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LGBTQ+ Cultural Competency

Introduction

There are many reasons occupational therapists must demonstrate cultural competence in the services they provide. Firstly, sexual orientation is one of many personal factors that impacts occupational participation as well as someone's mental health, risk for marginalization, and accessibility. In addition, cultural competence allows healthcare professionals to offer equitable care to the LGBTQ+ community and other diverse populations. Cultural competence intersects quite a bit with a therapist's ability to address concerns such as occupational injustice, occupational alienation, and occupational deprivation. Cultural competence also allows therapists to properly implement all methods of service delivery (including direct and indirect care) targeting at-risk and marginalized populations. Research shows that LGBTQ+ individuals are more likely to avoid healthcare services of all kinds due to perceived incompetence of providers in the healthcare industry. For this reason, therapists must understand how to best assist this population in a way that encourages participation and equity for all.

Section 1: Background and Definitions

References: 1-5

The concept of cultural competence was first discussed in the early 1960s when it was at the center of many political and social debates due to civil rights movements. Cultural competence has been mentioned in the literature at a steadily increasing frequency since that time. This idea has particularly garnered attention as the heart of cross-cultural relations as well as for its connection to improved health literacy, lower rates of health disparities, enhanced care accessibility, and more far-reaching health equity.

There are several definitions of cultural competence from sources across the past few decades. Some literature originally referred to cultural competence as ethnic competence, but this terminology was not popular among many experts and has fallen out of favor since that time. At the present time, the overwhelming majority of researchers agree that cultural competence is not only a necessity in efficiently managing interpersonal differences, but also a skill that can be taught and trained in real-life situations. Regardless of variations between definitions, cultural competence is widely understood as an approach that increases someone's knowledge about other cultures.

Cross et al. (1989) was one of the first authors to cite cultural competence, and this definition has been adapted many times by reputable sources over the years. This literature outlines the concept as cohesive actions, beliefs, and policies that are used as one among providers or systems to facilitate effective cross-cultural reasoning in any situation. Cross et al. also posits that cultural competence is comprised of five key elements: being conscientious of the cultural dynamics that are always at play, valuing diversity, possessing the skill of self-assessment related to one's cultural knowledge, having knowledge about cultural dynamics within institutions, and changing the way one delivers services to accurately reflect their cultural competence and understanding of diversity. Ideally, all of these elements should be implemented across policy making processes, clinical and social practice, and administrative operations within organizations. It is also recommended to incorporate cultural competence within the workplace culture itself in order to be the most effective. This source also notes that use of the word 'culture' refers to social, ethnic, racial, and religious groups as well as human behaviors including customs, beliefs, institutions, values, thoughts, actions, and communications.

Nearly 10 years later, the National Center for Cultural Competence took nearly all of the same aspects from the initial definition, but modified them by making one

important distinction. They specifically stated that organizations should use this definition as a general framework to assist with the pursuit of cultural competence. The National Center for Cultural Competence also noted that organizations should define values and principles in order to help with the demonstration of policies, structures, beliefs, and actions.

Another somewhat dated definition set forth by Lavizzo-Mourey & Mackenzie in 1996 mentions cultural competence as an overt integration and awareness of three defined issues pertaining to population health. Lavizzo-Mourey & Mackenzie identify these issues as the prevalence and incidence of diseases, the efficacy of all treatment types, and cultural values and beliefs related to health. What sets this definition apart from earlier research is not the three aspects themselves, rather the interrelatedness of each component when put into practice.

The most recent literature from the U.S. Department of Health and Human Services (HHS) and Centers for Disease Control and Prevention (CDC) jointly define cultural competence with a slight modification from Cross et al.'s original definition. The difference lies in their meaning of the word 'competence.' Cross et al. mentions competence very simply and generally: possessing the ability to effectively function. HHS and the CDC, instead, define competence from a cultural lens where an organization or individual can be effective with consideration for cultural needs, cultural behaviors, and cultural beliefs held by community members and the contexts important to them.

Research also attempts to detail cultural competency specifically related to the lesbian, gay, bisexual, transgender, and/or queer/questioning (LGBTQ+) population. One source identifies LGBTQ+ cultural competence as being able to meet three criteria: upholding structural and social equality of care, providing care tailored to a specific group of individuals, and the complete avoidance of prejudiced, discriminatory, or otherwise stigmatizing behavior. Each of these

criteria are the embodiment of cultural competence for those who are LGBTQ+ and cannot exist in isolation.

While cultural competence is crucial for all populations it impacts, it is becoming even more pertinent for those who identify as LGBTQ+. This is in large part due to marginalized populations being at risk of certain health concerns. This may occur due to intrinsic factors. For example, some research suggests that transgender individuals who receive hormonal treatments are at a greater risk of experiencing cardiovascular concerns at some point within their lives due to the impact that these hormones have on the heart and related structures. More research is needed to conclusively make this connection, yet there is a possibility this risk exists. LGBTQ+ individuals may also be impacted by extrinsic factors, such as receiving substandard care due to discrimination, which can negatively influence their long-term health. There are a host of other negative outcomes related to lack of or poor quality healthcare. For example, individuals who identify as LGBTQ+ are at a much higher risk of psychosocial distress than those who do not identify as LGBTQ+. These high levels of stress also increase their likelihood of developing cardiovascular conditions. There are many other factors that impact an LGBTQ+ individual's access to care and propensity for disease. This is an important aspect of LGBTQ+ cultural competence for healthcare providers, which we will discuss in greater detail later.

Section 1 Personal Reflection

What are some other extrinsic factors that impact the health and well-being of an individual who identifies as LGBTQ+?

Section 1 Key Words

Queer - An umbrella term used to describe anyone who does not identify as heterosexual or cisgendered

Questioning - Someone who is either unwilling or unable to describe their gender; a person may be questioning due to fear, hesitance, or curiosity regarding gender identity, or simply due to a lack of awareness of the ways in which they can identify

Section 2: Health Disparities Impacting LGBTQ+ Individuals

References: 4-32, 37, 38

There are several health concerns that LGBTQ+ individuals are at a greater risk of. Some disparities are related to habits such as substance use, while others pertain more to internal processes. Based on the reporting style of various research sources, a few health disparities are presented in a more general sense (i.e. individuals who identify under the umbrella of LGBTQ+). Most health disparities are specific to certain populations, such as bisexual men. As a whole, health disparities that relate to this population include:

- Individuals who identify as LGBTQ+ are more likely to use tobacco products than individuals who do not identify as LGBTQ+.
    - 15.3% of adults who are gay, lesbian, and bisexual smoke cigarettes compared to 11.4% of straight adults.
    - Rates of cigarette smoking in transgender adults are much higher than both other groups, currently at 35.5% .

