

# Counselor Competence for Treating LGBT Clients

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## Chapter 5 The Coming Out Process for Lesbians and Gay Men

Emily B. McNally, Ph.D., C.A.C., Naples, FL

### What providers will learn from this chapter:

- The definition of the coming out process and what is known about it
- Potential interaction among substance abuse, recovery issues, and the coming out process
- Ways counselors can use their understanding of coming out to help lesbian and gay clients

### Introduction

This chapter presents information on the coming out process so substance abuse treatment providers will understand what lesbian, gay, bisexual, and transgender (LGBT) clients may experience and how their support will help LGBT clients deal with this issue.

The term “coming out” refers to the experiences of some, but not all, gay men and lesbians as they work through and accept a stigmatized identity. The coming out process for many gay and lesbian people is a way of transforming a negative self-identity into a positive identity. This process is especially important to people who are trying to recover from substance abuse. For many people, feeling positive and hopeful about themselves is at the heart of recovering from addiction. It is noteworthy, however, that for many reasons not all gay men or lesbians come out. Many people who are attracted to, love, and/or are sexual with people of the same sex do not consider themselves gay or lesbian and do not go through any of the stages presented in this chapter.

### What the Coming Out Process Means for Counselors

The coming out process is a very important one. Many recovering LGBT clients spend years working through issues related to coming out (both to themselves and to others) and working through their internalized homophobia to feel good about themselves.

If all goes well, they will eventually be able to say, “I am who I am, and I accept myself as myself.” Because many recovery programs value authenticity and honesty, the process of coming out for many gay men and lesbians is crucial to becoming and staying sober.

Counselors who can accept and validate clients’ feelings, attractions, experiences, and identities can play an important part in those clients’ sobriety. Clients who drank and used drugs to medicate their negative feelings about being gay need to have those experiences understood. Others who used substances to accept their gay feelings and behaviors may need help in sobriety to work through those experiences again in a sober way. The coming out process does not happen according to a schedule. Some people may have come out during their teen years, and others may be working through the process during middle age or later.

No correct way exists to move through the coming out process. Some people may decide that they do not want to take on a gay or lesbian identity and may choose not to disclose their feelings and experiences to anyone. Counselors need to validate the needs of each client and find a way to understand their experiences.

A major issue for every client is how to become and stay healthy. To be most helpful, counselors need to assess at which stage of coming out the client is and understand the risks and needs of the client at that stage. For example, it is not advisable to refer a client in the first or second stages to gay or lesbian Alcoholics Anonymous (AA) meetings or to suggest that the client discuss his or her sexual identity in group therapy. The counselor may be the only person a fragile client can trust during the early stages. Or, if an LGBT client is in the fourth stage and distrusts straight people, attending gay or lesbian AA meetings or finding a gay or lesbian sponsor might be beneficial. In general,

counselors who can view coming out as a lifelong process of growth can help their clients with recovery and self-acceptance.

### **Stage Models of Transforming an Identity**

Stage models provide a useful description of the process by which some people come to call themselves gay or lesbian. The models also suggest a way of looking at how substance use and recovery interact with being gay or lesbian and with the ways people experience their sexual identities. Bisexual and transgender people may have some of the same issues and problems during recovery and learning to accept themselves. The available coming out models do not address the issues of transgender individuals, although some models discuss gender roles while addressing sexual orientation (DeCecco & Shively, 1985; Bockting & Coleman, 1993). Fox (1995) addresses the development of bisexual identity. In general, it is a false assumption that bisexual, transgender, gay, and lesbian processes are parallel, even when some similarities are noted.

Stage models are general guides to help counselors understand the coming out process; however, there are several points to remember. The models are not linear, and people do not necessarily move through them in order. One stage is not better than another, and people should not be seen as more advanced and mature if they are in a later stage.

William Cross (1971), an African-American psychologist, created one of the first models describing how a person with a stigmatized identity undergoes an identity transformation and then learns to manage and integrate this new identity. His stage model described the process by which a “Negro” recovered from the effects of discrimination by transforming internalized racist cultural values and attitudes and developed a positive identity. Similarly, Cass (1979) proposed a model for the process by

which gay men and lesbians transform their stigmatized identities from negative to positive.

A number of other models exist, usually with four or five stages and with some variations in focal point (Coleman, 1981/1982; Kus, 1985; Sophie, 1985/1986; Troiden, 1988; Woodman, 1989). For example, whereas Cass (1979) focused on ego functioning, Hanley-Hackenbruck's (1989) model examined superego functioning and the ways people changed their superegos from critical to ambivalent to accepting of themselves. McNally (1989) interviewed lesbian recovering alcoholics and proposed a model that described how lesbians transform their identities from active alcoholic to sober ones, how they came to feel positive about themselves as lesbians, and how their alcohol abuse and recovery interacted with the stages of developing a sexual identity. It is also noteworthy that these stage models resemble Prochaska, Norcross, and DiClemente's (1994) stages-of-change model, a model originally developed to determine treatment readiness.

### Stage One: Identity Confusion

Most identity stage models suggest that the first stage involves some denial and confusion regarding one's feelings of attraction and sense of self. Cass' (1979) stage one is **Identity Confusion**, which occurs when people see their behavior as homosexual and face a crisis about who they are. Many people use alcohol and drugs to manage the painful feelings of this stage. They may drink or use drugs to cope with their anxiety and shame or to socialize or be sexual with a person of the same gender. They may use substances to help block out unwanted feelings of attraction toward people of the same sex or to keep from ascribing personal meaning to behaviors they consider unacceptable. Consider the examples of "Joe" and "Mary." For many years, Joe drank to drown out a sexual experience in high

school in which he had sexual and loving feelings toward his best friend. He was terrified that he might be gay and did not want to bring shame to his religious family. Mary drank to cope with the confusion of being sexual with Sally, her roommate, and to avoid seeing herself as a lesbian.

### Stage Two: Identity Comparison

In stage two, **Identity Comparison**, people begin entertaining the possibility that they may be gay or lesbian. In this stage, anxiety can be considerable, as people deal with their denial about their sexuality. People in this stage are often in emotional pain and are quite vulnerable. Substance abuse may be the primary way they have to deal with the pain associated with an experience that breaks through their denial and shatters their sense of heterosexual identity.

The examples of "Matt" and "Joan" are instructive. Matt always thought that he was heterosexual, but when he became emotionally and sexually involved with his college roommate, he began to question his identity and feelings. When his roommate broke off the relationship, Matt was devastated. He drank excessively to cope with his feelings about the breakup and his identity confusion. He went in and out of several detoxification and rehabilitation facilities during this stage of confusion, secretly struggling with inner turmoil and anguish. He finally received help when a counselor identified his conflict and helped him describe his feelings, offering him some hope of resolving his conflict if he stayed sober.

Joan was so frightened when she felt attracted to a lesbian she met at work that her drinking increased and her job was in jeopardy. When she entered treatment to save her job, Joan whispered to her counselor that she might be "one of them" but did not want to be and could not talk about it. Her counselor reassured Joan it was her choice whether to discuss it.

### Stage Three: Identity Tolerance

In stage three, **Identity Tolerance**, people begin to have a greater level of commitment to a new identity (“I probably am gay/lesbian.”). These feelings increase the sense of alienation and isolation. In response, people seek out gay and lesbian individuals and try to connect with the gay community and culture. If a lesbian or gay man is in treatment at this point, the counselor can help by suggesting attendance at gay- or lesbian-affiliated AA or Narcotics Anonymous (NA) meetings. If people remain open to this growth process, their self-image may change and they can say, “I am gay” or “I am lesbian”—an assertion that marks the beginning of the next stage.

Some people identify themselves as bisexual before they identify themselves as gay or lesbian. This stance may be easier because they believe others may be more accepting of them as bisexual than as gay or lesbian. Because the transition from identity tolerance to identity acceptance is a highly individual process, it is important that counselors not force clients into declaring they are gay or lesbian but respect and support individuals in their process. Although some individuals may see themselves as bisexual as part of their coming out process, other individuals are clearly bisexual and need to be accepted as such.

### Stage Four: Identity Acceptance

The **Identity Acceptance** stage is characterized by increasing contacts with other gay and lesbian individuals. It also involves experiences that help “normalize” a gay or lesbian identity and way of life, and this stage can introduce new opportunities for drinking. Consider the experiences of “Veronica” and “John.” Veronica told her counselor that when she began to come out, her drinking “just took off and went through the roof!” She spent much of her time in gay bars and drank heavily at every opportunity to socialize and be sexual.

John had been quite close to his family, but he believed family members would reject him if they found out he was gay. While he was enjoying his new gay and lesbian friends and his activities in the gay community, he used marijuana and drank heavily every day to medicate his anger and sadness about the loss of his family. Thus, as people increasingly become able to accept rather than tolerate their homosexual self-image, their substance abuse problems may, in some cases, become more severe.

People in the early stages often have fragile identities and find it difficult to cope with non-LGBT people who do not understand the need to be with people similar to them. They may disclose their identities to intolerant people in unsafe situations. For example, “Ed” felt so good about being gay and falling in love with “Jorge” when he got sober that he wanted to tell his boss and coworkers his happy news. His counselor was able to help him exercise some restraint. “Jan,” for instance, was happy about coming out as a radical lesbian feminist separatist and claimed her identity with a great deal of enthusiasm. However, she refused to enter a rehabilitation facility that treated men and would go only to a women’s program that she felt would be sensitive to her needs as a lesbian. There her counselor could respect her political or emotional position while helping her recover.

### Stage Five: Identity Pride

If people move to **Identity Pride**, stage five in Cass’ model, they do so with an awareness of the difference between their acceptance of their own homosexuality and society’s rejection of it. There is a tendency to get angry, to split the world into gay and straight, and to respond to heterosexism by rejecting the dominant heterosexist culture. People may become active in the lesbian/gay community and spend the majority of their time with others who share their feelings and perspectives.

“Collette’s” drinking and political activity as a feminist have been deeply and passionately intertwined for many years. She angrily tells her counselor that he does not understand anything—no man can possibly understand her; no heterosexual can, either. She tells him that everyone she knows drinks the same way she does and that she cannot imagine how she can carry on her work as an activist without drinking. If she stops drinking, she will lose everything and everyone who means anything to her. Her counselor listens with concern and tries to empathize with her terror and rage in the face of what she believes is the loss of her whole way of life.

