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outsideIN BEST PRACTICES

Mental Healthcare Providers

INTENDED AUDIENCE

This document is intended to support mental healthcare providers (such as counsellors, therapists, mental health nurses, social workers, etc.) who work with gay, bisexual, trans, Two-Spirit and queer male **(GBT2Q**) clients, whether or not those clients have disclosed their sexuality.

AUTHORS

This document is written by GBT2Q-identified health promotion specialists located in Vancouver, BC and based on multi-level consultation with mental healthcare providers and GBT2Q community members.

INTRODUCTION

For the purposes of this document, we use the term **more out** and **less out** to describe the distinction between groups of people who engage with **outness** differently.

As mental healthcare providers, we recognize the many complex factors that can affect mental and overall well-being. When our clients belong to sexually diverse groups, these factors can be especially nuanced and difficult to navigate.

Mental healthcare most often prioritizes the importance of person-centred and trauma-informed care, which is why we must remain vigilant for certain assumptions which when acted upon that can make GBT2Q who are **less out** feel uncomfortable, coerced, silenced, and isolated. Experiences like these can discourage clients from accessing mental health support, while the data shows that this part of the community is in great need of it.

MORE THAN 1 IN 4 (27.2%) MEN WHO HAVE SEX WITH MEN IN CANADA SAY THEY HAVE NEVER 'COME OUT' TO ANYONE, INCLUDING ANY HEALTHCARE PROVIDER. [SEX NOW 2014-5]

HOW YOU CAN HELP

We encourage service providers to interrogate their assumptions around their clients' **outness** along with the concept of **outness** as a whole. We hope to help foster an environment where **less out** community members feel more comfortable accessing the services and help that they need.

UNIQUE HEALTH NEEDS OF THOSE OF US WHO ARE LESS OUT

Health Initiative for Men (HIM) conducted an extensive literature review of outness, self-identification, and mental health practices.

This literature review found that less out GBT2Q experience unique negative health outcomes compared to their more out GBT2Q counterparts:

> **"Stigma concealment" and its numerous negative outcomes which include:** increased levels of shame, guilt, and disrupted relationships (Pachankis et al., 2015); increased symptoms of depression and anxiety (Beals, Peplau, & Gable, 2009; Frost et. al, 2007); and impairment of intimacy, social relationships, and increase negative feelings related to secrecy (Herek 2003).

> **Social inequities including unreported intimate partner violence and weak support networks, which are associated with increased feelings of isolation and participation in 'riskier' sexual activity.** Those who are **less out** report higher rates of condomless and unprotected anal sex with a person whose sexual health status is unknown, and are less likely to report when experiencing intimate partner violence compared to other men who experience similar violence and isolation but are **more out** (Pitpitan et al., 2016; Goldenberg et al., 2016).

> **A significant preoccupation with one's stigmatized sexuality** associated with impairment of long-term social relationships, anxiety and decreased self-esteem (Frable et al., 1998; Smart & Wegner, 2000).

> **Higher levels of minority stress** that are associated with problematic stress responses (e.g., high blood pressure, anxiety) which eventually lead to poor mental and physical health (Meyer, 2003).

WE NEED TO SIMULTANEOUSLY RECOGNIZE THE UNIQUE STRESS RELATED TO BEING LESS OUT WHILE MAINTAINING A NEUTRAL STANCE; A STANCE THAT IS STRENGTHENED BY THE UNDERSTANDING THAT COMING OUT IS NOT THE SINGULAR SOLUTION. WE BELIEVE THAT THIS IS IN ACCORDANCE WITH PERSON-CENTRED MENTAL HEALTH PRACTICE.

BEST PRACTICES

The following practices on working with clients who are **less out** and/or have a complicated relationship with **outness** are based on key-informant interviews and focus groups with **less out** community members, and focus groups with mental healthcare service providers.

WHEN DISCUSSING OUTNESS

CREATE A SPACE THAT WELCOMES THE CLIENT TO RETURN.

Regardless of the setting, it is important that the client feels as comfortable as possible and leaves wanting to come back to seek your support, or the support of another healthcare professional. This might mean using the client's own words/language to describe their problem, and/or learning current and appropriate language that demonstrates our commitment to compassionate understanding.

CONCEPTUALIZE OUTNESS AS A SPECTRUM RATHER THAN A BINARY OF 'IN' OR 'OUT'.

Someone is not 'in' one day and 'out' the other, but rather is faced again with the decision to disclose with every new person they meet. A spectrum takes into account different experiences and better reflects this important nuance.

NAME IT.