    - Due to the known association between most forms of smoking and other health concerns, this means the likelihood of heart disease, chronic bronchitis, cataracts, lung and esophageal cancer, and other smoking-related health occurrences is also higher among gay, lesbian, bisexual, and transgender individuals than in straight individuals. LGBTQ+ individuals are also at a higher risk of other cancers, including breast cancer, colorectal cancer, and prostate cancer.

- Body mass index (BMI)
    - Women who identify as lesbian or bisexual are at a greater risk of being obese or overweight compared to women who identify as straight. Black women who are lesbian or bisexual were also more likely to be obese compared to White lesbian women.
    - Men who identify as gay are at a decreased risk of being obese or overweight compared to men who identify as straight.
    - Some groups within the LGBTQ+ population are more likely to be underweight. These include women who identify as being in the 'other' category and men who identify as being in the 'other' category, gay, or bisexual.
    - Women who identify as being in a sexual minority group are likely to have a higher BMI compared to women who are straight. Ethnic differences also play a role here, as women who are of Afro-Caribbean descent and consider themselves sexual minorities are more likely to be obese compared to White women who are sexual minorities. Afro-Caribbean women who identify as sexual minorities (particularly lesbian) are one of the most at-risk groups for obesity, hypertension, diabetes, and other obesity-related conditions.

    - There are no known disparities in cardiovascular health between Latina and White women who identify as sexual minorities.

- Black and Latina women who identify as being in a sexual minority group report lifetime trauma with a greater frequency than White women who identify as sexual minorities.
- Bisexual men are classified as obese at a rate of 69% more than heterosexual men.
- In general, LGBTQ+ individuals experience higher levels of stress along with higher rates of depressive disorders and anxiety disorders compared to straight-identifying individuals.
- In general, those who are LGBTQ+ experience higher rates of eating disorders relative to heterosexual individuals.
- Women who identify as LGBTQ+ are more likely to be the victim of sexual harassment in the workplace. The most common form of sexual harrassment LGBTQ+ women experience in the workplace is inappropriate comments from others, but this sexual harassment can also include microaggressions, hearing sexist jokes or comments, having explicit language directed toward them, or being pressured to participate in or ignore inappropriate comments, jokes, or discussions.
    - 82% of LGBTQ+ women reported being the target of microaggressions at work while 86% of bisexual women and 78% of lesbian women reported the same occurrence. This also happens to other genders, with 76% of LGBTQ+-identifying men reporting microaggressions at their place of employment. These numbers are significantly higher than microaggressions experienced by straight men (58%).

- As a group, LGTBQ+ individuals are more likely to become homeless at some point in their life when compared to straight individuals.
- LGBTQ+ individuals experience higher rates of sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) compared to straight individuals. This statistic especially applies to transgender and cisgender men who have sexual relations with other men and cisgender women who have sex with women who have male and female partners.
    - In 2021, adolescent and adult men who are gay or bisexual and reported recently having sex with other men accounted for nearly three quarters (71%) of all new HIV diagnoses in the United States. This shows men who have sex with men (regardless of their age) continue to be at an especially high risk of HIV.
    - This large disparity may be due in part to the advancements in HIV treatment that allow people a much longer life expectancy. Some experts believe this may have led to less vigilance about safe sex and HIV prevention in some people.
- In addition to tobacco misuse, research shows that LGBTQ+ individuals also misuse substances more often than straight individuals. In general, there is a strong connection between substance misuse and mental health concerns. Therefore, it's possible that many LGBTQ+ individuals misuse substances as a personal coping strategy for high stress levels, depressive symptoms, and anxiety.
- LGBTQ+ individuals are more likely to report difficulties in the healthcare process when they do seek medical care as compared to straight individuals. These difficulties include:

    - Having prior traumatic experience in the healthcare system due to interaction(s) with uneducated, insensitive, or largely ineffective healthcare professionals
    - Reporting communication with providers where derogatory language (knowingly or unknowingly) was used
    - Feeling unable to be transparent about hormone use, intimate relations, sexual health, and alternative or illegal medications (this is especially the case if hormone use is illicit)
    - Interacting with healthcare providers who made hasty, incorrect, or unfair assumptions based on the patient's appearance
    - Being the victim of discrimination due to reporting they have multiple intimate partners or one or more partners who are of the same sex as they are
    - Receiving treatment from healthcare providers who do not understand certain terminology and are either uncomfortable or unwilling to question their meanings
- LGBTQ+ individuals of all ages have less access to healthcare services than individuals who are not LGBTQ+ due to social determinants of health.
    - People who identify as lesbian, gay, or bisexual are 2.17 times more likely to delay seeking medical care compared to straight individuals. This disparity is even greater for LGBTQ+ individuals who are over the age of 65.
    - Older adults who are lesbian, bisexual, or gay are more likely to report being in poor physical health and having frequent bouts of mental distress compared to straight older adults.

    - 41% of lesbian, bisexual, transgender, and gay older adults identify as having a disability compared to 35% of straight older adults.
    - Over 30% of transgender individuals do not have their own primary care physician.
    - Individuals who are LGBTQ+ are also less likely to hold health insurance.
- LGBTQ+ individuals have higher rates of risk sexual practices, self-harm behaviors, and suicide compared to the general population.
    - In particular, adolescents who identify as sexual minorities or gender minorities are at a heightened risk of suicide.
    - One of the largest contributing factors to this disparity is minority stress, and incidence within various sexual orientations and gender identities of LGBTQ+ individuals varies.
    - In addition, factors such as socioeconomic status, race, ethnicity, geographic location, perceived stigma related to being LGBTQ+ and feeling distrustful or fearful of healthcare settings due to a history of discriminatory behaviors can all further increase this disparity.
- Bisexual women, women who are lesbians, and transgender men are less likely to seek out and receive pap smear tests compared to straight and cisgender women.
    - There are various theories on why this is the case. Most experts believe that it's due to a lack of knowledge about the risks and mechanisms of cervical cancer, which is what pap smear tests screen for.

