

# Queerness and Disability

The purpose of this binder is to educate LGBTQ people and their allies on all abilities on how queer communities experiences and intersects with disability. It is built in five sections:

- learning disability
- psychiatric disability
- sensory disability
- physical disability
- etiquette for being a good ally

This binder is not meant to diagnose or provide medical information but is intended to provide a starting point to thinking about these intersections and the people who live with identities within both groups.

This binder is also meant as a living document: it is not static or definitive, and is not a complete representation of either LGBTQ or disability communities.

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# Learning disability

AD/HD..... Error! Bookmark not defined.

# AD/HD

## 1. Being Gay with ADHD: An Open Discussion (Attention Talk Radio)

## 2. Other Resources

AD/HD is a diagnosis applied to children and adults who consistently display certain characteristic behaviors over a period of time. The most common core features include:

distractibility (poor sustained attention to tasks)

impulsivity (impaired impulse control and delay of gratification)

hyperactivity (excessive activity and physical restlessness)

In order to meet diagnostic criteria, these behaviors must be excessive, long-term, and pervasive. The behaviors must appear before age 7, and continue for at least 6 months. A crucial consideration is that the behaviors must create a real handicap in at least two areas of a person's life, such as school, home, work, or social settings. These criteria set ADHD apart from the "normal" distractibility and impulsive behavior of childhood, or the effects of the hectic and overstressed lifestyle prevalent in our society.

According to the DSM-IV (the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) some common symptoms of ADHD include: often fails to give close attention to details or makes careless mistakes; often has difficulty sustaining attention to tasks; often does not seem to listen when spoken to directly; often fails to follow instructions carefully and completely; losing or forgetting important things; feeling restless, often fidgeting with hands or feet, or squirming; running or climbing excessively; often talks excessively; often blurts out answers before hearing the whole question; often has difficulty awaiting turn.

Jaksa, Peter. "ADHD Fact Sheet - Attention Deficit Disorder Association." *ADHD Fact Sheet*. Attention Deficit Disorder Association, 1998. Web. 24 July 2013. <[http://www.add.org/?page=ADHD\\_Fact\\_Sheet](http://www.add.org/?page=ADHD_Fact_Sheet)>.

*This information is not intended to diagnose or treat a medical condition. If you have any questions or concerns please contact your health care provider.*

## Being Gay with ADHD: An Open Discussion

What is it like to be gay in a heterosexual world? What is it like being ADHD in a non-ADHD world? What is it like being gay with ADHD in our world? In this episode, co-hosts Jeff Copper and Kirsten Milliken have an open discussion with two individuals who both are gay and have ADHD... one out on both, but not the other. Listen in as we discuss the challenges, the pros and cons of disclosure, and the personal stories of our guests as they celebrate gay pride month.

Attention Talk Radio is the leading site for self-help Internet radio shows focusing on attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD), including managing symptoms of attention deficit disorder, adults with ADD, or adults who have children with ADHD. Attention Talk Radio, hosted by attention coach Jeff Copper, is designed to help adults and children (particularly those diagnosed with or impacted by attention deficit disorder or its symptoms) in life or business who are stuck, overwhelmed, or frustrated. It will help adults and children get unstuck and moving forward by helping to open their minds and pay attention to what works.

[Listen to the full episode online](#) :

<http://www.blogtalkradio.com/attentiontalkradio/2012/06/14/being-gay-with-adhd-an-open-discussion>

*Being Gay with ADHD: An Open Discussion. 13 June 2012. AttentionTalkRadio. Blogtalkradio, 13 June 2012. Web. 24 July 2013. <<http://www.blogtalkradio.com/attentiontalkradio/2012/06/14/being-gay-with-adhd-an-open-discussion>>.*

## Other Resources

### Adderworld

Adder World is a positive, supportive community for us to come together and talk about the challenges and inspirations of living with ADHD, whether we have it or know someone that does. *We are dynamic, vibrant, creative and unique*, and yet at times, we painfully struggle with ADHD.

<http://adderworld.ning.com/>

Hutchinson, Bryan. "ADDer World ADD ADHD Online Network Community." *ADD & ADHD Online Social Network Community*. N.p., 2013. Web. 24 July 2013. <<http://adderworld.ning.com/>>.

### ADDitude

Founded in 1998 by Ellen Kingsley, an award-winning journalist with a unique ability to convey credible information with empathy and inspiration, *ADDitude* magazine has provided clear, accurate, user-friendly information and advice from the leading experts and practitioners in mental health and learning for almost 10 years.

<http://www.additudemag.com/resources/addvocacy.html>

"ADHD Awareness: ADD Advocacy Resources." *ADDitude Magazine*. New Hope Media LLC, 2013. Web. 24 July 2013. <<http://www.additudemag.com/resources/addvocacy.html>>.

### ADHD Momma

On this website you'll find the personal stories of moms and dads parenting children with ADHD: what has worked (and not worked) for them; their struggles and adventures; links to helpful information and other similar stories; and a network of parents of children with ADHD who support one another. As well, you'll find helpful articles from our ADHD Consultants, many of whom also parent a child with ADHD.

<http://adhdmomma.com/>

Bashista, Adrienne E. "A Mom's View of ADHD." *A Moms View of ADHD RSS*. N.p., 2013. Web. 24 July 2013. <<http://adhdmomma.com/>>.

## ADHD & You

ADHD & You is a website offering support to People with ADHD, Parents and Caretakers, Educators and Other School Personnel, and U.S. Health Care Professionals. ADHD & You is dedicated to helping you understand the disorder and how it is managed.

<http://www.adhdandyou.com/>

"ADHD & You." *Is Dedicated to Helping You*. Shire US Inc, 2013. Web. 24 July 2013.  
<<http://www.adhdandyou.com/>>.

## Tumblrs:

- Actually ADHD

<http://actuallyadhd.tumblr.com/>

- Fuck Yeah ADHD Aardvark!

<http://fuckyeahadhdvark.tumblr.com/>

# Psychiatric disability

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Borderline Personality Disorder .....	Error! Bookmark not defined.
Depression .....	Error! Bookmark not defined.
Dissociative Identity Disorder .....	Error! Bookmark not defined.
Eating Disorders .....	Error! Bookmark not defined.
Post-traumatic Stress Disorder .....	Error! Bookmark not defined.
Schizophrenia .....	Error! Bookmark not defined.

# Bipolar Disorder

- 1. Lifting the Veil off Mental Health: Life with a Bipolar Partner (David Castillo)**
- 2. Can Bipolar Disorder Cause Homosexuality? (Bipolar Bisexual Blogspot)**
- 3. Coming out as mentally ill, or coming out as gay? Which is harder? (Keith Adams)**

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. Symptoms of bipolar disorder are severe. They are different from the normal ups and downs that everyone goes through from time to time. Bipolar disorder symptoms can result in damaged relationships, poor job or school performance, and even suicide. But bipolar disorder can be treated, and people with this illness can lead full and productive lives.

National Institutes of Health, and USA.gov. "Bipolar Disorder." *NIMH RSS*. National Institute of Mental Health, n.d. Web. 25 July 2013. <<http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml>>.

*This information is not intended to diagnose or treat a medical condition. If you have any questions or concerns please contact your health care provider.*

## **Lifting the Veil off Mental Health: Life with a Bipolar Partner**

Bil announced a couple of weeks ago that I was going to be blogging here about my experience living with my partner, Jim, who suffers from bipolar disorder.

Since Jim's first hospitalization, I've been on a personal journey to better understand my partner and this illness. I'm still learning and there are still trying moments when I have to do my best to remember it's Jim's bipolar talking, not him. It's a day-to-day process, but hopefully, my thoughts here will help other couples (especially the spouses who aren't bipolar), gay or straight, who are also doing their best to learn to live with this illness.

To fully appreciate how I arrived at the start of this journey to understanding, I think it's best to start from the beginning.

I knew Jim was diagnosed with bipolar disorder when I met him, but I knew very little about the illness and he seemed to be in good health so it didn't deter me from wanting to date him. He was a breath of fresh air for me and I appreciated his honesty about his affliction.

Our relationship moved quickly and before long we were living together. Jim mentioned to me when we started dating that he was no longer on medication and he wasn't in therapy.

His reasons for getting off medication seemed logical to me. He couldn't afford health insurance and the university's student health center was his only available resource. Their approach, however, involved drugging the hell out of him and after a year of overmedication that resulted in lethargy, a diminished sex drive and exhaustion, Jim decided he'd rather deal with the consequences than to be a zombie. He was 20 years old by this time.

Jim loved a good party and he loved to drink. We're kindred that way, but after a few months of living together I realized his moods could be very erratic and his irrational behavior was often unbearable. Add in my stubbornness and my penchant for being argumentative and you've got the recipe for a powder keg of fights!

We had many arguments over the first two years of our relationship, but I never suspected that part of the problem could be chocked up to bipolar symptoms that were just starting to manifest themselves, as it tends to do in folks in their early 20s. Plus, I just figured that most couples had their fair share of disagreements

Things really came to a head a year ago when a fun evening of wine drinking and show tunes suddenly turned ugly. I don't even recall what sparked the anger anymore, nor does it matter, but I do know that one moment we were laughing and the next I had wine thrown in my face and there was glass shattered against the walls. Jim also got physical and my immediate instinct was to call 911 as I feared for my safety.

In the hospital ER he was sedated and we waited there through the night until a bed in the psychiatric unit opened up. The next morning, I was told that it was best for Jim to stay there for an undetermined amount of time.

I couldn't make the decision for him, but I did counsel him and told him he should probably listen and stay. Soon after the decision was made it was time for me to go home. Alone. As I got up to leave, Jim's last words to me were, "Are you happy now? You've locked me up. Thank you." I wouldn't talk to him again until the next day.

That was the moment this illness became real for me and, I suspect, for Jim as well. Over the course of the next week, I spent my nights alone with my thoughts confused about what had happened and frightened for what lay ahead for both of us. I could not talk to him on the phone and I could not sleep with him at night.

It was awful, but I took solace in the fact that he was getting help. By the end of that week, he was home and we both talked about what was going to have to happen if we wanted to stay together.

Since then, our lives have changed dramatically. He's been in therapy ever since and, with the help of his doctors, has found the medications and dosages that work for him. About six months after this ordeal, I entered therapy myself.

Jim has effectively quit drinking and made marvelous progress in maintaining a healthy lifestyle. I admire him for that. And after some slow learning, I have made strides to curb my drinking in order to foster an environment in which we can both live more easily.

This brings us full circle to where we are today. My own progress has been steady and I learn something from Jim every day. I've taken an active role in talking about how he feels and I ask him for what I should be vigilant of in his behavior.

It is a responsibility that has taken me some time to accept, but I am happy to do it if it means our relationship will survive and if it makes it easier for Jim to stay healthy.

[http://www.bilerico.com/2009/07/lifting\\_the\\_veil\\_off\\_mental\\_health\\_life\\_with\\_a\\_bip.php](http://www.bilerico.com/2009/07/lifting_the_veil_off_mental_health_life_with_a_bip.php)

*Castillo, David. "Lifting the Veil off Mental Health: Life with a Bipolar Partner." Web log post. The Bilerico Project. N.p., 12 July 2009. Web. 25 July 2013. <[http://www.bilerico.com/2009/07/lifting\\_the\\_veil\\_off\\_mental\\_health\\_life\\_with\\_a\\_bip.php](http://www.bilerico.com/2009/07/lifting_the_veil_off_mental_health_life_with_a_bip.php)>.*

## Can bipolar disorder cause homosexuality?

Although the causes of homosexuality are the subject of much controversy, bipolar disorder is not one of the leading contenders. Theories of genetics and early environmental factors suggest that your sexuality has already started to cement, long before adulthood so it seems unlikely that something that usually kicks in at about 21, could change something already been largely decided for you.

However, many people believe that sexuality is on a spectrum, rather than categorical, with most people falling towards the heterosexual end of the scale but not necessarily right at the extremities. Factors such as inhibition and social pressures may prevent someone who was mainly attracted to their opposite sex, from exploring the small part of them that desires same sex encounters. Mania is known to decrease inhibition and raise sexual arousal, therefore being manic could lead to increased homosexual activity, if you were somewhere mid-scale. It is also possible that you could be entirely straight and have a homosexual encounter when manic, because mania distorts your thinking - likewise mania might lead a gay person to have a wild night of passion with a straight.

Nevertheless, homosexuality as a result of mania is likely to be a temporary condition which would stop once the mania stopped, with the exception being people with underlying bisexual or homosexual tendencies who needed something to kick-start their self-awareness.

Just as bipolar disorder leading to homosexuality is not a straight forward topic, neither is the debate as to whether or not homosexuality can cause mental health problems. Many theories about mental health problems suggest that an underlying genetic predisposition to an illness could lead to sickness if an individual experiences a stressful life event. Coming out to yourself and your loved ones is very stressful for some people.

So in conclusion, I don't think bipolar disorder can permanently change your sexuality, but mania could cause temporary homosexual activity, or open your eyes to tendencies you've had all along, but been too inhibited to explore.

<http://bipolar-bisexual.blogspot.com/2010/03/can-bipolar-disorder-cause.html>

"Can Bipolar Disorder Cause Homosexuality?" Web log post. *Bipolar Bisexual*. N.p., 25 Mar. 2010. Web. 25 July 2013. <<http://bipolar-bisexual.blogspot.com/2010/03/can-bipolar-disorder-cause.html>>.

## Coming out as mentally ill, or coming out gay? Which is harder?

I've often noticed the similarities between coming out gay, and as a person with a serious, "scary" mental illness, in my case bipolar disorder Type I – the most virulent type. Like all gay men, I have my "coming out" story down pat, and the simple version of it is rather generic. The self-knowledge that I was homosexual had been with me for most of my formative years. I don't think I'd even turned ten when I made the abrupt connection between my attraction to boys and the concept of "gay". I vividly recall that exact moment: a horrible sinking recognition that I'd be alone for life, in the darkness of the closet. (I'd grown up in a very macho society, near Newcastle, in the north-east of England, in the seventies.)

Of course, I was wrong about most of that, but it took coming out to make that obvious; not to mention moving to another continent. I went to U. of Penn to do a Ph.D., and it's only in retrospect that I realized that moving so far was really the means of giving myself space to deal with my sexuality. In my second year, my grades fell apart as I yearned with the insane physical desire to be touched by another man. I ended up pulling out of school early, and graduating with a Masters. The sequelae are conventional: I told my best friends, and, oh, it was no big deal; I told my parents, and ... dead silence for a year, followed by grudging acceptance so long as I never, ever talked about it. (Coda: turned out that my brother was a big poofter too, and, years later, one of my sisters turned into a lesbian. Coda upon coda: all three of us have life partners, and my Dad loves them all.)

The fear about coming out as gay is that people will be disgusted, or that you'll be disowned and rejected. In most civilized places, this disgust has become lessened by increasingly common marks of acceptance: gay marriage lawsuits, famous people coming out, etc. And even in less civilized places – oh, like Los Angeles – at least you won't be feared. (I joke about LA – I mean it is uncivilized, but being gay there is at least not much of an issue.) Coming out as mentally ill is something else entirely. As with being gay, you're facing prejudice and incomprehension. But most people also have a visceral fear of mental illness: it's a subject wrapped willfully in darkness and obscurity. People fear that you're unpredictable, and you're going to act "crazy" at any moment. Hell, I'd feel the same.

My coming out as a PoPD ("person of bipolar disorder") was, as with most PoPDs (I coined that term, by the way), abrupt and non-volitional. My rapid ascent into mania ended up with a fist-fight at a downtown luxury hotel with three security guards, a quite horrible night in jail capped by my faked suicide attempt (and one impersonation of the Anti-Christ), then four involuntary nights in a locked ER psych ward. It wasn't exactly easy to keep all of this quiet.

Nonetheless, I still had a more formal coming out to consider. I'd started up various business ventures when I was in the manic misconception that I could do anything I put my mind too, even in the absence of funding. And at the same time, I'd been maintaining a blog (still ongoing, at brokenwhole.com), documenting what I'd thought

had been an amazing recovery from decades of depression. Even after I'd been diagnosed as a PoPD, I still felt that some of my business ideas made sense: but I was faced, suddenly, with a horrible choice: should I keep my mental illness in the closet, as far as business was concerned?

This was not an obviously clear decision. There's so much shame associated with mental-illness, and my own two decades of pre-bipolar depression had been clouded with it. Light is the opposite of shame, and so, to counteract shame, I'd always been open in my various blogs about depression. But bipolar disorder is altogether more serious, and I'd doubt many people would consider going into business with a newly minted PoBD. So my choice was to "come out" in my blog about my new diagnosis, and kill my business ideas; or to keep it private, and carry on as normal albeit with a superadded burden of closet-shame.

In the end, the decision became obvious. In the space of ten minutes, I crashed from declining, medicated mania into acute depression so bad that I felt I was teetering on shaking ground on the edge of a chasm, all my dreams fleeing away. And I knew then that being quiet about my condition wasn't an option. It was hard ... very hard ... to say goodbye to my ideas, but being open about my diagnosis was much more important to me, and, ultimately, the only way to get a measure of healing. In fact, I even went one huge step further and wrote a book about it.

I still deal with the consequences of being an uncloseted PoBD. For instance, nobody's ever said it to my face, but there've been situations where I've started a potential new friendship which has come to a sudden end coincident with their reading my blog for the first time. Like I said: mental illness is scary: which is why I write about it; to remove the mystery; to show that people like myself form a colorful part of life's tapestry, offering qualities and insights perhaps not available to others. But not everybody can hear that. Of course, it's also possible that some of these potential friends were scared off by my bad writing. It's difficult to hide that in the closet (though I've several dusty drawers full of it.) Oh, and if this is my last appearance on this website, feel free to draw conclusions. (I'm joking, Bryce! I hope!)

<http://gayagenda.com/coming-out-as-crazy-too/>

*Adams, Keith. "Coming out as Mentally Ill, or Coming out Gay? Which Is Harder?" Web log post. Gay Agenda. Gayagenda.com, 18 July 2012. Web. 25 July 2013. <<http://gayagenda.com/coming-out-as-crazy-too/>>.*

# Borderline Personality Disorder

1. **The Borderline Personality and Gay People (Charles Silverstein)**
2. **Sexual orientation and relationship choice in borderline personality disorder over ten years of prospective follow-up. (Bradford D. Reich and Mary C. Zanarini)**

Borderline personality disorder (BPD) is a serious mental illness marked by unstable moods, behavior, and relationships. In 1980, the *Diagnostic and Statistical Manual for Mental Disorders, Third Edition* (DSM-III) listed BPD as a diagnosable illness for the first time. Most psychiatrists and other mental health professionals use the DSM to diagnose mental illnesses.

Most people who have BPD suffer from:

- Problems with regulating emotions and thoughts
- Impulsive and reckless behavior
- Unstable relationships with other people.

People with this disorder also have high rates of co-occurring disorders, such as depression, anxiety disorders, substance abuse, and eating disorders, along with self-harm, suicidal behaviors, and completed suicides.

National Institutes of Health, and USA.gov. "Borderline Personality Disorder." NIMH RSS. National Institute of Mental Health, n.d. Web. 25 July 2013. <<http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml>>.

