



Addiction Messenger

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Ideas for Treatment Improvement

LGBTQ Issues in SA Treatment Part 3 - Population Specific Considerations

The spectrum of lesbian, gay, bisexual, transgender, and questioning groups clearly includes a rich mix of gender roles and identities, sexual orientations, and cultural expression. In our last issue we discussed general principles and practices of LGBTQ-effective treatment. In this issue we will highlight information and clinical considerations for specific LGBTQ populations.

Transgender Clients

The term transgender includes a diverse, and sometimes confusing, spectrum of gender identities, expressions, and roles that challenge or expand the current dominant cultural values of what it means to be male or female.

Transsexual usually refers to a person whose anatomy is in conflict in some way with gender identity.

- *Male-to-female* describes transsexual individuals who gender identify as female and have predominant primary and secondary male sexual characteristics (primary characteristics include reproductive organs and glands; secondary include facial structure, breast formation/size, body shape/contour, and bone structures). About 50% report being attracted to men and therefore, in their female identity, see their sexual orientation as heterosexual; about 50 percent report being attracted to women and identify as lesbian or bisexual.

- *Female-to-male* describes those who identify as male and have predominant primary and secondary female sexual characteristics. Most report themselves as heterosexual men, that is, they are attracted to women. However, a growing number are coming out as gay men (attracted to men) and as bisexual.

No conclusive evidence to date supports any theory about the cause or etiology of transsexualism. Regardless of the "cause," transsexuals are not maladjusted mentally ill people or deluded about their gender. Most need respect and support to affirm their gender identity, and need assistance in making informed decisions about physical and social transition into living fully in their self-identified gender.

Clinical issues and implications for treatment for transgender clients may include issues about appearance, "passing" and body image; a history of hiding or suppressing gender identity; lack of family and social support; isolation/lack of connection to positive, proactive transgender community resources; hormone therapy; use or injection history; stigma and discrimination; employment problems; and, relationship/child custody issues.

Some tips for care providers:

- Become familiar and comfortable with the range of transgender identities and issues; and do not expect transgender clients to educate staff.
- Don't assume transgender women or men are gay; find out the sexual orientation of clients.

*"The white light
streams down to be
broken up by those
human prisms into
all the colors of the
rainbow. Take your
own color in the
pattern and be just
that."*

~ Charles R. Brown ~

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Next Series:

Rx Abuse

- Use the proper pronouns based on client's self-identity when talking to/about transgender individuals; don't call someone who identifies as a female "he or him" or call someone who identifies as male "she or her".
- Allow transgender clients to use bathrooms and showers based on their gender self identities and gender role, i.e., don't make transgender individuals living as females use male facilities or transgender individuals living as males use female facilities.
- Allow transgender clients to continue the use of hormones when they are prescribed. Advocate that the transgender client using "street" hormones get immediate medical care and legally prescribed hormones. Never make the transgender client choose between hormones and treatment and recovery.
- Create and maintain a safe environment for all transgender clients. Don't project transphobia onto the transgender client, share transphobic comments with other staff members or clients, or put transgender clients at risk for physical or sexual abuse or harassment.

Bisexual Clients

Contemporary understanding is that bisexuality – affectional, romantic, and sexual attraction toward same gender and other gender individuals – is a sexual orientation distinct from heterosexuality and homosexuality. To provide effective treatment to bisexual clients, providers will need to understand that bisexuality is a nonlinear, complex phenomenon. For example:

- Bisexual identity may be *continuous* (formed early in one's life and remaining intact for a lifespan); *sequential* (involving sexual attractions that occur toward same-sex or opposite-sex partners at different times during one's life); and/or *concurrent* (sexual desires felt toward men and women at the same time).
- Psychosocial variables (cultural/familial norms and standards, political views, and environmental factors) may influence bisexual identity and behavior, and keep them separate. Some examples include: 1) being in a same-sex setting or institution such as prison; 2) financial considerations, such as engaging in prostitution related to the use of alcohol or other drugs; 3) legal and child custody concerns; and 4) political views (for example, a person identifies as gay, but practices bisexuality). Other influential factors include race and ethnicity, family norms and parental upbringing, and religious values and beliefs.