- Women who are lesbians may be more likely to have a polycystic ovary (confirmed by imaging) or polycystic ovary syndrome compared to straight women. Lesbian women with a polycystic ovary or polycystic ovary syndrome may also be more likely to experience pronounced hyperandrogenism than straight women with these same health concerns.
    - The literature that discovered this disparity is dated, so more research is needed to conclusively confirm the link between lesbian women and polycystic ovary syndrome.
    - Hyperandrogenism is defined as having an excess of sex hormones, and this can impact anyone. Hyperandrogenism is a symptom of polycystic ovary syndrome that occurs due to hormonal imbalances.
- Chemsex practices place LGBTQ+ individuals at risk of many negative health outcomes. This risk is two-fold. A greater likelihood of dependency, addiction, unpleasant withdrawals, and (secondarily) functional changes can be attributed directly to chemsex. The act is also associated with unsafe sex, so chemsex participants are more likely to contract bacterial STIs, engage in disordered alcohol consumption, practice condomless anal sex, and experience mental health concerns or exacerbations.
    - One survey found that 10.3% of men who have sex with men reported chemsex use in the past 12 months. 65.1% of these participants reported ecstasy use, 42.5% reported methamphetamine use, and 21.7% of this sample took a sedative called gamma-hydroxybutyrate.
    - Chemsex practices - whether used in a sexual context or not - are often considered a maladaptive coping mechanism. Chemsex is largely viewed as a way to enhance one's own identity and avoid

related threats, which may make it more difficult to stop the habit as it can become central to the person.

    - Those who inject chemsex drugs are more likely to develop bloodborne viruses and infections; therefore, they are at a heightened risk of Hepatitis B, Hepatitis C, and HIV.

- Across the nation, LGBTQ+ adolescents are at a greater risk of bullying compared to their straight peers.

    - There are three main types of bullying LGBTQ+ youth experience: homophobic name-calling, sexual harassment, and peer victimization. Peer victimization involves repeated and long-term bullying by one's classmates.

    - 2021 data from the Centers for Disease Control shows that 23% of high school students who are gay, lesbian, or bisexual had been bullied on school property in the preceding 12 months. In addition, 27% of students with these sexual orientations had been cyberbullied in the previous 12 months. These numbers are compared to 7% of straight peers bullied on school property and 13% bullied on the internet in the same time frame. This research also found that 14% of lesbian, bisexual, and gay students have chosen not to go to school at some point due to safety concerns. This is compared to 7% of straight peers reporting this same tendency. This CDC inquiry also looked at the frequency of bullying in students who reported having sexual contact with others of the same sex. Data showed that 32% of these students were bullied on school grounds, 37% were cyberbullied, and 18% have at one point made the decision to not attend school due to concerns over their personal safety.

    - Numerous studies have found a link between the victimization of LGBTQ+ children/adolescents by their peers and reports or displays of depressive features.
    - More dated studies also suggest that LGBTQ+ youth are not effectively screened for violence or other secondary concerns related to gender identity or sexual orientation.
- Lesbian, gay, and bisexual individuals report overall poorer health outcomes compared to straight individuals.
    - The National Health Interview Survey looked at health outcomes for these and other individuals between 2013 and 2018. Data analysis showed definitive disparities between sexual minority groups and straight individuals, and these outcomes did not improve compared to the previous 5-year period. When looking at data from each respective groups (those who identify as lesbian, bisexual, and gay), data shows higher reports of labeling 'fair' or 'poor' as their overall health status, higher levels of functional limitations, more frequent psychological distress, and greater concern related to affording healthcare compared to straight individuals.

Section 2 Personal Reflection

Which of these health disparities feeds into other disparities listed? What other factors may lead health disparities to develop in the LGBTQ+ population?

Section 2 Key Words

Chemsex - The act of using legal and/or illicit substances as part of one's sex life; anyone can practice chemsex, but it is most common among men who are bisexual or gay

Microaggressions - Any environmental, behavioral, or verbal occurrence that is a slight toward those of different genders, races, cultures, or people who hold differing beliefs from others considered the norm; microaggressions may be intentional or unintentional and are often common and subtle, but they always send or perpetuate messages of hostility and negativity

Section 3: Research on Culturally Competent Care for LGBTQ+

References: 33-46

While there is still much research needed in the realm of LGBTQ+ cultural competency, existing studies share similar sentiments about the current state of LGBTQ+ healthcare. A range of literature discusses the need for more research, more inclusivity, and more education in this area to help all organizations overcome implementation barriers.

In terms of specific research, some studies have looked at the benefits of LGBTQ+ cultural competency training programs. Yu et al. (2023) performed a systematic review on the topic, which found that LGBTQ+ cultural competency training targeting healthcare professionals was effective. Investigators highlighted several elements that made this training efficacious, including: addressing skills to work with this population; knowledge of LGBTQ+ health concerns, culture, and historical issues that impact their lives; discovering providers' disposition toward LGBTQ+ individuals; and current capacity for following LGBTQ+- and gender-

affirming practices using a multimodal, interdisciplinary lens. This study also mentions a large barrier to the widespread adoption of LGBTQ+ cultural competency regulations: federal and state policies that restrict LGBTQ+ healthcare and inclusive practices as a whole. These barriers not only impact the efficacy of any competency training on this topic, but also the contents of that training. This two-pronged effect means participants must take these and other obstacles into consideration when crafting their approach with LGBTQ+ individuals.

The electronic health record (EHR) is another aspect of the healthcare process that is often inadequate in addressing the needs of the LGBTQ+ community. While many organizations are attempting to modify EHRs and related documentation systems to be more inclusive, there are still many barriers in the way of user action and technical systems. Chittalia et al. (2020) found there are two main challenges in creating inclusive EHRs. The first involves technical concerns related to enabling secure, comprehensive data collection that supports the unique needs of the LGBTQ+ population. The second barrier is moreso related to professional interactions, and entails crafting LGBTQ+ awareness and having empowering healthcare professionals on the treatment team to minimize stigma and build trusting relationships. In combination, remedying these two challenges stands to greatly improve access to high-quality care for this population.

Demographic traits and associated experiences have also been found to have an impact on LGBTQ+ competency. Nowaskie et al. (2022) dug deeper into the specific demographics of healthcare professionals who demonstrate higher levels of LGBTQ+ competency – both in their knowledge and clinical skills. Straight, cisgender, White women in the study possessed greater knowledge of LGBTQ+ principles than men with the same demographics did. Interestingly enough, these same women demonstrated significantly lower clinical preparedness for treating LGBTQ+ individuals compared to their male counterparts. Unsurprisingly, healthcare professionals who identified as sexual and gender minorities were

more competent in LGBTQ+ knowledge compared to straight and cisgender healthcare professionals. Healthcare professionals who were considered racial minorities also demonstrated some of the highest scores in LGBTQ+ knowledge. Such results lend support to the idea that healthcare professionals with these lived experiences should be central in the creation of competency training for optimal effect.