As mental health practitioners, we hold significant power, and it is possible that clients will expect that they are required to come out. In fact, this may be why they have avoided seeking support in the past. It is important to explicitly remind clients that we do not require that they come out, and we can help the client regain power and agency by reminding them that there is no singular path forward – there are many.

BE WARY OF A CLIENT'S PRE-OCCUPATION WITH INHERITED CONCEPTS OF SEXUALITY.

If a client is preoccupied with their sexuality, and that is creating significant depression and anxiety, it might seem that the best solution is to focus the intervention (counselling, etc.) on sexuality and coming out. It can be important to not conspire with the client's pre-occupation with rigid ideas about sexuality thereby worsening the depression and anxiety by promoting a singular (and potentially inaccessible) form of 'coming out'.

HELP CLIENTS BUILD TOOLS TO ADDRESS THE UNIQUE STRESSORS EXPERIENCED BY GBT2Q WITHOUT FRAMING 'COMING OUT' AS THE ONLY POSSIBLE SOLUTION.

Focus on equipping clients with new tools and skills to cope with stress, and honour their resilience with the aim of helping them build the lives they think will work best for them, whether one that is more 'out,' or not. This could also mean ways of navigating and maintaining relationships with family and friends even if it means not disclosing aspects of their sexual and romantic lives.

WHEN DISCUSSING OUTNESS IN PARTICULAR CIRCUMSTANCES OR WITH SPECIFIC PEOPLE, FRAME IT AS 'BEING OUT' RATHER THAN 'COMING OUT'.

"Have you come out to...?" or "Have you told your parents that…?" paint sexual disclosure as inevitable. "Are you out to…?" Or "Do your parents know…?" is descriptive and more accurate in that it is limited to the client's current reality.

NORMS AROUND SEXUALITY AND OUTNESS VARY VASTLY AMONG DIFFERENT CULTURES.

Some people are private about their sexual and romantic lives in order to follow familial and community customs and traditions important to them. Others may belong to cultures in which a person can live a queer life but isn't expected to 'come out' to family and friends, or where people may have sex and share intimacy with others of the same gender-binary but not identify as queer or GBT2Q.

BEING LESS OUT DOESN'T MAKE A PERSON LESS THAN.

'Coming out' is often seen as an important milestone for every GBT2Q person. This monolithic idea affects **less out** GBT2Q people by minimizing or erasing their experiences and resiliencies. When supporting **less out** clients, recognize that there are many GBT2Q people who are in similar situations and **outness** does not determine a person's worth as members of a queer community, should they choose to see themselves as such.

WHEN DISCUSSING SEX

TRY NOT TO MAKE ASSUMPTIONS ABOUT A CLIENT'S IDENTITY BASED ON THE SEX THAT THEY'RE HAVING

Instead of focusing on the client locating a fixed identity or label, give clients space to choose their words and identifiers. If someone is clear about their ongoing sexual practices it is appropriate to speak on those terms, but to begin with we should try to refer to different sex acts in a way that does not invoke identity. For example, using "anal sex with a guy" rather than generalizing it as "gay sex" empowers clients to label themselves, or not. This may mean using unconventional labels such as "brosexual" or "heteroflexible", or not using any particular word at all for their identity.

DON'T ASSUME THE SEX A CLIENT IS CURRENTLY HAVING IS SOMETHING THEY ALWAYS DO.

Sex with other guys may only be a small or infrequent part of a client's sexual preferences. Or maybe they only have sex with other men for work. Or perhaps gender doesn't matter to them when choosing sexual partners. By focusing too much on sex that they are having with same gender partners, we can accidentally push the client into thinking that the sex they have is the problem.

TALK ABOUT SEX WITH CONFIDENCE AND COMPASSION.

By avoiding certain terms, or making heteronormative assumptions about sex and relationships, we can inadvertently create a relationship permeated with sex-negativity. When we speak freely about sex knowledgably and confidently, we create a space for the client to feel held and supported to speak freely.

CITATIONS

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outsideIN HIM HEALTH INITIATIVE FOR MEN

Visit **outness.ca** for more information.
Questions or queries? Contact us at **outness@checkhimout.ca**

Health Initiative for Men (HIM) is a peer-based organization that serves the unique sexual, mental, social, and physical health needs of GBT2Q in Vancouver's Lower Mainland and across British Columbia.

HIM operates five health centres where we offer sexual health testing (including vaccination, treatment and prevention options), as well as professional counselling, sexual health education, and support groups. HIM is dedicated to strengthening the health and wellness of GBT2Q through trusted, tailored, and targeted health promotion.