We caution you not to assume bisexual individuals are psychologically or emotionally damaged, developmentally immature, or personality disordered. Fox (1996), in a review of bisexuality theory and research, notes that "research has found no evidence of psychopathology or psychological maladjustment in bisexual women and men". In fact, numerous studies

have found just the opposite. Self-identified bisexuals have been found to possess, among other attributes, high self-esteem, high self-confidence, and a positive self-concept independent of social norms.

Lesbian and Gay Clients

The following are clinical considerations for both lesbian women and gay men:

- *Don't make assumptions based on appearance.* Assuming a client could not really be a lesbian or gay because s/he appears too femme or masculine could lead you to inhibit or ignore a client's need to explore her same-gender sexuality; or, alternatively, to assume the client is in "denial and resistance" about being lesbian or gay.
- *Be sensitive to the individual's self-identification.* Not all individuals in relationships with people of the same sex, or engaging in same-sex behavior, consider themselves lesbian or gay.
- *Many lesbian and gay individuals are in long-term committed relationships with partners and parenting children.* Be sure to take same-sex lover relationships seriously and explore dating, intimacy in relationship, and partnering issues as salient to treatment. It is important to assess whether there are differences between how "out" both the client and his/her partner is. There is no universal terminology regarding significant others in the LGBTQ community; allow clients to choose and define the terms they use (e.g., lover, partner, significant other, etc.).
- *Lesbian and gay individuals may have a history of relationships with people of the opposite sex, and may have been married and have children.* Clients may need to address issues around being parents, and/or resolve co-parenting or family issues, and/or focus on restoring a former heterosexual relationship as "curative." (Note: published studies have established that children raised by gay or lesbian parents are no more likely to grow up gay or lesbian than other children [Patterson 1992].)
- *Barriers to Adequate Health Care.* Results of a Gay and Lesbian Medical Association Survey (1994) indicate substandard care for LGBTQ patients. Many gays and lesbians do not disclose their sexual orientation to their healthcare providers and are reluctant to use mainstream healthcare services.
- *Mental Health Issues.* Research indicates a higher rate of bipolar and depressive disorders in gay men than among heterosexual men. One study found higher rates of lifetime depression in homosexual males compared with heterosexual men (Atkinson et al, 1998); another found significantly higher prevalence rates of depressive disorders in lesbian women compared with heterosexual females (Gilman et al, 2001). Distinct barriers to mental health service utilization have been described for all sexual minorities, including a tendency to pathologize LGBT identity; lack of LGBT-sensitive care; discrimination and marginalization of LGBT clients;

unwillingness to address LGBT related issues in treatment; and unwillingness to work with partners and lovers of LGBT clients.

Lesbian Clients

- *Lesbian identity is about more than sex.* Although being lesbian certainly is about being sexually attracted to other women, many lesbians also talk about the power and importance of their emotional and affectional feelings and attractions for other women. Sometimes lesbians experience stress about negotiating social expectations of relationships between women versus the demands of a romantic and sexual relationship. In addition, there is a lesbian cultural identity. Be sure to explore and/or encourage development of lesbian social relationships and recovery and other support networks.
- *Relationships as a major treatment focus for all lesbians.* Providers need to assess clients' relationships with both men and women in their lives, sexual fears and guilt, patterns of sexual behavior, and relationship choices.
- *There is no research that suggests sexual, physical, or emotional abuse by men causes lesbianism.* Do not denigrate lesbian identity as pathological or sick or fail to explore or encourage development of a positive lesbian identity.