Just as members of the LGBTQ+ community are essential to training formation, all individuals working in healthcare should be required to take training of this nature. Including healthcare professionals of all levels and job types in LGBTQ+ competency training is hypothesized to improve the effectiveness of this training. Findings from a randomized controlled trial by Boekeloo et al. (2023) support this thought. This study involved testing the utility of a virtual multi-strategy training implemented via individual sessions with healthcare professionals from all levels. This study was unique in that it encompassed professionals involved in direct care and those on the administrative side of healthcare. Study results showed that, before the training, therapists demonstrated relatively high levels of knowledge and affirmative attitudes, but lower scores regarding displays of self-efficacy in the field, engagement in affirmative practices, and commitment to continued LGBTQ+ cultural competence. After the intervention, the control group demonstrated higher scores in self-reported affirmative attitudes along with affirmative practices. Satisfaction scores regarding the program itself were similarly high among therapists and administrators, which shows promise regarding participant interest and engagement.

Another way researchers can gauge (and address) participant motivation and engagement in these trainings is by looking at the aims of those who register for LGBTQ+ competency training. Some studies have looked into this by introducing novel evaluation factors when assessing LGBTQ+ competency training. Most of the existing body of research has weighed some of the same factors in their

assessment of competency programs: knowledge of LGBTQ+ information, self-efficacy, and affirmative attitudes. However, Rhoten et al. (2022) advocated for the incorporation of a new factor: 'intentions of those who seek out LGBTQ+ competency'. Rhoten et al. came to this conclusion after reviewing "Best Practices in Creating and Delivering LGBTQ Cultural Competency Trainings for Health and Social Service Agencies" and its associated training curriculum, which were both created by The National LGBT Cancer Network in New York. This best practices document and related materials were intended to educate health and human services professionals, and the training yielded improvements in attitudes, knowledge, self-efficacy, and intentions. In particular, improvements in self-efficacy and intentions were closely correlated with one another.

Some literature has looked at other aspects of effectiveness in LGBTQ+ training: the amount of education needed to produce the desired effect of cultural competency. Researchers tried to determine how many hours of education in this area is needed to produce improvements in LGBTQ+-related knowledge and clinical skills. Nowaskie & Patel (2020) assessed the relationship between annual LGBTQ+ curricular hours in medical programs and the attitudinal awareness, clinical preparedness, and overall knowledge of medical students. Results showed that medical students who engaged in 35 or more annual hours of continuing education (either via caring for 35 or more LGBTQ+ patients or spending this much time dedicated to learning) reported significantly greater levels of knowledge and clinical preparedness. Those who participated in fewer or much fewer hours did report high attitudinal awareness, but only moderate knowledge and low preparedness. Therefore, the higher number of 35 annual hours seems to be the most sound recommendation, as it's associated with improvements in all three domains.

Nowaskie decided to take this research one step further by looking at the amount of LGBTQ+ education in particular disciplines, such as dermatology. In this study,

Nowaskie et al. (2022) surveyed dermatology residents across the nation and found these providers received fewer than 75 minutes of continuing education related to LGBTQ+ competency each year. Results also showed that, in one year, these residents care for less than 20 patients who identify as LGBTQ+. Study participants reported higher attitudinal awareness compared to lower levels of clinical preparedness and basic LGBTQ+ knowledge. However, their levels of basic knowledge were significantly higher than their clinical preparedness, which scored the lowest of all three categories. Dermatology residents also stated they have insufficient LGBTQ+ competency, clinical training, supervision, and experience to feel skilled in the assessment and treatment of LGBTQ+ individuals in practice. It is of note that residents who were outliers (e.g. they received more than the average 75 minutes of annual LGBTQ+ continuing education and treated more than the average 20 LGBTQ+ patients yearly) also reported higher levels of LGBTQ+ cultural competency. There are several conclusions to be made from these two studies cumulatively. Firstly, setting minimum requirements for education may lead to improvements in LGBTQ+ competency; however, fulfilling these requirements is not necessarily an indicator of sufficient LGBTQ+ competency, knowledge, and actionable skills. In addition, these studies show that LGBTQ+ competency issues likely impact the entire healthcare field, regardless of discipline or education level. While physicians spend more years in academic programs than most other healthcare professions, there is still a major dearth of LGBTQ+ training for these (and other) clinicians.

Another piece of research by Nowaskie et al. (2020) assessed competency levels across students in various healthcare professions. The sample included pharmacy, physician assistant, medical, occupational therapy, dental, social work, and physical therapy students. Results from this comparative study found that most students reported very high levels of attitudinal awareness along with moderate basic knowledge and low clinical preparedness. This pattern aligns with many

other forms of research on the topic. However, this analysis also looked at the individual scores for each discipline across all categories. These researchers weighed scores on the LGBT-Development of Clinical Skills Scale (LGBT-DOCSS), the number of LGBT patients treated annually as part of clinical rotations, and the yearly formal curricular hours dedicated to LGBT topics. Students of social work were found to have the highest scores across the board while dental students had the lowest scores in all areas with the exception of clinical skills. Data showed a major difference between the amount of LGBT patients treated on a yearly basis and hours of education dedicated to LGBT care. Dental students had the lowest average for LGBT patients treated per year (<1), and physician assistant students reported caring for the highest amount (7.59). When looking at the annual amount of formal education related to LGBT individuals, occupational therapy students had the lowest at .51 hours while social work had the highest at 5.64 hours. Investigators also found a positive correlation between treating more LGBT patients and reporting higher attitudinal awareness scores.

Other pieces of literature support evaluating the impact of training as a crucial component of LGBTQ+ cultural competence for healthcare professionals. Pratt-Chapman et al. (2022) discuss this as well as knowing the audience being trained, incorporating feedback into the curriculum design as it is received, using multiple trainers for varied educational opportunities, and employing transformational and adult learning theories. This guidance helps vary the learning experience for participants while still tailoring it to each individual. Variable practice (combined with repetition) and instruction based on someone's learning style are important for knowledge retention and skill development, regardless of the subject matter. This also relates back to the systematic review by Yu et al. (2023), which mentioned the importance of using a multimodal approach in such training.

Physical rehabilitation is not the only aspect of healthcare that should be LGBTQ+ culturally competent, as behavioral healthcare is equally important for individuals.

