



Community

**Mental Health  
Support Handbook**

for Practitioners





# J-FLAG

J-FLAG is a human rights and social justice organisation which advocates for the rights, livelihood and well-being of LGBT people in Jamaica.

Our work seeks to build a Jamaican society that respects and protects the rights of everyone. Our board and staff are committed to promoting social change, empowering the LGBT community, and building tolerance for and acceptance of LGBT people.

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## Message of the Minister of Health & Wellness

### Dr. The Hon. Christopher Tufton

I commend the team at Equality for All Foundation Jamaica on the creation of their two latest publications – one, a handbook and the other, a guide – to be used to support the mental health of Jamaicans. Given the current emphasis on evidence-based interventions, this initiative, informed by research done by the Foundation, is especially timely.

It is well recognised that mental illness is highly stigmatised, even at the primary care level, which, for many people, is the first point of contact with the health system. Due to this stigma, individuals will either avoid or delay seeking care for fear of being treated differently from others, fears over losing their jobs, or out of concern for their relationships within family and friends.

This, in turn, can result in poor health outcomes and the loss of productive years. Persons from the LGBT community will have an additional layer of stigma due to sexual orientation or gender identity and are therefore at higher risk of poor outcomes than other persons living with mental illness.

This stigma is driven, at least in part, by a lack of knowledge among mental health practitioners as well as among the vulnerable population. The Mental Health Support Handbook for Practitioners and the Mental Health Guide for LGBT Jamaicans, developed by Equality for All Foundation Jamaica, should help to address this.

Once again, my commendations to Equality for All Foundation Jamaica. Stakeholders who identify an issue and who go further to propose or otherwise put in place solutions must be applauded. Indeed, that is the requirement for success in the effort to guard the mental health of all Jamaicans.

**Dr. the Hon. Christopher Tufton, MP**  
**Minister of Health & Wellness**

# Theories of Gender Identity



## Psychodynamic Theory

Psychodynamic theories, following on from Sigmund Freud's psychoanalytic theory, focus on unconscious drives, the relationship of the child and early experiences with the parents (or primary caregivers). Gender identity is a core part of personality that rests on the child's awareness of their anatomy and their identification with the same-sex parent. Central to its formation is the resolution of the Oedipus complex for boys and the Electra complex for girls. Both involve resolving sexual desire for the opposite-sex parent and competition with the same-sex parent. In successful resolution, the child aligns with the same-sex parent and copies their behaviour.

One issue with this theory is that it implies that children raised in single-parent households would fail to acquire gender identity in the normal way. A similar issue is that it implies that children raised by lesbian or gay parents would have a weaker sense of gender identity. This idea has been challenged by emerging research comparing children raised by heterosexual parents and children raised by lesbian or gay parents. The theory also posits that gender identity involves essentially picking a side by about 5 years old. However, current trends in gender identity formation suggest a more ongoing and fluid process.



## Social Learning Theory

Social Learning Theory emphasises the child's environment and learning experiences. This theory suggests that individuals develop gender by observing the behaviour of others and imitating role models. Social learning theory is based on outward motivational factors that argue that if children receive positive reinforcement they are motivated to continue a particular behaviour. If they receive punishment or other indicators of disapproval they are more motivated to stop that behaviour. In terms of gender development, children receive praise if they engage in culturally appropriate gender displays and punishment if they do not.

For example, parents tend to have more rough play with boys than girls, show more acceptance to boys expressing anger than girls, spend more time consoling girls than boys when they fall or bump into objects, or choose toys for their children based on assigned genders. Typically, children who do not act according to the widely accepted gender role are socially rejected and may conform to expectations to avoid being ostracized.

Social learning theory emphasizes that parents, peers and media figures act as gender-appropriate models whom children base their behaviours on. Children are more likely to attend to and imitate people they perceive as similar to themselves, but usually the assumption is that they will imitate behaviour modelled by people of the same biological sex.

This assumption does not account for the experiences and expressions of transgender or gender non-conforming individuals, especially in the face of punishment from non-comformity in many Jamaican households. Additionally, there is no evidence that the absence of a powerful same-sex model, or non-stereotypical models for male or female behaviour, affect a child's gender identity development.



## Cognitive-Developmental Theory

Cognitive theory emphasizes the development of cognitive processes which allow for the understanding of gender. The theory suggests that children actively search for ways to make sense of the social world that surrounds them. From gendered cues in their social worlds, children quickly form a constellation of gender cognitions, including gender self-conceptions (gender identity) and gender stereotypes. Gender identity develops as children realize that they belong to a gender group, and the consequences include increased motivation to be similar to other members of their group, selective attention to and memory of information relevant to their group, and increased interest in activities relevant to their group. As children mature, discrepancies between their knowledge and their experiences cause their ideas to shift accordingly. Gender identity can only be achieved when a child has reached a certain level of cognitive maturity.

The understanding of gender identity as a child's growing understanding that they belong to either the category of boy or girl, the idea that that one must belong to one or the other, and the idea that gender identity does not change over time perpetuates the binary understanding of gender and excludes gender fluid individuals. However, this theory posits that as children age, they come to understand that changing appearance, activities and characteristics does not change one's gender identity. This is an important point to be made in the discussion about gender identity.



## Erikson

Erikson theorized that people go through 8 stages of development in life, overcoming certain crises to gain specific virtues which contribute to psychosocial wellness. The tasks one must complete to successfully resolve each crisis are different for each stage. Therefore, what the individual tends to focus on in each stage is different. During adolescence, individuals encounter Erikson's Identity vs. Role Confusion stage, a time of finding out about oneself, about attraction, and about life choices. The focus of this stage is the development and acceptance of one's identity. A part of this crisis involves discovering and/or exploring one's gender identity.

The process of identity development consists of identity formation, in which the internal reality of the individual begins to assert and demand its expression as earlier identifications are discarded or reconfigured. It is thought that gender identity is developed in a similar fashion. It is a process of self-discovery and exploration of one's sexual and gender identity. Identity development also consists of identity integration, which involves an acceptance of the unfolding identity, its continuity over time and settings, and a desire to be known by others as such. If one becomes confused about one's gender identity, problems may arise, which will affect the individual's resolution of the current stage as well as how they navigate the next stage of Erikson's theory, intimacy vs. isolation.



## Symbolic Interactionism

Symbolic interactionism is a theoretical perspective that addresses the manner in which society is created and maintained through face-to-face, repeated, meaningful interactions among individuals. Interaction plays an important role in sustaining or modifying the gender system.