*This information is not intended to diagnose or treat a medical condition. If you have any questions or concerns please contact your health care provider.*

## The Borderline Personality Disorder and Gay People

Abstract:

This paper examines the diagnostic category called Borderline Personality Disorder (BPD) and its relationship to gay people. It discusses the psychoanalytic definition of borderline personalities, and to it adds a cultural definition. In the light of these cultural variables, the diagnosis is defined as a metaphor for the complexities and confusions of modern life. These confusions are important in the lives of gay people, who, it is suggested, are currently more prone to be diagnosed as BPD. Through the life study of a gay man, both the psychoanalytic and cultural variables are identified, then generalized to the problems of gay people in our transitional society.

doi: 10.1300/J082v15n01\_13

[http://www.tandfonline.com/doi/abs/10.1300/J082v15n01\\_13?url\\_ver=Z39.88-2003&rft\\_id=ori:rid:crossref.org&rft\\_dat=cr\\_pub%3dpubmed#.Ue69ntLBPTo](http://www.tandfonline.com/doi/abs/10.1300/J082v15n01_13?url_ver=Z39.88-2003&rft_id=ori:rid:crossref.org&rft_dat=cr_pub%3dpubmed#.Ue69ntLBPTo)

Silverstein, Charles. "The Borderline Personality Disorder and Gay People." *Journal of Homosexuality* 15.1-2 (1988): 185-212. 19 Oct. 2010. Web.

## **Sexual orientation and relationship choice in borderline personality disorder over ten years of prospective follow-up.**

### Abstract:

The purpose of this study was to assess the prevalence of homosexuality/bisexuality and same-sex relationships in a sample of 362 hospitalized subjects, 290 with borderline personality disorder (BPD) and 72 comparison subjects with other personality disorders. At baseline and at five contiguous 2-year follow-up intervals, subjects meeting DIB-R and DSM-III-R criteria for BPD or at least one other personality disorder were interviewed using a semi-structured interview about their sexual orientation and the gender of intimate partners. Subjects with BPD were significantly more likely than comparison subjects to report homosexual or bisexual orientation and intimate same-sex relationships. There were no significant differences between male and female borderline subjects in prevalence of reported homosexual or bisexual orientation or in prevalence of reported same-sex relationships. Subjects with BPD were significantly more likely than comparison subjects to report changing the gender of intimate partners, but not sexual orientation, at some point during the follow-up period. A reported family history of homosexual or bisexual orientation was a significant predictor of an aggregate outcome variable assessing homosexual/bisexual orientation and/or same sex relationship in borderline subjects. Results of this study suggest that same-gender attraction and/or intimate relationship choice may be an important interpersonal issue for approximately one-third of both men and women with BPD.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3203737/>

Reich, D. Bradford, and Mary C. Zanarini. "Sexual Orientation and Relationship Choice in Borderline Personality Disorder Over Ten Years of Prospective Follow-Up." *Journal of Personality Disorders* 22.6 (2008): 564-72. Print.

# Depression

1. **Depression and the GLBT Community Fact Sheet (NAMI)**
2. **Family Acceptance in Adolescence and the Health of LGBT Young Adults (Journal of Child and Adolescent Psychiatric Nursing)**
3. **To Be Young, Gay, and Clinically Depressed (B. Bama)**
4. **Other Resources**

Depression is a medical illness that causes a persistent feeling of sadness and loss of interest. Depression can cause physical symptoms, too.

Also called major depression, major depressive disorder and clinical depression, it affects how you feel, think and behave. Depression can lead to a variety of emotional and physical problems. You may have trouble doing normal day-to-day activities, and depression may make you feel as if life isn't worth living.

More than just a bout of the blues, depression isn't a weakness, nor is it something that you can simply "snap out" of. Depression is a chronic illness that usually requires long-term treatment, like diabetes or high blood pressure. But don't get discouraged. Most people with depression feel better with medication, psychological counseling or other treatment.

Mayo Clinic Staff. "Depression (major Depression)." *Mayo Clinic*. Mayo Foundation for Medical Education and Research, 10 Feb. 2012. Web. 25 July 2013.  
<<http://www.mayoclinic.com/health/depression/DS00175>>.

*This information is not intended to diagnose or treat a medical condition. If you have any questions or concerns please contact your health care provider.*

Gay, lesbian, bisexual and transgender (GLBT) people are likely to be at higher risk for depression. The reason for these disparities is most likely related to the societal stigma and resulting prejudice and discrimination that GLBT face on a regular basis, from society at large, but also from family members, peers, co-workers and classmates.

## Special Considerations

### *Dual or Double Stigma*

Mental illness is regrettably still stigmatized in our society. So, too, is being lesbian, gay, bisexual or transgendered. A GLBT person with depression may be in the unfortunate position, then, of having to contend with both stigmas. They may also have to deal with additional job stress or the loss of friends. This societal stigma can contribute to and exacerbate existing mental health problems. Rather than be stigmatized, some GLBT may choose to keep their sexuality a secret, which also causes psychological stress.

### *Family Support*

It is helpful for people with depression to rely on family for support. However, for some GLBT people, families are not accepting of their sexual orientation or gender identity. In extreme cases, GLBT people are disowned or kicked out of their homes, which leaves them without an important source of support. Such situations may contribute to more vulnerability among this population. Research released by Caitlin Ryan, PhD, Director of the Family Acceptance Project at the César E. Chávez Institute at San Francisco State University in early 2009 has established a predictive link between specific, negative family reactions to their child's sexual orientation and serious health problems for these adolescents in young adulthood—such as depression, illegal drug use, risk for HIV infection, and suicide attempts.

### *Violence*

The societal stigma and prejudice against GLBT people takes many forms. Too often, they can take the form of verbal or physical violence. Experiences of violence can have significant and enduring consequences for mental health. A recent study found that 25 percent of gay and bisexual men and 20 percent of lesbian and bisexual women had experienced victimization as an adult based on their sexual orientation. In turn, these groups also reported more symptoms of depression.

### *Internalized Homophobia*

Homophobia refers to irrational fear or hatred of gay people. Sometimes, GLBT people turn society's negative view about them inward, or internalize it. This can affect psychological well-being and can have consequences for healthy development, particularly among youth.

## Treatment Considerations

Self-acceptance of sexual identity is one factor that has been shown to predict recovery from depression and/or substance abuse in gay men.

It is often the case that GLBT people experience a mental health care system that is not comfortable with or sensitive to issues related to sexual orientation. At the same time, the GLBT community may not be sensitive to or educated about serious mental health issues. Mental health providers need to be aware of GLBT issues like stigma, family support, violence and internalized homophobia and how they may affect mental health and well-being among their GLBT clients and patients.

In sum, GLBT people have to contend with societal stigma and negative experiences that may contribute to an increased vulnerability to mental illnesses like depression. It is important to note, however, that despite this, most GLBT people ultimately live happy and healthy lives.

For more information, visit NAMI's Multicultural Action Center's GLBT mental health resources section at:

[www.nami.org/Template.cfm?Section=Resources&Template=/ContentManagement/HTMLDisplay.cfm&ContentID=28243](http://www.nami.org/Template.cfm?Section=Resources&Template=/ContentManagement/HTMLDisplay.cfm&ContentID=28243)

## Web Resources

- [www.therainbowbabies.com/Depression.html](http://www.therainbowbabies.com/Depression.html)
- [www.healthplace.com/gender/depression-and-gender/depression-and-mental-health-emerge-as-major-concerns-for-the-community/menu-id-59](http://www.healthplace.com/gender/depression-and-gender/depression-and-mental-health-emerge-as-major-concerns-for-the-community/menu-id-59)
- [www.glna.org/index.cfm?fuseaction=Page.viewPage&pageID=692](http://www.glna.org/index.cfm?fuseaction=Page.viewPage&pageID=692)
- [www.gay.com/news/roundups/package.html?sernum=1355&navpath=/channels/health/special](http://www.gay.com/news/roundups/package.html?sernum=1355&navpath=/channels/health/special)
- <http://familyproject.sfsu.edu>

## **Family Acceptance in Adolescence and the Health of LGBT Young Adults**

Extensive research has focused on the nurturing and protective role of families, in general, and connections to family have been shown to be protective against major health risk behaviors (e.g., Resnick et al., 1997). Although family relationships are understood to be a primary context for adolescent development, only a small number of studies have focused on the role of parent–adolescent relationships for lesbian, gay, and bisexual (LGB) youth and young adults. Literature addressing the family relationships for transgender adolescents and young people is miniscule. Given the crucial role of parents in promoting adolescent well-being, it is surprising that so little attention has focused on the parenting of lesbian, gay, bisexual, and transgender (LGBT) adolescents. Most existing research has focused on negativity in the relationships between LGB youth and their parents; no known research has considered the possible developmental benefits of family acceptance and supportive behaviors for LGBT youth. One study has assessed the relationship between LGB young adults' perceived family support (e.g., general closeness, warmth, and enjoying time together) and depression, substance use, and suicidality (Needham & Austin, 2010).

The lack of literature on family support is particularly surprising because LGB youth and adults (Cochran, Sullivan, & Mays, 2003; D'Augelli, 2002; Meyer, 2003) and youth with same-gender attractions (Russell & Joyner, 2001) are known to be at risk for compromised physical and emotional health. Research over the past decade has begun to trace the origins of health disparities associated with sexual identity; these studies have focused largely on the role of victimization and negative peer relationships during adolescence and associated health risks in adolescence and young adulthood (Diamond & Lucas, 2004; Lasser & Tharinger, 2003; Russell, 2005; Russell, Seif, & Truong, 2001; Ryan & Rivers, 2003; van Wormer & McKinney, 2003).

Studies show that LGB adolescents' relationships with their parents are often challenged, particularly around the time of disclosure of sexual identity or “coming out” (D'Augelli, Grossman, & Starks, 2005; Patterson, 2000; Savin-Williams, 1998a, 1998b; Savin-Williams & Dubé, 1998; Tharinger & Wells, 2000) or when parents learn that their children are LGBT. Researchers in one study (Rosario, Schrimshaw, & Hunter, 2009) examined substance use among LGB youth and asked youth whether they perceived reactions to their LGB identity from a range of people (including family members, coaches, teachers, therapists, neighbors, and friends) to be accepting, neutral, or rejecting. The number of perceived rejecting reactions were reported to predict substance use; although accepting reactions did not directly reduce substance use, such reactions buffered the link between rejections and substance use.

Another recent study assessed the relationship between family rejection in adolescence and the health of LGB young adults (Ryan, Huebner, Diaz, & Sanchez, 2009). That study showed clear associations between parental rejecting behaviors during adolescence and the use of illegal drugs, depression, attempted suicide, and sexual health risk by LGB young adults. Prior research clearly points to the role of family rejection in predicting health and mental health problems among LGB adolescents and adults, yet at the same time, while it is known that initial parental reactions to the disclosure of LGB identity may be negative—sometimes including ejection from the home—research has also shown that after parents become sensitized to the needs and well-being of their LGB children, many family relationships improve (D’Augelli et al., 2005).

Reports about researchers who study family reactions to their children’s LGBT identity indicate that parental acceptance and rejection are different constructs (e.g., Perrin et al., 2004); thus, accepting and rejecting behaviors can co-occur as families adjust to learning about their child’s LGBT identity. Nevertheless, the focus of prior research has been largely on compromised parent–adolescent relationships for LGB young people. Yet given the changes in public visibility and attitudes about LGBT people and issues over the course of past decades (Savin-Williams, 2005), some families react to learning about their child’s LGBT identity with acceptance (Ryan, 2009a).

Further, given the links between parental rejection and negative health outcomes (Ryan et al., 2009), we expect that affirmation or acceptance of LGBT adolescents will be associated with positive adjustment and decreased mental health and behavioral health risks in young adulthood: higher self-esteem, increased social support, and better general health status, along with decreased depression, substance abuse, sexual risk behavior, suicidal ideation, and behaviors.

This article presents findings related to family acceptance from the Family Acceptance Project (FAP), a research and intervention initiative to study the influence of family reactions on the health and mental health of LGBT adolescents and young adults. To our knowledge, no prior studies have examined the relationship between specific family reactions to their children’s sexual orientation and gender expression with health and mental health status in emerging adulthood.

Full Article: <http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6171.2010.00246.x/pdf>

Ryan, Caitlin, Stephen T. Russell, David Huebner, Rafael Diaz, and Jorge Sanchez. "Family Acceptance in Adolescence and the Health of LGBT Young Adults." *Journal of Child and Adolescent Psychiatric Nursing* 23.4 (2010): n. pag. Wiley Online Library, 15 Nov. 2010. Web. 25 July 2013. <<http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6171.2010.00246.x/pdf>>.

## To Be Young, Gay and Clinically Depressed

So you find yourself sitting at the edge of your bed in silence. On the side of you, there's a bottle of Jack Daniels and on your dresser, you're having a staring contest with a bottle of prescription pain pills. The tip of the bottle grazes your hand as it rolls closer to you, and your mind spins in chaos because you are actually considering combining the booze and pills to finally have some type of peace.

You've been here before. In fact, you've found yourself in this scenario 3 days in a row. You've already spent the last few days avoiding conversation with friends and family, and you'd rather spend your days in bed sleeping because it's much easier than facing the day. It's been 3 weeks since you've felt a smidgen of happiness, but you *know* that you have a lot going for yourself. You're young, successful and loved. However, you can't *feel* anything. Perhaps you haven't felt like this but this is my story. Welcome to the life known as clinical depression.

Almost 4 years ago, I was diagnosed with Clinical Depression. At first attributing my depression to being a closeted gay black male from the South, I felt that the majority of my depression would go away once I was able to finally establish myself as an open independent individual. However, I soon discovered that my depression extended past what I thought were the obvious problems. None of that mattered at that time since I was still living at home with my family, too afraid to tell anyone about my sexuality, yet alone discuss my bouts with depression. Since time has passed, it's now easier for me to openly discuss my experiences with the disorder.

Clinical depression, otherwise referred to as Major Depression Disorder, is a severe form of depression that affects a person's emotions and mental perception. Think of it like this, you know what you *should* feel when things are going well in your life, but for whatever reason, those good feelings filter through your brain as negative feedback. It's like a cloud is casted over you, blocking all the good sunshine from ever gracing your presence with its rays. In all honestly, it fucking sucks. No one wants to be depressed all the time, so by no means is this cry for attention. On the contrary, most severe cases of depression involve reclusive behavior to avoid drawing anyone's attention. Reclusiveness can be brought on by symptoms, such as loss of interest in hobbies and activities you've once enjoyed. In my case, I lost interest in performing poetry, writing, and yoga, all of which I used to combat my depression. Also, I grew less interested in going out with friends and being around family. Other symptoms included insomnia, self-loathing, lack of appetite, and sadly- thoughts of suicide. The opening paragraph spelled out a difficult period I had back in June 2010, before considering the use of antidepressants to help stabilize my mood as suggested by my therapist. Yes, therapist.

Therapy helped me a great deal during that period because I knew my emotions were out of whack. I blamed my emotional distress on trying to balance my personal life, academic studies, and career. Not mention dealing with the ups and downs of being a closeted black gay man. Black Gay Chat Live and Adam4Adam did not aid in my

quest for acceptance either; it actually served as fuel for my self-loathing, negative thoughts. My mind would tell me that I wasn't good enough to be like the men with whom I've chatted with online. With such thoughts, I began deeming myself an outcast amongst outcasts but an outcast, I am not.

Through cognitive therapy I learned to take my negative thoughts and flip them into something positive. Although it sounds simple, it actually took some practice. Sadly, some people find it hard to acknowledge their self-worth. Overall, others find it hard to accept that they may be experiencing some form of depression. If you feel depressed for more than 3 weeks, I implore you to seek the professional help necessary to get treated. Yes, you can try to treat yourself by adapting a healthy lifestyle, engaging in music/art therapies, and other relaxation therapies; however, some cases may require the aid of antidepressants. I opposed the usage of antidepressants for a great deal of my time in therapy, but after having an emotional breakdown to the point of considering suicide, I knew a change had to be made because I wanted to live to see things get better, which they have.

In the past two years, I've come out to my friends and parents, graduated Cum Laude, held down my job, and moved to Atlanta on my own. During all of this, I've put effort into my blog to reach out to other LGBT youth who may be experiencing similar issues.

Feelings of sadness, grief, and stress are a normal occurrence of life; however, if you possess these feelings more than usual, you may be depressed. Clinical depression can be treated, but you have to be proactive in getting the necessary help to lead a normal life. I have my ups and downs day-to-day, but I want those who are suffering to know that it can and will get better.

<http://www.musedmagonline.com/2012/10/to-be-young-gay-clinically-depressed/>

B, Bama. "To Be Young, Gay & Clinically Despressed." Web log post. *Mused*. Mused Magazine Online RSS, 30 Oct. 2012. Web. 30 July 2013. <<http://www.musedmagonline.com/2012/10/to-be-young-gay-clinically-depressed/>>.

## Other Resources

### Books:

“Queer Blues” by Kimeron Hardin, Marny Hall and Betty Berzon

**Queer Blues** is the only guide to focus on the triggers of depression specific to the gay and lesbian community and to offer concrete strategies to overcome them. The authors explain the many forms of depression and explore its unique impact on lesbians and gay men. If you're a lesbian or a gay man struggling with depression, this book offers you real tools for real change. A self-test helps you determine your own level of depression and assess its impact on your life. With this information, go on to explore the reciprocal relationship between mood and self-esteem. Examine your core beliefs about self-worth and identify self-sabotaging habits that may make you vulnerable to both insecurity and depression. A final section provides tested, practical methods distilled from the authors' more than twenty-five years of clinical experience to help you build a plan to effectively manage your depression.

“Depression: A Public Feeling” by Ann Cvetkovich

In *Depression: A Public Feeling*, Ann Cvetkovich combines memoir and critical essay in search of ways of writing about depression as a cultural and political phenomenon that offer alternatives to medical models. She describes her own experience of the professional pressures, creative anxiety, and political hopelessness that led to intellectual blockage while she was finishing her dissertation and writing her first book. Building on the insights of the memoir, in the critical essay she considers the idea that feeling bad constitutes the lived experience of neoliberal capitalism.

Cvetkovich draws on an unusual archive, including accounts of early Christian acedia and spiritual despair, texts connecting the histories of slavery and colonialism with their violent present-day legacies, and utopian spaces created from lesbian feminist practices of crafting. She herself seeks to craft a queer cultural analysis that accounts for depression as a historical category, a felt experience, and a point of entry into discussions about theory, contemporary culture, and everyday life. *Depression: A Public Feeling* suggests that utopian visions can reside in daily habits and practices, such as writing and yoga, and it highlights the centrality of somatic and felt experience to political activism and social transformation.

## **Website:**

Depressed Black Gay Men non-profit group:

DBGM hopes that by its work, through the medium of the documentary, community discussion forums, and the book (when it is published), to raise awareness of depression as it affects Black gay men. While looking at how they are affected, working to change perceptions, reactions and responses at the grassroots level: the family, church, school, and community; that a Black gay man need not hide or live his life in shame, or be made to feel ashamed, but be proud of who he is and his place in the human family. And, for those Black gay men who have lived and still struggle with depression, to know that they are not alone.

"If by what I'm doing, one Black gay man could be prevented from killing himself, then my job is done; his healing begins."

<http://www.dbgm.org/>

# Dissociative Identity Disorder

1. **5 Myths about Dissociative Identity Disorder (Discovery Fit and Health)**
2. **Other Resources**

Dissociative identity disorder is a severe form of dissociation, a mental process, which produces a lack of connection in a person's thoughts, memories, feelings, actions, or sense of identity. Dissociative identity disorder is thought to stem from trauma experienced by the person with the disorder. The dissociative aspect is thought to be a coping mechanism -- the person literally dissociates himself from a situation or experience that's too violent, traumatic, or painful to assimilate with his conscious self.