Williams et al. (2022) looked at the governing documents for several mental health professions to ascertain factors that contribute to LGBTQ+ competence in those clinicians. This study involved an analysis primarily of codes of ethics and training program guidelines, and found five common themes: direct practice, clinician education, advocacy, professional development that is culturally competent in nature, and missions and values. This review also determined that discipline-specific expectations for provider competency in LGBTQ+ topics varied greatly. Williams et al. goes on to state how critical competency uniformity is in meeting the wide breadth of needs LGBTQ+ populations express.

Research from Lee et al. (2021) looked at the efficacy of advanced LGBTQ2S+ training sessions implemented by LGBTQ2S+ elders and experts by comparing it to standard education in this area. Results showed the advanced training participants displayed significant improvements in knowledge of and attitudes toward LGBTQS+ individuals compared to those who took the standard training. In addition, the advanced training was associated with highly relevant performance changes during clinical simulations, whereas these same changes were not observed in those who partook in standard training. Lee et al. concluded that integrating specific LGBTQ2S+ training into academic education for healthcare professionals can greatly enhance the LGBTQ2S+ population's accessibility to appropriate, inclusive care.

As you can see, there is a range of evidence in support of LGBTQ+ cultural competency training within healthcare settings. Research also demonstrates the need for culturally competent care based on the current knowledge and skill levels of providers across many healthcare disciplines. In accordance with the profession's code of ethics, the Occupational Therapy Practice Framework, and other foundational documents, occupational therapists should be prepared to cultivate their own cultural competency in this and other areas to provide the most efficacious care.

Section 3 Personal Reflection

What are some resources occupational therapists can utilize to measure and improve their LGBTQ+ cultural competency?

Section 3 Key Words

Adult learning theories - A range of learning techniques based on someone's unique educational preferences; common adult learning theories include self-directed learning, project-based learning, experiential learning, constructivism, readiness to learn, and social learning

Attitudinal awareness - An accurate perception of one's disposition, non-verbal communication, tone of voice, and more in various situations

LGBTQ2S+ - A variation of the traditional LGBTQ+ spectrum that includes two-spirit (often abbreviated '2S'), which describes those who have both a feminine and masculine spirit within one body, therefore, identify as both male and female; two-spirit is a term created by and for indigenous people and is a reflection of indigenous cultures' views on gender and sexuality; two-spirit can be used as a gender identifier or a descriptor of sexual orientation

Transformational learning theory - A style of learning that involves a significant change in the way someone interacts with and views the world around them; transformational learning involves reevaluating personal values, beliefs, and assumptions

Section 4: Occupational Participation and Interventions for the LGBTQ+ Community

References: 15-17, 23, 47-63

Unfortunately, the LGBTQ+ community still experiences occupational challenges that impact participation and performance. This population may report some of the following concerns related to occupational participation:

- Being presented with safety concerns while engaging in occupations publicly or in settings with few LGBTQ+ individuals
- Difficulty accessing safe, stable housing, especially as LGBTQ+ individuals age
- Expending an excess of resources (time, mental effort, physical energy, and money) to seek new, meaningful occupations or alleviate barriers to participating in current occupations
- Experiencing discrimination against gender and personal identities across multiple contexts
- Facing economic obstacles such as employment discrimination, associated job instability, and difficulty obtaining health insurance coverage, all of which can lead to financial instability
- Having to navigate state policies and other legal barriers that prevent or limit LGBTQ+ individuals from accessing certain medical services
- Overcoming real or perceived stigma related to negative coping strategies and their effects
    - For example, many LGBTQ+ individuals engage in substance use as a way to cope with discriminatory behaviors, internal conflict, and feelings of unrest. If not managed, substance use has the potential to lead to dependence, which is associated with homelessness, job loss, financial instability, and other negative outcomes. Members of this community who are homeless have particular difficulty with

discrimination, as studies show the amount of time an LGBTQ+ individual is homeless is positively correlated with the frequency of discrimination they experience.

- Struggling to attain a sense of belonging within the contexts they frequent
    - This may apply to contexts where there are little to no other LGBTQ+ individuals
    - LGBTQ+ individuals may also feel a lack of belonging in contexts with other LGBTQ+ people; for example, a bisexual man may feel out of place or even be treated differently when going to a bar that primarily serves lesbian women
    - This very often comes along with isolation and underrepresentation in contexts where LGBTQ+ individuals are not often found or are not often openly integrated within, such as corporate workplaces.

Occupational therapists are uniquely positioned to help LGBTQ+ individuals through many of the occupational concerns pertinent to their lives. Some occupational therapy interventions for the LGBTQ+ community include:

- ADL retraining after gender reassignment surgery or during the social transition process
    - All ADL intervention should be mindful of the patient's personal needs and preferred terminology.
    - Dressing techniques may include donning/doffing form-changing garments or chest binders as well as education on wearing schedules and safe usage.
    - Hygiene and grooming retraining can include makeup application, shaving, and hair styling.

    - Toileting education (including proper seating and positioning while toileting) should include the maintenance of surgical precautions for those recovering from a vulvoplasty or vaginoplasty, the safe and consistent use of public restrooms along with education on the risks of holding bodily fluids in, planning bathroom trips, and the use of adaptive equipment to make the experience more comfortable.
        - Therapists should include education on the hazards associated with limiting urination and defecation, including constipation, UTIs, dehydration, and kidney damage.
        - Therapists should also avoid making assumptions about the way in which someone urinates, as this practice may be unique to the person and not follow traditional gender stereotypes
    - Sexual participation should be addressed after any gender-affirming procedure; therapists should also offer inclusive (non-cisgendered) sexual education focused on safe positions after other surgeries including but not limited to joint replacement surgeries and cardiac procedures.
        - During surgical recovery periods and for those with chronic conditions that cause physical symptoms such as joint pain or genital discomfort, OT intervention can also include education about other ways to increase intimacy outside of traditional sexual intercourse.
- Education on and advocacy for use of community resources that may assist with participation
    - For individuals who are transgender, this may include assistance with legal name changing.

- Community resources include food banks, domestic violence shelters, homeless shelters, places to seek orders of protection, processes for custody cases, and more.
- Therapists can assist LGBTQ+ students by advocating for accessible bathrooms, equal participation in traditionally gendered activities such as sports, diversity and anti-bullying training within school settings, and LGBTQ+-friendly programming for students and staff alike.
- Therapists can advocate for LGBGTQ+ employees experiencing difficulties in the workplace related to fair hiring and promotion practices, financial inequality, discriminatory treatment, workplace bathroom access, poorly aligned culture fits, and workplace attire requirements.
- For therapists working in academia, advocacy can extend to include LGBTQ+ individuals of all ages in problem-based learning and clinical simulations as well as in other aspects of curricula such as textbook writing, assignment topics, and fieldwork experiences.
- Therapists working with LGBTQ+ students in the school system should advocate for school mediation in LGBTQ+ youth who are at risk for violence or harassment. Research shows that mediation is a protective factor for this population, and these services may include new policies, having more resources regarding sexual orientation and gender identity, professional development to improve the responsiveness of educators, student-led organizations that promote positive gender and sexual orientation expression, and more supportive curricula.