Gender is socially constructed and gender identities are socially defined terms. The binary definition of gender identity is maintained through societal consensus. Because gender is learned through communication in cultural contexts, communication is vital for the transformation of such messages. When young girls are told to “sit like a lady” or boys are told “men don’t cry” girls and boys learn how to be gendered as masculine and feminine through the words (symbols) told to them by others (interaction).

Socially created definitions about the cultural appropriateness of sex-linked behaviour shape the way people see and experience gender. This negates the idea that men and women behave differently due to differences in their biology. This, in turn, leaves room for gender non-conformity since it suggests that gender-(biological) factors is not inherently determined by sex.

The most common criticism of theories of gender identity development have been based on their use of binary constructions of gender. Some theories have also contributed to the understanding of gender non-conformity as pathological. However, one defense often used is the fact that these theories are reflective of the prevailing norms of when they were created. The extent to which gender is determined by socialization (environmental factors) versus innate (biological) factors) is part of the ongoing nature versus nurture debate in psychology. While genetic makeup influences gender identity it does not inflexibly determine it. Further, society merely offers suggestions of how one may express gender and any theory of gender identity formation should take into account the active role individuals play in the development of their gender identity. We constantly receive information about how to behave and decide which parts to accept.

# LGBTQ+ Identity Development



Several theories on LGBTQ+ development have been proposed. All of these theories include achieving the awareness that one is not feeling or behaving in ways that their society typically expects them to. Most theories also include a period of exploration of ideas related to varying genders, romantic endeavours and/or sexual behaviours. LGBTQ+ development may also include a period of comparing one's feelings and behaviours to the feelings and behaviours of others who they perceive as similar to them. Although the process may include disclosure to loved ones, the ultimate goal is self-acceptance and commitment to self-knowledge, self-fulfillment, and the solidifying of ideas about one's gender identity, gender expression and sexual orientation.

Similar to sexual orientation identity, gender expression is not necessarily constant throughout childhood. Gender variance, as it relates to expressing and exploring gender identity and gender roles, is a part of normal development. Similarly, adolescents are engaged in an ongoing process of sexual development so self-identification of sexual orientation and the sex and gender of romantic or sexual partners may change over time. Further, they may not necessarily be congruent with one's true desires. All of this is as normal as it is to explore different versions of any part of personality in the quest to find what feels comfortable.

One's gender identity often helps to determine the type of roles and activities that one participates in as well as one's future place in society. Society shapes the norms for what roles men/boys and women/girls play based on sex assigned at birth, but not all adolescents fit into these binary norms. Having a non-binary gender identity is not the same as having gender identity confusion. Often, the distress encountered by transgender youth and those whose gender identity is non-binary is as a result of the pressure they experience to conform to what is expected.

One common reason for failure to assume a heterosexual identity is that the adolescent in question is not heterosexual and therefore cannot assume that identity in any truthful sense. Many LGBTQ+ adolescents have felt such strong social pressure to conform to heterosexual and cis-gender identities that they attempted to assume these identities and face disastrous personal consequences later in life. It is important to recognize the impact of stigma on the formation and expression of gender identity as well as sexual orientation. LGBTQ+ adolescents may struggle with development of and commitment to their gender and sexual orientation identities because of discrimination or instances of bullying. Having the support and acceptance of loved ones and integration into LGBTQ+ peer groups or organizations appear to protect against the negative effects of stigma. They help LGBTQ+ adolescents to achieve identity development and self-acceptance.

For those who experience difficulties with their sexual identity development, poorer psychosocial adjustment may result. This may manifest as difficulty with forming and maintaining meaningful relationships, often leading to loneliness and isolation during early adulthood. In early adulthood, individuals strive to have healthy, fulfilling relationships. It involves developing deeply personal connections and sharing yourself with others. Both these tasks are difficult if you are confused about your identity or unable to express your authentic self. Further, if you are afraid that you'll be turned down or pushed away from a friend or potential romantic partner because of your gender identity or sexual orientation, you may avoid interactions entirely.

Another outcome may be engaging in superficial relationships with people you do not share a connection with or are unable to fully express yourself around.

Having social support, maintaining contact with the LGBTQ+ community and maintaining social involvement can not only protect against feelings of loneliness and isolation, but can also help individuals overcome them. Often, LGBTQ+ individuals benefit from creating “families of choice” with allies or community members. A family of choice provides the experience of having a supportive family for those who have little to no contact with their biological family. While many LGBTQ+ individuals may not openly express their gender identities or sexual orientation out of fear of discrimination and violence against them, LGBTQ+ organizations and community members typically exercise discretion even as they offer support.



# The Current Situation

The Mental Health Needs of  
LGBTQ+ Jamaicans and  
What This Means for  
Practitioners



Mental health professionals work with individuals and families to help develop skills and strategies to manage thoughts, emotions and behaviours that impact on mental health. While mental health is sometimes minimized in individuals' quest for wellness, having poor mental health can lead to impairment in any or all areas of life. Members of the LGBTQ+ community face mental health challenges just like everyone else. In fact, research shows that community members experience more mental health issues than the general population. This is mostly due to minority stress and a higher incidence of trauma among LGBTQ+ individuals. However, members of the community tend to experience more hurdles to caring for their mental health than the general population due to sexual stigma, discrimination and service providers being uninformed about how to best serve the LGBTQ+ population.

A recent study commissioned by Equality for All Foundation Jamaica suggests that most health care providers are willing to provide care for LGBTQ+ individuals (Morgan & Palmer, 2021). However, less than half of these practitioners were willing to be included in a list of LGBTQ+-friendly service providers. This points to the challenge many LGBTQ+ persons face when trying to determine where to access care. Additionally, while most healthcare providers indicated an understanding that there is a difference between sex and gender, 35% of these providers indicated that they did not feel competent to care for transgender people. Therefore, it may be helpful for practitioners to have information regarding the expressed needs of LGBTQ+ persons as well as information that can guide them in providing effective care for members of the community.

Of the LGBTQ+ persons who participated in the study, over 90% indicated that they had mental health concerns, particularly anxiety (69%), depression (69%) and trauma symptoms (40%). Many of the LGBTQ+ participants reported suicide attempts (27%), drug and alcohol issues (23%) and cutting and burning (21%). It is, therefore, clear that great need for mental health services exists in the LGBTQ+ community. Though most of the sample reported having mental health concerns, 37% had not accessed mental health services. Among the barriers to seeking mental health services, concerns that services may not be LGBTQ+ friendly was the most frequently endorsed. Additionally, LGBTQ+ individuals had concerns about the possibility of discrimination and negative attitudes toward them, were unsure of how to access the services they needed and/or had concerns about confidentiality and privacy while accessing care. It may, therefore, be helpful for health care providers to participate in referral programs with LGBTQ+ organizations or provide indicators of their LGBT-friendly status. Additionally, when LGBTQ+ individuals do come in for mental health services, it is important to provide equitable care that is sensitive to their unique experiences.

