is it actually clinically relevant? Are you working with this person to prepare for a genital surgery? Are you working on issues of sexual functioning related to genitals?

There are very limited situations in which knowing someone's genitals is important to mental health care. Unless there is a clinical reason to be talking about the person's genitals, do not ask.

I'm scared of getting it wrong!

If this content is new to you, or you have not had many opportunities to work with LGBTQIA+SB peoples, it may feel a bit overwhelming to start.

It is okay to be honest and say you are learning, however it is not the client's job to teach you. You can ask for clarification if something is unfamiliar, and then make a commitment to learn more in your own time. You will not become an expert overnight, but being willing to learn and letting your client know you will do your own education can go a long way for rapport.

If you misgender your client, or make a misstep, do not panic. Apologise once, correct yourself, and continue with the conversation. If they correct you, thank them, and continue. Be mindful of not putting the onus on the client to ease your guilt or discomfort about the mistake.

(*Source: Binan Goonj as cited by Williams, 1999)

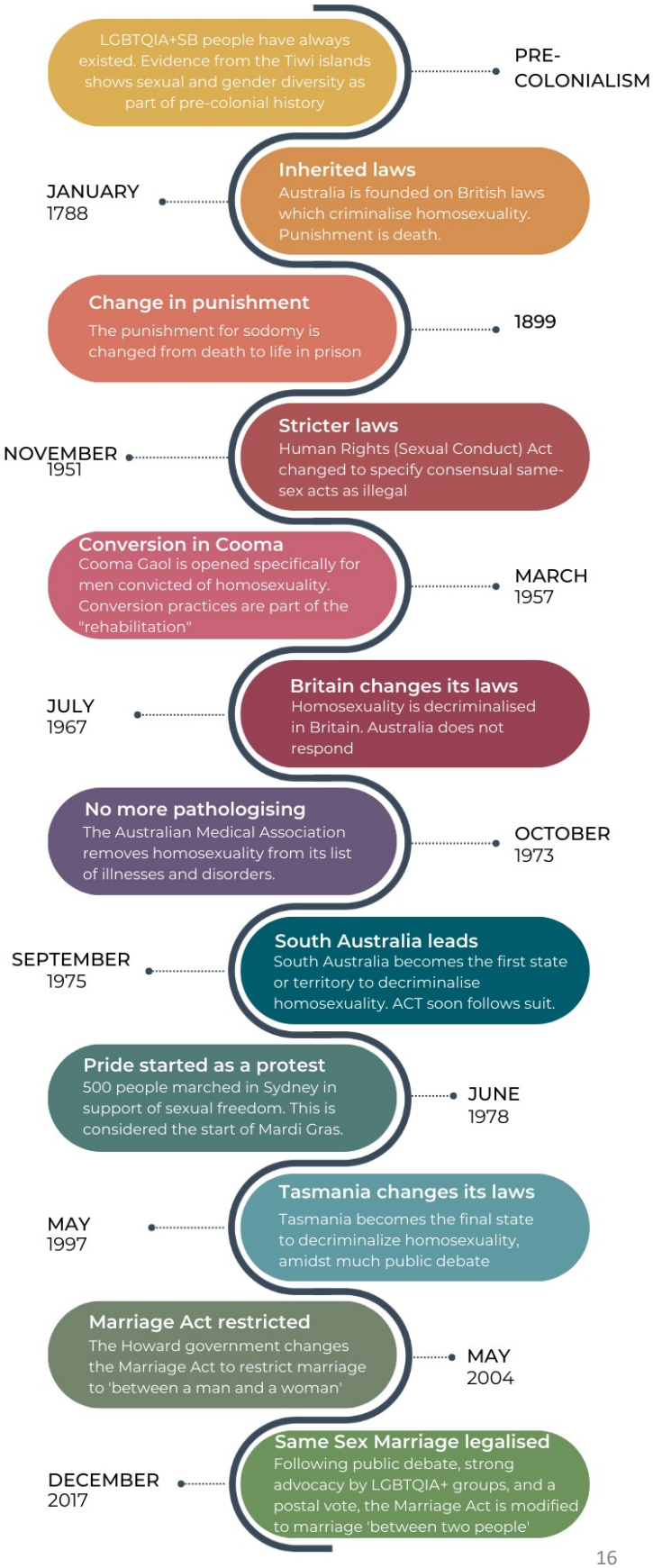
The past is recent

It is important to remember how recent discriminatory policies are, and be mindful of current discriminatory policies, particularly those targeting the trans community. The timeline opposite focuses on Australia's history of discrimination towards homosexuality, particularly male homosexuality.

Trans people have faced their own history of discrimination, and neglect. This discrimination has wide ranging impacts on people, not only on their mental health, but also physical with close to a third of transgender people reporting avoiding necessary medical care for fear of discrimination.