Gay Male Clients

- *Gay men may link substance use and sexual expression.* Brought up in a society that says they should not act on their sexual feelings, gay men are likely to internalize homophobia. Many gay men report using alcohol and drugs to cope with guilt and shame about same-sex sexual desire and behaviors; often their first same-sex sexual experience was while drinking or being high to overcome fear, denial, anxiety, or even revulsion about gay sex. This linking of substance use and sexual expression may persist and become part of the personal and social identity development processes. Do not make the mistake of blaming same-sex sexual behaviors on using alcohol and drugs and/or believing/implying or counseling that homosexual desire will stop with sobriety and/or avoid exploring same-sex sexuality, shame, and drug use.
- *Substance use and HIV/AIDS.* HIV/AIDS is still a major health problem in the gay community and a health risk for men who have sex with men. Using drugs and alcohol can inhibit safer sexual practices as well as negatively impact immune system function in HIV positive gay men. Stressors for HIV-positive gay men include dealing with being positive and being sexual, living longer, medication decisions, maintaining safer sexual practices, and risk of secondary HIV infection. Stressors for HIV-negative gay men are staying negative and maintaining

safer sex practices. Many gay men lost many friends and lovers to the AIDS epidemic in the 1980s and early 1990s before the new medications were available and have not yet dealt fully with loss and bereavement issues.

This series has only provided highlights from the new LGBTQ curriculum developed by Prairielands ATTC. More in-depth information about issues and clinical considerations involved in providing LGBTQ-effective treatment services can be found in the resources listed at the end of each issue, or through contacting your regional ATTC for training.

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Sources

- Prairielands Addiction Technology Transfer Center (2008). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals: Training Curriculum*. Downloaded from the World Wide Web at: <http://www.public-health.uiowa.edu/pattc/lgbttrainingcurriculum>
- Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (2001). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Washington, DC: U.S. Department of Health and Human Services. Publication No. (SMA) 01-3498.
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- Patterson, C. (1992). Children of Lesbian and Gay Parents". *Child Development* 63:1025-1042.
- For updated information and resources on the transgender communities see:
- World Professional Association for Transgender Health at www.wpath.org
- National Center for Transgender Equality at www.nctequality.org
- F to M International at www.ftmi.org
- International Federation for Gender Education at www.ifge.org
- For updates on LGBT Youth go to:
- National Youth Advocacy Coalition at www.nyacyouth.org
- Sexual Minority Youth Assistance League at www.smyal.org

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TEST Series 32

1. Programs that consider acknowledging one's sexual orientation a key factor in recovery have successful (fill in the blank)
_____.
2. Studies have found that LGBTQ people generally have higher rates of substance use disorders than among the general or heterosexual population.
True or False
3. Transgender does not denote sexual orientation but is an umbrella term for a variety of gender expressions, including which of the following?
 - a. Drag and Cross-dressing,
 - b. transsexuality,
 - c. bigender experience,
 - d. All of the above
4. A modality of treatment that may be particularly helpful for LGBTQ clients is _____ (fill in the blank)
5. LGBTQ-affirmative agencies/providers never offer specific therapy groups for LGBTQ people:
True or False
6. List 8 clinical issues and implications for treatment for transgender clients:
 1. _____ 2. _____
 3. _____ 4. _____
 5. _____ 6. _____
 7. _____ 8. _____
7. LGBTQ people need to think carefully before disclosing their sexual orientation to others (e.g., to employers, landlords, and/or judges).
True or False
8. Contemporary understanding holds that bisexuality is a sexual orientation distinct from heterosexuality and homosexuality.
True or False
9. *Male-to-female* describes transsexual individuals who have predominant primary and secondary male sexual characteristics and gender identify as _____ (fill in the blank)
10. Barriers to mental health service utilization for sexual minorities include the following:
 - a. a tendency to pathologize LGBT identity,
 - b. a lack of LGBT-sensitive care,
 - c. discrimination and marginalization of LGBT clients,
 - d. unwillingness to work with partners and lovers of LGBT clients.
 - e. All of the above

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