# LGBT-friendly and Appropriate Services



## Tips For Setting Up An LGBT-Friendly Physical Space

Provide visual clues for LGBTQ+ patients that your practice is a safe place.

- Rainbow flag, pink triangle or other LGBT-friendly symbol or sticker.
- Brochures, magazines and educational materials about LGBTQ health concerns.
- A statement expressing that equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, or gender identity/expression.
- Posters from non-profit LGBTQ+ organization
- Posters with same-sex couples or transgender people



# Creating appropriate registration/ intake/history/taking documents

Update intake and health history form questions. Four important adjustments should be made in intake and health history forms to make them inclusive: **sexual orientation, current gender identity, sex assigned at birth, chosen name, and gender pronouns.**

## For example:

My current gender identity is: \_\_\_\_\_

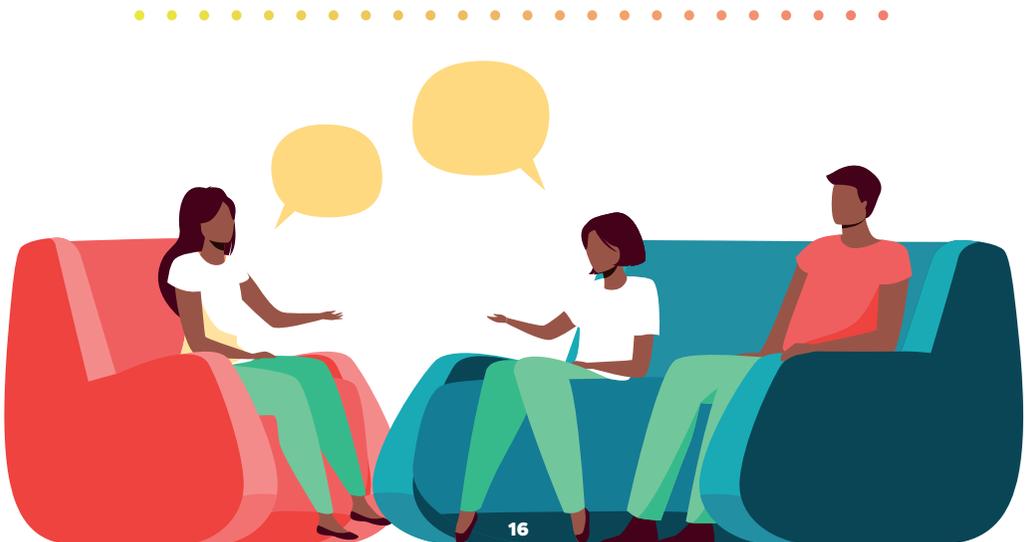
My sexual orientation is: \_\_\_\_\_

My sex assigned at birth is: \_\_\_\_\_

My pronouns are: \_\_\_\_\_

Using categories/close-ended questions regarding sexual orientation and gender identity may feel limiting to people whose identities may not fall in those categories. Additionally, using an “Other” category as many forms do, may make people feel alienated. It is also important to recognize that some people may not be sure about their sexual orientation or gender identity and may not be comfortable writing them down. Therefore, they should be given the option to decline to answer those questions.

In order to acknowledge the different types of relationships which exist in the LGBTQ+ community as well as the legal non-recognition of same-sex relationships in Jamaica, intake forms should ask about relationship status rather than marital status.





## Creating A Welcoming And Warm Environment

- ☑ Provide sensitization sessions for staff (security personnel, administrative assistants, etc.). Train all front-line staff in office standards of respect for all patients. This training may include understanding the different gender and sexual orientation identities, the importance of pronouns and other important LGBTQ+ terms.
- ☑ When meeting new clients, do not assume their gender identity or sexual orientation based on their appearance.
- ☑ Be aware of your own misconceptions, biases, and stereotypes you may have learned about the LGBTQ+ community and how these may influence your interaction with LGBTQ+ clients.



- ☑ Do not refer to a client’s sexual orientation or gender identity as a “lifestyle” or “preference” as this may be seen as offensive.
- ☑ Create a safe space which allows people to disclose their sexual orientation and gender identity, but be aware that disclosure or “coming out” is an individual decision, which your client may not be ready for.
- ☑ Establish strict protocols for the handling of client information and be clear with clients about who has access to information they provide while accessing care.

Participating in provider referral programs through LGBTQ+ organizations or advertise your practice through LGBTQ+ social media pages.



## Why does language matter?

The correct usage of LGBTQ+ terms matters because they are not synonyms and not interchangeable. Their acknowledgement and use help people to feel seen and find communities of like-minded people. LGBTQ+ terms help with describing one's identity and communicating to others what you want. By using the correct terms, you show respect for individuals.



## Sexual Orientation and Gender Identity

**Sexuality** has to do with the way you present yourself to the world, how you experience sexual and romantic attraction (if you do), and your interest in and preferences around sexual and romantic relationships and behaviour. People are creating new language to describe nuances of sexual attraction and behaviour that have always existed.

**Sexual orientation** is how a person identifies in relation to the gender(s) that they are sexually, emotionally, or romantically attracted to. This attraction is inherent, is not merely a choice and cannot be changed.

**Gender Identity** is seeing oneself as a man, woman, neither or both and what one calls oneself. It is a person's internal, deeply held sense of their gender. Gender identity exists on a spectrum. It is not contingent upon biological sex, which is the biological attributes of humans such as chromosomes, hormone levels and reproductive/sexual anatomy. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two categories and they may identify as “non-binary” or “gender nonconforming”.

**Gender Expression** is the external manifestations of gender, expressed through a person's name, pronouns, clothing, haircut, behaviour, voice, and/or body characteristics. Society identifies these cues as masculine or feminine, but what is considered masculine or feminine changes over time and varies by culture. Often, transgender people seek to align their gender expression with their gender non-conforming identity, rather than the sex they were assigned at birth.

*A full glossary of terms is included at the end of this guidebook.*

## Pronoun Etiquette



Pronouns are used in place of a proper noun (like someone's name). We most often use pronouns when referring to someone without using their name. She/her/hers and he/him/his are commonly used pronouns. They/them/theirs is a pretty common gender-neutral pronoun and it can be used in the singular.

We often use pronouns based on a person's appearance or name, but such assumptions can be wrong. Verbal introductions and check-ins are great opportunities to solicit gender pronouns.

A crucial part of creating a safe space for people of all sexes and gender identities is the respectful use of gender pronouns. A recent study showed that in transgender youth, using correct pronouns and names reduces depression and suicide risks. Furthermore, when someone is referred to with the wrong pronoun, it can make them feel disrespected, invalidated, dismissed, alienated, or hurt.