### Stage Six: Identity Synthesis

In stage six, **Identity Synthesis**, an awareness develops that the dichotomy of “them and us” is not valid. Anger decreases, pride becomes less aggressive, and the gay or lesbian identity is more integrated with other aspects of the individual. It may be difficult for people to attain this level of identity integration and synthesis if they have been drinking heavily and using drugs for a considerable length of time.

Counselors should explore the meaning of clients’ stating they have been out for 30 years or they have been gay since the age of 7. The length of time they consider themselves gay or lesbian does not necessarily predict whether people have worked through the process of claiming a positive gay or lesbian identity or of feeling good about themselves as gay men or lesbians, especially when they have spent many years abusing alcohol or drugs. Clients’ meaning of the word “out” may be highly individual. A client who describes herself as out for 2 years may mean that 2 years ago her mother discovered that she was involved with a woman.

### Recovery Issues for Lesbians and Gay Men

People who have been using alcohol and drugs for many years may have anxiety and confusion about who they are and how to make sense of the experiences and feelings they encountered during their active addictions. Counselors need to help people in recovery begin to address the task of struggling with the question, “Who am I, now that I’m clean and sober?” People in recovery need help sorting out various aspects of themselves, such as, “What does it mean to be a man? A woman? Gay? Lesbian? Straight?”

If we look at gender identity and sexual identity on a continuum with male and female being the endpoints of gender and gay and straight being the endpoints of sexual identity, we can see that society forces people to one or the other of the endpoints—even though this may not actually characterize their feelings or experiences. An important part of treatment may be helping people tolerate ambiguity and diversity. Counselors may be the first people to tell substance abusers that whoever they are is okay, that they do not have to declare themselves gay or straight or bisexual, and that an important part of recovery may be to spend time exploring who they are. Clients may need to explore the meanings of their various feelings and experiences. At the same time, other individuals may arrive in treatment stating they are “okay about being gay” but in reality are still struggling with self-acceptance. Counselors can help these individuals to identify the pain masked by their addiction and to accept who they are and the identity they may wish to embrace. In addition, some “out” clients may find that their gay or lesbian friends may not understand or may resent their recovery efforts. Counselors can alert clients to this issue and can assist them in making choices about how and with whom they share their recovery.

**Case Example**

Lee is a 43-year-old Asian-American married woman who has been relapsing for over a year and is currently in an aftercare relapse group. She is quiet and shy, never offering to say much in the group about herself, but she is quite supportive and helpful to others when they discuss their problems. However, when people in the group ask her about problems in her life with sobriety, her husband and children, or other relationships, she looks at the floor and seems quite uncomfortable. She responds in short, whispered phrases and then falls silent. Lee's counselor notices that, after a woman in the group comes out as a lesbian, Lee becomes even more anxious and agitated. She asks the lesbian client why she has to come out and flaunt her sexuality.

During an individual session with Lee, the counselor asks her if something is going on in her life that makes her feel uncomfortable with the lesbian client. Lee says no. The counselor asks whether Lee has ever been approached by a lesbian. Lee says no. The counselor asks whether Lee has ever had any lesbian feelings herself. Lee says no. The counselor feels frustrated, but tries again. She asks whether anything of a sexual nature happened when Lee was drinking that upset her in any way. Lee is silent, looking at the floor. She begins to cry and tells the counselor that she can't talk about anything. She says she is too afraid. She doesn't want to lose her family. She can't bring shame on herself and her whole family. The counselor reassures Lee that whatever they talk about is confidential and will not go any farther.

Through much crying and sobbing, Lee tells the counselor that she is terrified that she might be a lesbian. She says that she sometimes has dreams and fantasies about being sexual with women, and once when she was drinking, a woman flirted with her at a party. She thinks they might have been sexual, but she's not sure; she was having blackouts at the time. She doesn't know what to do. She doesn't feel attracted to her husband and thinks this must mean she's a lesbian, but she doesn't want to be a lesbian. Lee cries and expresses deep despair and shame, but relief, too, at finally telling someone what she thought she could never disclose. The counselor, too, knows that Lee finally has a chance to stop relapsing and to begin her sobriety.

## Suggested Interventions

What stage a person is in should determine which interventions are appropriate for and sensitive to the patient's needs. In the example above, the counselor created a safe atmosphere for Lee by asking questions in private rather than in the group and by asking them in a way that reassured Lee, while telling her that she could talk about herself. The counselor might follow up on Lee's disclosure with some private sessions and refer her to a knowledgeable therapist to help her with her feelings and concerns about her sexual orientation. Because clients in stages one and two usually are frightened, confused, and vulnerable, they need help and support from counselors to talk about their feelings and experiences. Because of their shame and anxiety, clients are vulnerable to relapse, and counselors need to help them by talking freely about their sexual identity, raising the issues, and discussing them openly.

Guided by the stage model, counselors need to intervene in ways that fit the client's particular needs, desires, culture, experiences, and feelings. For example, if a person in stage four wants to come out to his parents, boss, and family, a counselor could help the client explore the possible positive and negative consequences of such disclosures. Clients in this stage may not know where to socialize with other sober gay or lesbian people. Referral to sober resources is important. If a client comes out to himself or herself while in treatment and begins to move into stage three, a counselor might need to help the client with family or job issues, religious guilt, and other problems that could threaten the client's sobriety. Making a referral to gay and lesbian AA/NA or other support group meetings at this time and to gay or lesbian therapists is quite important to clients to help them maintain their sobriety and cope with all the complex and difficult issues related to being gay and lesbian and recovering from substance abuse.



## Chapter 6 Families of Origin and Families of Choice

*Philip T. McCabe, C.S.W., CCGC, C.A.S., CDVC, Ocean Grove, NJ*

### What providers will learn from this chapter:

- What a counselor needs to know about relationships and families when counseling LGBT clients
- The difference between families of origin and families of choice
- How a counselor can identify unresolved issues with a client's family of origin that could trigger a relapse
- How a counselor can be sensitive to an LGBT client's family of choice in treatment

### Introduction

This chapter addresses the family dynamics that are important in working with lesbian, gay, bisexual, and transgender (LGBT) individuals and how counselors can put their understanding of these dynamics to work in counseling LGBT clients and their families.

Like nongay clients, LGBT individuals seeking recovery are involved in multidimensional situations and come from diverse family backgrounds. Family, relationships, friends, social interactions, work issues, self-esteem, increased understanding of self-identity, and community support all are part of the focus of the treatment and recovery process. During the course of treatment, it is important to identify stressors that can trigger a return to substance abuse and addiction. LGBT individuals, in particular, need an intake assessment that is comprehensive, inclusive, and culturally sensitive.

### Family of Origin

Family of origin refers to the birth or biological family or any family system instrumental or significant in a client's early development. Taking a family history and reviewing the dynamics of the family of origin should be part of a thorough biopsychosocial assessment. Counselors should exercise great care in asking sensitive questions, particularly about members of the family of origin. The client's cultural norms will be particularly important during this

questioning and should be respected for an assessment to be effective.

LGBT clients often will have unresolved issues about their family of origin, particularly regarding sexual orientation or gender identity. As they do with all clients, counselors need to review the client's role in his or her family of origin, because unresolved issues with the family of origin can act as emotional triggers to a relapse.

The following questions can help the counselor gather relevant information and assess what unresolved issues might interfere with clients' ability to maintain sobriety.

- What were the rules of the family system?
- Was there a history of physical, emotional, spiritual, or sexual trauma?
- Were all family members expected to behave or evolve in a certain way?
- What were the family's expectations with regard to careers, relationships, appearance, status, or environment?
- In general, was sex ever discussed?

Concerning sexual orientation and gender issues, counselors can begin by reviewing with clients how differences were perceived in the family. The following questions would be appropriate to explore:

- Was anyone else in the family acknowledged to be or suspected of being a lesbian, gay, bisexual, or transgender individual?
- How did the family respond to other individuals coming out or being identified as LGBT individuals?
- Is the client out to his or her family?

- If the client is out, what type of response did he or she receive?

The family of origin's response to one's disclosure of an LGBT identity can have a long-lasting and—if it is negative and unaccepting—often devastating effect on an individual. Responses can range from abusive, rejecting, or avoiding to tolerant, supportive, or inclusive. LGBT individuals need to process these messages, roles, rules, images, and stereotypes about sexuality in addition to the messages they receive from society in general.

What makes the LGBT experience different from the experience of other cultural minorities is that LGBT individuals experience prejudice and, most frequently, a disconnection from other members of their minority group. Even in a multicultural family, an adolescent is able to look beyond his or her immediate family to the cultural community and find someone to identify with. This typically is not true for LGBT individuals, who usually grow up without information on or contact with other LGBT individuals.

In his book, *Healing the Shame That Binds You*, John Bradshaw, Ph.D. (1988), refers to the "toxic shame" that is created in childhood and stays until the individual learns to purge it. Similar processes have been explored by authors who write about recovery and families, for example, Janet Woititz, *Adult Children of Alcoholics* (1990); Earnie Larsen, *Stage II Recovery* (1991); Ann Wilson Schaef, *When Society Becomes an Addict* (1988); and Michael Picucci, *The Journey Toward Complete Recovery* (1998), as well as numerous others who acknowledge the importance of resolving these conflicts from our childhood and our family of origin.

## Family of Choice and Relationships

Providing support for LGBT clients and their families of choice is a crucial element of substance abuse treatment, just as it is for all clients. A family of choice is made up of individuals who are significant to the client, and it needs to be included in any assessment. It includes individuals who have died or are no longer an immediate part of clients' lives, sometimes because of addiction, HIV/AIDS, or other life events. A family of choice does not necessarily exclude blood relatives. By definition, it includes those who, by their support, nurturing, and understanding, have earned a significant place in the LGBT individual's life.

Substance abuse counselors and treatment centers need to create a safe place for healing. This safety needs to include respect, understanding, and support for the life partners and significant others of their LGBT clients. It cannot be overstated that these individuals must be included in services similar to those offered to the spouses of heterosexual clients.