"Dissociative Identity Disorder (Multiple Personality Disorder): Signs, Symptoms, Treatment." *WebMD*. Ed. Kimball Johnson. WebMD, 2012. Web. 25 July 2013. <<http://www.webmd.com/mental-health/dissociative-identity-disorder-multiple-personality-disorder?page=4>>.

*This information is not intended to diagnose or treat a medical condition. If you have any questions or concerns please contact your health care provider.*

## 5 Myths about Dissociative Identity Disorder

### 1: Dissociative identity disorder is the same as schizophrenia

Lots of people confuse dissociative identity disorder with schizophrenia. They're actually two very different disorders.

Schizophrenics do not have multiple personalities at all. They have, in general, confusion about what is real and what is imagined. In schizophrenia, delusions are common. Delusions are beliefs or thoughts that are not based on anything real or justified. A "paranoid schizophrenic" may suffer from delusions of persecution, for instance. Some sufferers also hallucinate -- they see or hear things that aren't really there.

There are, however, a few common threads between dissociative identity disorder and schizophrenia. Both may hear voices in their heads, and may withdraw from social interaction. Both are often accompanied by other mental illnesses, like depression or addiction. And both disorders carry an increased risk of suicide.

Factoid:

According to WebMD, DID affects up to 1 percent of the population.

### 2: People with "multiple personalities" must be faking it

Lots of people are skeptical of "multiple personalities," but there's actually good physical evidence suggesting the disorder is real. Studies have found that "alters" (secondary personalities) have different heart rates and blood pressures than the main personality.

Other dissociative disorders are widely accepted as real, including dissociative fugue, dissociative amnesia and depersonalization disorder. DID is the most extreme form of dissociation.

Diagnosing it is difficult. People suffering from DID typically spend years in the mental health system before anyone considers they might have alters. There are some diagnostic criteria, though, that can help identify people as suffering from dissociative identities, including "lost time," frequent and extensive memory lapses, and often being accused of lying when they sincerely believe they are telling the truth. And of course, they have at least two separate personalities -- often with different names, appearances, mannerisms and attitudes -- that control behavior, thought and perception at different times. The primary personality is typically unaware of the presence of alters. Many experts believe that people suffering from DID are genuinely ill. That doesn't mean, however, that no one is faking it. People accused of crimes and those suffering from Munchausen's syndrome have been found to pretend to have "alters" in order to escape jail or get attention, respectively.

### 3: Someone with DID acts like Sybil

Media representations of dissociative identity disorder evoke images of severe disturbance: alter Eve Black trying to kill primary Eve White's daughter, or Sybil walking away from her students and into a river, fully dressed. The 1953 movie "The Three Faces of Eve" was based on the real life of Chris Sizemore, and "Sybil" (1976)

ostensibly told the story of Shirley Mason -- but like most media images, these portrayals are only partly true, dramatized for effect.

Dissociative personality disorder can lead to extreme behavior, but it is seldom so outwardly stunning. Symptoms associated with DID include profound memory loss and confusion, hearing voices, substance abuse, compulsive behavior, panic attacks, suicidal thoughts and actions, insomnia and depression. Most people who suffer from the illness had previously been diagnosed with one or more different disorders, and they go years, perhaps decades, before discovering they have alternate personalities.

Did You Know?:

Retired NFL and University of Georgia star Herschel Walker was diagnosed with DID. He had 12 alternate personalities to manage during his 14 years as a pro running back.

#### **4: Childhood trauma couldn't be the cause of DID**

No one knows what causes dissociative identity disorder. All signs point to extraordinary trauma, particularly during childhood. Some people object to that causation, though, because lots of children who go through traumatic experiences never develop multiple personalities.

On the other hand, not all smokers develop lung cancer.

Childhood trauma, particularly repetitive trauma like physical or sexual abuse, is a notable common thread in a majority of DID cases. According to WebMD, at least 98 percent of people diagnosed with DID experienced extreme, possibly life-threatening ordeals. The hypothesis is that sometimes, these experiences can simply be too much for a child to integrate into conscious experience. The child's brain, as a coping mechanism, essentially "turns off" the conscious identity and creates alternate personalities to experience the pain.

It's possible that some minds are stronger than others, more capable of coping consciously with extreme trauma, so not all children in those situations develop split personalities.

Factoid:

DID is nine times more common in women than in men.

#### **5: Someone with DID could never really recover**

Most mental illnesses are treatable, and dissociative identity disorder is no different. The disorder can't be cured, but it can definitely be managed. It can take a long time, perhaps many years, and requires an intense commitment to treatment on the part of the patient, but it is entirely possible for someone suffering from DID to lead a normal, fulfilling life.

Recovering from dissociative identity disorder involves seeking treatment with a mental health professional like a psychiatrist, psychologist or clinical social worker. Treatment methods vary, and may include psychotherapy ("talk therapy"), medication (typically for accompanying conditions like depression or anxiety) and hypnotherapy. Some experts have found that alternate personalities may respond to the therapist under hypnosis, which allows not only the therapist but also the primary identity to gain information about the alters and what they have experienced.

One aspect of treatment that has changed in the last decade is the ultimate goal regarding the alters. Once, therapist sought to integrate them into the primary personality. They found, though, that this could trigger a survival response -- that the other personalities felt the therapists was trying to eliminate them. Now, the goal is to facilitate a more peaceful coexistence between each of the alters and the main identity.

Did You Know?:

In the 1953 movie "The Three Faces of Eve," the main character had three personalities and was in treatment for one year. The real-life "Eve," Chris Sizemore, had 22 personalities and spent 45 years in treatment.

<http://health.howstuffworks.com/mental-health/mental-disorders/5-dissociative-identity-disorder-myths.htm>

Discovery Fit and Health Writers. "5 Myths About Dissociative Identity Disorder." Discovery Fit and Health, 2013. Web. 25 July 2013. <<http://health.howstuffworks.com/mental-health/mental-disorders/5-dissociative-identity-disorder-myths.htm>>.

## Other Resources

### TV Show:

#### United States of Tara

Plot: Tara Gregson is a wife and mother of two children in Overland Park, Kansas, a suburb of Kansas City, who has been diagnosed with dissociative identity disorder (DID). When stressed, Tara often transitions into one of her alternate personalities: wild and flirty teenager T; 1950s housewife Alice; and male, loud, beer-drinking Vietnam vet Buck. A fourth personality, Gimme, is introduced later in the first season. During the second season of the series, two further personalities were introduced. The former, called Shoshana, is Tara's "therapist" of sorts, while the sixth personality's name is Chicken, an infantile representation of Tara when she was 5 years old. Another personality emerges in Season 3; that of Tara's previously unknown half-brother Bryce. Tara is supported by her husband Max, daughter Kate, and son Marshall. Her sister, Charmaine, is initially not very supportive of Tara, expressing doubts about the validity of her sister's disorder, though she becomes increasingly more understanding and receptive as the series progresses. The show is a representation of a seemingly typical American family who must cope with the daily struggles of Dissociative Identity Disorder.

"United States of Tara." *Wikipedia*. Wikimedia Foundation, 24 July 2013. Web. 25 July 2013. <[http://en.wikipedia.org/wiki/United\\_States\\_of\\_Tara](http://en.wikipedia.org/wiki/United_States_of_Tara)>.

### Movies:

#### Me, Myself & Irene

After years of continuous abuse, Charlie develops a rude and violent split personality named Hank, caused by "advanced delusional schizophrenia with involuntary narcissistic rage". As Hank, he goes around retaliating against anyone who has accosted him — and even harms those who really haven't. A psychiatrist prescribes a medicine to keep Hank suppressed.

"Me, Myself & Irene." *Wikipedia*. Wikimedia Foundation, 24 July 2013. Web. 25 July 2013. <[http://en.wikipedia.org/wiki/Me,\\_Myself\\_&\\_Irene](http://en.wikipedia.org/wiki/Me,_Myself_&_Irene)>.

#### The Uninvited

Anna Rydell returns home to her sister (and best friend) Alex after a stint in a mental hospital, though her recovery is jeopardized thanks to her cruel stepmother, aloof father, and the presence of a ghost in their home.

"The Uninvited." *IMDb*. IMDb.com, n.d. Web. 25 July 2013. <<http://www.imdb.com/title/tt0815245/>>.

## **Books:**

### **Amongst Ourselves: A Self-Help Guide to Living with Dissociative Identity Disorder**

*Amongst Ourselves* is a self-help guide written expressly for individuals with DID/MPD—and the first to provide readers with the practical steps they can take to cope with the condition and emerge with greater self-awareness and the skills to live a rich and rewarding life.

Authors Tracy Alderman and Karen Marshall explain what DID is and provide a clear account of its underlying causes and symptoms. They describe what it's like to live with DID and make practical suggestions for coming to terms with the condition, managing the confusion and self-destructive behaviors that often accompany it, and deciding to “come out” to others.

Karen lends a unique and immensely important perspective, in that she is able to speak as both a therapist and as an individual with DID. Through her insights, as well as guided exercises throughout the text, readers learn:

- New skills and strategies to help them manage living with DID
- An appreciation for DID's positive aspects
- What to expect from therapy and available treatment options
- How to become more aware of themselves and the ways in which DID affects their lives

"Amongst Ourselves: A Self-Help Guide to Living with Dissociative Identity Disorder." Amazon, n.d. Web. 13 Aug. 2013. <[http://www.amazon.com/Amongst-Ourselves-Self-Help-Dissociative-Identity/dp/1572241225/ref=sr\\_1\\_1?s=books](http://www.amazon.com/Amongst-Ourselves-Self-Help-Dissociative-Identity/dp/1572241225/ref=sr_1_1?s=books)>.

### **Which One Am I?**

There are at least 16 personalities inside James Darrell Williams. But who is he really? And why? “Which One Am I?” is a singular story about universal truths, horrors and grace. Setting their work apart from other memoirs, the authors explore the nature of family and how Darrell – and all of us -- are shaped by culture, history and geography. After two years of research, Darrell and his partner Thomas Smith dug deeply into family secrets, Southern culture and Darrell's own psyche to explore portrayals of Dissociative Identity Disorder (DID) in popular culture and the psychiatric community, linking them with the events that made Darrell the man he is.

"Which One Am I?: Multiple Personalities and Deep Southern Secrets." Amazon, n.d. Web. 13 Aug. 2013. <<http://www.amazon.com/Which-One-Am-Multiple-Personalities/dp/1479120774>>.

# Eating Disorders

1. **Types of Eating Disorders (NEDA)**
2. **Eating Disorders in LGBT Populations (NEDA)**
3. **Finding Me: Looking Past the Surface to Discover My Transgender Identity (NEDA)**
4. **Eating Disorders and Body Image: What Do Gender and Sexuality Have to Do With It? (NEDA)**
5. **Eating Disorders in Diverse Lesbian, Gay, and Bisexual Populations (Matthew B. Feldman and Ilan H. Meyer)**
6. **Body Image and Eating Disorders within the GLBT Community (William Jarvis and Holly Gomez)**
7. **Other Resources**

Eating disorders -- such as anorexia, bulimia, and binge eating disorder – include extreme emotions, attitudes, and behaviors surrounding weight and food issues. Eating disorders are serious emotional and physical problems that can have life-threatening consequences for females and males.

NEDA. "General Information." National Eating Disorders Association, n.d. Web. 25 July 2013. <<http://www.nationaleatingdisorders.org/general-information>>.

*This information is not intended to diagnose or treat a medical condition. If you have any questions or concerns please contact your health care provider.*

## Types of Eating Disorders

### Anorexia Nervosa

Anorexia nervosa is a serious, potentially life-threatening eating disorder characterized by self-starvation and excessive weight loss.

#### Symptoms

- Resistance to maintaining body weight at or above a minimally normal weight for age and height.
- Intense fear of weight gain or being “fat,” even though underweight.
- Disturbance in the experience of body weight or shape, undue influence of weight or shape on self-evaluation, or denial of the seriousness of low body weight.
- Loss of menstrual periods in girls and women post-puberty.

### Bulimia Nervosa

Bulimia nervosa is a serious, potentially life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviors such as self-induced vomiting designed to undo or compensate for the effects of binge eating.

#### Symptoms

- Regular intake of large amounts of food accompanied by a sense of loss of control over eating behavior.
- Regular use of inappropriate compensatory behaviors such as self-induced vomiting, laxative or diuretic abuse, fasting, and/or obsessive or compulsive exercise.
- Extreme concern with body weight and shape.

### Binge Eating Disorder

Binge Eating Disorder (BED) is a type of eating disorder not otherwise specified and is characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.

#### Symptoms

- Frequent episodes of eating large quantities of food in short periods of time.
- Feeling out of control over eating behavior during the episode.
- Feeling depressed, guilty, or disgusted by the behavior.
- There are also several behavioral indicators of BED including eating when not hungry, eating alone because of embarrassment over quantities consumed, eating until uncomfortably full.

## Eating Disorders Not Otherwise Specified (EDNOS)

Eating disorders such as anorexia and bulimia include extreme emotions, attitudes, and behaviors surrounding weight and food issues. They are serious disorders and can have life-threatening consequences. The same is true for a category of eating disorders known as eating disorders not otherwise specified or EDNOS. These serious eating disorders can include any combination of signs and symptoms typical of anorexia and bulimia, so it may be helpful to first look at anorexia and bulimia.

<http://www.nationaleatingdisorders.org/general-information>

NEDA. "General Information." National Eating Disorders Association, n.d. Web. 25 July 2013.  
<<http://www.nationaleatingdisorders.org/general-information>>.

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## Eating Disorders in LGBT Populations

Eating disorders have historically been associated with straight, young, white females, but in reality, they affect people from all demographics and they are not caused by any single factor. They arise from a combination of long-standing behavioral, biological, emotional, psychological, interpersonal, and social factors. Research suggests that eating disorders disproportionately impact some segments of LGBT populations, though there is much research still to be done on the relationships between sexuality, gender identity, body image and eating disorders.

The myriad of unique stressors LGBT-identified people experience, such as coming out and harassment in schools or the workplace, can impact levels of anxiety, depression, low self-esteem, and unhealthy coping mechanisms such as substance abuse - all of which are common co-occurring conditions and can be contributing factors in the development of an eating disorder. Eating disorders among LGBT populations should be understood within the broader cultural context of oppression.

Potential factors that may interact with an LGBT person's pre-disposition for developing an eating disorder may include, but are not limited to:

- Coming out: Fear of rejection/experience of rejections by friends, family and co-workers
  - Internalized negative messages/beliefs about oneself due to sexual orientation, non-normative gender expressions, or transgender identity
  - Experiences of violence (gay bashing), contributing to development of Post-Traumatic Stress Disorder, which research shows sharply increases vulnerability to an eating disorder
  - Discrimination
  - Being bullied
  - Discordance between one's biological sex and gender identity
  - Homelessness or unsafe home environment
    - Up to 42 % of homeless youth are LGBT-identified
    - 33% of youth who are homeless or in the care of social services experienced violent assault when they came out
  - Body image ideals within some LGBT cultural contexts
  - LGBT people, in addition to experiencing unique contributing factors, may also face challenges for accessing treatment and support. Some of those barriers include:
    - Lack of availability of culturally-competent treatment, which addresses the complexity of unique sexuality and gender identity issues
    - Lack of family/friend support if not a part of an accepting family/community
1. Insufficient eating disorder education among LGBT resource providers who are in a position to detect and intervene. The emergence of LGBT youth drop-in centers, gay-straight alliances, LGBT community centers and LGBT healthcare resources have created more safe spaces to access support and mental health care. However, many LGBT people still remain isolated in communities that do not offer such services/programs.

## Research on LGBT Populations and Eating Disorders

- Research is limited and conflicting on eating disorders among lesbian and bisexual women.
- While research indicates that lesbian women experience less body dissatisfaction overall, research shows that beginning as early as 12, gay, lesbian and bisexual teens may be at higher risk of binge-eating and purging than heterosexual peers.
- In one study, gay and bisexual boys reported being significantly more likely to have fasted, vomited or taken laxatives or diet pills to control their weight in the last 30 days. Gay males were 7 times more likely to report bingeing and 12 times more likely to report purging than heterosexual males.
- Females identified as lesbian, bisexual or mostly heterosexual were about twice as likely to report binge-eating at least once per month in the last year.
- Elevated rates of binge-eating and purging by vomiting or laxative abuse was found for both males and females who identified as gay, lesbian, bisexual or “mostly heterosexual” in comparison to their heterosexual peers.
- Compared to other populations, gay men are disproportionately found to have body image disturbances and eating disorder behavior (STATS). Gay men are thought to only represent 5% of the total male population but among men who have eating disorders, 42% identify as gay.
- In a 2007 study of Lesbian, Gay and Bisexual (LGB)-identified participants, which was the first to assess DSM diagnostic categories, rather than use measures that may be indicative of eating disorders (e.g., eating disorder symptoms), in community-based (versus those recruited from clinical or academic settings) ethnically/racially diverse populations. Researchers found:
  - Compared with heterosexual men, gay and bisexual men had a significantly higher prevalence of lifetime full syndrome bulimia, subclinical bulimia, and any subclinical eating disorder.
  - There were no significant differences between heterosexual women and lesbians and bisexual women in the prevalence of any of the eating disorders.
  - Respondents aged 18–29 were significantly more likely than those aged 30–59 to have subclinical bulimia.
  - Black and Latino LGBs have at least as high a prevalence of eating disorders as white LGBs
  - A sense of connectedness to the gay community was related to fewer current eating disorders, which suggests that feeling connected to the gay community may have a protective effect against eating disorders

NEDA. "LGBTQ." National Eating Disorders Association, n.d. Web. 25 July 2013.  
<<http://www.nationaleatingdisorders.org/general-information>>.

## Finding Me: Looking Past the Surface to Discover My Transgender Identity

There have been many moments in my life where I have questioned if I am lovable. My belief about what being lovable looked like began when I was a toddler and realized I'd much rather play with the boys than be around the girls. As we aged together I began to feel rejected as some of the boys uttered, "You can't play with us. You're a girl!" The words, "you're a girl" would be repeated by many others as I grew into my young adult years. Each time was another blow to my gut, knocking the wind out of my body and leaving me feeling lost, broken and unaccepted.

I grew up in a small farming community and struggled to find a place where I felt accepted by anyone, since my baggy pants, untucked athletics t-shirts and disheveled hair didn't fit with my female body and the expectation that I should be feminine. I was often asked by the younger kids in the school's hallways, *Are you a girl or boy?* I was asked by my family, *Don't you want to look pretty like your sister?* I was then picked on and labeled a lesbian because the answer to everyone's questions was . . . *No.*

The discomfort I felt by all the outward attention people paid to my appearance only heightened an insecurity that I felt I couldn't tell anyone; I was a girl, but I wanted to be a boy. When my puberty began, my insecurities with my physical appearance became my obsession. As my body grew into a curvy female form I let go of the fantasy of turning into a boy and surrendered to the idea that I'd forever be uncomfortable in my own skin.

My curves made me feel fat.

My curves scared me.

At the age of eighteen I decided that all of my discomfort in life would go away if I just lost weight. I believed that if I could look a certain way, which for me meant skinny, then my life would align itself, my parents would love me, and my social interactions would improve. So, I set my sights on a goal that I didn't think I would be able to achieve, to be skinny.

By the time I turned 19, I was diagnosed with anorexia nervosa. A part of me liked my eating disorder because my body quit menstruating, my breasts were almost non-existent and I could wear boy's pants that hung off of my body. The other part of me just wanted to die and was scared of everything; people, my body, family, going out with friends, and eating outside my controlled environment.