Asking community members what their gender pronouns are and consistently using them correctly is one of the most basic ways to show respect for their gender identity. It may feel awkward at first, but it's not offensive to ask. It is a small gesture that makes a big difference. Below are some examples of how one might ask about gender pronouns:

- "What pronouns do you use?"
- "How would you like me to refer to you?"
- "How would you like to be addressed?"
- "Can you remind me which pronouns you like for yourself?"
- "My name is Jason and my pronouns are he, him, and his. What about you?"

When talking/asking about sexual or relationship partners, use gender-neutral language such as "partner(s)" or "significant other(s)." Use the same language that the client does to describe self, sexual partners, relationships, and identity. Ask the patient for clarification regarding any terms or behaviours with which you are unfamiliar.



# Experiences and Expressed Needs of LGBT Jamaicans



## Lived Experiences of LGBTQ Jamaicans

Many LGBTQ Jamaicans face stigma, prejudice and discrimination. The following information comes from a situational analysis of services in public health clinics in Jamaica and how they serve the LGBTQ population by Brown (2015) on behalf of J-FLAG. In 2011, members of the University of the West Indies' Department of Sociology, Psychology and Social Work found, from a large-scale poll with Jamaicans that Jamaicans were strongly against same sex relationships. Additionally, females and people who are university-educated showed slightly less homophobia. This stigma affects their health practices. Furthermore, lesbian and gay men also report that homophobia and HIV-related stigma make them reluctant to get tested and get treatment, and makes those with HIV feel more reluctant to tell their partner that they are seropositive (White & Carr, 2005).

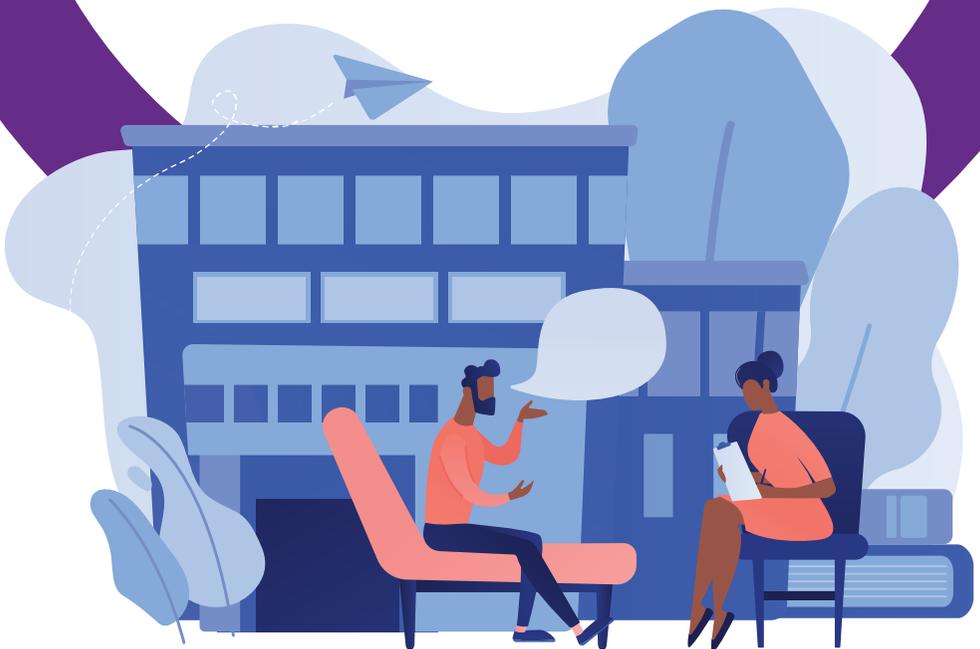
LGBT individuals also experience a great amount of violence and abuse. According to a report by Amnesty International (2006) the levels of violence against transgender people in Jamaica in some contexts is even greater than that of violence against women. Moreover, Wortley and Seepersad (2013) found that LGBT individuals are 5 times more likely to experience violent crimes and 20 times more likely to experience sexual crimes.

According to Brown (2015), the biggest issues that transgender people in Jamaica face are: 1) social exclusion which leads to vulnerability, 2) insufficient public health and epidemiological research about transgender Jamaicans, 3) stigma, discrimination, and violence related to their gender identity, 4) our outdated Charter of Rights which looks at protection from discrimination based on being either male or female which excludes transgender persons, 5) a lack of a national gender policy which includes a range of gender identities, and 6) the presence of rigid categories on official documents regarding sex and gender.

Furthermore, currently our Charter of Fundamental Rights & Freedoms does not provide protection from discrimination based on sexual orientation. In a 2019 survey of 1000+ Jamaicans done by J-FLAG (also known as Equality for All Foundation Jamaica) 69% of Jamaicans indicated that they would not support an amendment to the Jamaican Charter of Rights that would grant equal rights to LGBT Jamaicans. Additionally, of 21 politicians, 48% also indicated they would not support this change.

Furthermore, there is some amount of stigma and discrimination against the LGBT population among public healthcare workers. A public health clinic staff survey (Brown, 2015) conducted with 50 public health clinical staff members found that 16.3% of them believed that men who have sex with men (MSM), lesbians and transgender people should be ashamed of themselves. Furthermore, 19.1% of public health clinic staff believe that MSM are responsible for spreading HIV across the country. Furthermore, 1 in 3 public healthcare workers from this same study indicated that they do not think that LGBT clients should be able to fully exercise their reproductive rights. When it comes to enacted stigma, 8% of the healthcare workers said that they had either seen or heard of LGBT clients getting less care or attention compared to other clients, 16% said that they have seen or heard of an LGBT client being mocked or laughed at, and 18.4% said that they had seen or heard of a LGBT client's HIV status being gossiped about.

# Special Considerations In Providing Care



Developing rapport and trust with LGBTQ+ patients may take longer and require added sensitivity from the practitioner. Be patient and open.

## i. Confidentiality

Confidentiality is especially important in the treatment of sexual and gender minority individuals in Jamaica due to the perception and prevalence of stigma and discrimination in our society. It can be reassuring to have confidentiality rules stated and explained to an individual who has concerns about this. It can be helpful to include information about the importance of guarding client information in general and especially in serving LGBTQ+ clients. It may also be helpful to implement stricter disciplinary actions for when patient confidentiality is breached.

Inquire about difficulties commonly encountered by LGBTQ+ individuals that increase risk of mental health problems. Ask questions necessary to assess the presenting issue, but avoid unrelated probing.