In order to work effectively with LGBT clients, substance abuse treatment counselors need to have some understanding of the dynamics of LGBT interpersonal relationships. This includes awareness of the internal and external problems of same-sex couples and the diversity and variety of relationships in the LGBT community. As noted previously, not all individuals in relationships with people of the same sex, or engaging in same-sex behavior, consider themselves lesbian or gay. The counselor needs to be sensitive to the individual's self-identification. Counselors also need to be aware of the lack of universal terminology with regard to significant others in the LGBT community. The terms "lover" or "significant other" can mean different things depending on cultural or generational differences. Interpersonal relationships span a spectrum of emotional significance that is as diverse as LGBT communities. Although many individuals

seek out a life partner, others are single or may find themselves in nontraditional arrangements. Counselors need to be aware of their own biases when working with individuals who—as a result of their affections—find themselves outside the cultural norm of a heterosexual, monogamous, and legally sanctioned marriage.

Lesbian, gay, and transgender (LGT) individuals with a previous history of opposite-sex relationships add a new level of complexity to their relationships that approaches that of bisexual individuals. Like their heterosexual counterparts, some LGT individuals maintain close contact with their opposite-sex partners. Others consider such relationships to be part of a previous "life" before coming out.

One particular stressor for LGBT individuals in interpersonal relationships is the level of comfort with one's sexual orientation. A couple could, for instance, consist of one person who is closeted while the other is out. When couples are at different stages of self-acceptance regarding sexual orientation, it can be a source of great tension within the unit.

## Parenting Issues

A common misconception is that LGBT individuals are not partnered and do not have children. The reality is that many LGBT individuals are coupled, have children, and exercise the same responsible parenting as their heterosexual counterparts. Many LGBT individuals have children from previous heterosexual marriages. Moreover, as more LGBT couples adopt, become foster parents, or use alternative routes of insemination to become pregnant, substance abuse treatment counselors can expect to be working with more LGBT clients who are parents, either as part of a couple or as single parents.

When children are added to a family system, parent-child relationships, the role of

stepparents or members of the blended family, and the birth parent (if any) must be factored into the family dynamic. Counselors may have a concern that children growing up in LGBT families are likely to become LGBT individuals, but this concern is unfounded. As we have seen in chapter 1, the etiology of sexual orientation is so complex that the sexual

orientation of parents or family members is not an issue.

Individuals in treatment need to be concerned about losing custody of their children. See chapter 3 for a discussion of this issue and other legal issues of particular concern to LGBT parents.

## Chapter 7 Clinical Issues With Lesbians

*Dana G. Finnegan, Ph.D., C.A.C., Naples, FL*

### What providers will learn from this chapter:

- The range of diversity among women who see themselves as lesbians or whose sexual/emotional/affectional feelings and behavior are primarily directed toward women
- The myths and stereotypes about lesbians that need to be explored and corrected
- The clinical issues and concerns specific to lesbian clients
- How counselors need to respond to issues specific to lesbians who are substance abusers

### Introduction

Perhaps the most important thing a counselor needs to bear in mind when working with lesbian clients is that there is no **one** lesbian client—that there is tremendous diversity among lesbians. As women, lesbians share the diversity inherent in womanhood; they also share the experience of dealing with sexism. The range of their experiences, perspectives, life situations, and statuses can hardly be overstated. Lesbians are from all races and ethnic groups, all socioeconomic levels and ages, all areas of the country and indeed of the world. Some lesbians are sexual with men at times, yet see and identify themselves as lesbians. Some women have same-sex relationships, but do not see themselves as lesbians. There are also women who choose to self-identify as lesbians on the basis of their emotional attraction to other women and in spite of being sexually attracted to men.

While some lesbians have children or want to have them, others do not. Some women have known they were lesbians since the age of 5 or 6 years (but were without the vocabulary to describe it at the time). Others become aware of their attractions to other women only in later life, often after having been in a heterosexual marriage for a number of years. Some lesbians are very comfortable with and public about their lesbian identity. Others have great difficulty taking on a lesbian identity and may keep it secret and hidden, whether from shame (internalized homophobia) or from a need to

protect their jobs or maintain relationships. Some lesbians may look and act “masculine,” whereas others may look and act “feminine.” Many lesbians are not at all distinguishable from the general population of women.

Lesbians exhibit great diversity in their drinking or drug-taking behavior as well. There is no single pattern of such behavior among lesbians who are substance abusers. In this sense, again, they also may be indistinguishable from the general population of women.

### Destructive Myths and Stereotypes

Counselors need to be aware of the numerous myths and stereotypes that our society tolerates and sometimes promotes even though they are inaccurate and can be destructive. Such awareness enables counselors to check out their own belief systems and help work with their lesbian clients on issues specific to their sexual orientation.

One set of myths is that lesbians hate men, that they are afraid of men, or that they want to be men. The truth of the matter is that a small number of lesbians may hate men, but so do some heterosexual women. A small number may be afraid of men (as are some heterosexual women) and often for good reasons (e.g., rape, sexual abuse, physical violence, sexism). It can certainly be said that many lesbians **and** many heterosexual women want the same power that men have by virtue of having been born male. Most lesbians do not hate men; they are not afraid of men, nor do they want to be men. Likewise, the idea that all lesbians are masculine or “butch” is not true.

Another myth is that lesbians do not have stable relationships and are either particularly loath or anxious to form committed relationships. A number of younger lesbians engage in serial dating and are not monogamous. Like their straight counterparts, some might be judged promiscuous, but it is more

accurate to see them as following the mores of their peers and their generation’s culture. Conversely, a myth exists that lesbians form committed relationships instantly and stay together as long as they possibly can. Again like heterosexual women, some lesbians may form lasting committed relationships too soon for their own good, whereas others may not.

A pervasive myth to consider is that life as a lesbian is only—or predominantly—about being sexual or that a lesbian identity is purely a sexual identity. Although being lesbian most 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.

Common myths also suggest that there is a sexual cause for lesbianism, such as having had bad sexual relationships with men, or having been sexually abused by men, or not being sufficiently sexually attractive to men.

An offshoot myth is that lesbians are sexual predators, that they are always looking to seduce one another and heterosexual women. This myth strains credulity since women are not known to be sexual predators and indeed receive strong messages from our society discouraging sexual aggression.

One other set of myths that needs to be challenged relates to the idea that sexual orientation is a matter of choice. These myths merit some discussion here, although a fuller treatment is provided in chapter 1. It is true that lesbians can change their sexual **behavior**. Many women who eventually self-identify as lesbians live for years behaving as heterosexuals. They may take husbands and have and raise children. Despite appearances, however, they cannot always be said to have changed their sexual orientation. Two related myths are (1) that lesbians would prefer to be heterosexual and would, in fact, choose to change their

sexual orientation if they could, and (2) that sexual orientation is caused by a hormonal imbalance and could be changed by taking the right hormones.

What is important about the myths are the underlying assumptions—that heterosexuality is superior to homosexuality: more moral, healthier, and more natural. These beliefs can make life in recovery harder to negotiate.

### **Clinical Issues With Substance-Abusing Lesbians**

Too little is written on the incidence, prevalence, and patterns of substance use among lesbians. Many formal studies have generalized from gay males to lesbians, whereas others have used unreliable sampling methods. In the literature that is available, certain risk factors are noted repeatedly, such as:

- The reliance of many lesbians upon women’s bars for socializing and peer support
- The interaction of sexism, stress, and substance use
- Issues related to coming out such as alienation from loved ones upon revealing one’s lesbianism, the emotional dissonance of “passing” as heterosexual, and the use of substances to reduce the anxiety of these conflicts
- The interaction of trauma (discriminatory experiences, physical or sexual assault because of one’s lesbianism) and substance use.

The traumas that lesbians may have suffered need to be recognized and understood as integral parts of their behavior, outlook, and emotional makeup. For example, the research findings of the National Lesbian Health Care Survey (Bradford, Ryan & Rothblum, 1994) reported that 21 percent of lesbians had been

sexually abused as children and 15 percent as adults. (However, it is a myth that being sexually abused makes a woman a lesbian. That is false, even though some lesbians believe the myth.) For every lesbian client, the trauma of alcohol and drug abuse is added to the negative effects of homophobia and heterosexism. Finally, there may be other traumas, such as being African American or Latina in a prejudiced society. Attention to trauma issues may, therefore, be a key part of the overall recovery process of the substance-abusing lesbian.

In their 1997 review, Hughes and Wilsnack note some general patterns in lesbians’ use of alcohol, including:

- Fewer lesbians than heterosexual women abstain from alcohol.
- Rates of reported alcohol problems are higher for lesbians than for heterosexual women.
- Drinking, heavy drinking, and problem drinking among lesbians show less decline with age than among heterosexual women.

Along with addressing the above concerns, counselors will find lesbian clients with a variety of issues as women and as homosexual persons. The roles partners and children play in the clients’ use of alcohol and drugs and recovery are particularly important (see chapters 2 and 6), as are confidentiality and legal concerns (see chapter 3).

### **Counselors’ Responsibilities**

Because myths and stereotypes pervade our culture and influence our thinking and our behaviors, it is important for counselors to be aware of them and to help their lesbian clients not be further injured by them. This means counselors need to assess their beliefs in the myths so they do not impose them on their clients. Counselors need to be able to help

their lesbian clients deal with the effects of homophobia and heterosexism as they affect their clients' recovery. All people struggling to recover from alcoholism or drug addiction are vulnerable and easily hurt and can relapse when wounded or unsupported. Negative

experiences can undermine or destroy the strength necessary to recover. An informed and sensitive counselor can make an enormous difference in a lesbian client's treatment and recovery.

### Case Examples

**Example #1:** Rita, 52, a very attractive woman dressed in high heels and a form-fitting suit, is wearing tasteful, but dramatic, makeup. She looks like anything but an alcoholic. She is from the Dominican Republic and separated from her husband; she has two children, but is currently living alone. She is seeking treatment for "problems I'm having because of my drinking." She will lose her 7-year position in her company if she doesn't stop drinking, she is estranged from her family, and she has lost all her friends because of her drinking. Rita has tried Alcoholics Anonymous (AA) but is having great difficulty finding a sponsor ("Nobody is very warm or accepting"); she is also having trouble relating to other women in the program ("They're not very friendly. Maybe because I'm Latina."). When asked about her relationships with others, she looks embarrassed and mumbles something noncommittal. When the counselor directly asks, "Have you been in any long-term relationship with anyone in the past 10 years?" Rita stammers out that she had lived with a friend for 5 years. The counselor then asks if Rita can say more about the nature of the relationship, the quality of it, and the reasons for its ending. Rita answers in vague terms that she and her friend argued about how much Rita drank and that the friend finally left. As Rita continues her description, her vagueness suggests that the difficulty she is having talking about it might stem from a lesbian relationship (or her fear that it might have been one). The counselor must now decide whether to ask for more information.