My eating disorder caused me to live in a world that revolved around all the things I was trying to avoid; my body, food, fear and loneliness.

After a year-and-a-half of torturing myself through anorexia, my spirit was ready to surrender. As I felt the beats of my heart decrease to the point of stopping, a voice inside me said, "It's not your time." As it became silent, I felt a new rush of energy pulse through my veins and I decided it was time to quit living in fear and hiding. To do this I knew I had to be dedicated to going to therapy and seeing a nutritionist.

I went to weekly appointments for another four-and-a-half years.

From the ages of 19 to 24 my eating disorder controlled my life and kept me from exploring my true feelings. Through therapy, I finally accepted that I had to quit

looking at my body and my appearance to judge my feelings of self-worth. Instead, I turned my attention inward where I was able to face the one thing that scared me the most, sexuality.

At the age of 24 I came out as a lesbian. When I did this, my eating disordered behaviors started to decrease, and my posture straightened as I walked on my college campus. The energy I spent focusing on food dissipated with each day that passed after coming out, but the energy I spent dissecting my appearance and body increased. As a child I knew I was supposed to be a boy, as a teenager I was scared of being a girl, and as an adult I didn't know there was a way to fix what was wrong. Eight months later I discovered how to fix what was wrong when I found a book about transgender men. Looking at their bodies and reading their stories I immediately knew why I was struggling with my own.

I am transgender.

After this discovery I took the steps to transition into the man I always felt I was. Through my transition I have lost relationships with some loved ones and minor friendships, but I have learned that if I would have continued to make choices in life based on what makes other people happy, then I would still be stuck in my eating disorder today.

The one thing that I am still learning is how to explore feelings without taking them out on my body. My biggest trigger is my estranged relationship with my parents. My sister tells me that my dad loves me, but that he is caught up in "appearances," his "pride" and how people see me. The ironic thing is, through my transition and my ability to state, "This is me, and this is how I am going to live my life." I've gained respect from others and have developed it for myself. I have a newfound confidence, but the negative self-talk toward my body is always heightened when I learn of another comment my dad has made that hints towards his pride being more important than his kid. Because of my experiences, I work hard to help support and build self-confidence with youth while asking parents to let go of their own pride and remember how they felt as a child when the adults in their life weren't truly listening and seeing them.

For me, all I want (and wanted in my recovery) is what I feel every kid wants regardless of their gender: To be loved, to be supported, but also to be allowed to explore this world and let others know who we are, not what they want us to be. There is hope for recovery. I am now 32-years-old and have been free of abusing food for nine years. I now know what hunger signals are, and I am able to nourish my body. Recovery begins when you allow yourself to love and recognize that being lovable is about respecting oneself and allowing your inner spirit to guide your actions. It is a life-long process, but I know I wouldn't be where I am today if I wouldn't have allowed myself to do one of the scariest things in my life, to honor my truths and recognize my internal identity.

My life with an eating disorder, my struggle with my body image and my transition from female to male are explored in my book, *Second Son: Transitioning Toward My Destiny, Love and Life*.

NEDA. "Finding Me: Looking Past the Surface to Discover my Transgender Identity." National Eating Disorders Association, n.d. Web. 25 July 2013. <<http://www.nationaleatingdisorders.org/general-information>>.

## **Eating Disorders and Body Image: What Do Gender and Sexuality Have to Do With It?**

When I think about the challenges around being an LGBTQ-identified (Gay, Lesbian, Bi, Transgender, Queer) person, the word that best describes my experience is confusion. Life is confusing anyway, and being Queer - the term that I personally use - in our culture can add to that confusion, as well as create a great deal of stress, anxiety, and overwhelming emotions. The myriad of unique struggles related to sexuality and gender expression, such as coming out and harassment in schools or the workplace, can impact experiences of anxiety, depression, low self-esteem, trauma and developing unhealthy coping mechanisms such as substance abuse - all of which are common co-occurring conditions or contributing factors in the development of an eating disorder.

Eating disorders are often associated with straight, young, white females, but in reality, they affect people from all demographics and they are not caused by any single factor. They arise from a combination of long-standing behavioral, biological, emotional, psychological, interpersonal, and social factors. Research suggests that eating disorders disproportionately impact some segments of LGBTQ populations, though there is much research still to be done on the relationship between sexuality, gender expression, body image and eating disorders. There is a strong genetic predisposition to the development of an eating disorder, but it interacts with the many contributing factors that can trigger onset.

LGBTQ people may also experience unique contributing factors such as trauma in the form of gay-bashing or harassment, losing social support, family, and potentially their home as a result of coming out (up to 42 % of homeless youth are LGBTQ), and extreme anxiety or depression associated with their sexuality or gender expression. In one study, gay and bisexual boys reported being significantly more likely to have fasted, vomited or taken laxatives or diet pills to control their weight in the last 30 days. While research indicates that lesbian women experience less body dissatisfaction overall, recent research found that beginning as early as 12, gay, lesbian and bisexual teens may be at higher risk of binge-eating and purging than heterosexual peers, with those identified as lesbian, bisexual or mostly heterosexual being about twice as likely to report binge-eating at least once per month in the last year.

LGBTQ people, in addition to experiencing unique contributing factors, they may also face challenges for accessing treatment and support. In my own personal development, growing up I always felt confused because like so many of us, I did not fit into the stereotypes of what it is to be a girl. I was a tomboy and lived this out through my dress, play, actions and behaviors. Eventually I became a champion athlete, and I believed that if I was to be a great athlete, I had to be a boy. In my day as a professional runner, women only got trophies if men did not show up for their awards. I tried to be a boy by trying really hard not to grow up as a girl. In other words I tried not to develop a female body and was terrified to get my menstrual cycle. For years I struggled with anorexia and exercise bulimia, which kept me frail, underdeveloped, confused and very androgynous. I thought that these behaviors would somehow keep me from being a woman, but who I was born to be was always fighting to come through. In order for me

to get the treatment I needed, addressing these complex issues of sexuality and gender would be crucial. LGBTQ people who struggle with body image issues and eating disorders need culturally competent care.

It took me a long time to learn to be myself in a culture that devalues those who challenge narrow beauty standards and transgress gender norms. Now at 50, I don't think of myself around the confines of being a woman or a man, being male or female. I feel my authentic self beyond the limiting ideals our culture has created and imposes upon us. I have learned that the incredible variety that exists among people is what is truly beautiful. If you or someone you know is struggling with an eating disorder or body image issues, I encourage you to seek treatment and support.

NEDA. "Eating Disorders and Body Image: What do Gender and Sexuality Have to Do With It?." National Eating Disorders Association, n.d. Web. 25 July 2013. <<http://www.nationaleatingdisorders.org/general-information>>.

# Eating Disorders in Diverse Lesbian, Gay, and Bisexual Populations

## Abstract

**Objective**— This study estimates the prevalence of eating disorders in lesbian, gay, and bisexual (LGB) men and women, and examines the association between participation in the gay community and eating disorder prevalence in gay and bisexual men.

**Method**— One hundred and twenty six white heterosexuals and 388 white, black, Latino LGB men and women were sampled from community venues. DSM-IV diagnoses of anorexia, bulimia, and binge eating disorder were assessed using the World Health Organization's Composite International Diagnostic Interview.

**Results**— Gay and bisexual men had significantly higher prevalence estimates of eating disorders than heterosexual men. There were no differences in eating disorder prevalence between lesbian and bisexual women and heterosexual women, or across gender or racial groups. Attending a gay recreational group was significantly related to eating disorder prevalence in gay and bisexual men.

**Conclusion**— Researchers should study the causes of the high prevalence of eating disorders among gay and bisexual men.

Full Text can be found at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2080655/pdf/nihms32619.pdf>

Feldman, Matthew B., and Ilan H. Meyer. "Eating Disorders in Diverse Lesbian, Gay, and Bisexual Populations." *NIH Public Access*. National Institutes of Health, Apr. 2007. Web. 25 July 2013.

<<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2080655/pdf/nihms32619.pdf>>.

## **Body Image and Eating Disorders within the GLBT Community**

It is important to talk about Eating Disorders and body image as it applies to the GLBT community because of the prevalence of the belief in the myth that these issues are restricted to the population of White upper/middle class heterosexual women/girls. Research has shown that compared to heterosexual men there are higher levels of Each Disorder symptoms within the gay and bisexual male community and that gay men present with higher rates of body dissatisfaction and score higher on eating disturbance evaluations. Additionally, although studies support the idea that heterosexual women endorse more extreme thinness ideals than lesbian women, women in the GLBT community are by no means immune to body image dissatisfaction or Eating Disorder behavior.

Researchers have found that the ideal body image is becoming more rigid for both men and women in the GLBT community. Studies have shown that according to GLBT community norms, gay men are aspiring to a thinner and more muscular ideal as well as an image of young, White, and smooth. This has prompted the genesis of the phrase “twenty-five is the new forty-five,” expressing the perceived reality of many gay and bisexual men that men in the GLBT community are physically “over the hill” by their midtwenties. There is a myth that women in the GLBT community do not have body image concerns because of the strong Feminist perspective and emphasis on fat acceptance within the community. Although research has indicated that lesbians reported feeling freer to discard more mainstream female appearance styles and notated greater rates of body acceptance after coming out, the same population reported high ratings of eating disorders and weight concerns. These results may be explained in part by the internal struggle caused by the incongruence between the values of the Lesbian community as it relates to the standards of self acceptance and the personal beliefs of women within the GLBT community. There are, however, differences between the beliefs of women within the GLBT community, with research indicating that feminine women report greater instances of lower body satisfaction than either masculine or androgynous females. Additionally, studies suggest that younger generations within the GLBT community have more idealized and rigid body images than older members within the community.

A model which has gained in popularity in the recent past for conceptualizing body image and Eating Disorders is The Multi-Determined and Self-Perpetuating Model of Eating Disorders. This model takes into consideration the predisposing factors of biological, family, and individual variables, as well as social cultural and multicultural factors. It also takes into account the precipitating stressors that serve as a catalyst to the development of disordered thoughts of body image and eating patterns that develop into Eating Disorder behaviors. Additionally, this model also addresses perpetuating factors such as cognitive disturbances, distortion of hunger and satisfaction, and compensatory activities as well as cultural pressures, secondary gains, guilt, shame, anxiety, interpersonal difficulties and body image distortion.

Proper assessment of an Eating Disorder is imperative because the individual struggling with such a disorder will develop significant physical and mental issues as the disorder progresses. Such disturbances can include, but are not limited to, the following: deficits in concentration and memory, mood swings, depression, anxiety, loss of hair,

dry skin, skin that turns yellow in appearance, pleading from blood vessels in the esophagus, bowel irregularities, inability to ovulate, muscle cramping and weakness, joint and/or bone pain, osteoporosis, changes in the brain structure, a decrease in red blood cells, deficits in white cell functioning, and overall weakness and fatigue. Proper assessment will include categories that include details on the individual's weight history, information on bingeing behaviors, compensatory behaviors, calorie restriction, and impact on daily functioning. It will also include an assessment of medical problems, family issues, interpersonal and romantic relationships, a mental health history, and a review of any previous or current treatment.

Jarvis, William, and Holly Gomez. "Body Image and Eating Disorders within the GLBT Community." Illinois School of Professional Psychology, n.d. Web. 25 July 2013.  
<<http://www.uic.edu/orgs/convening/33-VIF.pdf>>.

## Other Resources

### Books:

#### Unbearable Lightness

Now in paperback, the *New York Times* bestselling memoir from Portia de Rossi explores the truth of her long battle to overcome anorexia and bulimia—“an unusually fresh and engrossing memoir of both Hollywood and modern womanhood” (*Los Angeles Times*, 5 stars).

In this groundbreaking memoir, Portia de Rossi reveals the pain and illness that haunted her for decades, from the time she was a twelve-year-old girl working as a model in Australia, through her early rise to fame as a cast member of the hit television show *Ally McBeal*. All the while terrified that the truth of her sexuality would be exposed in the tabloids, Portia alternately starved herself and binged, putting her life in danger and concealing from herself and everyone around her the seriousness of her illness.

She describes the elaborate rituals around food that came to dominate hours of every day and explores the pivotal moments of her childhood that set her on the road to illness. She reveals the heartache and fear that accompany a life lived in the closet, a sense of isolation that was only magnified by her unrelenting desire to be ever thinner, ever more in control of her body and the number of calories she consumed and spent.

From her lowest point, Portia began the painful climb back to a life of health and honesty, falling in love and marrying Ellen DeGeneres and emerging as an outspoken and articulate advocate for gay rights and women’s health issues. In this remarkable and landmark book, she has given the world a story that inspires hope and nourishes the spirit.

"Unbearable Lightness: A Story of Loss and Gain." Amazon, n.d. Web. 13 Aug. 2013.  
<<http://www.amazon.com/Unbearable-Lightness-Story-Loss-Gain/dp/1439177791>>.

#### Authentic and Free: A Journey from Shame to Self-Acceptance

Have you ever looked in the mirror and hated the person looking back at you? Has the voice in your head ever said you’re not good enough, smart, thin or attractive enough? Bullying is a serious problem among today’s youth, especially those who are lesbian, gay, bisexual, transgender, questioning or queer (LGBTQ). What about those of us who bully ourselves? If you’re like Courtney was, you are tired of your inner bully, tired of self-doubts, and ready for a dose of confidence, self-acceptance and self-love. Ready to Spread Your Wings and Soar as the Authentic You? Here’s Your Inspiration... “The authentic you is the person inside—the one who’s always been there, hiding beneath the fears, masks, and costumes. She just needs to know it’s safe to step out and show up.” Smiley and caring, Courtney seems to have it all—an adoring boyfriend, loving family, good grades, and bright future. However... -Why does she never feel smart, pretty, thin or good enough? -Raised in a household and religion with rigid rules, what happens when she realizes her attraction to boys... AND girls? -Will she honor the call

of her authentic self, or will she spiral downward in self-destruction? -With a critical inner bully and invisible eating disorder, how can she possibly shake off the shame and learn to love and accept herself? *Authentic and Free* is a thought-provoking work of creative nonfiction that will inspire you to transform self-doubts into self-love by discovering your inner beauty, strengths and light. It's time to set aside rules and expectations, be the powerful person you came here to be and experience the sweet freedom of an authentic life!

"Authentic and Free: A Journey from Shame to Self-Acceptance." *Amazon.com: Books*. Amazon, n.d. Web. 16 Aug. 2013. <[http://www.amazon.com/Authentic-Free-Journey-Shame-Self-Acceptance/dp/1456309307/ref=cm\\_cr\\_pr\\_product\\_top](http://www.amazon.com/Authentic-Free-Journey-Shame-Self-Acceptance/dp/1456309307/ref=cm_cr_pr_product_top)>.

# Post-traumatic Stress Disorder

- 1. Gay men, lesbians at higher risk for violence, PTSD (Elizabeth Cooney)**
- 2. A third LGBT youth suffer from mental disorders (The Indian Express)**
- 3. Documentary on LGBT veterans' PTSD trauma and recovery premieres tomorrow (Lia Steakley)**
- 4. Other Resources**

When in danger, it's natural to feel afraid. This fear triggers many split-second changes in the body to prepare to defend against the danger or to avoid it. This "fight-or-flight" response is a healthy reaction meant to protect a person from harm. But in post-traumatic stress disorder (PTSD), this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they're no longer in danger.

PTSD develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers.

PTSD was first brought to public attention in relation to war veterans, but it can result from a variety of traumatic incidents, such as mugging, rape, torture, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters such as floods or earthquakes.

National Institute of Mental Health. "Post-Traumatic Stress Disorder (PTSD)." USA.gov, n.d. Web. 13 Aug. 2013. <<http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>>.

*This information is not intended to diagnose or treat a medical condition. If you have any questions or concerns please contact your health care provider.*

## Gay men, lesbians at higher risk for violence, PTSD

Gay men, lesbians, and bisexuals experience more violence over their lifetimes than their heterosexual peers, many small studies have shown. A new large, national study led by Boston researchers reports that exposure to violence begins in childhood, from abuse at home to bullying at school. Gay men, lesbians, bisexuals, and heterosexuals who have ever had same-sex partners -- a group the researchers call sexual orientation minority members -- are up to twice as likely to grow up experiencing violence. Sexual orientation minority members are also twice as likely to suffer from post traumatic stress disorder as heterosexual people, the study found.

Andrea Roberts and colleagues from the Harvard School of Public Health and Children's Hospital analyzed records from the the National Epidemiologic Survey on Alcohol and Related Conditions, which asked more than 34,000 people in face-to-face interviews about their sexual orientation and partners, traumatic events they might have witnessed or suffered, and symptoms of PTSD. They found that 45 percent of sexual minority women and 28 percent of sexual minority men experienced violence or abuse in childhood, compared with 21 percent of women and 20 percent of men in the general population. Nine percent of men and 20 percent of women reported symptoms that fit the criteria for PTSD, compared with 4 percent of men and 10 percent of women in the general population.

"It was known that sexual orientation minorities have a higher exposure to violence, bullying, and also family-driven abuse in childhood than heterosexuals, and the high prevalence of mental illness among sexual orientation minorities was also known," Roberts, lead author of the study published April 15 in the online [American Journal of Public Health](#), said in an interview. "We connected those two pieces."

Roberts urges parents and health care providers to be aware that children may be at risk before they identify their sexual orientation. "Their behavior may well be different. There is plenty of evidence that shows people who will later identify as gay as children have [different] mannerisms or clothing choices or activity choices" that make them targets of bullying or abuse.

Roberts thinks parents should also examine their own behavior.

"In any given school in any given community, some of these parents are going to have children who will later identify as sexual minorities. It may be that their behavior as young children, parents find a little disturbing," she said. "Our message is, they need to get over that."

Cooney, Elizabeth. "Gay Men, Lesbians at Higher Risk for Violence, PTSD." *White Coat Notes*. Boston.com, n.d. Web. 13 Aug. 2013.  
<[http://www.boston.com/news/health/blog/2010/04/gay\\_men\\_lesbian.html](http://www.boston.com/news/health/blog/2010/04/gay_men_lesbian.html)>.

## **A third LGBT youth suffer from mental disorders**

A new study by University of Illinois at Chicago has revealed that one-third of lesbian, gay, bisexual and transgender (LGBT) youth have attempted suicide in their lifetime prevalence comparable to urban, minority youth – but a majority do not experience mental illness.

The researchers recruited 246 ethnically diverse 16- to 20-year-old LGBT youth in Chicago and conducted structured psychiatric interviews to assess major depression, post-traumatic stress disorder, suicide attempts and conduct disorder.

While a third of participants did meet criteria for at least one of the mental health disorders, about 70 percent of LGBT youth did not meet criteria for any mental disorders.

"One of the most important findings from our work is that most of these youth are doing very well and are not experiencing mental health problems," said Brian Mustanski, assistant professor of psychiatry at UIC and lead author of the study.

Nearly 10 percent of study participants met criteria for post-traumatic stress disorder (PTSD) and about 15 percent met criteria for major depression.

A third had made a suicide attempt at some point in their life, and about 6 percent had made a suicide attempt in the last year.

The researchers also looked at differences between sub-groups of LGBT youth to determine if bisexual youth tend to have more mental health problems than gay and lesbian youth, or if racial-minority youth experience more mental health problems than white youth.