Consider specific stressors related to sexual orientation, gender expression and/or gender identity in addition to other psychosocial and contextual issues. These may include internalized homo-negativity or trans-negativity, behavioural efforts to conceal sexual orientation or gender identity, as well as prejudice and discrimination faced based on sexual orientation or gender identity.

## ii. Traumatic Experiences

Compared to their heterosexual peers, research indicates that individuals who are members of sexual and gender minority groups experience a higher prevalence of violence against them. They also report higher incidence of Adverse Childhood Experiences (ACEs).

ACEs are potentially traumatic events that occur before a child reaches the age of 18. They include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, family dysfunction, bullying and community violence. These experiences often involve strong, frequent, or prolonged activation of the body's stress responses in the absence of a supportive, adult relationship.

The repeated activation of stress response systems alters the way the brain and the body function, putting members of the community at higher risk of developing a number of mental health challenges:

- Anxiety Disorders
- Depressive Disorders
- Substance Use Disorders
- Trauma and Stressor-Related Disorders
- Self-harming and Suicidal Behaviours

Additionally, a child who has experienced trauma is more likely to develop learning and behavioural issues and is at higher risk for early initiation of sexual activity and adolescent pregnancy. The behavioural and learning challenges experienced by trauma survivors often contribute to a higher incidence of poverty, as academic or vocational achievement may be hampered.

### iii. Intimate Partner Violence

Within the LGBTQ+ community, intimate partner violence occurs at a rate equal to or higher than that of the heterosexual community (Rolle et al., 2018). While the dynamics of intimate partner violence in LGBTQ+ relationships are the same as those in heterosexual relationships, homophobia, heterosexism and transphobia offer unique tactics abusers can use and create extra barriers for victims/survivors. LGBTQ+ individuals are less likely to report intimate partner violence out of fear of discrimination or violence because of their sexuality or gender identity. Many also fear perpetuating the idea that their relationships are less likely to be healthy than heterosexual relationships.

### iv. Sexual Stigma

Sexual stigma is the negative regard and inferior status accorded to people who are non-heterosexual because of their beliefs, identities, behaviours and relationships. Sexual minorities are thought to diverge in a disfavoured way from the majority's understanding of normalcy. LGBTQ+ individuals, therefore, often have less access to resources, less influence over others, and less control over their own fate.

Sexual stigma can manifest institutionally, indirectly affecting individuals in sexual minority groups, for example, discriminatory policies. It may also manifest as physical or psychological violence against non-heterosexual individuals, for example, verbal harassment or ridicule, being treated as different or less-than in social relationships, physical abuse or sexual abuse.

The experience of sexual stigma has been associated with social isolation, depression, and the increased risk of suicide. Individuals may practice social avoidance (try to pass as heterosexual; limit interaction with LGBTQ+ individuals in public) or withdrawal from relationships in an attempt to limit exposure to the stigma.

Those who have experienced sexual stigma tend to have significantly worse educational attainment, earning potential and employment prospects. Repeated exposure also often results in poor physical and mental health outcomes.

## vi. Family Dynamics

The effects of family dynamics on sexual orientation, gender identity and gender expression in the context of cultural values of the client, their family, and community cannot be ignored. Parent–child relationships remain as one of the strongest predictors of LGBTQ+ adolescent adjustment. Many LGBTQ+ individuals experience traumatic hostility and maltreatment within their family because of their sexual and gender identities. This is even more likely to occur in the Jamaican context than it is to occur in societies that are adopting more progressive views and policies related to sexual orientation and gender. In other cases, LGBTQ+ individuals are ostracized within their homes or forced to “tone down” their identities to make other family members more comfortable. Family relationships may become strained. However, family members who are willing to work on improving their understanding of and interactions with their LGBTQ+ family members have been successful in doing so. Family support and acceptance are associated with greater self-esteem, social support, general health status, less depression, less substance abuse, and less suicidal ideation and behaviours among LGBTQ+ individuals.

## vii. Coming Out

Also described as “coming out of the closet”, this process can include:

- sharing about a same-gender or similar gender sexual or romantic attraction or experience
- openly identifying as LGBTQ+
- disclosing one’s specific gender identity, gender expression, or sexual or romantic orientation

For some people ‘coming out’ can be exciting and liberating. For others it can be difficult. It could also be a combination of the two. The client should decide beforehand when and to whom they are coming out.

It may be helpful for the practitioner to guide the client in assessing the risks and rewards that are likely to be attached to their coming out. The client’s safety must be considered. The likelihood of acceptance or rejection by their family and community should also be discussed. Consider the support available or absent if the client discloses transgender, gender diverse, and/or LGBTQ+ identity. More important, however, is having a plan for several alternate outcomes.

## viii. Gender Dysphoria

Gender Dysphoria is significant psychological distress that results from a marked incongruence between one's experienced or expressed gender and the sex one was assigned at birth or sex-related physical characteristics. Though gender dysphoria often begins in childhood, some people may not experience it until after puberty or even much later in life.

Gender dysphoria can impair many aspects of life and interfere with daily activities. People experiencing gender dysphoria may refuse to go to work or school, due to pressure to dress or behave in a way that does not align with their gender identity. This may be particularly difficult in the Jamaican context, where individuals are required to wear uniforms to school up to the secondary level and are expected to wear particular articles of clothing based on their assigned sex. Individuals who have gender dysphoria are at increased risk of self-harming, suicidal ideation, suicide attempts and suicide.

Some people whose gender identities do not align with the sex they were assigned at birth do not experience distress or dysphoria. Some transgender and gender-non-conforming people feel at ease with their bodies, with or without medical intervention. Family and social support for expressing their gender authentically appear to be protective factors.



# Support for Transgender Individuals



A transgender individual is a person whose identification as a man or a woman differs from the biological sex or sex at birth. The term transgender includes people who live full-time in their gender identity, as well as people who express their gender identity only in spaces where they feel safe doing so. One aspect of the dominant narrative about transgender individuals is the presumption of heterosexuality. For example, that the transition from female to male is due in large part to a sexual attraction to women and the desire to fulfil a male role within a heterosexual relationship. Gender identity is separate from sexual orientation. Gender identity is one's personal conception of one's gender or how one experiences one's gender.

**MTF (Male-to-Female):** a person assigned male at birth who transitions to or identifies as female

**FTM (Female-to-Male):** a person assigned female at birth who transitions to or identifies as male.

Based on local research, transgender individuals are more likely to experience difficulties or discomfort than other members of the LGBTQ+ community when accessing care. An issue often cited by transgender individuals is the sense of alienation experienced because of how intake and other forms are worded. One study found that many forms did not account for gender identity as distinct from sex and not all officials were respectful in their use of pronouns when referring to transgender individuals. Further, some healthcare workers were open to correction, but others were not.