Acting on the basic premise that Rita's secretiveness indicates a high level of anxiety about this subject and that her anxiety probably makes her distance herself from others for fear of being found out, the counselor presses on. How? Not by using the term "lesbian" or by going directly for this particular topic. Instead, the counselor asks such questions as, "Were you close to one another? Was your friend emotionally supportive of you?" And the counselor can empathize, saying such things as, "The breakup must have been very painful for you. When he or she left, how did you cope with the loss?" Now the counselor has introduced the possibility that the friend is a woman and offers Rita the opportunity to edge a little closer to being able to talk about the fact that this close relationship was with a woman. It is important to note here that the counselor is not using any label (such as "lesbian") and is only indirectly exploring the quality and nature of the relationship. If and when Rita can begin to talk in more detail about this relationship, the counselor needs to continue the exploration in this restrained manner because the topic is so frightening to Rita. Such restraint on the counselor's part is crucial because Rita has been able to pass for straight, something that has been of great importance to her because the Latino culture and her family are extremely homophobic. Restraint is also crucial because it creates the safety essential to engendering the patient's willingness to participate in her treatment and recovery.



**Example #2:** Andrea, 23, has been drinking alcohol since she was 12. She also became addicted to her mother's Valium and uses it to "smooth out" her hangovers and to come down from her occasional cocaine highs. Andrea has known since she was about 9 that she is attracted to girls and has been sexually active since the age of 14. She is totally out as a lesbian and says she has no problems about her sexual identity. But she is troubled by her inability to sustain any relationship for longer than a few months. She also says that since she's achieved sobriety, she doesn't know how to meet women who want to date her. She has become shy and uncertain—she says, "retarded." The counselor needs to help Andrea assess where she is in the development of a sober and clean identity and how that relates to her sexual orientation. She has not been able during her formative years to learn the necessary developmental lessons of adolescence. Furthermore, she tended to act out her feelings when drunk or drugged, including a lot of sexual feelings. She never learned how to date or communicate or relate emotionally to others. The counselor needs to point out to Andrea that she will probably need to go back and come out again in some form, now that she's clean and sober, and that she will need to learn the tasks of adolescence that she missed learning.

### Suggested Interventions

Although the responsibilities involved in counseling substance-abusing lesbians may seem daunting, there is no denying the importance and influence of the caring counselor. Counselors who don't know a lot about lesbians can still offer much of value to their clients if they start with what they know about women and take the time and make the effort to understand the special problems of lesbians.

Some suggestions for treatment are as follows:

- Empower the client—this should be the primary goal, no matter how it is reached.
- Honor diversity.
- Use nonjudgmental language.
- Avoid labeling.
- Do not confront, but support and explore.
- Respect the client's position, whatever that may be ("I'm not a lesbian"; "I'm confused"; "I'm a lesbian and proud of it!").
- Respect some lesbians' unwillingness to attend AA or Narcotics Anonymous because they consider these programs male institutions with no room for them as women, and especially as lesbians, or because of the emphasis on powerlessness, which they feel emphasizes their status as victims.

## Chapter 8 Clinical Issues With Gay Male Clients

*Robert Paul Cabaj, M.D., San Mateo County Mental Health Services, San Mateo, CA*

### What providers will learn from this chapter:

- The social, cultural, psychological, and developmental issues and treatment considerations specific to gay men
- Some of the societal, cultural, and emotional factors and expectations with which gay males must contend

### Introduction

Many factors may contribute to the prominent role of substance use and abuse in gay men. At one point, American psychoanalysts even postulated that homosexuality itself caused alcoholism. We know now, of course, that homosexuality, repressed or not, does not “cause” alcoholism, because alcoholism and substance abuse are the result of the complex interactions of genetic, biological, familial, and other psychosocial factors.

However, the psychological effects of heterosexism, antigay bias, and internalized homophobia may make gay men more prone to using alcohol and other substances, and that use, in turn, may lead to substance abuse or dependency and may trigger the genetic expression of alcoholism and drug abuse. Higher rates of alcoholism have been documented in societies or cultures in turmoil or undergoing social change—a description that can be said to apply in the case of lesbian, gay, bisexual, and transgender (LGBT) individuals (Cassel, 1976). For most of the 20th century, societal pressures forced most gay people to remain “in the closet,” hiding their sexual orientation or not acting on their feelings. Legal prohibitions against homosexual behavior, overt discrimination, and the failure of society to accept or even acknowledge gay people have limited the types of social outlets available to gay men to bars, private homes, or clubs where alcohol and drugs often played a prominent role. The role models for many young gay

people just coming out are often gay people using alcohol and drugs at bars or parties.

Some gay men, in fact, cannot imagine socializing without alcohol or other mood-altering substances. Brought up in a society that says they should not act on their sexual feelings, gay men are very likely to internalize this homophobia. Often their first homosexual sexual experience was while drinking or being drunk to overcome fear, denial, anxiety, or even revulsion about gay sex. For many gay men, this linking of substance use and sexual expression persists and may become part of the coming out and social and personal identity development processes. Even after coming out, many gay men will use mood-altering substances to temporarily relieve persistent self-loathing, which is then reinforced in the drug withdrawal period.

Given the lack of widespread acceptance of homosexuality and bisexuality in our society at this time, the stages of developing a gay identity may be intimately involved with substance use. Swiss psychoanalyst Alice Miller (1981) sheds light on the link between the psychodynamic forces in developing a gay identity and the use of substances in her work on the emotional lives of children who are talented or otherwise different. Her description of how parents influence the emotional development of these children has strong parallels with the development of a gay identity. Parental reactions shape and validate expressions of children's needs and longings. Parents reward what is familiar and acceptable to them and discourage or deemphasize behavior or needs they do not value or understand. To get rewards, children eventually learn to behave the way parents expect and to hide or deny the longings or needs that are not rewarded.

Many gay men fit Miller's description of being aware of being different early in life. They recognize that their loving and sexual needs and longings make them different from others

around them. Some male children who will grow up to be gay may desire a closer, more intimate relationship with their father, but this desire often is not encouraged or even understood. The "prehomosexual" child learns to hide such needs and longings, creating a "false self." Real needs and desires often are repressed or rejected as wrong, bad, or sinful. Dissociation and denial become major defenses to cope with this conflict.

The psychology of being different, and of learning to live in a society that does not accept difference readily, shapes sexual identity development as a boy emerges from childhood and the latency period. Accustomed to the rewards of the false self, the child suppresses his more natural feelings. He usually has no clear role models to show him how to be gay.

In latency, boys who will become gay, especially boys who may be effeminate, may fear other children and become more isolated. In adolescence, gay sexual feelings can emerge with great urgency but with little or no permission for expression. Conformity is certainly encouraged, which may support further denial and suppression of gay feelings. Adolescents often reject and isolate those who are "different," so the gay adolescent further develops a disconnection between his feelings and his external behavior.

These same factors may also help explain the many problems facing gay youth—such as depression, suicidal thoughts (or attempts), and running away from home, as well as drug use—even if they have accepted their sexual orientation (Savin-Williams, 1994). Gay youth are subject to sexual abuse and violence and sometimes are introduced to sex via hustling or prostitution. They may be otherwise "used" or exploited sexually by others. The extreme difficulty many gay men have in coming out and integrating sexuality and personal identity makes sense from this perspective.

Substance use serves as an easy relief, can provide acceptance, and, most important, simulates the comforting dissociation or disconnection developed in childhood where feelings become separated from behavior. Alcohol and drugs cause a dissociation of feelings, anxiety, and behavior and may, in a sense, mimic the emotional state many gay men develop in childhood to survive. The “symptom-relieving” aspects help fight the effects of homophobia, allow “forbidden” behavior, provide social comfort in bars (or other unfamiliar social settings), and alleviate somewhat the familiar experiences of disconnection and isolation.

The easy availability of alcohol and drugs at gay bars or parties and the limited social options other than at bars and parties encourage the use of substances early in the coming out and gay socialization process. For gay men especially, sex and intimacy are often split. Substance use allows them to act on feelings long suppressed or denied but also adds a new disconnection and makes it harder to integrate intimacy and love. As some longings and needs find easy relief with sex and/or substance use, the much more challenging needs for love and intimacy may be ignored.

Substances help many gay men brace themselves for the rejection that they expect from others. They allow for denial and even “blackouts” about sexual behavior, including risky sexual behavior. They certainly can make living in the closet with its built-in need for denial and dissociation possible or even easier (the “I-was-so-drunk-I-didn’t-know-what-I-did-last-night” scenario often used in high school and college).

The state that accompanies internalized homophobia and the one that occurs with substance abuse are very similar—the “dual oppression” of homophobia and abuse described by Finnegan and McNally (1987). The following traits are seen in both: denial;

fear, anxiety, and paranoia; anger and rage; guilt; self-pity; depression, with helplessness, hopelessness, and powerlessness; self-deception and development of a false self; passivity and the feeling of being a victim; inferiority and low self-esteem; self-loathing; isolation, alienation, and feeling alone, misunderstood, or unique; and fragmentation and confusion. These close similarities make it very difficult for gay men who cannot accept their sexual orientation to recognize or successfully treat their substance abuse. Providers need to know that self-acceptance of one’s sexual orientation may be crucial to recovery from substance abuse.

### **Being Male and Being Gay**

Cultural expectations about what it means to be male, regardless of one’s sexual orientation, add social and personal pressures. These cultural expectations—basically gender role expectations—vary by culture and ethnicity and can present quite different issues, for example, for gay men of color than for Caucasian gay men.

In general, however, the stereotypical male in America can be described as powerful, masculine, independent, emotionally reserved, and career motivated, rather than relationship motivated. Boys and men who do not seem to fit this stereotype—or who do not wish to act like this stereotype—may have trouble fitting in or being comfortable with themselves.

Part of societal heterosexism is confusion about what homosexuality is and what gay men are. Since most heterosexuals cannot imagine what it is like to be attracted to someone of the same sex or to be gay, they often mistakenly assume that a gay man is in some way like a woman. If a man wants to be with another man emotionally or sexually, they think, then gay men see themselves as like women. Cultures, especially Latin-based cultures, stigmatize any man who is like a woman. Some have speculated that this may be one

basis for antigay bias in America and a major factor in homophobia.