Contrary to previous research that suggested that bisexual youth are more likely to have mental disorders than other groups, Mustanski found just the opposite. Bisexual youths had a lower prevalence of mental disorders compared with others in the study.

"A Third LGBT Youth Suffer from Mental Disorders." The Indian Express, 2 Dec. 2010. Web. 13 Aug. 2013. <<http://www.indianexpress.com/news/a-third-lgbt-youth-suffer-from-mental-disorders/719284/>>.

## **Documentary on LGBT veterans' PTSD, trauma and recovery premieres tomorrow**

“The Camouflage Closet,” a short documentary directed by Stanford medical student Michael Nedelman, offers a snapshot into the lives of nine lesbian, gay, bisexual and transgender (LGBT) veterans and their personal stories involving post-traumatic stress disorder (PTSD), trauma and recovery. The documentary will premiere tomorrow night in San Francisco as part of the National Queer Arts Festival.

Discussing the importance of making the film, Nedelman said, “Many of us rely on two things to cope with traumatic experiences: community and identity. In the military, this was actively suppressed for LGBT service members. Even though [Don’t Ask, Don’t Tell] DADT has ended, we will continue to see the impacts of anti-LGBT policies, and it is becoming clear that there is much that can be done to address it.”

In the brief Q&A below, he talks about the motivation behind the project and what impact he hopes the film will have on the public:

### **What was the catalyst for creating the film?**

The film came about fortuitously, like it was waiting to be shot. There were many things that led us to create the film: I bumped into Andrew V. Ly, now the film’s composer, on my first day as a Californian. We became fast friends, exchanged clips of our own work, and attended an arts workshop together called “Creating Queer Communities,” where we began putting together a proposal for a project that would combine our interests in art and advocacy, as well as my interests in health and medicine. We thought about the LGBT veteran community as something we were very interested in, but there was so little information out there—only 18 empirical studies had ever been published in peer-reviewed journals.

Meanwhile, little did we know that Heliana Ramirez, LISW, was facilitating one of only 15 known LGBT groups at VA hospitals in the country—right here in Menlo Park! Moreover, she had done digital storytelling projects in the past, so I’d say our interests were uncommonly well aligned. Finding the right collaborators, having such a supportive VA, and meeting a group of nine inspiring, artistic LGBT veterans signaled to me that this project was a special one—a unique opportunity that, at least for now, would be difficult to produce anywhere else.

### **What impact do you hope the film will have on audiences? For example, is the goal to raise awareness, amplify the voice of an underrepresented group, etc?**

We think this project has many important audiences, including other people in the LGBT, veteran, and medical communities. We really hope it will foster discussion about opportunities for research, growth, and advocacy in addressing LGBT veteran health issues. This summer, Heliana and I will be working on a teaching guide to accompany clips from the film.

But first and foremost, we used a “video voice” model—which puts cameras into people’s hands—as an empowering tool for participants to share their stories in a structured group setting. At the heart of the methods we used to create this film are the goals of positive change for marginalized communities, and understanding the challenges and strengths of these communities.

Teaser: [http://www.youtube.com/watch?feature=player\\_embedded&v=XLiEWxj-KME](http://www.youtube.com/watch?feature=player_embedded&v=XLiEWxj-KME)  
<http://scopeblog.stanford.edu/2013/06/03/documentry-on-lgbt-veterans-ptsd-trauma-and-recovery-premieres-tomorrow/>

Steakley, Lia. "Documentary on LGBT Veterans' PTSD, Trauma and Recovery Premieres Tomorrow." *Scope Blog*. Stanford University, 3 June 2013. Web. 13 Aug. 2013.  
<<http://scopeblog.stanford.edu/2013/06/03/documentry-on-lgbt-veterans-ptsd-trauma-and-recovery-premieres-tomorrow/>>.

## Other Resources

### Facebook:

GLBT Military Members With PTSD- <https://www.facebook.com/GLBTPTSD>

### Blog:

The Distant Panic

Hi, I'm Sadie! There are two main reasons I originally made this blog: (1) To encourage new ways of thinking about mental illness that acknowledge how living in an oppressive/exploitative society situate certain people as mentally ill and disabled; and (2) To provide resources and advice on dealing with mental illness from a non-judgmental, harm reduction, and (trans)feminist perspective — because we can't heal ourselves without changing the world, we can't change the world without healing ourselves, and we can't do either alone.

<http://thedistantpanic.wordpress.com/>

Sadie. *The Distant Panic*. N.p., n.d. Web. 16 Aug. 2013. <<http://thedistantpanic.wordpress.com/>>.

# Schizophrenia

- 1. Schizophrenia: Diagnosis or Difference? (Ronald E. Hellman and Helene Kendler)**
- 2. Trans and Schizophrenic: When Diagnosis Impacts Transition (Sam Ashkenas)**

Schizophrenia is a group of severe brain disorders in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions, and disordered thinking and behavior.

Contrary to some popular belief, schizophrenia isn't split personality or multiple personality. The word "schizophrenia" does mean "split mind," but it refers to a disruption of the usual balance of emotions and thinking.

Schizophrenia is a chronic condition, requiring lifelong treatment.

Staff, Mayo Clinic. "Definition." *Mayo Clinic*. Mayo Foundation for Medical Education and Research, 27 Jan. 2012. Web. 16 Aug. 2013.  
<<http://www.mayoclinic.com/health/schizophrenia/DS00196/DSECTION=risk-factors>>.

*This information is not intended to diagnose or treat a medical condition. If you have any questions or concerns please contact your health care provider.*

## Schizophrenia: Diagnosis or Difference

The subject of this case study is a woman with schizophrenia who sought treatment at her current outpatient clinic when she concluded, after several years, that her former mental health providers did not understand her needs. She was referred to the clinic by a support program for lesbian, gay, bisexual, and transgender (LGBT) people with major mental illness, because of the clinic's subspecialization in LGBT issues. The LGBT program is one of several culturally specific offerings at the clinic, providing a full range of core psychiatric services in a culturally sensitive and affirmative environment for LGBT-identified patients. It provides an affirming and comfortable environment for LGBT patients within an otherwise mainstream, primarily heterosexual, cis-gendered setting (Hellman 2011; Hellman et al. 2010)

At the time of intake, Alexis did not clarify what her unaddressed needs were. Only after seeing her therapist for several months did she disclose that she did not feel comfortable or safe discussing her sexual orientation and gender identity issues with her former providers, and so she had remained silent about these. The case illuminated her concerns while challenging the clinician to discern what is pathological and what it merely different.

For the full case study:

<http://books.google.com/books?id=aLmhmxGDafUC&pg=PA113&lpg=PA113&dq=lgbt+and+schizophrenia&source=bl&ots=yTOjDbDcUB&sig=ktwk2dFWN2hU7xUakJWc9go2Rj8&hl=en&sa=X&ei=X4MKUrq9J4Ok2AWtkoDYBg&ved=0CFAQ6AEwBDgK#v=onepage&q=lgbt%20and%20schizophrenia&f=false>

Hellman, Ronald E., and Helene Kendler. "Schizophrenia." *Google Books*. N.p., n.d. Web. 13 Aug. 2013. <<http://books.google.com/books?id=aLmhmxGDafUC>>.

## Trans and Schizophrenic: When Diagnosis Impacts Transition

The Diagnostic and Statistical Manual of Mental Disorders (DSM) recognizes both gender identity disorder and schizophrenia as mental illnesses that can and do coexist. So I was surprised to find that, when my doctor would not prescribe me hormones without a letter from my psychiatrist stating that my gender identity issues weren't a product of my schizophrenia, the psychiatrist said he would never write such a letter.

"You can't prove a negative," he said. "I'm not saying you're not transgendered, but I can never be sure that this transgendered thing is legitimate."

So there it was. Although I could pass pretty well without the hormones, one day I would develop male-pattern baldness and other secondary sex characteristics of the wrong gender. I was doomed to become irreversibly masculine.

My parents and I were stunned. In modern times, most people wouldn't think it was mentally healthy for a person to conceal her gender identity and live as the wrong gender for the rest of her life. How, then, could it be not only right, but necessary for someone who had already suffered a psychotic break to live that way? Even worse, my mother asked him if he understood what an emotional blow it was for me to hear that I could never have hormones for the rest of my life. Basically he shrugged and said "that's protocol." Before my mother could recover from her shock at his response he went on to say that because my medicine was so effective for me, he would only need to see me once every three months. I was forced to consider the possibility that he just didn't give a damn about my happiness.

If he had read my medical records he would have known that my first psychotic break was exacerbated by my fear that I would never be recognized as a woman. In my senior year of high school I had come out to my parents and friends as trans. I began seeing a therapist and after six months I got her to sign off on my getting hormones. At the time, my therapist's approval was all I needed, and so I initiated hormone replacement therapy. All this time I had been taking anti-psychotics for past mental health issues that included toileting in a bucket, fear of robots from the future, and running around in my underwear in the middle of winter. But I hadn't actually been diagnosed with schizophrenia yet, so no one stood in my way of getting hormones. That would change as my symptoms progressed. Despite loyally sticking to my medication regimen, I fell ill again. I was afraid that Israel would invade the U.S. and so I thought I had to get the president's attention. Jill Biden taught at the school I was attending, and when I saw her secret service detail I began to scan them closely with my eyes to see if they had any devices to communicate to the president with.

"Who is she?" one of them whispered to another.

"I think she's a student."

I became fearful, so I left. Next week when I came back for class, a couple of secret service agents pulled me aside and interviewed me.

"Why did you run from them? Did you know they were secret service agents?" they asked.

I became fearful so I started banging my head against the wall to control my thoughts, but they then decided to take me to the hospital because I was hurting myself.

"We need to take you for a psychological evaluation because we think you're a danger to yourself."

I turned and tried to run, so they wrestled me into handcuffs and brought me to the emergency room. At the emergency room I tried to run away and so they tied me to the bed. Blinded by rage I screamed, "You can't stop me from killing the president!"

"How would you kill the president?" one agent asked.

"If you donate to his campaign you're entered into a raffle. The prize is a seat at a dinner with him. I'm going to win and choke him at the dinner."

I was committed to a psychiatric unit, and when I was discharged three weeks later the secret service pressed charges and I was arrested. They dropped the charges after I'd spent nine months in jail because they decided I was too mentally ill to understand the charge or the court proceedings. I was transferred back to the same psychiatric unit and two months later I went home.

But I was haunted by memories of my time as a female in a male jail. While in jail, I ran into several problems because I looked like a woman. I had inmates chasing me around the corridors, offering me food for sex, and one inmate even sexually assaulted me. The worst part was that they wouldn't give me my hormones in jail. So when I got out I immediately went back to the doctor who had prescribed them to me. She wouldn't do this without a letter from my psychiatrist because I had been diagnosed as schizophrenic.

"I know you were on hormones before, but I just need some extra assurance," she said.

When I was actively psychotic I never mentioned my desire to transition. It's only when I'm healthy that I pursue hormone replacement therapy and laser hair removal. When I was at my worst, I couldn't even think about my gender identity. I was too preoccupied by my fears. I was afraid harmless things, like street signs or trees, were trying to kill me. I became concerned only for my survival. I couldn't even think about my gender identity.

My parents have noticed the trend that I only talk about transitioning when I'm healthy, and they support me in my transition. But even with my parents on my side my psychiatrist refuses to write me the letter I need. No matter how long I'm mentally stable, no matter how long I live full time as a woman, he will never approve me for hormone replacement therapy. This is why my parents and I were so stunned at my psychiatrist refusal to even discuss the matter. It doesn't mean I can't transition. What it does is create an additional financial barrier. This doctor was not the first to refuse to write me a letter for hormones. Every doctor that I've seen within my health insurance has refused. So I have to see a private psychiatrist for several months to get his or her approval. The only way around this is to take black market hormones, which I don't want to do.

With my parents' encouragement, I hope to share my story to help other people in my position. No one should have to live as the wrong gender for his or her entire life because they have a mental illness.

Ashkenas, Sam. "Trans and Schizophrenic: When Diagnosis Impacts Transition." Web log post. *Transcribe*. Autostraddle, 10 Apr. 2013. Web. 16 Aug. 2013. <<http://www.autostraddle.com/trans-and-schizophrenic-171487/>>.

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# Visual

1. **Blind LGBT Pride International (Blind Pride International)**
2. **Blind, Lesbian Opera Singer Inspires With Her Story (Andrew Villagomez)**
3. **Other Resources**

## Blind LGBT Pride International



# BLIND LGBT PRIDE INTERNATIONAL

Blind LGBT Pride International, formerly known as BFLAG, is a special interest affiliate of the American Council of the Blind (ACB). In 1996 members of ACB who were LGBT and their friends began meeting at the National ACB Convention to discuss issues faced by people who were LGBT and vision impaired. In 2000 Blind Friends of Lesbians and Gays, BFLAG, was chartered as a special interest affiliate of ACB. In 2009 the name was changed to Blind LGBT Pride International.

Blind Pride is the largest organization of its kind in the world serving vision-impaired people in Canada, England and Japan, as well as the United States. The current membership is now over 200. Blind LGBT Pride is a 501 (c) (3) non profit organization.

The purpose of Blind LGBT Pride is to provide for the betterment of the lives of those who are visually impaired and who are LGBT; By providing a forum for the views and concerns of visually impaired persons interested in issues facing those who are LGBT; By providing information about publications of interest to members that are produced in accessible format and by encouraging the production of such material in accessible format; & by providing education on accessibility awareness.

Website: <http://www.blind-lgbt-pride.org/>

Facebook: <https://www.facebook.com/BlindIGBTPrize>

Twitter: <https://twitter.com/blindprideintl>

*Blind Pride International. Blind LGBT Pride International. Blind Pride International, 2013. Web. <<http://www.blind-lgbt-pride.org/>>.*

## Blind, Lesbian Opera Singer Inspires With Her Story

Blind since birth, mezzo-soprano Laurie Rubin tells her empowering story in memoir 'Do You Dream in Color? Insights From a Girl Without Sight'

Acclaimed mezzo-soprano opera singer Laurie Rubin has been blind since birth, is openly lesbian, and of Jewish background. What better reason to write a memoir? On paper, she was, obviously, not your typical everyday teenager growing up. But with determination and a strong support system, she continually surpassed and redefined others' expectations—both professionally in the music industry and outside of it.

Defying the naysayers since childhood, the lively and charismatic Rubin releases *Do You Dream in Color? Insights From a Girl Without Sight* this week, recounting her experiences from childhood to full-fledged opera singer. An uplifting story about her journey to follow her dreams, Rubin's story asks those universal questions—"Who am I?" and "Where do I fit in?"—while giving an insight into a musical world you probably know nothing about. Not only does she have a busy concert schedule, Rubin is also in developing a curriculum for Yale music (where she earned her masters) that will aim to dispel stereotypes and better the

perceived value of people living with disabilities by allowing people of all ages and walks of life to share in the experiences of blindness. We caught up with her by phone while she was in Hawaii to discuss her phenomenal life story.

**Out: Growing up blind, how did you tap into your determination and find the power from within to keep going and continue to your goals?**

**Laurie Rubin:** A lot of it came from just being ingrained in me, because when I was younger my family always supported everything I wanted to do, and they never told me that I shouldn't be able to do something. They encouraged me to do everything from snow skiing to water skiing and river rafting to just going full force into singing. That and my natural feisty personality, I just don't like to be told I can't do something no matter what it is. And I certainly also had enough support beyond family too with teachers, mentors, and friends.

**You started your musical aspirations at a very young age. When did you know you wanted to focus on opera and become an opera singer?**

When I was younger, 4 and 5, my grandparents would play things from various different operas. They really enjoyed [Edward] Strauss and they would play things from *Carmen*, and I would imitate the sound of opera because I just naturally gravitated toward it. They were amazed that I wanted to sing like that, so they suggested to my parents that I take voice lessons and as I wasn't a very good piano student. When I was about 11, I went to see *Phantom Of The Opera* and I was mesmerized by it, and that was when I decided to switch my focus of music to opera shortly after. It kind of snowballed from there. As I got to middle and high school, already different for being blind, the students had a difficult time figuring that they could relate to me; even though I felt that I was a

pretty normal kid and the others kids took me at face value and were afraid to become friends with me.

Opera and singing was sort of a way to connect with kids outside of school who were interested in the same things that I was since it didn't really matter that I was blind or what everybody's socioeconomic or culture background was since we all connected because we have this mutual love of music and opera. Because it was such a social force for me, I decided that I really wanted to go into this for the rest of my life.

**While finding your passion for music at a young age, did you also realize your sexuality anytime at the stage in your life?**

It all started with dreams. When I was 12 years old, I had my first full on lesbian dream and it was really a shock to me and I was scared. My mom told me a lot of kids have that and doesn't mean anything, but then I realized when I was about 16 or 17 it was definitely not just a dream, and I had more dreams and they were more vivid than any kind of dreams I had about being with guys. At that time I was more open to it and excited about the idea because my brother actually came out before me, and I realized that it wasn't so scary to come out [having him as an example]. By the time I got to college, I went to Oberlin which of course is known as a gay Mecca—if you aren't gay when you start at Oberlin you will have some kind of gay experience, I did get into my first relationship with a woman and never turned back.

**You've faced hardships in the music industry such as people thinking your partner Jenny is your assistant or helper, and they don't realize she is in fact your partner and a musician herself. How has that been, and has it been changing recently?**

It's been difficult for many reasons, because of course I want people to see her as wonderful musician because she is, and in fact she's going to be producing and composing for an album that we are working on together. Also the fact that we are partners, I want people to recognize that too. But I know we [as a nation] have moved forward in terms of acceptance and understanding gay issues, but because certain parts of the country still don't get it, it is a difficulty. A lot of the concerts we do are in those parts of the country, and I think a lot of the time men will assume, even if they know we are together, that we don't take the relationship as seriously as a heterosexual couples because there is still this idea that, unfortunately, people think there is promiscuity within gay relationships, since some are open. [I think] once the book comes out, it will be interesting to see if people do end up changing [how they act and opinions] or are defensive.

||

**Being a lesbian, blind, and Jewish are three distinct traits that some can see as a triple minority, but you strived for success and followed your goals. What was the pivotal moment or reasoning for you to decide to take your story and immortalize it through writing?**

When I was in New York, I realized that even though I had this rich life [where I could go water skiing and cook, but] when in the public, most people didn't even realize how independent I was and they actually kind of treated me like a delicate flower. Some of that treatment even led to people being so afraid of me that they wouldn't even hire me for gigs.

I also realized that there is a ridiculous amount of blind people that are not employed, about 70-80%. [While talking out ideas with Jenny and friends,] I realized if there was a really great need to have this story told because people they were curious, educationally for understanding [blind people], and breaking down barriers; and so that is why I started writing. Of course being Jewish was such a big part of my life, and being gay. And I think a lot of times blind or disabled people in general are just decentralized because people assume that they don't embody the same sexuality as people who are "able-bodied" and I really wanted to write about my experiences and relationships because I feel that would open people's minds to the fact that of course I'm still a human being and the only thing that doesn't work is my eyes.

### **Have you always been out in your career?**

I was never really in the closet; I never made a blatant point of talking about it with people because I just would introduce Jenny as my partner and talk about it that way. But when Proposition 8 in Los Angeles was passed, we were so upset and with our chamber music ensemble, we decided to perform a concert called "Love Has No Bounds" of a gay and lesbian composer, and we also did an opera feature from the opera called *Patience and Sarah*, which was about a lesbian relationship in the 1800s. We ended up giving the proceeds to the Hetrick-Martin Institute because we felt that so many people in LA were fighting for Prop 8 because they said "we have to protect the children," but then we felt like they are not protecting the children, they aren't protecting these gay and lesbian children that are on the street and that is why we ended up giving money to the Institute. So I definitely try to be involved and use my art form to be politically active in the causes I feel are very important.