An individual can be transgender without undergoing any hormone treatment or surgery, since people who are transgender may pursue multiple domains of gender affirmation. These include social affirmation (e.g., changing one's name and pronouns), legal affirmation (e.g., changing gender markers on one's government-issued documents), medical affirmation (e.g., pubertal suppression or gender-affirming hormones), and/or surgical affirmation (e.g., vaginoplasty, facial feminization surgery, breast augmentation, masculine chest reconstruction, etc.).

The decision to pursue different domains of gender affirmation is highly personal and individual. Not all people who are transgender will desire all domains of gender affirmation. For example, some people choose one surgery; others choose multiple surgeries; and some choose no surgery at all. Issues of health and affordability often factor into an individual's decision to have or not have surgery. Many individuals spend time pursuing social affirmation before exploring other domains of gender affirmation. How one chooses to pursue affirmation is up to them.

## Social Transition

Social Transition - involves taking steps to assert one's gender identity through social cues, such as choosing a hairstyle or clothing that reflect one's gender identity or using a name and pronouns congruent with one's gender identity.

Social transition can occur across all environments, or may be limited to specific settings, such as in the home, at specific supportive events, or on vacation.

Patients may need support to process positive or negative emotions associated with this transition. It may also be helpful to help clients evaluate their options, weigh risks and benefits, and tolerate uncertainty.

The client's family may also require support and guidance in navigating gender transition of their loved one. Provide tips on how they can affirm and support the individual transitioning, for example, by using appropriate pronouns. Family members may also need help processing their feelings about their loved-one's transition.

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## Medical Transition Gender

### ***(Confirmation Surgery)***

The process of confirmation surgery often involves several steps, beginning with an evaluation of the patient's medical eligibility and psychological readiness for surgery.

Each client should have a good understanding of the interventions to be performed as well alternative procedures available to them. Discuss goals and expectations of the surgery with the client, including a review of risks and complications associated with the procedure.

Help clients to assess the availability of post-surgery support and assist them in building out a social network which may provide assistance where needed. This may include family members and/or members of local LGBTQ+ organizations. Be sure to discuss the incidence and causes of post-surgical regret.

# Evidence-based Best Practices

Bullying, verbal harassment, fear of rejection from family members, anti-LGBT messages heard in places of worship, and in the media, hiding big parts of their identities are some things that fuel the mental health problems of LGBT individuals in Jamaica.

Persons who experience homophobia, biphobia or transphobia may turn these feelings inwards and may experience negative feelings about their own sexuality or gender identity. That is, they experience internalized stigma.

Mental health professionals can help LGBTQ+ individuals improve social support, coping methods, and problem-solving skills.

General tips and strategies to improve clients' coping skills include:

- ☑ Encouraging your clients to seek social support- seeking support from loved ones in times of stress can greatly reduce stress, while self-isolating and internalizing one's stress tends to make a difficult situation worse.
- ☑ Relaxation techniques - Meditation, progressive muscle relaxation, deep breathing exercises, and grounding techniques are helpful ways to reduce stress.



Physical activity - Running, swimming, walking, yoga and dancing are all forms of physical activity that are helpful ways to cope with stress.



Avoiding the following maladaptive coping mechanisms: attempting to escape the situation by social isolation or becoming absorbed in a solitary activity, using unhealthy self-soothing activities such as binge eating, drinking, using drugs, or excessive internet use, numbing their emotions through drug and alcohol use, attempting to feel an adrenaline rush through risk-taking, and self-harm.

Ways to improve problem solving skills: **Problem Solving Therapy**

Problem-solving therapy is a form of therapy that helps clients to develop tools to identify and solve a variety of problems such as everyday life stress, mental health issues, coping with loss, relationship problems, stress related to physical health issues, financial difficulties and wanting to create personal meaning in your life. This type of therapy helps clients to see problems as challenges to be solved rather than obstacles that cannot be overcome. Then once the client becomes problem-solving oriented, the client learns to use problem-solving skills which include the following steps:

- 1 Identifying the problem.
- 2 Defining the problem in a way that is clear and specific.
- 3 Understanding the problem more deeply.
- 4 Setting goals related to the problem.
- 5 Coming up with creative solutions to the problem.
- 6 Determining and choosing the best solution.
- 7 Implementing the chosen solution.
- 8 Evaluating the outcome of this strategy and determining whether any adjustments should be made.

# Cognitive-Behavioural Therapy (CBT) Techniques for Addressing Anxiety, Depression and Trauma

## Anxiety & Depression:

### Thought Challenging

People with anxiety and depression tend to have negative thoughts that contribute to their anxiety or depression, seeing situations as worse or more dangerous than they actually are. It is important to identify the negative thoughts that trigger the anxious feelings. Then together the therapist and client evaluate the evidence for the negative thoughts and explore how realistic the client's predictions are. Once the unrealistic predictions and distortions in the clients' thinking are identified, the therapist helps the client to come up with more realistic and positive thoughts as well as calming statements to be used in times of anticipated anxiety.

### Thought Records

Thought records are used to keep track of the negative or distorted thoughts that a client has when they are feeling negative emotions. It also helps with identifying the triggers of the negative thoughts.

### Systematic Desensitization

People tend to avoid things or situations that provoke their anxiety. However, avoidance does not allow you to overcome your fear and often makes the fear stronger. Systematic desensitization involves exposure, in increments, to the source of anxiety. The goal is, after being exposed to the source of anxiety repeatedly, to help the person to feel more control and less anxiety over time. Gradually, the client will challenge their fears, feel more confident, and be better able to manage any feelings of panic.

### Behaviour Action

This involves scheduling pleasant or enjoyable activities that your clients may have put off or delayed doing. Purposeful engagement in pleasurable activities promotes positive emotions and may also create good habits.

# Trauma:

## **Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)**

This is a type of CBT that focuses on the emotional and mental needs of trauma survivors who are having difficulty with conquering the negative effects of a traumatic experience. It is particularly effective in helping children and adolescents.

The idea behind TF-CBT is that how we think affects how we feel and what we do, not external influences such as situations, people and events. This form of therapy helps trauma survivors to process their thoughts and associated emotions which helps to decrease any stress, anxiety and depression that may have come from the experienced trauma.

The goals of TF-CBT are to help survivors recognise that their trauma is not their fault and to help survivors feel less shame, guilt, and embarrassment. Other goals also include decreasing symptoms related to the trauma and to improve the functioning of the survivor.