Gay men are not like women even though they are attracted to other men. Certainly men may be “effeminate”—that is, having some traits that are in general culturally attributed to women. Yet effeminacy has nothing to do with sexual orientation. Many effeminate men are heterosexual. Unless a gay man is also transgender, he does not think he is a woman or wish to be a woman.

Many gay men do, however, grow up differently from their heterosexual peers, and a good percentage of gay boys and men have traits and behaviors that are more commonly associated with girls or women. Examples of this include avoiding rough and tumble play and being less aggressive and less interested in sports than stereotypical heterosexual males. These traits do not cause homosexuality, but they may lead to a child being stigmatized. Many gay men report being made fun of in school, feeling isolated, and avoiding contact with the more “macho” types of boys—which, of course, adds to the stress of being different.

The alleged link between being gay and being effeminate or weak sometimes is believed even by gay men and makes them more ashamed of their gay feelings than they might be otherwise. Gay men who are more passive or who enjoy being the “passive” or receiving sex partner may feel deep shame and embarrassment about that behavior and desire, and that shame may contribute to their using alcohol and drugs to try to cope.

Some gay men may feel pressure—even or especially by other gay men—to be more “butch,” masculine behaving, or macho than they feel comfortable with. This conflict may lead to acting more reserved or aloof in general, making it hard for them to relax. This pressure to be “aggressive” may also lead to alcohol and drug use, especially to drugs that

make one feel more sexual or enhance sexual performance, such as amphetamines or amyl nitrate. This desire to be ultramasculine also contributes to the focus on looks and body image for many gay men, including working out at the gym and the use and abuse of steroids.

### Gay Male Social Life

Gay men are an extremely diverse group, and generalizations, even about large subsets of gay men, tend to be more harmful than accurate. A few examples illustrate the point. Life for a gay man in a small midwestern town bears little resemblance to that of a gay man living in Los Angeles or rural Texas. A Latino gay man may have a social environment quite different from that of a Caucasian gay man or an African-American gay man, even in the same city. A single, 18-year-old gay man lives a life quite different from that of a 65-year-old gay man in a committed relationship. Gay youth who have run away from home may find little to recognize in the life of a gay university professor living in a well-furnished apartment. Such diversity cannot easily be squeezed into neat stereotypes. In attempting to capsuleize and target “gay demographics,” media concerns and advertising agencies have taken on a daunting challenge.

The popular media portrays gay men in various stereotypes. A gay man is young, beautiful, and materialistic and focused on sex and partying. A gay man is into leather. A gay man dresses in drag (as a woman) and is extremely effeminate. Although some gay men may fit each of these stereotypes, the majority resists acting in ways that can be neatly summarized, or indeed fit any stereotype.

Young gay men just coming out, however, with limited role models or none at all, may believe these are indeed the ways to act if one is a gay man. If they do not comply with the stereotypes they see, they may feel they do not fit in. Gay

men of all ages may feel pressure to somehow be like the image of the gay man they see in the popular gay press or the general media—to be young, thin, well-built, usually Caucasian, and sexually focused—and feel that there is “ageism,” “lookism,” and even racism in the “gay community.” Although these “isms” may exist in certain individuals, they certainly cannot be attributed to all gay men.

Gay men of color sometimes describe feeling invisible in settings where most of the other gay men are Caucasian, but this experience varies by city and region of the country.

Besides the general antigay bias in our society, gay men of color may also face racism—from heterosexuals as well as other gay people. In addition, they may have specific cultural or ethnic issues about homosexuality or ways of having sex with which to contend (as may many Caucasian gay men). For example, many cultures do not condemn sex between men but at the same time do not acknowledge or discuss it, especially if the man is married to a woman or considers himself straight (or bisexual).

In spite of growing awareness and acceptance of gay people, social outlets for gay men still tend to be limited in both scope and location. The “gay ghetto,” the section of town where gay people feel comfortable being and getting together, usually is identified by the presence of gay bars. The number of gay coffee shops, bookstores, and activities that do not involve alcohol and drugs is increasing, but gay bars and parties that focus on alcohol and drug use are by far the best advertised and most identifiable elements of gay social life.

An activity that seems unique to gay people—mostly men, though some lesbians take part—is the “circuit party.” These parties are weekend-long gatherings that focus on dancing, sexual activity, and alcohol and drug use. Attended primarily by gay men in their early twenties to late forties, these parties are held all across the country (and indeed, around

the world), forming a “circuit” of connected activities frequented by many of the same people who travel from event to event. The parties encourage drug use—to enhance the dancing (like at a “rave”) and sexual activity. The “designer” drugs—ecstasy, gamma hydroxybuturate (GHB), Special-K, and others—as well as amphetamines (speed or crystal)—are heavily used and promoted. Fatalities have even been associated with the use of these drugs at some parties.

### **Alcohol and Drug Use and Sexual Activity**

Many people think of gay men as sexually obsessed, in part as a result of the general media’s focus on gay male sexual activity and reporting on and concern over human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Gay men are probably no more sexually obsessed or active than males in general, and certainly interest level and activity vary with age. Still, there are important links between sexual activity and alcohol and drug use that add to the risk of gay men developing substance abuse problems and that pose challenges for recovery.

As noted earlier, many gay men may feel particularly ashamed or uncomfortable about having sex with another man. This manifestation of internalized homophobia can lead to sexual activity in inappropriate places such as parks or public bathrooms, and it can strengthen the link between alcohol and drug use and sexual activity.

A small subsection of gay men focus on sexual activity with many partners and/or with great frequency. Many have discovered that using nitrates, cocaine, and, primarily, amphetamines greatly enhances sexual intensity and activity. Amphetamines, in particular, seem to increase and prolong sexual feelings and sexual stamina. Many gay men who use amphetamines also develop a side effect associated with amphetamines—transient

impotence. Sexual desire is still greatly enhanced—for up to 14 hours—thus these men are at greater risk for HIV infection if precautions are not taken.

### Gay Male Life Cycles and Relationships

At each stage of their lives, gay men face challenges unique to being gay. **Adolescents** who are gay, bisexual, or questioning whether they are gay or bisexual, for example, face possible taunts or threats from their peers. Their families may reject them, and some gay youth run away from home. Such gay youth may end up homeless and may also get into drug use (especially intravenous [IV] use) and turn to prostitution. Anecdotal reports exist of gay youth who were living on the street attempting to become infected with HIV for the purpose of qualifying for medical and social services as well as disability income and housing programs.

Their suicide risk, including thoughts, attempts, and successful suicides, may be three times that of other youth (Rotheram-Borus, Hunter & Rosario, 1994). Gay youth who do not leave home may also have more problems with schoolwork, sexual abuse, and alcohol and drug use than their nongay counterparts. Experimentation with drugs and sex is likely to be part of the development of gay youth even if they are accepted by family and self-accepting—just as with any adolescent or young adult.

**Young gay men and middle-aged gay men** may face discrimination and antigay bias in school, at work, and from friends and family. Most gay men form relationships, but same-sex relationships are not readily accepted or even acknowledged in America (Cabaj, 1988; Cabaj & Purcell, 1998). Gay people still are fighting for the right to same-sex marriages. Many gay men have children—by marriage or a relationship with a woman, by adoption, or by a co-parenting relationship with a lesbian friend,

for example—and face the struggles of raising children with little support from society or even from other gay people. Such pressures may contribute to alcohol and drug use.

**Older gay men** face the same issues as all older people but may feel more isolated and disconnected from others because of growing up gay at a time of even more prejudice against and denial of gay people. Many gay men, however, have developed strengths from personal networks that serve them well in coping with older life. Some older men will be facing the loss of a long-term relationship; such “gay widows” may have few social supports. Of course, alcohol and drug use may be a major part of an older gay man’s life, and he needs interventions appropriate to his age as well as his sexual orientation. The emphasis in gay culture on youthful looks and perfect bodies may also impact the gay man as he ages.

All gay men—all LGBT people in general—also face the possibility of violence and hate crimes directed at them because of their sexual orientation. Such violence ranges from verbal to physical attacks; many victims of such violence turn to alcohol or drug use.

Domestic violence is also a real possibility with gay couples and is greatly underreported. As with all couples, there is a link between alcohol and drug use and domestic violence. Finally, gay people are subject to physical and sexual abuse when growing up and are at the highest risk for alcohol and drug use associated with such abuse (Island & Letellier, 1991).

### HIV/AIDS: Loss and Grief

HIV/AIDS continues to be a major factor in gay male life. Though not a “gay disease,” HIV/AIDS has long been associated with gay men. Behaviors—risky sex or sharing needles, for example—are the risk factors, not the orientation. Still, gay men are at greater risk, since so many gay men are HIV-infected, and

having sex or sharing needles in an unsafe way with another gay man may increase the risk of exposure to the virus. For more information, please refer to the Center for Substance Abuse Treatment's Treatment Improvement Protocol 37, titled *Substance Abuse Treatment for Persons With HIV/AIDS* (2000).

The percentage of HIV-infected people in the United States who are gay has steadily dropped, but there are still many infected gay men. There are recent increases in the HIV-infection rates in younger gay men, especially in urban areas (Centers for Disease Control and Prevention, 1998).

New infections are, of course, due to exposure to HIV through risky behaviors. Studies of gay men who have risky sex and know about precautions for safer sex report that they were much more likely to have risky sex after alcohol or drug use (Stall & Wiley, 1988).

Almost every gay man has lost friends or lovers to AIDS, and almost every gay man knows someone who is HIV infected. The grief and loss gay men feel and share is profound and has to be a consideration in working with any gay man.

### Case Example

Greg is a 28-year-old, hearing-impaired, HIV-infected, Caucasian gay man living in a large west coast city in a "gay ghetto." He works as a sign language interpreter for an AIDS organization. He is single, loves to go to parties, works out at the gym almost every day, and tries to maintain his health by following his HIV medication regime carefully. He loves to go to "circuit parties" and even helped develop a special area for other hearing-impaired participants to meet and sign the announcements made at these events.