- Healthy rest and sleep
    - Individuals who are LGBTQ+ experience lower sleep durations than non-LGTBQ+ individuals, so interventions can target this through the use of sleep hygiene, a healthy diet, adequate physical activity, and the use of relaxation strategies.
    - Therapist education should cover the difference between rest and sleep along with how someone can improve the quality of both occupational areas.
- Inclusive play and leisure
    - This can include non-gendered toy recommendations for toddlers and children, promoting fair participation in sports and other activities that still follow traditional gender roles, and enabling LGBTQ+ children to participate equitably in activities with others who may or may not share similar needs and interests.
    - Children and adolescents who identify as LGBTQ+ may benefit from participating in LGBTQ+ community centers to help with shared social and leisure opportunities.
- Personal development through productive leisure and other means
    - This may entail finding new leisure activities or resolving and minimizing barriers to existing leisure activities.
    - Therapists may use empowerment and meaningful occupations to help LGBTQ+ individuals develop a positive self-image to help with personal development efforts.
    - Confidence building, healthy coping techniques, developing social supports, exploring new skills, community reintegration, personal

safety plans, and setting goals are just some ways OTs can assist with mental health and personal development concerns in this population.

- Medication management
    - This is a fitting intervention for many LGBTQ+ patients with chronic conditions, but may be particularly salient for older adults who identify as LGBTQ+ and members of this community who are undergoing hormone therapy or recovering from gender-affirming procedures.
- Mental health support for any LGBTQ+ individual during the initial transition period
    - This can focus on multiple contexts, including the workplace, healthcare settings, the home environment, religious gatherings, social outings, and more.
    - Some individuals may benefit from virtual and in-person mental health resources for more person-centered, preferential support.
- Modifying patient education materials not only to be inclusive of LGBTQ+ individuals, but also to accommodate older adults in this community
- Navigating social barriers that prevent occupational engagement
    - To improve ADL participation, intervention may involve finding clothing to help with gender expression and identity confirmation.
    - To improve social participation and interpersonal relationships, intervention may focus on communication skills when speaking with family members who are not accepting of their identities.
- Participation in spiritual or religious practices

    - Therapists should be sure not to make any assumptions about LGBTQ+ patient's spiritual or religious affiliations.
    - While some religious organizations have discriminated against LGBTQ+ individuals, it is also important to not make assumptions about this history.
- Safe, supportive engagement in nighttime leisure
    - Therapists may provide education and intervention surrounding chemsex and related risks as well as safe sex practices, hydration, protection against intimate partner violence, and safety associated with traveling in groups.
- Screening consistently for chronic health problems
    - Since this population is at a greater risk of health disparities such as low access to care, preventive interventions are especially important.
- Securing safe long-term housing
    - Many long-term care facilities are not LGBTQ+-friendly, so older adults and even younger members of this community with chronic conditions may have difficulty finding comfortable, long-term accommodations on their own.
- Social participation and community integration
    - Community connectedness is one of the most important protective factors for LGBTQ+ adolescents and adults who are at risk of suicide. This type of integration (and other interventions) reduces exposure to minority stress.

- Vocational training to assist with finding and/or maintaining gainful employment
    - Some LGBTQ+ individuals may benefit from supportive employment programs for more structured job-related assistance over time.

General LGBTQ+ Cultural Competency Considerations for OTs

- Adopt principles from affirmative therapy, which embraces a positive view of all LGBTQ+ aspects including identities, relationships, and expression.
    - Within primary care settings, affirmative therapy providers can use tailored assessments and interventions to help with the therapy process.
    - Observe holidays relevant to this population, including LGBTQ+ Pride Day, National Transgender Day of Remembrance, and World AIDS Day.
- Advocate for the improvement of quality medical care for LGBTQ+ individuals
    - Previous research we reviewed emphasized the importance of each healthcare profession implementing changes across direct practice, advocacy, and other areas. Advocacy is an often overlooked aspect of OT practice, but a crucial one, especially for underserved and underrepresented populations such as those who are LGBTQ+.
    - Advocacy can be within a clinician's organization (e.g. a clinical setting) but should also go as far to reach others who are involved in the healthcare process such as payers, lawmakers, stakeholders,

social service providers, and other affiliates who collaborate with healthcare professionals at any rate.

- In particular, some research has outlined how therapists can lead insurers in enhancing quality LGBTQ+ care. One study notes clinicians should follow five key steps in this process:
    - Aim for organizational buy-in not only through verbal support but also tangible means such as clear messaging from leadership, the formation of new initiatives, and the allocation of resources
    - Improve customer service for and engagement from LGBTQ+ individuals by collecting meaningful feedback from existing LGBTQ+ members and using this data to aid in strategy development for change and continual quality improvement efforts; customer service improvements can come from training to improve inclusivity and effectiveness of interactions; member satisfaction surveys should gain insight into the member experience and can include but is not limited to the use of inclusive language and programming that meets individual needs
    - Tailor the physical environment of treatment spaces to offer a sense of safety, privacy, comfort, and warmth
    - Ensure all forms and other methods of data collection are in line with other inclusive practices; for example, a practice's EHR should be modified as often as is needed as well as integrated forms within the system, non-integrated forms the

practice has created, and any other materials patients may interact with

- Offer staff training on innovative topics for all healthcare staff and their affiliates in order to usher in a new culture and encourage continued professional development; relevant topics in this realm include best practices when working with LGBTQ+ individuals, recent EMR changes at said organization to assist with improved treatment, LGBTQ+ terminology to help with documentation and interpersonal relations; for optimal outcomes, continuing education should be in a multimodal learning format using methods such as panel discussions and workshops; ideally, there should also be easily accessible internal resources for all staff to refer to as needed to enhance retention (e.g. an internal web page with definitions of common terms, external links for more information, presentation slides for staff to refer back to, etc.)
- Implement health system policies that support an encouraging environment and offer protection for all those in need

- In terms of policies that should be added or updated, some examples include nondiscrimination policies, equal visitation policies (in residential institutions such as hospitals and skilled nursing facilities), policies that delineate a patient's ability to openly select a support person, protocols for disciplinary action when any inclusive policies are violated, and gender-neutral/inclusive language in all job postings.
- Therapists should join professional therapy associations specializing in LGBTQ+ practice and LGBTQ+ advocacy groups, and also

collaborate with LGBTQ+ healthcare organizations whenever possible to promote inclusivity and take on health disparities impacting this population.