The main components of TF-CBT are:

- P** - Psychoeducation and Parenting Skills
- R** - Relaxation Methods
- A** - Affective Expression and Regulation Skills
- C** - Cognitive coping skills and processing of the trauma
- T** - Trauma Narrative and Processing
- I** - In Vivo Exposure and Mastery of Cognitive Reminders
- C** - Conjoint Therapy Sessions with Parent and Child
- E** - Enhancing Personal Safety and Future Growth

# Affirmative LGBTQ Psychotherapy

Affirmative LGBTQ Psychotherapy is not a psychotherapy orientation, but rather an approach to therapy that helps psychotherapists to view lesbian, gay, bisexual, transgender and queer (LGBTQ) clients in a more positive way. This approach adds LGBTQ-affirmative attitudes, knowledge, and skills to the therapist's existing repertoire of psychotherapeutic skills. This therapy approach also focuses on how homophobia, transphobia, and discrimination or prejudice based on the assumption that heterosexuality is the norm, can negatively impact the lives of LGBTQ clients.

As an Affirmative LGBTQ Psychotherapist:

- You are able to reflect on how you were raised and what attitudes and beliefs you hold; what privileges you may have, what biases may exist in a society that believes that heterosexuality is the norm and that believes that gender is binary.
- You view same-sex attraction and gender diversity as normal variants of human gender and sexuality.
- You affirm LGBTQ clients' sexual orientation and gender identity and do not believe a client's sexual orientation or gender identity should change.

-  You do not assume that a client is heterosexual or make a client's sexual orientation or gender identity the focus of therapy when it is not related to the presenting problem.
-  You are aware of the issues that LGBTQ clients may face.
-  You create an LGBTQ friendly space in your office or clinic by providing LGBTQ friendly reading material, pamphlets and other resources, including affirming language about sexual orientation and gender identity in paperwork, using the client's preferred name, and not making assumptions about the gender of a client's sexual or romantic partners.
-  You engage in LGBTQ continuing education training and access resources for clinical practice.

In a study by Pepping, Lyons, and Morris (2018), a training protocol for LGBT-affirmative therapy was found to be effective, when given to mental health practitioners, in increasing knowledge and skills related to working with LGBT clients. It also helped to decrease negative attitudes towards homosexuality and transgender individuals. Therapists who received the training also reported that they were better able to form supportive therapeutic relationships with their LGBT clients. Additionally, they believed that they were better able to conduct appropriate assessment for LGBT clients. Therapists' years of experience and religious background both did not influence how much the training benefitted them.

## Social Support for LGBTQIA Clients

LGBTQIA clients may experience stress which is caused by experiences of discrimination, hypervigilance, expecting to be rejected by others because of their sexual orientation or gender identity, the burden of having to manage how visible they want their LGBTQIA identity to be, and negative thoughts about self. As part of a marginalized group, they may experience more stress and have fewer resources to cope with their stress in comparison to non-marginalized groups. Thus, it is important for LGBTQIA individuals to seek social support through community resources such as support groups and participating in the local LGBTQIA community events. These resources may help your clients feel a sense of connectedness to a community with individuals who may have similar experiences.



# Glossary of Terms

**Allosexual:** A word and category describing those who experience sexual attraction. Use of this term helps to normalize the experience of being asexual and provides a more specific label to describe those who aren't part of the asexual community.

**Allosexism:** This refers to norms, stereotypes, and practices in society that operate under the assumption that all human beings experience, or should experience, sexual attraction.

Allosexism grants privilege to those who experience attraction and leads to prejudice against and erasure of asexual people.

**Ally:** A person who does not identify as LGBTQ+ and is supportive of LGBTQ+ equality.

**Androsexual:** A term used to communicate sexual or romantic attraction to men, males, or masculinity. This term includes attraction to those who identify as men, male, or masculine, regardless of biology, anatomy, or sex assigned at birth.

**Asexual:** Asexual identity or orientation includes individuals who don't experience sexual attraction to others of any gender.

**Aromantic:** A romantic orientation that describes people who experience little or no romantic attraction, regardless of sex or gender.

**Autosexual:** A person who is sexually attracted to themselves. Someone's desire to engage in sexual behaviour such as masturbation doesn't determine whether they're autosexual.

**Autoromantic:** A romantic orientation that describes a person who's romantically attracted to themselves. Those who identify as autoromantic often report experiencing the relationship they have with themselves as romantic.

**Bicurious:** This refers to people who are questioning or exploring bisexuality, which typically includes curiosity about one's romantic or sexual attraction to people of the same or different genders.

**Bisexual:** Bisexual, also referred to as "bi," is a sexual orientation that describes those who experience sexual, romantic, or emotional attractions to people of more than one gender.

**Bioromantic:** Those who experience romantic attraction, but not sexual attraction, to individuals of more than one gender.

**Bottom:** A bottom is the person that is usually receiving during sex - this could be in penetrative sex, oral sex, or other sexual acts. Being a bottom may also refer to power dynamic during sex in which the bottoms are the person who are submissive or relinquish control during sex and are led by tops. This does not mean that the person who is the bottom cannot be assertive or play an active role during sex.

**Cisgender:** This refers to a person whose gender identity matches their sex assigned at birth.

**Closeted:** Closeted, also referred to as "in the closet," describes people in the LGBTQ+ community who don't publicly or openly share their sexual identity, sexual attraction, sexual behaviour, gender expression, or gender identity. Closeted is often understood as the opposite of "out," and refers to the metaphorical hidden or private place a LGBTQ+ person comes from in the process of making decisions about disclosing gender and sexuality. Some individuals may be out in certain communities but closeted in others, due to fear of discrimination, mistreatment, rejection, or violence.

**Coming out:** A phrase that refers to the process of being open about one's sexuality and gender. Often, "coming out" isn't a one-time event, but a process and series of moments and conversations.

**Cupiosexual:** Cupiosexual describes asexual people who don't experience sexual attraction but still have the desire to engage in sexual behaviour or a sexual relationship.

**Demisexual:** On the asexual spectrum, this sexual orientation describes individuals who experience sexual attraction only under specific circumstances, such as after building a romantic or emotional relationship with a person.

**Demiromantic:** This romantic orientation describes individuals who experience romantic attraction only under specific circumstances, such as after building an emotional relationship with a person.

**Fluid:** The term is used to describe those who experience shifts in their sexuality, sexual attraction, or sexual behaviour in different situations or throughout the course of their lifetime. You may hear someone describe their sexuality as "fluid."

**Gay:** The adjective used to describe people whose enduring physical, romantic, emotional and/or spiritual attractions are to people of the same or similar gender (e.g., gay man, gay people).

Some gay-identified women prefer the term lesbian, while others prefer queer or gay. It's often best to ask which word or term someone uses to describe themselves.