### **I read you also opened up a community music school with a summer program in Hawaii where you reside now. How long has it been open and how did you come up selecting to do that?**

Yes, [Ohana Arts] is a music festival and school, and we actually have a lot of LGBT youth in our program. It's so great and exciting how free they are about coming out now a days the way they weren't so many years ago, it's really refreshing.

### **What advice you would tell either your young self going through figuring out your identity or LGBT youth today going through it with the questions of "who am I?" and "where do I fit in?" always fluttering through their minds?**

Well, actually, Jenny and I wrote a song about that called "The Girl I Am," and the song is all about no matter how awful you are made to feel or that you feel about yourself in those really awkward times in your life, you have to know that you have to believe in yourself so much that you get through that time. And just remember to always love the person you are because when things seem rocky at those times, it really can only lead

you to better times. Those times also build upon compassion so much, you really end up becoming a better person for having gone through that, and you can take that and be kind and helpful to others who are experiencing the same things. Dream big and always pursue your dream, and be resilient to find your place. Never believe the naysayers, only believe your mentors, because those are the people who know who you are, and they are going to help you become the person you are going to want to be because they understand you.

*Villagomez, Andrew. "Blind, Lesbian Opera Singer Inspires With Her Story." OUT 22 Oct. 2012: n. pag. Web. <<http://www.out.com/entertainment/art-books/2012/10/22/blind-gay-opera-singer-laurie-rubin?page=full>>.*

## Other Resources

### Books:

#### **Do You Dream in Color?: Insights from a Girl Without Sight**

Colors, Rubin tells us, affect everyone through sound, smell, taste, and a vast array of emotions and atmospheres. She explains that although she has been blind since birth, she has experienced color all her life.

In her memoir *Do You Dream in Color?*, Laurie Rubin looks back on her life as an international opera singer who happens to be blind. From her loneliness and isolation as a middle school student to her experiences skiing, Rubin offers her young readers a life-story rich in detail and inspiration drawn from everyday challenges. Beginning with her childhood in California, Rubin tells the story of her life and the amazing experiences that led her to a career as an internationally celebrated mezzo-soprano.

Rubin describes her past as a "journey towards identity," one she hopes will resonate with young people struggling with two fundamental questions: "Who am I?" and "Where do I fit in?" Although most of us aren't blind, Rubin believes that many of us have traits that make us something other than "normal." These differences, like blindness, may seem like barriers, but for the strong and the persistent, dreams can overcome barriers, no matter how large they may seem. This is what makes her story so unique yet universal and so important for young readers.

*Rubin, Laurie. "Do You Dream in Color?: Insights from a Girl Without Sight." : Books. Amazon, n.d. Web. 23 Sept. 2013. <[http://www.amazon.com/Do-You-Dream-Color-Insights/dp/1609804244/ref=la\\_B009ANLXCC\\_1\\_1?ie=UTF8](http://www.amazon.com/Do-You-Dream-Color-Insights/dp/1609804244/ref=la_B009ANLXCC_1_1?ie=UTF8)>.*

#### **The Color of Sunlight**

The true story of a rural nurse's journey with her remarkable patient; a blind, terminally-ill transgender woman who teaches her much about compassion, understand and unconditional acceptance. This is not just a story for all who seek to understand the phenomenon of transgender. It's a memoir of a truly unique experience with lessons for all of us.

*Alexander, Michelle. "The Color of Sunshine." Amazon, n.d. Web. <[http://www.amazon.com/Color-Sunlight-R-N-Michelle-Alexander/dp/145158332X/ref=sr\\_1\\_1?s=books&ie=UTF8&qid=1377547731&sr=1-1&keywords=the+color+of+sunlight](http://www.amazon.com/Color-Sunlight-R-N-Michelle-Alexander/dp/145158332X/ref=sr_1_1?s=books&ie=UTF8&qid=1377547731&sr=1-1&keywords=the+color+of+sunlight)>.*

## Films:

### Eu Não Quero Voltar Sozinho

The arrival of a new student in school changes Leonardo's life. This 15 year-old blind teenager has to deal with the jealousy of his friend Giovana while figuring out the new feelings he's having towards his new friend, Gabriel. (17 mins.)

Watch it: <http://www.youtube.com/watch?v=1Wav5KjBHbl>

*Ausrick. "Short Films - LGBT and Gay Theme." IMDb. IMDb.com, 19 Sept. 2011. Web. 23 Sept. 2013. <<http://www.imdb.com/list/s5Aenxi9dUk/>>.*

### Cloudburst

It stars Oscar®-winning actresses Olympia Dukakis and Brenda Fricker as Stella and Dot, an aging couple who escape from a nursing home in Maine and drive to Nova Scotia on a quest to be legally married. Stella and Dot have been together for 31 years and have faithfully accompanied one another through life's ups and downs. Now in their seventies, Stella is hard of hearing and Dot is legally blind. Dot's prudish granddaughter, Molly (played by Genie Award-winner Kristin Booth), decides the best place for Dot is a nursing home that will provide all the necessities. This forces Stella and Dot to make a bold decision: they will leave their hometown and make their way to Canada, where same-sex marriage is legal. It's a last-gap bid to stay together. En route to Canada, they pick up a young hitchhiker, Prentice, played by newcomer Ryan Doucette. A small-town boy turned modern dancer, he is returning to Nova Scotia to visit his dying mother. Despite his bravado, Prentice is a confused and wounded soul who has much to learn from Stella and Dot as they wage their own unexpected battle – after three decades, can they keep their family together?

*"About." Cloudburst Movie. N.p., n.d. Web. 23 Sept. 2013. <[http://www.cloudburstmovie.com/Cloud\\_Frameset-4.html](http://www.cloudburstmovie.com/Cloud_Frameset-4.html)>.*

# Auditory

1. **Rainbow Alliance for Deaf Seeks to Overcome Barriers (South Florida Gay News)**
2. **Joseph Lewis: Next Generation Awards (John Riley)**
3. **Other Resources**

## **Rainbow Alliance for Deaf Seeks to Overcome Barriers**

South Florida Rainbow Alliance for the Deaf, SFRAD is dedicated to the “social, cultural and educational welfare” of the hearing impaired community. Its president, Jordan Isea is only twentyeight years old but carries himself and the organization with a seasoned commitment beyond his years.

The group began one year ago when Isea got together with a few other deaf LGBT friends in Broward County. An earlier organization, Coconut City Society of the Deaf (CCSD), was the first Rainbow Alliance for the Deaf (RAD) in the country. They were in existence from the 1970s but due to internal conflicts closed shortly after Isea’s move to South Florida in 2006.

“I saw the benefits of a similar RAD organization in Houston,” Isea said from his home in Miami. “After seeing nothing happen for three years, I decided to work with some people in reestablishing a prominent deaf LGBT organization in the area. I wanted the new name to be easily identifiable for those who are deaf and hard of hearing in the region.” Isea, whose family moved from Caracas, Venezuela to Houston when he was three years old, did so to guarantee him an education. In Caracas, at the time, education for the deaf stopped in the fourth grade. Given that Isea recently completed a Master of Science in Mass Communications the move proves that the hearing impaired can certainly earn an education, and in his case, foster the needs of what he feels is an “invisible community.”

“It’s hard to spot a deaf person anywhere unless you notice either a hearing aid or someone communicating using sign language. The communication problem is a major concern. Especially when I noticed some deaf people don’t even bother being proactive in mainstream society because many do not even want to deal with the communication barriers that exists between the deaf and hearing communities,” he added.

At the core of SFRAD’s mission – and the mission of any organization for the deaf – is bridging the communication barrier. Many deaf people do not feel comfortable communicating with hearing individuals, which contributes to their needs not being met. “It is for this [communication barrier] that for many deaf LGBT individuals identify as deaf first, gay second. That is,” Isea added on a more positive note, “until they’re able to overcome the communication issue.”

The barrier goes beyond social isolation, and often extends to health issues. HIV and AIDS among the deaf LGBT community is problematic. Due to privacy concerns, many HIV-positive deaf do not seek out the aid of an interpreter, to avoid gossip about the person’s status. As a result the deaf and positive individual mat not be correctly informed on what to do to address their health.

Bridging the barrier of communication is at the core of SFRAD’s mission. In addition to social events, including a Gay Tea Cruise on June 6 and an upcoming car wash at Equality Park, the group will teach hearing individuals American Sign Language.

“There has been a lot of interest in the classes primarily because it’s new, fun and affordable,” Isea told SFGN. “Classes are \$15 for the whole year, which is pretty much the cost of becoming a member for most people.”

The group currently has 22 members, with 2/3 in Broward and 1/3 in Miami-Dade. Isea wants to expand the group to at least 50 members by the end of the year, and hopes to develop a Palm Beach County branch.

*"Rainbow Alliance for Deaf Seeks to Overcome Barriers." South Florida Gay News. N.p., 24 May 2010. Web. <<http://southfloridagaynews.com/articles/rainbow-alliance-for-deaf-seeks-to-overcome-barriers/101259>>.*

## Joseph Lewis: Next Generation Awards 2013

Throughout his life, 26-year-old Joseph Lewis has struggled with embracing the different facets of his identity – as a gay man, a deaf person and an adopted son. He's also refused to allow life's obstacles to deter him from achieving his goals.

Born in South Korea to a single mother who placed him for adoption, as a small boy Lewis joined an Iowa family with 14 other children, including two other brothers who are deaf.

"I feel like I've had a very positive upbringing with my family, even though I am a minority and my hometown is less than 5 percent Asian," he says. "I was definitely the odd one out."

After learning sign language and literacy skills, Lewis attended public school with his own interpreter, but later joined his brothers at the Iowa School for the Deaf to connect with other deaf people – nearly five hours from home. Even there, however, fitting in was difficult.

"I was brought up with Signed Exact English (SEE)," Lewis explains. "It's not really recognized by the deaf community. At the Iowa School for the Deaf, it was very much an ASL (American Sign Language) community. People looked at me and said, 'You can't sign.'"

Despite that rough start, Lewis mastered ASL and excelled in academics and extracurricular activities. He did particularly well in speech competitions, placing first at local, state and regional levels.

That foundation paved the way to D.C. and Gallaudet University, where he earned a degree in government. That work also landed Lewis a 2009 spot as an intern for his state's Sen. Tom Harkin, allowing him access to congressional hearings for the Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act and the confirmation hearings of Supreme Court Justice Sonia Sotomayor. He topped that placement with an internship at the White House.

Walking the halls of power, however, left Lewis feeling a need to be more engaged in community. So, after graduation, he served as a volunteer for Public Allies, an AmeriCorps program, then with AmeriCorps directly as a computer literacy instructor for low-income deaf/hard-of-hearing District residents.

Now a correspondence specialist at the U.S. Department of Labor for the Office of Federal Contract Compliance Programs (OFCCP), Lewis is involved with overseeing whether federal contractors are compliant with equal-opportunity hiring guidelines for veterans, the disabled and minority populations. But he still finds time to volunteer at the White House helping sort through correspondence, and with The DC Center's HIV Working Group packing safer-sex kits.

From South Korea to Iowa to D.C., Lewis's identity has expanded, and he says he's comfortable with all of it: gay, deaf, Asian, a Pentecostal Christian and a Democrat. He grants, however, that he's the "black sheep" of his conservative Republican family, and that his parents are still not fully comfortable with his sexuality, though he's been out for several years.

"They have their own vision of what success means for their children," he reasons. "When it doesn't match up, it's a shock."

Lewis learned that just before a recent trip home his parents questioned one of his brothers to find out if he was still gay.

"My brother actually stood up for me and said, 'Yeah, he's successful, he's got a great job, he's enjoying his life, so why would you criticize him and his sexuality?'" Lewis recounts. "It was just taboo. But, eventually, I do want to get married, I do want to have children. So my parents are going to have to accept it. Or don't accept me."

As Lewis and his parents continue that journey, there is plenty to keep Lewis – a self-described "political geek" – occupied in D.C. He has about 700 Twitter followers joining him on the political journey, where he tweets as [@AsianGlowJoe](#).

"If there's something that's bothering me, I will let people know my opinion," he says. "To my surprise, I've actually been re-tweeted. It's funny, actually, because Karl Rove is following my tweets. I was trying to figure out why, since he's a Republican, but it's interesting."

Lewis also makes no secret of wanting a more hands-on experience: public office.

"I'm up for any challenge," he says of a future run for office. "I think my life experience shows I'm used to challenges, I like challenges. I feel it's all about tailoring my vision and making sure I present ideas that make a better place, that provide a better opportunity for everybody."

Aside from his own political ambitions, Lewis says he would love to work for Hillary Clinton's presidential campaign, should she run in 2016. He says he would "give his life" to work on that campaign, and believes Clinton could be competitive in his home state in the general election.

For now, though, Lewis is focused on smaller goals. First, he'd like to earn at least a 155 on his LSATs. Second, he'd like to gain Chelsea Clinton as a Twitter follower.

"We have such similar personalities," he says. "Just from everything I've read about her, we're very much alike."

*Riley, John. "Joseph Lewis: Next Generation Awards 2013." MetroWeekly 9 May 2013: n. pag. MetroWeekly. 9 May 2013. Web. <<http://www.metroweekly.com/feature/?ak=8322>>.*

## Other Resources

### Movie:

#### Austin Unbound

Deaf transman, Austin, has struggled with feeling burdened by his female anatomy all his life. "I felt like I was wearing a Halloween costume," he signs. In middle school, he changed his name and began to dress as a boy. Despite his challenges, Austin is a regular guy with a comedic sense and flair for romance. Gathering varying intimate glimpses from his mother, girlfriend, and best friend, Austin shamelessly counters with his own reflections on his personal journey.

The film follows Austin and his best friend on a road trip to finally undergo a double-mastectomy. Unbound at last, Austin is eager to get on with life. His journey is an inspiration to his community and beyond as he shares his intimate insights with self-awareness and humor. Austin's Deaf experience is portrayed in cinematic effect.

*"About Austin Unbound." Austin Unbound. Greensoda Productions, n.d. Web. 23 Sept. 2013. <<http://austinunbound.org/about-austin-unbound/>>.*

### Books:

#### Mean Little Deaf Queer

In 1959, the year Terry Galloway turned nine, the voices of everyone she loved began to disappear. No one yet knew that an experimental antibiotic given to her mother had wreaked havoc on her fetal nervous system, eventually causing her to go deaf. As a self-proclaimed "child freak," she acted out her fury with her boxy hearing aids and Coke-bottle glasses by faking her own drowning at a camp for crippled children. Ever since that first real-life performance, Galloway has used theater, whether onstage or off, to defy and transcend her reality. With disarming candor, she writes about her mental breakdowns, her queer identity, and living in a silent, quirky world populated by unforgettable characters. What could have been a bitter litany of complaint is instead an unexpectedly hilarious and affecting take on life.

*Galloway, Terry. Mean Little Deaf Queer: A Memoir. Boston: Beacon, 2009. Print.*

#### Assembly Required

"Raymond Luczak shares stories from his days growing up as a deaf gay man in Michigan's Upper Peninsula and learning signs in secret, trying to follow the music on the radio in order to be cool like his hearing classmates, and feeling clueless whenever gay cultural icons like the Village People, Queen, and Bette Midler were promoted in his small hometown. After he graduated from high school and enrolled at Gallaudet University, the world's only university for Deaf people, he discovered gay literature and

came out soon after. He eventually got involved with Deaf theater collaborators, educators, and sign language interpreters, from which his worldview is substantially reshaped on issues of identity, literacy, technology, and family.

*Assembly Required* offers a rare in-depth glimpse into what it means to be a Deaf gay man who lives between the Deaf and hearing worlds."

*Luczak, Raymond. Assembly Required: Notes from a Deaf Gay Life. Alexandria, Va: RID, 2009. Print.*

## **Other:**

### **deaf lesbian festival**

The mission of Deaf Lesbian Festival is to provide a nurturing space for multicultural Deaf Lesbians to gather, build networks, share emotional support and expand knowledge about civil rights, health, leadership, and multi-identities issues.

What do Deaf Lesbian do at the festival? There are a variety of activities and there is a balance of work and play. There are workshops where we look at ourselves as lesbians, from all walks of life. There are also workshops that focused on health, aging, spirituality, domestic violence, understanding laws, and financial advice. But, we are not limited to these topics. Hosts are often open to new topics and are open to the needs of this small oppressed group of Deaf people.

What do we do for fun during festivals? Arts and crafts, cruises (whale watching in Provincetown), dancing and swimming, to name a few. There is some time for some relaxation in the hotel lounges. It is up to the host city to provide entertainment.

The festivals usually open with a keynote speaker and close with an entertainment. There are some games during the festival, too. Games are among the favorite activities during the week.

It sounds like fun. It is. It sounds like work. It is. It sounds like one big yet small social event. It is. Deaf Lesbians need time and space where we can be ourselves and DLF is the place to be. So, come join with us and have fun!!!

*Deaf Lesbian Festival. "About Deaf Lesbian Festival." Deaf Lesbian Festival. N.p., 2012. Web. 23 Sept. 2013. <<http://www.deaflesbianfestival.org/about.html>>.*

### **Deafout.com**

The mission of this website is to provide visible and accessible advocacy for the needs of Deaf Queer individuals while expanding awareness and knowledge of Deaf, Queer and Deaf Queer issues in our community. deafOut works to encourage relationship building between the Deaf and Queer communities and support systems in order to

empower every person to have a positive lifestyle, grow as a self-aware individual, and be a responsible community member.

*DeafOut, and IMGmatters. "DeafOUT." DeafOUT. N.p., 2012. Web. 23 Sept. 2013. <<http://www.deafout.com/>>.*

### **Planet DeafQueer**

Planet DeafQueer ("DeafQueer" is one word) is a new community website devoted to empowering the DeafQueer community and our Allies through information, knowledge, visibility, resources, support, and activism.

*Deaf Queer Resource Center. "Planet DeafQueer." Planet DeafQueer. Deafvision, 2013. Web. 23 Sept. 2013. <<http://planet.deafqueer.com/welcome/>>.*

### **Rainbow Alliance of the Deaf**

The Rainbow Alliance of the Deaf (RAD) is a 501(c)(3) nonprofit organization established in 1977. The purpose of this Alliance is to establish and maintain a society of Deaf GLBT to encourage and promote the educational, economical, and social welfare; to foster fellowship; to defend our rights; and advance our interests as Deaf GLBT citizens concerning social justice; to build up an organization in which all worthy members may participate in the discussion of practical problems and solutions related to their social welfare. RAD has over fifteen chapters in the United States and Canada.

*"Rainbow Alliance of the Deaf." Rainbow Alliance of the Deaf. RAD, n.d. Web. 23 Sept. 2013. <<http://www.rad.org/>>.*

# Physical disability

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## Misadventures in Queer Lady Dating While Disabled: It's Not Me, It's You

I'm a virgin. Not only do I lack any sexual experience, but I have no romantic experience to speak of either. We're talking 12 year old pre-spin the bottle levels of physical intimacy here. Of course, there's nothing wrong with this, assuming that it's your choice. There are a million reasons to take relationships at your own pace. Where it starts to be a problem is when you recognize that you possess and want to express these desires and society denies them. Worse, society takes the authority upon itself to deem you undesirable and ascribes a complete and total sexual absence to you and your entire community at large, with few exceptions.