    - Another best practice when advocating for LGBTQ+ rights is staying informed about existing and new legislation at the local, state, and national level that impacts this community.

    - In order to receive insurance coverage for gender-affirming medical care, transgender and non-binary individuals must be diagnosed with gender dysphoria. While this unfortunately limits those in need of urgent care and those who cannot easily obtain diagnostic services, therapists should educate patients on this important first step. This is also another point for advocacy – either removing this requirement or making it more accessible.

    - Therapy practices can participate in referral programs such as GayHealth or the Gay & Lesbian Medical Association (GLMA), not only to gain access to cultural competency resources but to expand their patient base.

- Be aware of and make accommodations for specific health concerns facing bisexual women, lesbian women, gay men, bisexual men, and transgender individuals, rather than treating the community with blanket recommendations.

    - Clinicians treating lesbian and bisexual women should offer education to dispel the myth that they do not need regular pap smears and other gynecological screenings. Additional areas of discussion and education for this population that should not be omitted or overlooked include:

        - Contraception
        - The desire to bear children
        - Safe sexual practices to combat higher rates of sexually transmitted infections and HIV
        - Mental health support to manage higher risk and rates of tobacco, alcohol, and drug use, chronic stress, and depression
        - Screenings for conditions related to obesity including heart disease, diabetes, and hypertension, and related counseling for those who are overweight or obese
        - Comprehensive cancer screening to lower the risk of some forms of cancer, which can be higher in women who do not bear children
        - Complications related to geriatric pregnancies, which are common in lesbian and bisexual women
        - Health insurance coverage with consideration given to women who are prescribed expensive medications and require frequent follow-up visits for chronic or active health concerns
        - Safe, inclusive resources to assist with intimate partner violence, as some states do not recognize domestic violence between same-sex partners and women may be unable to utilize women's shelters in a fair and equitable manner as a result
    - The same applies to bisexual and gay men, as there are some salient points of education and intervention that should be covered with these individuals:

        - Mental health concerns stemming from isolation and depression related to potential loss of family/community, which may be the case in bisexual and gay men from certain cultures
        - Mental health support to manage higher risk and rates of tobacco, alcohol, and drug use, chronic stress, suicide, and depression
        - Comprehensive cancer screening to include human papillomavirus (HPV) testing and that for anal cancer
        - Screenings for conditions related to obesity including heart disease, diabetes, and hypertension, and related counseling for those who are overweight or obese
        - Community resources to assist with those experiencing financial instability and prevent poverty, homelessness, and related concerns
        - Safe sexual practices to combat higher rates of HIV and other sexually transmitted infections associated with anal sex
        - Community resources to assist with the poor insurance access those with same-sex partners may experience
    - Before asking patients about their sexual health and other personal habits, therapists should clearly state their reasoning prior to doing so. This not only makes the patient more comfortable, but helps them understand the relevance.
    - Make patient reading materials relevant and accessible. This may include adding brochures, magazines, and fact sheets to the waiting

room on topics such as safe sex, hormone therapy, substance misuse, and STI treatment.

- Consistently screen for intimate partner violence and mental health concerns to address the greater risk in this population
- Refrain from making assumptions
    - This is good practice for all therapists, but it is paramount for therapists working with LGBTQ+ individuals. Providers must avoid making assumptions about a patient's sexual orientation based on their gender or vice versa. For example, it is perfectly reasonable for an OT to have a transgender male patient who identifies as straight or gay.
    - Another recommendation for providers is to ask necessary questions to discern what is needed to treat the patient. Clinicians should avoid unrelated or extraneous probing, which can make an LGBTQ+ patient uncomfortable.
    - Making assumptions, especially surrounding disclosure, can be very harmful to the therapeutic relationship and the mental health of LGBTQ+ patients. Healthcare providers can facilitate disclosure, but should tread very carefully and follow their patients' leads at all times. Disclosure is a very personal event in an LGBTQ+ individual's life, so they should have complete autonomy over the entire process of disclosing their gender identity and/or sexual orientation.
- Use inclusive language at all times
    - There is often slight variation across many acronyms and terms within the LGBTQ+ arena, which can lead to confusion and even frustration from some individuals attempting to use the most inclusive language

possible. Rather than viewing language in a linear or black-and-white manner, researchers urge people to instead look at language as a vehicle of social change. For example, some people view the 'Q' in LGBTQ+ as standing for 'queer' while others may define it as 'questioning.' The overarching intent of language is to be used in a way that does not exclude anyone from the conversation. This means that our language is undergoing constant change (specifically related to LGBTQ+ matters) to ensure it is descriptive, inclusive, and clear enough to convey the message it wants to.

- When speaking about a patient's relationships, use terms like 'partner' or 'spouse' rather than 'husband' or 'wife.' It's also more appropriate to use the term 'they' instead of 'he' or 'she' until the patient has specified their pronouns.
- Therapists are encouraged to ask about a patient's pronouns if they do not express them on their own. After that point, therapists should use the language the patient prefers. Another way to incorporate inclusive language is to ask open-ended questions and gather data to inform next steps.
- This guidance regarding inclusive language should extend to all physical and virtual spaces in the healthcare setting, such as websites, magazines, pictures, brochures, bathroom signage, non-discrimination policies, consent forms, intake paperwork, OT records and other types of medical documentation, and more. Therapists tasked with managing these areas (i.e. those who are self-employed) should make adjustments and therapists who work in larger organizations should advocate to administration for changes in this area, as needed.

- When amending forms, healthcare organizations can add a box for transgender individuals that sits next to the ‘male’ and ‘female’ boxes. However, for the most inclusivity, forms can simply have a fill-in box to allow someone to identify in a different, more descriptive manner. This is just one example, but considerations like this should be made to optimize the healthcare experience for everyone.
- When creating health service materials, use general terms (e.g. “We treat the full spectrum of women’s health concerns.”) or be inclusive of all sexual orientation categories (e.g. “We treat homosexual, bisexual, and heterosexual individuals with any type of health concern.”) as this maintains patient privacy and inadvertent disclosure.
- Another way for healthcare facilities to remain inclusive is to devise systems that allow patients to automatically meet with the same provider over the course of their treatment plan.
- LGBTQ+ patients may prefer providers of the same gender as them, and organizations should make every attempt to pair patients based on preference.