People who are LGBTQIA+SB have shown **consistent resiliency and advocacy** and have made considerable progress in the face of systemic discrimination. Ideally, we work to create a society that does not ask for the resiliency and advocacy of LGBTQIA+SB people anymore. To do that, the onus is for people who are not LGBTQIA+SB to acknowledge the history of harms, and understand where we have come from in order to move forward.

For practitioners to understand the underlying fear and isolation that this community can face when accessing help and support also helps in understanding the power practitioners hold in creating healthcare spaces that are affirming and welcoming.



Working with young people

In this space it is important to let the young person lead when it comes to inviting in other people.

Offer to allow time in session to have this conversation with parents, if appropriate and when ready. Discuss what information can be shared with parents, other staff, and with other care providers.

Talking with parents

When working with young LGBTQIA+SB people, it is crucial to also work with parents where able.

Even for accepting parents, there can be transition period where the parent is trying to learn how to relate to their young person and process their own expectations and emotions. Parents can start with some very simple actions to support their young person.

Parents report feeling a mix of emotions ranging from pride to guilt to fear and even grief. A parent team may also have different reactions, with one parent being accepting, and the other not. It is important to address these head on. **This is not a time for neutrality**. You can hold compassion for the struggle of the adult in understanding and coming to terms while also communicating clearly the need for the adult to manage their own emotions away from their young person.

Parents can feel alone when their young person has come out. Providing resources such as The Gender Centre's First Steps or Parenting SA's Parent Guide for LGB youth can help parents read about the experience of other families. Linking in with support groups may also be beneficial.

Helpful resources for parents:

- The Gender Centre
- Parents of Gender Diverse Children
- Minus18: What to do when your child comes out
- Transcend Guide for Parents and Carers
- The Conversation: How Parents Can Support a Child who comes out as Trans

Common Stuck Points For Parents

I'm scared of getting it wrong/saying the wrong thing

Mistakes will happen. They have known their child in one way for the child's whole life. After making a mistake, apologise once, correct, and continue. With new name and pronouns, practise using the correct name and pronouns often.

Their life will be harder

That's why it's so important they have a safe base to land when things go wrong. Using the Circle of Security model to talk through allowing people to explore and live their most authentic life, and have somewhere safe to return to and grow from can be helpful.

It's just a phase

It can be helpful to reframe this as an opportunity for the parent to show their unconditional love and support for the young person. It is also helpful to provide education on the impact of familial support on wellbeing and psychological symptoms.

What if they transition and regret it?

There is a lot of misinformation about de-transition. De-transitioning does happen, but it is incredibly rare. A meta-analysis pooled seven studies totalling 7928 people who received gender affirming surgery. Of these, 77 (0.97%) reported regret. Reasons for regret primarily related to lack of social acceptance, or poor surgical outcomes. People who detransition more frequently cite external pressures rather than a change in their identity.

I wanted grandchildren

Even if the child was straight/cis, there was no guarantee of that. However, there are now many reproductive options available, including IVF, surrogacy, and adoption.

It's just because its trendy

Awareness and information of sexual and gender diversity is growing. LGBTQIA+SB people have always existed but have not always been safe to be authentic in their existence. Research does **not** support the 'social contagion' fear.

Consider the appropriateness of talking with parents with the young person present. It may be more helpful to have a separate session or phone call for parent support.

Working with cultural and societal biases

Sometimes families and other loved ones will have a hard time accepting their loved one's identity. They will have their own cultural and societal biases that shape beliefs about the lives that LGBTQIA+SB people can lead.

Cultural and religious beliefs can be challenging to navigate, as you will have your own cultural and religious beliefs that might be activated as well. It can be helpful to provide education, and to correct any myths that families may hold. Emphasise that sexuality and gender identity are not choices, just as we don't choose our eye colour or height. Sexual and gender diversity are found throughout nature, and humans are not an exception to this. Sexual and gender diversity has always existed across cultures, with binary systems being introduced through colonisation. How you as the clinician choose to approach this is up to you, however it is important to keep the wellbeing of your client front and centre. Reinforce to loved ones that social support is very protective against psychological distress.

Loved ones may worry about what their networks will think of them, particularly in small communities. They may fear losing family and friends if they show support for LGBTQIA+SB people. These are valid fears, but they are not valid reasons to not show support. Sometimes loved ones will need to seek out their own professional support to work through these issues.

Helpful cultural and religion resources:

- Australian GLBTIQ Multicultural Council has resources in a number of languages
- Transcultural Mental Health Centre
- Rainbow Cultures is a directory of LGBTQIA+SB affirming cultural and religious organisations
- The Trevor Project: Navigating LGTBQIA+ identity and religion

A family can be found

It is an unfortunate reality that not all families will accept their LGBTQIA+SB family member.

In the case of explicit risk of harm to a young person, including neglect, always consult the Mandatory Reporter Guide and follow reporting guidelines.