**Gender Nonconforming:** This is a term given to people who don't conform to the gender norms that are expected of them. The term usually refers to gender expression or presentation (that is, how someone looks and dresses). It can also refer to behaviour, preferences, and roles that don't conform to gender norms.

**Graysexual:** Graysexual is a term used to acknowledge the gray area on the sexuality spectrum for people who don't explicitly and exclusively identify as asexual or aromantic.

Many people who identify as graysexual experience some sexual attraction or desire, but perhaps not at the same level or frequency as those who identify their sexuality as being completely outside of the asexual spectrum.

**Grayromantic:** A romantic orientation that describes individuals whose romantic attraction exists in the gray area between romantic and aromantic.

Many people who identify as grayromantic experience some romantic attraction, but perhaps not at the same level or frequency as those who identify their sexuality or romantic orientation as something other than asexual.

**Gynosexual:** A term used to communicate sexual or romantic attraction to women, females, or femininity. This term includes attraction to those who identify as women, female, or feminine, regardless of biology, anatomy, or the sex assigned at birth.

**Heterosexual:** A term that describes people who experience sexual, romantic, or emotional attraction to people of the “opposite” gender (e.g. male vs. female, man vs. woman) or a different gender.

Both cisgender and transgender identified people can be heterosexual. This sexual orientation category is commonly described as straight.

**Homosexual:** An outdated term rooted in the fields of medicine and psychology that refers to individuals who experience sexual, romantic, or emotional attraction to people of the same or a similar gender.

**Intersex:** Intersex is a general term which describes individuals born with any of several variations in sex characteristics including chromosomes, gonads, sex hormones or genitals that do not fit the typical definitions for male or female bodies.

**Lesbian:** A woman or female-identified person who experiences sexual, romantic, or emotional attraction to people of the same or a similar gender.

**LGBTQIA+:** The acronym describes individuals who don't identify as exclusively heterosexual or exclusively cisgender. The letters stand for lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual.

The + symbol in LGBTQIA+ accounts for the fact that there are many sexual orientations and gender identities that are part of the broader LGBTQIA community, but aren't included as part of the acronym.

**Libidoist asexual:** A term used to describe an asexual person who experiences sexual feelings that are satisfied through self-stimulation or masturbation. This label acknowledges that, for some people, acting on libido or sexual feelings doesn't necessarily involve sexual behaviour with others.

**Monosexual:** A broad sexual orientation category that includes people who experience romantic or sexual attraction to people of one sex or gender. Monosexuality typically includes those who are exclusively heterosexual, gay, or lesbian.

**Non-binary:** This is a term used to describe someone who experiences a gender identity that is neither exclusively man/boy nor woman/girl.

**Non-libidoist asexual:** Referring to an identity on the asexuality spectrum, a non-libidoist asexual is someone who doesn't experience any sexual feelings or have an active sex drive.

**Omnisexual:** Omnisexual is similar to pansexual and can be used to describe individuals whose sexuality isn't limited to people of a particular gender, sex, or sexual orientation.

**Pansexual:** A term that describes individuals who can experience sexual, romantic, or emotional attraction to any person, regardless of that person's gender, sex, or sexuality.

**Panromantic:** A term that describes individuals who can experience romantic, or emotional (but not sexual) attraction to any person, regardless of that person's gender, sex, or sexuality.

**Polysexual:** A term that describes individuals with a sexual orientation that involves sexual or romantic attraction to people with varying genders. Polysexual orientations include bisexuality, pansexuality, omnisexuality, and queer, among others.

**Pomosexual:** A term (not necessarily an identity) used to refer to those who reject sexuality labels or don't identify with any of them.

**Passing:** Passing refers to society's perceptions and assumptions of someone's sexuality or gender. Specifically, this term is most commonly used to discuss the frequency and extent to which an LGBTQIA+ person is perceived as or assumed to be straight or cisgender.

It's important to note that some LGBTQIA+ people have the desire to pass while others do not. The act of being perceived as straight or cisgender can be a source of discomfort and discrimination for some in the LGBTQIA+ community.

**Queer:** An umbrella term that describes individuals who aren't exclusively heterosexual. The term queer (the Q in LGBTQIA+), acknowledges that sexuality is a spectrum as opposed to a collection of independent and mutually exclusive categories.

Use of the word queer opens up options to individuals who don't fit neatly into common categories or prefer a category that isn't dependent on sex and gender.

**Questioning:** The process of being curious about or exploring some aspect of sexuality or gender. Questioning can also be used as an adjective to describe someone who's currently exploring their sexuality or gender.

**Romantic attraction:** The experience of having an emotional response that results in the desire for a romantic, but not necessarily sexual, relationship or interaction with another person or oneself. Some people experience romantic attraction but don't experience sexual attraction.

**Romantic orientation:** This is an aspect of self and identity that involves the way you experience romantic desire (if you do), the gender(s) or sex(es) of the people who someone engages in romantic relationships with (if any) and the gender(s) or sex(es) of the people someone is romantically attracted to (if any).

**Sapiosexual:** This term describes those who experience attraction based on intelligence, rather than sex or gender.

**Sexual attraction:** Sexual attraction refers to experiencing sexual desire or arousal in relation to another person or group of people.

**Sex-averse:** Sex-averse describes those who are asexual and are averse to or extremely disinterested in sex or sexual behaviour.

**Sex-favourable:** On the spectrum of asexuality, sex-favourable is viewed as the "opposite" of sex-repulsed and describes those who are asexual, but whom, in certain situations, can have favourable or positive feelings toward sex.

**Sex-indifferent:** Sex-indifferent describes those who are asexual and feel indifferent or neutral about sex or sexual behaviour.

**Sex-repulsed:** Similar to sex-averse, sex-repulsed is on the spectrum of asexuality and describes those who are asexual and are repulsed by or extremely disinterested in sex or sexual behaviour.

**Skoliosexual:** A sexual orientation that describes those who are sexually attracted to people with non-cisgender gender identities, such as people who are nonbinary, genderqueer, or trans.

**Straight:** Also known as heterosexual, straight describes people who experience sexual, romantic, or emotional attraction to individuals of the "opposite" gender (e.g. male vs. female, man vs. woman) or a different gender. People who identify as cisgender and transgender can be straight.

**Top:** This is the person who takes on a more active role during sex. In sex between persons with penises, a top may be the person who penetrates rather than the person who receives penetration. In sex between persons with vaginas, a top may be the person who prefers to give oral sex than receive it. Being a top does not necessarily refer to how sex is had, it could also refer to the power dynamic during sex in which the person who is the top leads and is more dominant.

**Verse:** This is a person who enjoys both the roles of top and bottom and may switch between them. They may be less concerned with power dynamics during sex and may oppose the use of labels.

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