He used to drink alcohol, but stopped after he learned his HIV status. He does, however, use crystal meth (amphetamines, speed, crank) to allow himself to party longer and get sexually motivated and aroused. He does not see that as a problem, since he only uses on weekends, has a low sexual drive otherwise because of the many HIV medications and a low testosterone level, and has many friends who do the same thing. He has missed some Mondays and even a few Tuesdays at work, but everyone there assumes these absences are due to his HIV status. He used to snort the crystal but now shoots it intravenously to get a more rapid effect. Again, he does not see that as a problem since he needs to be economical in his use on the weekend—"more bang for the buck." He has a fair amount of sex, usually as a "passive" partner, since the crystal makes it difficult for him to get an erection. Because he is already HIV infected, he says he does not worry about safer sex practices.

Although almost all of his friends also use crystal, a few friends have talked to Greg recently about how haggard he looks and how they think he may be "tweaking," that is, shooting crystal too often. They don't want to tell him what to do, but they also think he should be more careful when having sex because he might infect someone else or get a different strain of the HIV virus. Greg says they should mind their own business because he works for an AIDS organization, knows what he is doing, and can stop the crystal use any time he pleases.



### Suggested Interventions

This case points out many of the issues discussed in this chapter—the frequent link between substance use and social activities for gay men, the special role of amphetamines, the concerns about HIV/AIDS. Greg has many reasons to feel different: being deaf, being gay, being HIV positive, having a low sex drive. He has a great deal of denial and will need much support to see the impact of substance abuse on his life. The primary care provider who manages Greg’s HIV care may be the best person to intervene. Ideally, all HIV medical providers should be well versed in substance abuse treatment. If the primary care provider is able to refer this client to a substance abuse counselor, the counselor will need to keep many points in mind in the intervention and treatment planning including the following:

- 1) Denial is part of all substance abuse. Denial seems to be particularly strong with amphetamine use and abuse. Many gay men who use “speed” use it intravenously and still do not consider themselves as having a problem. Point out the current and possible effects of the amphetamine use, such as health problems, loss of time at work, and the concern of friends who want to help break the denial.
- 2) Many gay men will say they are out and quite comfortable being gay. Although this statement is usually true, gay men have not always addressed the internalized homophobia that they picked up from growing up in a homophobic society. Some gay men, such as Greg, may have very subtle self-esteem problems and not recognize that their drug or alcohol use, poor selection of dates or lovers, or lack of ambition on a job may be related to shame and doubt about being gay. Just being out to others does not mean that someone really has dealt with the issues he has had to live with as a result of growing up gay. The substance abuse counselor working with Greg will have to communicate with Greg about his self-acceptance and any shame and doubt he is dealing with, even if he is out with his close circle of friends.
- 3) Gay men with disabilities and substance abuse problems face extra barriers to accessing care and to living clean and sober lives. Finding a counselor or program that has other deaf staff or staff who can sign may be difficult. Finding 12-step programs that have services for the hearing impaired may be an additional challenge. There are, luckily, many sensitive programs for hearing-impaired gay people. The counselor working with Greg can help him find a 12-step program with such sensitivity in their local community, since most large cities have specific gay- and lesbian-identified services.
- 4) If Greg is able to accept the fact that he has a substance abuse problem, ongoing self-care will remain a challenge unless he is able to find new social outlets that do not involve alcohol and drugs or unless he is able to develop new friendships with people who do not have substance abuse problems. Greg’s counselor will need to work with him to explore other social avenues or work on a program that will allow Greg to develop the skills to avoid alcohol and drug use in his old social environment. The counselor will have to help Greg talk to his current friends about not bringing him drugs or trying to convince him it is okay to use just a little. It may be hard to make new friends, but it may be necessary. It is also the counselor’s responsibility to encourage Greg to engage in safer sex practices and to provide or refer him to information regarding such practices, including their benefits (e.g., preventing reinfection that could forfeit a successful HIV medication regime).

## Chapter 9 Clinical Issues With Bisexuals

*Donald McVinney, MSSW, ACSW, C.S.W., CASAC, New York, NY*

### What providers will learn from this chapter:

- The myths and misconceptions about bisexuals that might interfere with their treatment
- What substance abuse counselors need to know about bisexual women and men (including transgender women and men who identify themselves as bisexuals) in treatment
- Psychosocial issues unique to bisexuals in treatment

### Introduction

This chapter presents information to help providers who treat bisexual clients. The information includes some of the misconceptions about bisexuals that might interfere with their treatment, some of the psychosocial issues that may arise when treating bisexuals for substance abuse, and some counseling strategies effective in treating bisexual women and men.

Counselors working with self-identified bisexuals need to assess their clients' sexual behavior and identity issues and also focus on a range of psychosocial issues that may complicate substance abuse treatment of bisexual clients.

Bisexual identity is not exclusively or necessarily defined by sexual behavior. Indeed, the contemporary conceptualization of bisexuality is that it should be understood as a sexual orientation in and of itself and distinct from heterosexuality and homosexuality. The current view has developed over time. Our understanding of bisexuality has not been historically fixed and, in fact, has shifted along a continuum of validation to a denial of its very existence. Sigmund Freud, for example, writing in 1925, affirmed his belief in "the constitutional bisexuality of all human beings" (Fox, 1996, p. 148) and reaffirmed this again in 1937. In stark contrast Bergler wrote in 1959 that "Bisexuality . . . is an out and out fraud," suggesting that bisexuals were in denial about their homosexuality (Fox, 1996, p. 149). Although it is not uncommon for gay men and lesbians to

look back at their coming out process and recall a time in their lives when they self-identified as bisexual, this does not negate the fact that some individuals clearly are bisexual and that bisexuality can be understood as a distinct sexual orientation.

### Myths

For some bisexuals, their bisexual identity is continuous and fixed across their lifespan. For others, sexual orientation may be more fluid and marked by changes from heterosexual to either lesbian or gay or vice versa. This observation may be behind some of the more common myths and misperceptions regarding bisexual individuals.

These mistaken beliefs are prevalent among lesbians and gays as well as among the heterosexual population and unfortunately may also be internalized by bisexual individuals, thus complicating their treatment. Some of the more persistent myths are listed below.

- Bisexuals are confused about their sexual orientation.
- Bisexuals are afraid to be lesbian or gay because of social stigma and oppression by the majority.
- Bisexuals have gotten “stuck” in the coming out process.
- Bisexuals have knuckled under to the social pressure to “pass” as straight.
- Bisexuals are in denial about their sexual orientation.
- Bisexuals are hypersexual and will have sex with anyone.
- Bisexuals are not “fully formed” lesbians or gay men.

### Professional Biases Versus Research

Since professionals are also influenced by the dominant culture and social environment, service providers may bring their own biases to their work with bisexuals. They may be inclined to view individuals who used to have, or who continue to have, sexual relations with both men and women—transitionally, sequentially, or concurrently—as psychologically or emotionally damaged, as developmentally immature, or as having a personality disorder. Individuals classified under the last category are generally labeled as having a borderline personality disorder, with changing sexual behavior manifesting as a symptom of poor impulse control or acting-out behavior. According to Fox (1996), however, “research has found no evidence of psychopathology or psychological maladjustment in bisexual women and men” (p. 154). After reviewing the literature, Fox reported that numerous studies have found just the opposite. In particular, 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 (p. 155).

### What Counselors Need To Know About Bisexual Clients

To provide effective treatment to bisexual clients, providers will need to understand that bisexuality is a nonlinear, complex phenomenon. For example:

- A variety of sexual behaviors may be engaged in by bisexual women, bisexual men, and transgender individuals at any time because behavior and identity can be separate issues.
- Bisexual identity may be formed early in one’s life and remain intact across the lifespan. This is known as **continuous** bisexuality.

- Desire may be experienced by bisexuals as sexual attractions to same-sex or opposite-sex partners at different times during their lives. This is known as **sequential** bisexuality. For example, a bisexual woman may have engaged in sexual relations exclusively with men in her twenties and in sexual relations exclusively with women in her thirties.
- Bisexuals may express sexual desire toward men and women at the same time. This is known as **concurrent** bisexuality. For example, a bisexual man may be attracted to and will actively date men and women during the same timeframe.
- Women and men (including transgender women and men) who identify themselves as heterosexual may have had, or may continue to have, sexual relations with partners of the same sex.
- Women and men (including transgender women and men) who identify themselves as gay or lesbian may have had, or may continue to have, sexual relations with partners of the opposite sex.
- People of transgender experience, including male-to-female and female-to-male individuals, may identify themselves as bisexual. This is because bisexuality (and sexual identity generally) is a separate phenomenon from gender identity.
- Community or cultural norms and standards, especially culturally constructed gender roles (acting “male” or “female”)
- Religious values and beliefs
- Political views (For example, identifying with the majority or with socially oppressed groups may be a political stance. Therefore, some bisexuals may identify themselves as gay or lesbian in order to make a political statement.)
- Legal issues, such as not having the legal sanction of a recognized sexual partnership through the institution of marriage
- Environmental factors, as in the case of individuals in institutions, such as prisons, jails, or exclusive private schools, who may engage in sex with partners of the same sex only while they are in the institutional environment
- Financial considerations, such as the need to engage in prostitution and hustling, especially as a function of substance use, in which individuals are paid to engage in sexual behavior that is inconsistent with their sexual identity.

All of these social factors may result in, or contribute to, separating identity and behavior by bisexual women and men (including transgender women and men who identify themselves as bisexual).

Counselors should develop their sensitivity to these social issues and to issues of gender, age, psychological development, socio-economic status, and modes of sexual expression and desire.

### Counseling Strategies

Recovery from substance abuse and addiction for bisexuals will be facilitated by empathetic,

### Psychosocial Issues

The fact that bisexual identity and bisexual behavior are separate phenomena may be due, in part, to a variety of social factors that mediate between identity and behavior. These variables include the following:

- Race or ethnicity
- Family norms and parental upbringing

nonjudgmental counselors who support clients in:

- Becoming more self-accepting
- Healing from the shame caused by heterosexism and internalized biphobia
- Referring bisexual clients to either straight or gay/lesbian 12-step fellowships, or both, depending on what is more appropriate to their recovery needs.