As a mental health practitioner, continue to provide a welcoming and affirming space for your client, in whatever way feels right for them. This reinforces the validity of them living as their true self, even in the face of rejection.

Do this in consultation with your client. Do they want you to continue to advocate for them with family? Should you continue to use their chosen name and pronouns with family and other people, including when being greeted and on letters? It may be prudent to explore how your client can continue to care for themself, including setting and holding boundaries, and engaging in self-care.

Social supports become more important. Treatment may turn to focus on building affirming friendships. For young people it may be identifying other appropriate adult supports, such as relatives or teachers. Support groups such as Twenty10's online hangOUT can assist with connecting with other LGBTQIA+SB young people. For rural and remote people, online support groups can be very helpful to help connect with other LGBTQIA+ people. QLife is a peer-run support and referral line that also offers web chat, 3pm-midnight every day.

What do I need to know...

when a trans client wants support with their gender affirmation process.

The affirmation process is not a linear pathway and is intensely personal and individual. No two people will have the same pathway, and undertaking affirmation processes is not a prerequisite for being trans. It is important to consider that there may be additional barriers such as finances, health concerns, age.

Social affirmation

This is when someone may start going by a new name (though they may choose to keep their birthname) and change their pronouns.

They may begin to change their clothing and appearance to be more in line with their gender. For young people, this may mean wanting to wear a different uniform at school and changing their name and gender marker in the school system. With parental support, schools should support this even without formal name change paperwork.

Using chosen name and pronouns is an easy way to support trans people, that significantly reduces depression and suicidality.

Legal affirmation

No formal paperwork needs to be completed for social affirmation, however when it comes to identity documents or milestones such as getting a learner's permit, it may be prudent to apply for a name change through Births, Deaths and Marriages. People under 18 need consent of both parents/guardians, or a court order.

TransHub has an excellent resource section on navigating legal affirmation.

NOTE. This is not a complete comprehensive guide of the steps to affirmation. Practitioners should seek further education and supervision. This is intended as a beginning guide to allow practitioners to support trans clients through their journey, including being able to identify appropriate support services and further information sources.

Medical affirmation

Not every trans or gender diverse person will seek out medical affirmation. Desiring surgery is not a requirement to be trans.

There are three stages of medical affirmation, though not everyone will move through all three in order, or at all.

Stage 1
Commencement of puberty blockers. This is entirely reversible.
Stage 2
Starting cross-sex hormones (e.g., oestrogen or testosterone). This stage is partially reversible.
Stage 3
Surgical intervention to change a person's physical appearance. This may include surgery directly on sex characteristics, such as mastectomy or phalloplasty, as well as plastic surgeries such as facial surgeries. The law has changed in the last decade regarding who can access what stage. Previously, people under 18 had to apply to court for the right to access any stage. Now, in cases where both parents agree, and the treating medical professional agrees, stages 1 and 2 can be pursued without court involvement. Stage 3 requires court application for people under 18 years of age. Rarely do people under 18 access stage 3.

For people under 18, there are thorough assessment processes. A paediatrician or psychiatrist will conduct an assessment, examining for gender dysphoria, and their understanding of the impact of medical treatment (Gillick Competence). Accessing medical affirmations takes time, at each stage, to make careful consideration of the young person's understanding of the risks and consequences, as well as the benefits, of each stage.

Additional Resources

Resources for organisations:

Welcome Here packs from ACON. Organisations can sign up to become a member, committing to

1) Welcome and include LGBTQ people;
2) Create positive change in your local community and;
3) Celebrate LGBTQ+ diversity.

In a more formal capacity, organisations can become Rainbow Tick accredited through Rainbow Health Australia. This is an extensive accreditation practice that involves aligning business practices with six national standards developed by Rainbow Health Australia.

Resources can be found on our portal, by navigating to the Resources page and selecting 'LGBTQIA+' from the list of categories. A few brief selections are also included here.

For practitioners:

- Australian Professional Association for Trans Health (AUSPATH)
- ACON has a range of training options here
- NSW Health's NSW LGBTIQ+ Health Strategy 2022-2027
- The Peregrine Rural Mental Health podcast: Working with sexuality and gender diverse people
- Australian Psychological Society information sheet on trans affirmation
- From Emerging Minds: Trans and gender diverse support referral matrix
- BlaQ Aboriginal Corporation provide case management support and training for First Nations people

For clients:

- National and State support services
- TransHub
- Minus18
- OutSpoken – Run by headspace for young LGBTQIA+SB people
- Rainbow Network Collection of organization and groups supporting LGBTQIA+ people
- Qlife
- Twenty10
- ACON regional NSW support services

- For family/support people:
- Rainbow Health Australia
- List of LGBTQIA+SB affirming cultural and religious organisations
- PFLAG Australia

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