My name is Erin and I'm a graduating college senior majoring in film and minoring in LGBT studies. I self-identify as a queer feminist who believes that personality / aesthetic / confidence wins out over anatomy in terms of who you love. I also happen to have a disability - cerebral palsy. My disability is very visible in that I use an electric wheelchair for daily transportation. Today I wanted to talk to you all about the ways in which being a disabled woman has shaped my romantic and erotic (mis) adventures.

Before we get started, a few things:

1. I want to discuss my use of the word "cripple," which is obviously a loaded term and can be triggering for many people. It's important to recognize that I use this term in a political sense and as a means of radical reclamation of a positive self-identity. It might make you cringe, but I want you to embrace the discomfort. Pain and repression can incite crucial discussions. If we can resist our natural impulse to avoid negativity by trying to paper over and redeem subjects that make us upset, we might start to see some actual change.
2. At no point do I ever claim to speak for the entire disabled community. I acknowledge that my perspective is shaped by a specific set of biases that other individuals with disabilities may or may not share.
3. On that note, I am fully aware that there are many disabled people that enjoy active, fulfilling sex lives. Just because no one has yet deemed me bangable does not mean that I think all individuals with disabilities are doomed to perpetual sexual Siberia indefinitely. However, my experience is valid and I would hate to see it belittled or swept under the rug under lofty promises of love, acceptance, and progress. I'm not here for pie in the sky. I'm here for right here, right now, and everything that has influenced me up to the current moment.

With nervous trepidation, I awaited the move all the way across the country to California. I had lived my entire life in an incredibly rural area of Pennsylvania and so I was eager to prove to myself that my relative lack of a social life or love interest was a result of being stuck with the same people and needing transportation to get just about anywhere. Berkeley is known for its socially liberal attitudes as well as being the epicenter of the disability rights movement so I anticipated that I could manage to scrounge together a clique somewhere. First, I determined that I needed to find a boyfriend in order to experience all the connection that high school seemed to deny me. Through online dating, I went on

a few comically disastrous blind dates, little half-baked cyberspace petri dishes of human connection that never seemed to gain traction in real life. Either they would realize I was disabled and power through it, or I would tell them beforehand and they would stop talking to me or avoid opportunities to meet.

My discovery of my own queerness served to multiply the prejudice that I encountered rather than providing me a safe haven from it. I joined my college's queer-straight alliance initially as a straight ally (lolz) and rapidly developed a crush on a girl. Thus began a long, equally unsuccessful stint of pining after women. Given the message of acceptance and sex positivity that the queer community so openly espouses, I was hopeful that I had finally found a niche where my sexuality would be respected and validated. To my dismay, the same passive discrimination was alive and well. In the event that infantilization proved inadequate, some would disguise their aversion to disabled sexuality with good old fashioned biphobia. My most recent crush, made painfully aware of my feelings after a night of drunken confession, dodged the subject by insisting that I would date a woman for a few years and then inevitably leave her for a man. When I protested that I would never leave a committed relationship on the basis of gender alone, she said I had no way of knowing that because I had never slept with a man. She was so desperate to escape the discomfort of acknowledging me as having romantic capacity that she created an obscure hypothetical to pigeonhole me as the untrustworthy, promiscuous bisexual while paradoxically virgin shaming me. (Fun plot twist: she began dating an able-bodied bisexual woman soon after this conversation.) I finally had to swallow the bitter pill that the reason I was never considered a viable partner was not because I failed to conform to some outdated criteria for heteronormative womanhood, but because individuals with disabilities are viewed as children and sexual nonentities through the eyes of all beholders across the sexuality spectrum.

Many of my caretakers and friends insist that I could have a love life if I would only date disabled people and proceed to combat my hesitation point by point if I object. The problem is that the logic of disability dating follows the rather simplistic formula of like goes with like. In my case, this boils down to wheelchair goes with wheelchair. I'm not opposed to dating someone with physical impairments in the abstract, but I resent the notion that other people in wheelchairs are my only option and that I'm "uppity" if they're not my type. By insisting that disabled people should only date those with similar disabilities, the able community not only reaffirms their perception of our undesirability, but indirectly admits that they fail to view us as having any kind of adult sexuality at all. Here's where the myth of the bitter crippled virgin comes into play. If disabled individuals are accused of rejecting sexual options, we are often held responsible for our own repression. The unfortunate thing is that usually the only group that recognizes the sexual capacities of disabled people is the disabled community itself, which ironically has the greatest difficulty in building a sexual exchange as an outlet of this appreciation due to the prominence of physical barriers.

The challenge then lies in cultivating and claiming romantic and sexual viability in an able world determined to infantilize you. In the past, I depended on strict adherence to gender expression as a way of using femininity to overcompensate for my lack of assumed sexuality. This proved frustrating and ineffective on many

levels. On one hand, presenting in a hyper-feminine fashion apparently confirmed the collective perception that I was just an adorable little girl. In retaliation, I went to the opposite end of the spectrum at night and would dress very provocatively to go to parties as part of a "I will force you to see me sexually, dammit!" mentality. I once went to a party in a black and red corset with matching fishnets. Throughout the night, I had at least five people come up and ruffle my hair to tell me cheerfully that I looked great. Even at my most overtly sexualized, I could still only manage to conjure up the image of a seven-year-old walking around in her mother's high heels.

Eventually, I realized that my quest would be much more complicated. As someone with a deep love and respect for femininity as a personal expression of style, self-confidence, and social presence, the revelation that I wouldn't be able to combat decades of cultural stereotypes with the right dress and a dab of red lipstick was devastating. It goes without saying that appearance isn't everything and I have much greater pride and value in my intellect, but I have difficulty sharing my interior self with others if they're so quick to write me off on snap judgments of my exterior. As a result, I spend most of my time trying to counteract the social stigmas that accompany the physical presence of my chair. The chair seems to suggest a medicalized microcosm that must mean its user is devoid of romantic or sexual impulses because of their assumed lower quality of life. Regardless of how much individuals will probably agree that disabled people have the right to their own sexuality, that doesn't mean that the prevalence of these stereotypes doesn't affect our lives and relationships on a daily basis. By assigning the designation of bitter crippled virgin, able society attempts to absolve itself of guilt and accountability for disabled sexual repression. If they can somehow make our discontent a function of our own flaws, they don't have to examine themselves. If we could just be happier, just be more passive, just not worry about it, all of our problems would be solved. There is one simple, glaring error in this train of thought: society can't pathologize the individual for responding to conditions that society itself has constructed and reinforced. The bitter crippled virgin becomes a cautionary tale to promote quiet assimilation and prevent critical examination of the forces that cause us to continually be perceived as always a little bit less than human. There is no such thing as the bitter crippled virgin. This myth acts as an ugly mask to obscure those individuals with disabilities who are courageous enough to acknowledge social inequality and demand their right to sexual expression. Unlike the myth, their efforts are vibrant and very, very real.

*Erin. "Misadventures in Queer Lady Dating While Disabled: It's Not Me, It's You." Autostraddle. N.p., 16 July 2013. Web. 30 Sept. 2013. <<http://www.autostraddle.com/misadventures-in-queer-lady-dating-while-disabled-its-not-me-its-you-175782/>>.*

## **LGBT's Living With Disabilities: Also Here, Also Queer**

I recently sat down with Andrew Morrison-Gurza, a 28 year old gay male who lives in Richmond Hill, Ontario, Canada. Andrew is a grad student who is finishing his MA in Legal Studies with a concentration on Disability and currently looking for work. Andrew has spastic quadriplegic Cerebral Palsy. He cannot walk and uses an electric powered wheelchair to get around.

### **How has your disability hindered your experiences in the LGBT community?**

Well, first off, many LGBT establishments are not wheelchair accessible. Because of this, I cannot easily access gay establishments or be readily involved in LGBT themed events or meet other gay men the conventional way. I also think that the attitude around disability and difference in our community plays a huge role in how I have been hindered.

### **Very interesting as we are supposed to be a community banded together by our "differences". Do you find that members of the LGBT community look down upon more so, the same or less than members of the heterosexual community?**

This is a loaded question for me. My guttural response is to say: "Yes. Gay men have looked down upon me so much more. They are so oppressive!" but I know that is not fair. I believe overall that the gay community has a very small frame of reference for disability. Many of them have never encountered [someone with a] disability, so they're not sure how to process me. I am uncharted territory for many. So, before I go off on many an unnecessary tangent, I'll say that while they haven't "looked down", the community has been unable to embrace me because of a lack of exposure and lack of knowledge.

### **How has your dating life been affected by your disability? Do you find that gay men are put off by your disability?**

To be 100% honest with you, my disability has completely affected my dating life. When I came out at 15, my family was very accepting. It was when I was 19, and trying to navigate the LGBT community that I found to be the most difficult. The first time I was intimate with someone, they told me that they had done so because [I was in a] chair and that it was, in effect an act of pity. Many guys have told me, "I can't handle your chair" or "it scares me". In my youth and sometimes [even in adulthood], those words really, *really* hurt me. What this has caused me to realize is that the LGBT community needs an education on the LGBTD (Gay, Lesbian, Bisexual, Transgendered and Disabled) community. They need more exposure in gay themed media, at clubs, online. From that, perhaps our ideas of what constitutes "body beautiful" will start to shift.

### **What kind of philanthropic efforts do you take to let your voice be heard in the community regarding your disability?**

Well, this is all a new territory for me. I just got tired of not seeing myself represented in our media, so I started contacting LGBT themed media outlets such as Fab Magazine in Toronto saying: "Hey, I'm here too." I just recently did a photo shoot with them. I am looking to do more photos, articles, activism etc., in the vein of gay themed media. I think that gay men are predominantly visual creatures, so by showing off my body one that in many respects, interrupts the homo-normative ideals, I am opening up a discussion. I am making the average gay man stop and take notice. I am very active on twitter under the handle @amgurza1. I want to do whatever I can to make members of the LGBTD community feel like they have a voice, or an advocate. I really want to change perceptions of not only the larger community, but of the LGBTD members too.

**What do you want the LGBT community to know about people with disabilities that they may not already know?**

I want them to know that we are here and also queer. We are sexual beings that harbor all the same feelings as others in the LGBT community. We can love, feel, and be loved. I also want the larger community to know that it is perfectly okay to ask questions. You have my permission to do so. But remember, any of us could end up in a wheelchair, and we'd all want to still be loved or be given the opportunities to make love as it were.

**What advancements, if any do you think the LGBT community has made in recent years regarding people with disabilities?**

In truth, I don't think there have been many significant advancements, but that isn't a result of any true prejudicial behavior. In my view, it is in direct correlation with a lack of knowledge. Gay men in particular need to be exposed to other disabled gay men. As of right now, they have no frame of reference. With exposure will come acceptance. To advance we need gay disabled models and gay disabled persons to help in the design of gay night clubs, etc. We need to give LGBT members the chance to voice their fears, and discuss how they are new to the world of disability without being made to feel like an oppressor. That is how we begin this shift.

**Do you feel an outcast because you are not only gay but have a disability as well?**

Again, it's not fair to say that I have been made an outcast. I haven't been given the same opportunities as other LGBT men, but I must stress I don't want to assign blame here. I will say, I don't necessarily feel a part of the community though. I have a responsibility to create changes, and that is what I hope to do. It all comes down to exposure.

*Rosenberg, Mark Brennan. "LGBT's Living With Disabilities: Also Here, Also Queer." The Huffington Post. TheHuffingtonPost.com, 05 Apr. 2013. Web. 30 Sept. 2013. <[http://www.huffingtonpost.com/mark-brennan-rosenberg/lgbts-living-with-disabil\\_b\\_3016564.html](http://www.huffingtonpost.com/mark-brennan-rosenberg/lgbts-living-with-disabil_b_3016564.html)>.*

## On Ableism within Queer Spaces, or, Queering the “Normal”

Our daily existence as two black queer men—one a (dis)abled queer femme man and the other an able-bodied (sometimes) masculine queer man—informs our belief that our quest for liberation from oppressions based on sexuality and gender expression must also account for the ways that ableism also often subjugates some queer people. Ableism shapes attitudes, policies and systems that ultimately dehumanize, pathologize and criminalize people whose bodies do not fit into socially constructed notions of what constitutes a “normal” human being. Indeed, ableism shapes our understandings of gender expression.

As Eli Clare brilliantly puts it, “the mannerisms that help define gender—the way in which people walk, swing their hips, gesture with their hands, move their mouths and eyes when they talk, take up space—are all based upon how non disabled people move...The construct of gender depends not only upon the male body and female body, but also on the non disabled body.” Ableism renders invisible those bodies not privileged by dominant definitions of ability, those bodies that do not fit the conceptions of gender that we often imagine.

We “read” the movement of bodies, the ways people walk, hair styles, and the ways our bodies interact with other bodies in social spaces without ever realizing that all of the aforementioned performances are gendered expressions that center on the privilege of physical movement. We tend to place a lot of emphasis on the body, and one’s use of the body, without attending to the fact that for some the use of the body is an impossibility. Indeed, for one of us, a queer who relies on attendants for personal care and grooming, such understanding wholly ignores the ways he exists in the world.

As a result, it is time to fully acknowledge ableism as a pervasive form of oppression within our queer communities. Take, for example, Pride Parades, which are visual representations of queer and trans\* communities. Pride Parades are organized around the notion of marching and, therefore, requires that people are able to physically move to showcase their belonging. This does not account for the experiences of those who are not able to walk or who have to use special equipment to move. And so when we rely on our physical abilities to express ourselves, we inadvertently reproduce disability oppression. In addition, consider the ways that ableism functions in queer dating spaces, virtual or otherwise. Pervasive in many queer and trans\* dating spaces is a type of self-expression that centers on the body and the need to make ourselves desirable to others. Queer and trans\* folks of different abilities, who live with chronic illnesses, or battle with addictions are left out of so many of the spaces that purport to be designed for “us.” The “party culture” that is ubiquitous within many of our communities alienates those who are not able to feel safe, validated, and affirmed within these contexts. Our lack of access to such spaces has an impact on our ability to claim our identifications and belonging within these communities.

That one of us is (dis)abled, black and queer makes his lived experience of the world unmistakably political. His corporeality cannot be separated from a broader sociohistorical context in which (dis)abled bodies are read as tragic and irreparable; queer bodies as immoral; and black bodies as criminal and expendable. These complex layers of dehumanization make it so that his body is deemed undesirable within society.

Those of us accorded with able-bodied privilege must do the work of analyzing our privileges and ensuring that we do the work of undoing ableism. While we might all be queer—resisting heteronormativity and bodying forth new ways of being in the world—we must attend to the ways that our resistance and new ways of being might easily render invisible those queers who are differently-abled. Ensuring that we respond to the diverse needs of queers during Pride, at events, at clubs, and other social spaces is a start, but the more difficult work is naming and mitigating ableist thought. In order to do that work, we have to be willing to listen, if we can, and vision, if we are able, a future that decenters our conceptions of the “normal” and truly celebrates the queer.

*Ndopu, Edward, and Darnell L. Moore. "On Ableism within Queer Spaces, Or, Queering the "Normal"" PrettyQueer. N.p., 7 Dec. 2012. Web. 30 Sept. 2013.*  
<<http://www.prettyqueer.com/2012/12/07/on-ableism-within-queer-spaces-or-queering-the-normal/>>.

## Queers on Wheels

**Queers On Wheels** is an organization for physically disabled people. Founded by Eva Sweeney in 2004, Queers On Wheels produces literature, gives classes and workshops on sexuality and disability, offers support, and provides community for physically disabled folks, regardless of orientation, gender expression, or physiology.

An important issue for Queers On Wheels is the issue of a healthy sex life for disabled LGBTQ people. The healthways of people with AIDS and safer sex practices promoted by the Gay community has likewise brought sexuality to the fore in ways that the general public has been unable or unwilling to do. Queers On Wheels' work on the topic of erotic pleasure for disabled people may be seen as a further development of Gay folkways concerning health and sexuality.

### Eva Sweeney

Sweeney is a Lesbian who is active in the Queer community. Due to lack of oxygen to her brain during birth, she has cerebral palsy. She uses a wheelchair and is non-verbal, communicating by means of an alphabet board and a laser pointer. She requires full-time help for daily tasks.

Sweeney came out to her parents while in her teens, and became president of her high school's Gay-Straight Alliance. But her willingness to engage the public did not provide her with a community made up of people who faced the same issues she faced, neither could she find information and services that dealt with people in her situation. Like other disabled and differently-able Gay people, Sweeney discovered that her sexual orientation isolated her:

*When I first started exploring my unique identity, I wanted to find people like me. I searched online, called disability organizations, and GLBTQ organizations. Nobody had information pertaining to my identity as a Queer disabled person. I felt lost, caught between two communities. The GLBTQ community, although it had no information for me, was welcoming. The disabled community, however, ranged from being politely negative to downright rude. They always have been scared and discouraging about sex, even heterosexual sex. I have had experiences where organizations have hung up on me for asking the simple question, "Do you have information pertaining to the disabled Queer community?" Having these experiences not only made me feel alienated, but it also made me think of other people who might be calling and asking these same questions.*

## **The Organization**

Sweeney began Queers on Wheels in her early twenties. The internet has been a major aid for Sweeney and her organization, which has its own site at [disqueers.tripod.com](http://disqueers.tripod.com). Through the internet, Sweeney is able to contact thousands of people and form a community. The website offers various workshops on sexuality, disability training, and LGBTQ sensitivity training.

## **Sex as a Healthway**

Sweeney and Queers On Wheels expanded the healthways of LGBTQ people to include sexuality in the discussion of wellbeing. One problem that disabled people have is an unspoken assumption that disabled people do not have sex. This precludes any discussion as to what challenges might be encountered when desiring sex, not just as a source of pleasure but as an important part of an individual's overall health. One of the most important topics for Queers On Wheels is how to have sex, a subject that even members of the LGBTQ community often view as personal in ways that disabled people cannot if the disability prevents engagement in sex without help. The sexuality workshop is designed to discuss the following topics:

- How to hire and maintain healthy working relationships with aides
- How to talk to a girlfriend or boyfriend about one's disability
- How to deal with having aides when one is dating
- How and when to discuss safer sex with a significant other
- How to adapt sex toys such as vibrators and dildos and many other sexual devices
- How to masturbate if one needs assistance

*"Queers on Wheels." Qualia Folk. N.p., 8 Dec. 2011. Web. 30 Sept. 2013.*  
<<http://www.qualiafolk.com/2011/12/08/queers-on-wheels/>>.

# Etiquette

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## **Etiquette - Interacting with people who are Blind and Vision Impaired (BVI)**

### What is Blindness?

A person who is "legally blind" has central visual acuity of 20/200 or less in the better eye, with corrective lenses; or central visual acuity of more than 20/200 if the field of peripheral vision is 20 degrees or less.

This means people are legally blind if they can identify only at 20 feet or less what people with normal vision (20/20) can identify at 200 feet. Or they are legally blind if their field of vision is so restricted that they can see only a very small area at one time.

Legal blindness, then, does not necessarily mean that a person has no sight at all. More than 90 percent of people who are legally blind have some residual vision.