## Chapter 10

# Clinical Issues With Transgender Individuals

*Dominique Rosa Leslie, ReDiscovery Consulting, San Francisco, CA*

*Barbara Ann Perina, CASAC, NCAC I, Human Service Centers, Inc., Elmhurst, NY*

*Mariano C. Maqueda, Ph.D., Human Service Centers, Inc., Elmhurst, NY*

### What providers will learn from this chapter:

- The definition of transgender
- The different theoretical models used to describe the development of gender identity in transgender women and men
- Transgender-specific clinical issues
- Treatment “do’s” and “don’ts” in dealing with issues related to transgender men and women

### Introduction

This chapter presents a brief introduction to issues facing transgender clients and the substance abuse treatment providers caring for them. The chapter provides an explanation of the term transgender, a brief overview of the theoretical models that describe transgender identity development, and the clinical issues specific to transgender clients.

**Transgender** is an umbrella term that encompasses a variety of people including transsexuals, cross dressers, and drag kings and queens, as well as bigender and androgynous individuals (Tewksbury & Gagne, 1996). Transgender, as a term, came into common usage during the 1980s. Previously, people with mixed gender and sexual characteristics were described as transsexuals and transvestites, terms that come from the psychiatric vocabulary. Transgender comes from the transgender community itself and is, therefore, the preferred term in working with transgender individuals.

The psychiatric model views both transsexuality and transvestitism as psychopathological in nature. Transsexuality is viewed by this model as an insufficient identification with the same-sex parent or overidentification with the opposite-sex parent in infancy or early childhood. Transvestitism, understood as an abnormal dependence on wearing female attire for sexual arousal, was also traced to early

childhood experiences (Warren, 1997; Docter, 1990; Denny, 1994).

In addition, medical models of transsexuality currently are being explored. These models focus on physiological etiology and range from prenatal hormonal effects on the fetus to differences in brain structure. However, neither the psychiatric nor medical models for defining transgender individuals have been accepted by the transgender community.

Research on the various theories of the medical model of transgender experience has led the transgender community to question the role the psychiatric and medical fields play in providing services. In order to avoid malpractice issues, medical doctors currently require two letters from psychotherapists supporting sex reassignment before they will approve a transsexual for sex reassignment surgery. The transgender community strongly advocates that the current psychiatric classification for gender identity disorder (GID), 302.85, should be eliminated from the *Diagnostic and Statistical Manual of Mental Health* (Fourth Edition) (DSM-IV). These concerns have caused a vigorous and ongoing discussion about how well the medical and psychiatric fields serve the needs of the transgender community.

In a society and culture that perceives them as “sick,” “abnormal,” and having a disorder, it is no surprise that transgender individuals sometimes seek escape from hatred, violence, discrimination, and misunderstanding through the use of alcohol and drugs. Transphobia (the irrational fear and dislike of transgender individuals) is a part of our culture. Because they live in a society that discriminates against them, condones violence against them, and denies them basic civil rights, many transgender individuals have internalized the prejudices of their culture and ended up hating themselves. Substance abuse treatment providers may be some of the few people to whom transgender

individuals will talk about their feelings and pain. The substance abuse counselor has an opportunity while helping transgender individuals with their substance abuse issues to refer them to resources to help them cope with their transgender issues.

## Definitions

As our understanding of transgender individuals and human sexuality improves, the terminology used by the transgender and medical communities continues to evolve. Substance abuse treatment professionals should use the definitions included here as a guide, with the caution that some transgender clients or health professionals may use slightly different definitions.

**Transgender** includes a continuum of gender expressions, identities, and roles that challenge or expand the current dominant cultural values of what it means to be male or female.

One’s **gender identity** is the gender (male or female) with which one identifies. A person may be biologically male and have a female gender identity (male-to-female, or MTF) or be biologically female and have a male gender identity (female-to-male, or FTM). **Gender role** refers to how individuals present their gender in the world (e.g., through the clothes they wear). The gender one defines as one’s identity is a matter distinct from sexual orientation.

One’s **sexual orientation** may be described as the sex or gender one is attracted to (see chapter 1). Many MTF transsexuals identify themselves as heterosexual (they are female identified and attracted to men). However, transgender individuals, including transsexuals, may identify themselves as heterosexual, bisexual, lesbian, or gay. Gender identity and sexual orientation are not the same thing, and all people have both. The common misconception about MTF individuals is that they are gay. This is often not true.

The terms “sex” and “gender” are often confused in common usage. **Sex** refers to the biological characteristics of a person at birth, while **gender** relates to his or her perception of being male or female and is known as the **gender role**. Many transgender individuals are born one sex and identify themselves as the opposite gender (for example, they are born biologically male and identify themselves as female).

**Intersexed** individuals are born with ambiguous biological sex characteristics. These individuals often are put through genital surgery, and their sex is decided by the doctor, sometimes with or without the parents’ consent. These individuals may later grow up to have gender identities that are the opposite of the manufactured sex constructed for them at birth and have feelings similar to transgender individuals. An international organization has been formed to help and advocate on behalf of individuals who are born intersexed or with ambiguous sexual characteristics.

**Transsexuals** are transgender individuals with the biological characteristics of one sex who identify themselves as the opposite gender. There are FTM and MTF transsexuals. Transsexuals usually desire to change their bodies to fit their gender identities. They do this through hormone treatment and gender reassignment surgery (sex change surgery). Transsexual individuals who have embarked on this process are often known as preoperative transsexuals (before the sex reassignment surgery). Transsexuals requesting this surgery must live and work as someone of the gender to which they are changing for at least 1 year prior to surgery and be evaluated by therapists. The costs of hormones, therapy, and surgery are highly restrictive and are not covered by most medical insurance. Some transsexuals identify themselves as nonoperative transsexuals because they have decided not to have surgery, either for medical or for other personal reasons. Transsexuals who are HIV positive are routinely denied surgery, and the surgeries

currently available for FTM individuals are not functional or realistic. These nonoperative individuals make up the group most commonly referred to as **transgender**. They live and work as the gender opposite the one they were born with. Transsexuals who have completed their sex reassignment surgeries can and do live as someone with the new gender would and are legally either female or male. They are sometimes referred to as post-op (i.e., postoperative) transsexuals. Most will live as women or men, without being noticed. For personal or political reasons, however, they may continue to identify themselves as transsexuals even though technically they no longer fit the definition.

**Cross dressers** or **transvestites** are transgender individuals who usually identify themselves as of the same gender as their sex; however, they like to dress in clothing of the opposite sex for erotic or personal pleasure. Although by far the largest category of transgender individuals, they usually live a very closeted existence. Many of them are heterosexual men, married with families, often in stereotypically masculine jobs, who, on occasion, dress as females. A number of national and international organizations exist to provide safe places for cross dressers to meet, usually at social gatherings in private homes or private membership bars or clubs.

**Drag queens** (i.e., gay men who dress in female clothing) and female impersonators (who perform in clubs or cabarets) are not transgender individuals. The choice that these individuals make to dress in the clothing of the opposite sex is not a matter of gender identity. The same is true of drag kings (i.e., women who dress in men’s clothing) and male impersonators.

**Bigendered** transgender individuals may identify with both genders, or as some combination of both, while **androgynous** transgender individuals usually do not identify with either gender; that is, they identify as neither male nor female.



These general definitions are not meant to be used as diagnostic criteria. In fact, it is extremely important that individuals presenting for treatment be allowed to self-identify whenever possible. Questions about whether someone is or is not a transgender individual should be asked privately and respectfully.

### Research Into Substance Abuse and HIV Among Transgender Individuals

The little research that has been done on the prevalence of substance abuse in the transgender community suggests significantly high substance abuse rates. Some of the best information available comes from studies of HIV prevalence.

Substance use also plays a significant role in the high HIV prevalence in MTF transgender individuals (transgender women) (Longshore, Annon & Anglin, 1998; National Institute on Drug Abuse, 1994; Longshore et al., 1993). There are more than 15 studies that concluded that transgender individuals (primarily MTF transgender sex workers) have a high rate of HIV infection.

The most recent study on HIV prevalence in transgender individuals conducted by the San Francisco Department of Public Health AIDS Office (Clements et al., 1998) investigated more than 515 individuals with transgender experiences, which included MTF (sex workers and nonsex workers) and FTM transgender individuals (transgender men). The study showed that

- 35 percent of the MTF transgender individuals in the study tested HIV positive
- 63 percent of the African-American MTF transgender individuals in the study tested HIV positive
- 1.6 percent of the FTM transgender individuals in the study tested HIV positive.

Although the FTM individuals studied had a low HIV prevalence rate, they commonly reported engaging in many of the same HIV risk behaviors as the MTF individuals.

The same study is one of the best available on substance abuse among transgender individuals. It showed a lifetime rate of intravenous drug use of

- 34 percent among MTF transgender individuals
- 18 percent among FTM transgender individuals.

Longshore and Hsieh (1998) found that substance use treatment does influence people's HIV risk behavior. Treatment can help reduce transgender individuals' risk of HIV infection if they remain in treatment; however, discrimination and prejudice against transgender individuals can make access to service agencies and health care resources problematic (Transgender Protocol Team, 1995; San Francisco Department of Public Health, AIDS Office, 1997; Bockting, Robinson & Rosser, 1998; Moriarty, Thiagalingam & Hill, 1998).

A study from Hollywood, California, reported that the drugs most commonly used by MTF transgender individuals were alcohol, cocaine/crack, and methamphetamine (Reback & Lombardi, 1999). In the Clements and colleagues (1998) study conducted in San Francisco, 55 percent of the MTF individuals reported they had been in alcohol or drug treatment sometime during their lifetimes.

In addition, violence and discrimination have been found to have negative effects upon gay, lesbian, and bisexual youth, encouraging substance abuse, prostitution, and suicide (Savin-Williams, 1994; Kreiss & Patterson, 1997; Rodgers, 1995). Garnets, Herek, and Levy (1992) stated that experiences of violence and harassment can significantly affect the

mental health of gay men and lesbians, which in turn could influence their substance use as well as their experience in treatment.

Experiences of violence and harassment could similarly affect transgender individuals. Transgender individuals are likely to experience some form of discrimination, harassment, and/or violence sometime in their lives. The first major study (Lombardi et al., submitted for publication) on violence and discrimination against transgender people in the United States found that:

- 60 percent experienced some form of harassment and/or violence sometime during their lives
- 37 percent experienced some form of economic discrimination.