Section 4 Personal Reflection

What is the best way for therapists to find LGBTQ+ organizations to partner with or work for?

Section 5: Case Study #1

An OT has begun working at a newly-established outpatient clinic and is quickly promoted to therapy manager. She is excited about the new role as well as the

ability to bring positive change to her local community. She lives in a large city with a notable LGBTQ+ population. The OT is in the planning stages to prepare for their launch and is not aware of any considerations being given to inclusive and accessible services for LGBTQ+ individuals.

1. What are some of the first steps she should take to create a welcoming environment for her clinic?
2. What partners should this OT collaborate with from the beginning to help with her efforts?
3. Since they are in the early stages of operation, would this facility benefit from LGBTQ+ cultural competency training for their staff?
4. If this clinic were to expand their services beyond just rehabilitation therapies, what can they consider adding to best meet the needs of local LGBTQ+ individuals?

Section 6: Case Study #1 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What are some of the first steps she should take to improve accessibility for LGBTQ+ patients in her clinic?

   Creating a welcoming environment for LGBTQ+ patients is crucial for this therapist, given there are many LGBTQ+ individuals in their local area. The physical space will need to be welcoming along with their processes. Since they are not yet in their clinic, the therapist can make a plan of how she wants it to look once they open. She can reach out to LGBTQ+ organizations

to get educational reading materials for the waiting room. She can also plan to work with the builders to create and affix some LGBTQ+-friendly signage, including non-gendered bathroom signs and rainbow-colored art pieces, as well as interior designers to create some stylized LGBTQ+ information posters for treatment spaces. In terms of processes, this therapist can work with clinic leadership to develop the company's mission, vision, purpose, and policies with heavy consideration given to inclusive lingo. This manager may also be involved in the creation of documentation and forms for the clinic along with helping choose an EMR. Whether she is solely responsible for these items or has a say in them, the therapist should ensure all forms use gender-neutral language and fill-in boxes whenever possible to allow for personal descriptors. The EMR chosen should be inclusive or, at the very least, heavily modifiable to allow their clinic to personalize it according to their patient base. The therapist should ensure the clinic sets forth a non-discrimination policy early on along with other foundational policies.

2. What partners should this OT collaborate with from the beginning to help with her efforts?

   Regardless of whether the clinic aims to market to LGBTQ+ patients or not, they should partner with and/or learn from other LGBTQ+ healthcare organizations. This sets the precedence early on that the clinic will be a welcoming space for this population. This can help with structuring their care respectfully and garnering referrals when the time comes. This clinic would also benefit from a partnership with LGBTQ+ organizations, especially within the healthcare sphere, to assist with resources for their staff and general guidance.

3. Since they are in the early stages of operation, would this facility benefit from LGBTQ+ cultural competency training for their staff?

Yes, absolutely. It doesn't matter how early on this company is in its tenure – their staff still need to demonstrate and maintain LGBTQ+ cultural competency in order to provide effective care.

4. If this clinic were to expand their services beyond just rehabilitation therapies, what can they consider adding to best meet the needs of local LGBTQ+ individuals?

   LGBTQ+ individuals have a higher risk of mental health concerns, substance use disorders, and certain chronic health conditions. Therefore, this clinic could benefit from hiring a few LGBTQ+-informed primary care providers to provide preventive health screenings and referrals for more concentrated services. This clinic could also hire a few counselors, social workers, or other dedicated behavioral health professionals with LGBTQ+ experience to offer mental health support services to their patients.

Section 7: Case Study #2

A school-based OT is treating a 12-year-old bisexual male for motor coordination concerns related to a resting tremor. The therapist has been treating this student for 1.5 years and they have a great rapport. The student told the therapist that he recently came out to his family. He appeared quite distressed during this session because his family did not take the disclosure well. The student was considering coming out to his peers afterwards, but is now reconsidering that. Two days later, the therapist hears from other teachers that the student's academic performance has declined sharply this past week and they are concerned for his mental health.

1. What initial interventions and approaches can the OT use with this student?
2. Would this student benefit more from direct or indirect intervention addressing these mental health concerns?

3. Should the OT involve this student's family in intervention to attain more benefit?

Section 8: Case Study #2 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What initial interventions and approaches can the OT use with this student?

   Since the student is being treated in a school-based setting, his mental health should be addressed but from a lens of how it impacts his academic performance and function. The therapist should work with the student to develop healthy coping strategies within his routine as well as other aspects of his coming out and community integration/social interaction with his peers.

   The therapist should utilize an affirmative approach with a focus on validating the student's feelings and ensuring as much inclusivity as possible within the school environment. This can blend together with OT advocacy to help the student get more involved and feel more accepted and comfortable within his school.

   If the student is not already receiving formal mental health services, the therapist should also make a referral to the school psychologist or guidance counselor to prevent more severe mental health concerns from arising. The therapist should use their rapport with this student to have a conversation regarding new areas of priority regarding his transition. If these mental health concerns prove to not be temporary and there is a major change in the student's status, the OT should contact the Director of Special Education

at the school to perform a review of the student's IEP and add other services and support, as needed.

2. Would this student benefit more from direct or indirect intervention addressing these mental health concerns?

   If these mental health concerns persist, the student may need direct OT intervention in the areas of study skills, routine building, goal setting, and management of concerns related to anxiety, depression, and/or chronic stress. However, the student can also benefit from indirect OT services through advocacy for LGBTQ+ programming and curricula as well as LGBTQ+ competency training for school staff. The OT can also engage in advocacy when speaking with the student's parents to encourage carryover to the home and community environments. This may include finding support within the local neighborhood, sense of belonging and acceptance at home, and family-based therapy on an outpatient basis.

3. Should the OT involve this student's family in intervention to attain more benefit?

   As mentioned above, it's ideal for the student's family to be at least somewhat involved in intervention. At minimum, this would require correspondence to relay some outpatient resources to more effectively support the student. This level of involvement is recommended for most school-based therapies, as parents have the ability to weigh in on the IEP formation and intervention over the course of the school year. However, due to the tension between the student and his family regarding his coming out, the student may have difficulty with this. The therapist should mention this to the student and allow him to be part of this discussion with his parents if he chooses to do so. If he opts to be part of the discussion, the therapist can review coping strategies with him, do role play so he knows

what to expect and how to respond effectively. If he chooses not to participate, the therapist should relay to him the same information she gave to his parents so they are all on the same page.

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