- When offering assistance ask, "May I help you?" This lets the person know you are willing to assist when necessary, but it also indicates your confidence in his or her ability to act independently.
- Let the person take your arm and follow your body movements.
- When leading, tell the person of steps ahead (either up or down), a curb (up or down), coming to a doorway, moving through crowded aisles or crowds of people, or any obstacle ahead.
- Never grab or hold onto a person's white cane.
- Never speak to or pet the person's service animal.
- Talk to the person the same way you would to anyone. People who are BVI can hear, so don't shout ... speak in a normal tone of voice.
- It is perfectly appropriate to use common words and expressions such as "look" and "see".
- Speak to the person directly, not to a third person.
- When traveling alone, people who are BVI may need to ask for directions. Replying "over there" doesn't provide appropriate assistance to someone who cannot see where you're pointing. Give specific and accurate verbal directions in terms of so many feet to the right, straight ahead, etc.
- When directing a person to a seat, place the person's hand on the back or arm of the chair and say "your hand is on the left arm of the chair".
- In a restaurant, you may need to describe the location of food on a plate or where the drink glass is placed using the clock system such as "Your drink is at 1 o'clock, the potatoes are at 3 and the meat is at 10."
- When counting out money to the person, be sure to identify each bill as it is counted, such as "there's a 10 on top and a 20 on the bottom". Always give change to the person, and not to a companion, unless the person directs you to do so.
- When you leave the presence of the person, remember to tell him that you are departing.
- Use common sense and be sensitive to the person's special needs.

- Make encounters natural and not solicitous or condescending.
- When introduced to a person who is BVI, it is appropriate to offer to shake hands.
- Relax. Don't be embarrassed if you happen to use accepted common expressions such as "see you later" that seem to relate to the person's disability.
- In certain situations, it may be necessary to explain emergency procedures to the person, i.e., on an airplane, in a hotel, or any large facility. This would include where elevators, escalators, stairs, telephones, all doors, and emergency exits are located.
- If necessary, you may need to read printed information to the person. (It is more appropriate for Braille, audio and/or electronic information to be available.)
- Remember that partially open doors to a room, cabinet, or a car is a hazard to a person who is BVI.
- In all 50 states, the law requires drivers to yield the right of way when they see an extended white cane.

### **When you see a person who is BVI using a Service Animal**

- Never call the dog's name, speak to the dog or make distracting noises while it is in harness and working.
- Never feed the dog.
- Never pet or play with the dog while it is working.
- Never take hold of the person, the dog or the dog's harness at any time. The person has been taught how to listen to traffic patterns and to give the dog a "forward" command when it is safe to cross. Although the dog is color blind, it avoids cars as it would any other obstacle.
- Do not assume that the dog automatically knows where the person wants to go. The person must know where he is going in order to give the dog appropriate directional commands. If the person is traveling in unfamiliar surroundings, he may ask for directions just as a sighted person would.
- When giving directions to the person, do not call the dog or try to get the dog to follow you. Be specific about where turns are to be made using verbal directions so that the person can then direct the dog accordingly.
- If assistance is requested by the person, allow him to take your arm or to give the dog the command to follow you. The person should be the only one to choose which method is best.
- If the person takes your arm to follow, he may drop the harness handle to let the dog know he is "off duty" temporarily.

## Sighted Guide Techniques

There are a variety of techniques that are easy to learn and an efficient way to provide a person who is BVI with meaningful assistance. A significant percentage of people who are BVI are adept at traveling, either alone, using a white cane, or with a guide dog, yet many appreciate assistance in an unfamiliar environment.

Even the most proficient travelers utilize sighted guides on occasion to become better acquainted with new areas, to cross unfamiliar streets or to maneuver around obstacles.

The sighted guide techniques outlined here will help make assisting a BVI person easier.

Making Contact - When approaching a person who is BVI, introduce yourself and ask whether they would like your help. Do not grab or pull at them. If they indicate they would like assistance, verbally offer your arm and brush it against theirs.

Grasp - The blind person should grasp your arm just above the elbow with their fingers on the inside near your waist and their thumb on the outside. The grasp must be firm to be maintained while walking, yet not so tight as to cause discomfort. If the grip is too tight, say so. This technique allows you flexibility and freedom of motion with both of your hands, and gives the blind person a sense of your body motion.

Children's Grasp - The standard grasp often is too high for children, so it may be best to have them grasp your wrist or hold your hand. This gives you and the child greater comfort and sense of control.

Support Grasp - Some BVI people may be frail. Others might have balance problems that make use of the standard grasp inadequate. Rather than holding your arm above the elbow, a BVI person may prefer to link their arm with yours; this will decrease the space between the two of you and provide added support. To accommodate a BVI person who is unsteady you likely will need to slow your walking pace.

Stance - Hold your arm relaxed and steady at your side. The BVI person's arm is at a 90-degree angle and held close to their side. They should proceed by being one half-step behind you. The blind person will follow your movements. Do not steer them.

Taking a Seat - When possible approach a chair from the front or side. Tell the blind person they're at the front or side and slowly bring them up to it until their knees or shins touch the seat. Say whether the chair has arms. Place your hand on the chair back and let them follow your arm down to locate it with the hand they have been grasping your arm with. Allow BVI people to seat themselves. Do not help them physically or move the chair or other furniture unless asked to. Say if there is a table.

Narrow-area stance - When you are approaching areas that are crowded or narrow, such as a doorway, move your forearm and hand so that they rest against the lower portion of your back, with your elbow at a 90-degree angle and your palm facing outward. The blind person will take this cue, slide their hand down to your wrist and

move directly behind you at an arm's length, while still maintaining a firm grip. Take smaller steps and walk slower as you move through the narrow area. After walking through the narrow area, return your arm to the guide position and walk normally.

Doors - When approaching a door, assume the narrow-area stance and tell the BVI person in which direction the door opens. This allows them to help you by holding the door with their free hand while passing through it. Do not try to turn around to hold the door open. This is awkward and diverts your attention.

Stairs - In advance of reaching the first step, tell the BVI person you are approaching stairs. Approach them directly and in such a way that the BVI person's free hand is closest to the rail.

Mention whether the stairs go up or down and how many there are. Pause to allow them to locate the first step and the railing. Always remain a step ahead and proceed as you normally would. Remain to the right-hand side of stairs to avoid a collision with others. Pause at each landing to allow the BVI person to stand beside you and to cue them that there are no more steps until you begin to move again. Tell the BVI person when you have reached the top or bottom of the stairs.

## **Myths & Facts about Blindness and Visual impairment**

### **Myth**

Blindness means living in a world of darkness.

### **Fact**

What a person is able to see depends upon the age of onset, degree of visual memory, and degree of usable vision regarding light, shape, etc.

### **Myth**

All people who are blind read Braille.

### **Fact**

Only about 10% read Braille, but there are many other assistive devices that promote independence.

### **Myth**

A person who is blind cannot cross the street without assistance.

### **Fact**

A person who is blind can cross the street without being pushed or pulled, so if you offer to help, let the person take your arm to follow the motion of your body.

### **Myth**

People who are blind can hear and feel things no one else can; they have a "sixth sense."

### **Fact**

Certain senses often become more highly developed because people who are blind rely upon them more. There is nothing mystical about this phenomenon.

### **Myth**

All blind people are alike.

### **Fact**

Blind people are people who happen not to see. There is no single characteristic that applies to all visually impaired people. For example, some persons who are blind choose to use a white cane as a mobility aid, while others may choose to use a dog. People who are blind enter into as many varied professions, leisure activities, and lifestyles as do sighted people.

*Blind Pride International. "1.2 Etiquette - Blind Vision Impaired." Disability Awareness & Accessibility Toolbox. N.p., n.d. Web. 25 Sept. 2013. <<http://www.blind-lgbt-pride.org/node/10>>.*

## Etiquette - Deafness & Hearing Impairments

Deafness is a fact of many people's lives -- more than 22 million Americans have some form of hearing loss. People who are deaf build successful careers, have families, watch television, and talk on the phone, play sports, and travel.

Deafness is called "the invisible disability" because you cannot see it. You may not know at first that you have met a person who is deaf. Some will use their voices, others will not. Some who use their voices may be highly intelligible; others may be difficult to understand. Some speech read, others do not. Some finger spell, others do not. Some use sign language while others speak in all communication situations. Some wear hearing aids others do not.

With all of these possibilities, how will you know how to communicate when you meet a person who is deaf? ASK THE PERSON.

People who are deaf can and do speak. The terms "deaf-mute" and "deaf and dumb" are archaic and considered offensive by people who are deaf. Most people who are deaf have normal vocal chords but because of their loss they are unable to hear their own voices, they cannot modulate them as hearing people can.

### **DEFINITIONS**

Deaf/Deafness -- a term to describe a person who has a profound hearing loss and uses sign language.

Hard of hearing -- a term to describe a person with a hearing loss who relies on residual hearing to communicate through speaking and lip-reading.

Hearing impaired -- a general term used to describe any deviation from normal hearing. This encompasses hearing losses ranging from mild hearing loss to profound deafness. Note: Hearing impairment is the single most prevalent chronic physical disability in the United States, affecting more than 22 million people.

Residual hearing -- this term refers to the hearing that remains after a person has experienced a hearing loss. The greater the hearing loss, the less the residual hearing.

\* There are no recent surveys to determine how many people of the 22 million are deaf. As a result, estimates range anywhere from 350,000 to 2 million

## **PROBLEMS OF COMMUNICATION**

It is important to understand that the major disability is not the inability to hear, but the difficulty in communication. Remember, reading and writing English is a SECOND LANGUAGE. American Sign Language (ASL) is the primary language for a person who is deaf.

Society has enforced a communication barrier for people who are deaf. These problems of communication were either ignored or the person with deafness was sent to special schools or institutions. As a result of this separatism, people who are deaf began to form a culture among themselves. They employed their own language and sought each other's company. Even today, 80% of people who are deaf marry within their own culture.

Communication is more complicated for the person who never heard speech than for someone whose hearing loss developed at a later age.

## **COMMUNICATION ETIQUETTE**

Get the person's attention before speaking. A tap on the shoulder, a wave, or another visual signal usually works.

Ask the person if they prefer using written communication, sign language, gesturing or speaking.

Communicate using paper and pen, if necessary. Getting the message across is more important than the medium used.

When using writing, take into consideration their reading and writing skills depend on whether they were born deaf or became deaf later in life.

- keep your message short and simple
- it is not necessary to write out every word
- do not always use "yes" or "no" questions
- face the person after you have written your message
- use visual representations (drawings or diagrams can help)

Use open-ended questions that must be answered by more than a "yes" or "no". Do not assume that the deaf person has understood your message just because they nod yes or no in acknowledgment. Make sure your information has been communicated.

Speak slowly and clearly, but do not yell, exaggerate, or over pronounce as this makes speech-reading more difficult. Short sentences are easier to understand than long ones.

Look directly at the person when speaking.

Don't smoke, chew gum or hold your hands in front of your mouth.

Maintain eye contact with the deaf person because, it conveys the feeling of direct communication. Even if an interpreter is present, continue to speak directly to the person.

Use the words "I" and "you" when communicating through an interpreter, not "tell him" or "does she understand"

First repeat, and then try to rephrase a thought if you have problems being understood, rather than repeating the same words again and again.

Use body language, facial expression or pantomime to help supplement your communication.

Be courteous to the deaf person during conversation. If a phone rings or someone knocks at the door, tell the person why you have to excuse yourself. Do not ignore the person and carry on a conversation with someone else while he or she waits.

Know where to find an interpreter. They are usually available through the local Commission for the Deaf.

Be patient.

## **Myths & Facts**

### **Myth**

All people with a hearing loss lack the ability to speak.

### **Fact**

People who have lost their hearing after the development of speech have little difficulty speaking. Many persons with "prelingual" deafness have learned to use their voices in speech classes. This may present some initial difficulty for the listener to understand.

### **Myth**

All people with a hearing loss can read lips.

### **Fact**

Many people with a hearing loss have had formal training in lip-reading. Even hearing people rely on lip-reading, but it is an imperfect process (about 30-40% accurate). It is rarely used in isolation of other communication methods.

**Myth**

Hearing aids totally correct hearing loss.

**Fact** Hearing aids may improve hearing for many people with a hearing loss, but they are not corrective devices. They usually lessen the severity of the hearing loss.

**Myth**

People who are deaf use one system for communicating.

**Fact**

In the United States, people who are deaf use a variety of communication systems. Among the choices are speaking, speech-reading, writing, and manual communication. Manual communication refers to the use of manual signs and fingerspelling.

**Myth**

Many people who are deaf have not even learned to speak. People who are deaf cannot be very bright.

**Fact**

It is extremely difficult to learn to speak if a hearing loss occurs before speech develops. Many other persons with deafness who have some speech have not mastered the fine grammatical points of their second language -- English. The problem is one of communication, not intellect.

*Blind Pride International. "1.3 Etiquette - Deaf Hearing Impaired." Disability Awareness & Accessibility Toolbox. N.p., 2012. Web. 25 Sept. 2013. <<http://www.blind-lgbt-pride.org/node/10>>.*

## Etiquette - Wheelchairs & Mobility Devices

People who use a wheelchair consider them to be energy-saving, independence-giving substitutes for lost muscle power that help them to take their rightful places in society. There should be no stigma attached to using a wheelchair; it is just another aid. Rather than a sign of weakness, it is a symbol of independence which increases participation in life and does not diminish one's value as a person.

No matter how independent a wheelchair user is, inevitably there are situations where an assistant is needed. To help effectively, a helper who will give more than casual assistance needs guidance from the person using the wheelchair.

- The basic rule is to always ask first if the person wants help, then ask how to do it.
- Always tell the person what you're going to do before you do it. Always let the person know what the next move will be so they feel safe.
- As it might be difficult for the person in the wheelchair to hear you when you are behind him/her, it is advisable to speak face-to-face when possible.
- Know where accessible restrooms, drinking fountains and telephones are located.
- Use a normal tone of voice.
- Treat adults in a manner befitting adults. Never patronize a person in a wheelchair by patting them on the head or shoulder.
- When addressing a person in a wheelchair, never lean on the chair. It is part of the space that belongs to the person who uses it.
- Relax. Don't be embarrassed if you happen to use accepted common expressions such as "I've got to run along now" that seem to relate to the person's disability.
- When talking with a person in a wheelchair for more than a few minutes, use a chair, whenever possible, to place yourself at eye level to facilitate conversation.
- When introduced to a person in a wheelchair, it is appropriate to offer to shake hands. For those who cannot shake hands, touch the person on the shoulder or arm to welcome and acknowledge their presence.

### **About Wheelchairs**

- To fold most wheelchairs, remove the seat cushion; pull upward on the seat at the center front and back.
- Don't lift the chair by the armrests -- they'll probably come off.
- To open a wheelchair, press the heels of the hand on the two sides of the seat to spread it open.
- Don't put your fingers between the chair frame and the seat to avoid pinching them.

- To put a wheelchair into a car trunk, grab the struts of the chair, not the wheels, armrests or movable parts. Lift the chair vertically and balance on the edge of the trunk. Tip the chair horizontally and slide into the trunk.
- When lifting, don't bend your back -- keep it straight and bend your knees and hips.

### **Wheelchair Safety**

- THE BASIC RULE IS TO ALWAYS ASK FIRST IF THE PERSON WANTS HELP, THEN ASK HOW TO DO IT.
- Don't push a power chair. Since they are very heavy, don't try to move one up or down stairs or over curbs. Nor should you ever try to operate one. Don't touch the control, even for a moment. The control is very sensitive and you could very quickly do damage to the chair and anything near the chair. You could also hurt someone.
- For a manual wheelchair, first ask if the person wants to be pushed. More often than not, they do not need this assistance. However, someone might need assistance going up or down a curb or in loading a wheelchair into their car. Never try to help someone in a wheelchair up or down stairs. This could have disastrous consequences.
- ALWAYS BELIEVE THE WHEELCHAIR USER WHEN HE OR SHE WARNS YOU ABOUT THE CHAIR'S CAPACITY. THEY KNOW BEST AND IT IS NOT A POINT TO BE ARGUED.
- To push a wheelchair down a curb, turn the chair around backward. As you step down the curb backwards, you gently lower the back wheels to ground level and then lower the front wheels. You have to control this motion by taking some of the weight to make sure both rear wheels touch the ground at the same time.
- Never take a wheelchair down a curb by tipping it forward.
- To push a wheelchair up a curb, face the chair toward the curb, place your foot on the tipping lever and lift the chair off its front wheels, moving them forward onto the curb. Grip the handgrips firmly as you lift the back wheels off the ground and roll onto the curb.
- Don't tip a wheelchair to one side. If necessary, use a second person to help lift the back wheels onto the curb or, if possible, the person in the wheelchair can assist by pushing on the back wheels as your lift onto curb.
- To cross sand or dirt or a rocky path, it is best to pull the chair backward. And always watch for rocks if you're pushing someone in a chair -- one small rock under the front wheel can quickly tip the chair forward, dumping the person out on their face.
- Never push a wheelchair too fast as this can be very unsettling.
- Make sure any clothing or blankets are tucked in out of the way of the wheels.
- Watch for holes, uneven ground or roughly paved surfaces.
- Don't enter a crosswalk or try to cross a street unless you can do so safely. As a helper, you should never push someone across unless you have time to safely walk. Never run across.

- Never come up behind someone in a wheelchair and start pushing them--identify who you are, ask if they need your help, and before starting, make sure you know what help is required.
- A wheelchair should not be rocked.
- Never let go of the wheelchair unless you put on the brakes. The person in the wheelchair that you are helping is counting on you to have complete control.
- If your hands are not on the chair, the brakes must be used to guarantee their safety.
- When going through a door that does not have an automatic opener, or if the person in the wheelchair cannot push the door open, it is advisable to turn the chair backward and pull it through the door as you hold it open with your body.
- IN EVERY SITUATION, REMEMBER TO ALWAYS TELL THE PERSON IN THE WHEELCHAIR WHAT YOU ARE GOING TO DO.

### **Transferring to and from a wheelchair**

- If a person in a wheelchair needs assistance in transferring follow these guidelines:
- Plan the move. Ask how you can assist and decide together the safest and most comfortable way to make the transfer. Always listen to the person's requests as he/she knows best. Ask how much the person can do to help, and decide if you can do the transfer alone or if you will need a second person to assist.
- For your safety while making the transfer, keep your feet apart and your back straight. Be sure to bend your knees. It is best to stay close to the person in the wheelchair, move slowly and work together.

### **Myths & Facts about people who use Wheelchairs & Mobility Devices**

#### **Myth**

All wheelchair users are paralyzed and are "confined" to their wheelchairs.

#### **Fact**

Many wheelchair users can walk with other mobility aids, but their speed, range, and convenience of movement is enhanced by wheelchair use. Wheelchairs liberate those who need them.

#### **Myth**

People with paraplegia are paralyzed from the waist down and people with quadriplegia from the neck down.

### **Fact**

Both paraplegia and quadriplegia are conditions with varying degrees of paralysis. A person with a high cervical injury may have total paralysis from the neck down, requiring the assistance of a respirator for breathing. Someone with a low cervical injury may have movement and control of the upper extremities except for finger grasp.

### **Myth**

Accommodations for people with mobility limitations mean the complete removal of all architectural barriers.

### **Fact**

The term “accommodation” covers a multitude of possibilities. Making worksite modifications, adjusting schedules, and acquiring specialized equipment are examples of accommodation. It is a highly individualized matter.

### **Myth**

Accommodating a person with mobility limitations is expensive.

### **Fact**

The overwhelming majority of accommodations (over 80%) cost less than \$500.

*Blind Pride International. "1.4 Etiquette - Wheelchairs & Mobility Devices." Disability Awareness & Accessibility Toolbox. N.p., 2012. Web. 25 Sept. 2013. <<http://www.blind-lgbt-pride.org/node/10>>.*