### **Clinical Issues in Substance Abuse Treatment With Transgender Individuals**

Ratner (1993) points out that treating substance-abusing gay men and lesbians means being aware of their unique problems in order for treatment to be effective. The same can be said for transgender substance abusers. Aspects such as societal and internalized transphobia, violence, discrimination, family issues, isolation, lack of education and job opportunities, access to health care, and low self-esteem, among others, need to be addressed in the treatment environment.

Like all potential clients, transgender substance abusers bring a variety of experiences with substances and readiness to change into the treatment setting. Many transgender people have had one or more negative experiences with institutions, including those that provide health care. They may be unusually distrustful of professionals and treatment recommendations. It is vital to remember that these clients, like all clients, need to be met with sensitivity and respect. Clients should be allowed to

self-identify and cannot be judged on the basis of their self-identification.

Conducting a comprehensive biopsychosocial assessment is very important with transgender individuals. Because all assessments should be designed to elicit the full spectrum of relevant information, it is appropriate to ask **each** client about his or her sexuality, gender identity, and comfort with his or her sex role. It is vital that counselors avoid the common pitfall of focusing on gender issues as the assumed root cause of the addiction problem. When inquiring about the client's substance use, counselors need to recognize that substance abuse among transgender people can involve multiple patterns of use, misuse, and abuse; that multiple causal variables combine to produce problems; that treatment should be multimodal to correspond to a client's particular pattern of abuse; and that treatment outcomes vary from individual to individual (Lewis, Dana & Gregory, 1994). Using this broader view, treatment providers can better understand substance abuse problems with transgender people and diagnose and treat them less dogmatically.

Another point is to recognize that transgender people will bring unique issues into the treatment setting. Some of these issues are obvious, like the lack of family and social supports, isolation, low self-esteem, internalized transphobia, etc., but other issues may not be as obvious. Getting these other issues to surface will require an environment that is sensitive and nonjudgmental. This is especially true when attempting to access inpatient medical or inpatient substance abuse rehabilitation services. Clinicians working with transgender people must have a solid and reliable referral network that they are sure can work with transgender clients in the most sensitive manner possible.

Hormone therapy is an often overlooked clinical issue. Many transgender clients will be on estrogen or testosterone therapies upon

entering treatment. Clients should not be asked to choose between hormones and substance abuse treatment. Hormone treatment is a standard and accepted medical treatment for transsexuals, and clients should be supported by providers to maintain regular, legally prescribed hormonal treatment under proper medical care without interruption. It is important that both the clinician and the client understand that both estrogen and testosterone therapies can affect mood, especially when taken improperly. There may be additional risks associated with using and/or self-injecting “street” or “black market” hormones. This is a particular concern for transgender men, since testosterone must be injected. Obtaining or using needles may be relapse triggers for clients in early recovery.

The issues and difficulties with inpatient treatment and the placement of preoperative or nonoperative transsexuals extend to housing and homeless shelters. The housing issues that face homeless transgender people are a major issue in recovery. Very often the stigma and discrimination that transgender individuals face in the homeless services system are their justification for reengaging with individuals who are not a positive recovery influence and increase their relapse potential.

Additional relapse triggers or significant clinical issues for transgender clients might include (1) the inability to find, engage in, or maintain meaningful or gainful employment simply because they are transgender; (2) a lack of

formal education or job skills because they were forced to leave school or home prior to obtaining those basic skills; (3) being HIV positive, asymptomatic, and healthy and desiring sex reassignment surgery but having trouble obtaining it due to their HIV status; (4) the overall lack of accepting social supports who are sober and positive role models; (5) issues of sexual orientation as well as gender identity; and (6) stress resulting from their invisibility and the dissonance caused by “passing” (blending into the mainstream).

An additional clinical issue is that many substance abuse treatment providers feel they cannot identify or empathize with transgender people, thereby creating a barrier in developing a therapeutic relationship. It is worth noting that many of the issues faced by transgender men and women may be those faced by non-transgender men and women. Many transgender women have sexual abuse histories, have co-occurring eating disorders or depression, or have never been in a sober relationship or experienced sober sex. Due to their particular invisibility, less is known about transgender men, but clinicians might expect to see a variety of men’s issues in such clients. To provide the best care possible, it is the responsibility of clinicians to enhance their knowledge of substance abuse issues along with their understanding of any issues that will help clinicians understand the treatment needs of their clients.

## DO'S

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- Use the proper pronouns based on **their self-identity** when talking to/about transgender individuals.
- Get clinical supervision if you have issues or feelings about working with transgender individuals.
- 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.
- Require training on transgender issues for all staff.
- Find out the sexual orientation of all clients.
- Allow transgender clients to use bathrooms and showers based on their gender self-identity and gender role.
- Require all clients and staff to create and maintain a safe environment for all transgender clients. Post a nondiscrimination policy in the waiting room that explicitly includes sexual orientation and gender identity.

## DON'TS

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- Don't call someone who identifies himself as a female he or him or call someone who identifies herself as male she or her.
- Don't project your transphobia onto the transgender client or share transphobic comments with other staff or clients.
- Never make the transgender client choose between hormones and treatment and recovery.
- Don't make the transgender client educate the staff.
- Don't assume transgender women or men are gay.
- Don't make transgender individuals living as females use male facilities or transgender individuals living as males use female facilities.
- Never allow staff or clients to make transphobic comments or put transgender clients at risk for physical or sexual abuse or harassment.

**Case Example**

A 24-year-old African-American pre-op transsexual presents for intake at your residential drug treatment program. She is dressed in female attire and tells you she has been living full time as a female for more than 5 years. She has had a legal name change and has identification that states she is a female. She tells you she is revealing that she is transsexual because she “doesn’t want there to be any trouble.” She also tells you she has been in treatment before and says she had a very bad experience, including the fact that the staff refused to address her as a female and other clients sexually and verbally harassed her. She says she has a long history of abusing heroin and alcohol and that she is ready to change her life and wants to enter your residential treatment program.

**Suggested Interventions**

Accept her into your residential treatment program and house her as you would other women in your program. If rooms for women are dorm-type rooms, this should be acceptable. If smaller, more private rooms are available, housing her in a single room is also acceptable. If only group showers are available, have a special time at which she can use them. If individual showers for women are available, this is preferable. Insist on all staff referring to her and treating her as female. She should also find outside support for transgender individuals, if it is available. Address any issues clients have, as you would any other counseling issues, in individual counseling. Staff and client education about transgender and transsexual issues will help alleviate some of these concerns.

## Chapter 11 Clinical Issues With Youth

*Caitlin Ryan, M.S.W., ACSW, Health Services and Policy Consultant, Washington, DC*  
*Joyce Hunter, D.S.W., HIV Center for Clinical and Behavioral Studies/NYSPI, New York, NY*

### What providers will learn from this chapter:

- The stresses and challenges experienced by LGBT youth that increase their risk for substance abuse and related health and mental health concerns
- The role of stigmatization in increasing vulnerability to and risk for substance abuse
- How to approach assessment and treatment with LGBT youth

### Introduction

Adolescence is a time of significant physical and psychosocial development. As adolescents develop, they rely increasingly on peers for information and support. They must also learn how to deal with boundaries and begin to integrate various aspects of their identity. Experimentation, exploration, and risk taking characterize adolescence, and many adolescents explore the use of alcohol and drugs. In fact, most adolescents have tried alcohol and drugs at least once by age 18 (Johnston, O'Malley & Bachman, 1995). According to the 1998 National Household Survey on Drug Abuse (Office of Applied Studies, 1999) 21.3 percent of youth ages 12 to 17 years reported using an illicit drug at least once in their lifetime, while a Centers for Disease Control and Prevention (CDC) survey found that more than half of high school students reported having at least one drink during the preceding 30 days (CDC, 1996).

Adolescents who use alcohol and drugs are more likely to engage in sexual intercourse, to have sex at younger ages, and to have more partners; they are less likely to use condoms during their sexual activity than youth who do not use alcohol and drugs (MacKenzie, 1993). Many adolescents report using alcohol before sexual intercourse. Of these, more than half report having five or more drinks before having sex, which impairs their judgment and increases the potential for high-risk behaviors such as anal intercourse (Fortenberry, 1995). Adolescents who

use crack cocaine, in particular, are at high risk for HIV infection. A study of HIV-positive adolescents found that two-thirds of girls and more than half of boys reported using crack; of these, four out of five reported exchanging sex for money, drugs, food, or shelter (Futterman et al., 1993).

Because adolescents are developing physically and psychologically, substance use can impair their intellectual, emotional, and social development. Drug experimentation in adolescence may be a part of their development. However, the transition from use to abuse is a maladaptive response defined by a failure to successfully achieve the developmental tasks of adolescence (Duncan & Petosa, 1994).

### **Alcohol and Drug Use in LGBT Youth**

Most of the available research about this population has focused on lesbian and gay adolescents; little information is available on bisexual identity development during adolescence (and related risks). Even less is known about the experiences and needs of transgender youth. Information about substance use among lesbian, gay, and bisexual youth is limited, and there are virtually no studies targeting transgender youth. Early community-based studies of urban gay youth show high rates of alcohol and drug use (Remafedi, 1987; Rotherman-Borus, Hunter & Rosario, 1994), while others show rates that are comparable to adolescents in general (Boxer, 1990; Bradford & Ryan, 1987; Herdt & Boxer, 1993). In a recent study among a multi-ethnic group of self-identified lesbian, gay, and bisexual youth (N=154; 66 percent gay/lesbian; 31 percent bisexual), 93 percent of females and 89 percent of males reported using licit or illicit substances, with alcohol the most popular licit drug and marijuana the most popular illicit drug (Rosario, Hunter & Gwadz, 1997).

The lack of information is mirrored by a lack of assessment, prevention, and treatment

services. Recently, some providers and agencies have attempted to address these gaps (e.g., Ryan & Futterman, 1998; Simpson, 1994; Travers & Schneider, 1996). However, more research is needed on the level of substance abuse among these youth as well as treatment and relapse prevention strategies.

Lesbian, gay, bisexual, and transgender (LGBT) youth use alcohol and drugs for many of the same reasons as their heterosexual peers: to experiment and assert independence, to relieve tension, to increase feelings of self-esteem and adequacy, and to self-medicate for underlying depression or other mood disorders. However, LGBT youth may be more vulnerable as a result of the need to hide their sexual identity and the ensuing social isolation. As a result, they may use alcohol and drugs to deal with stigma and shame, to deny same-sex feelings, or to help them cope with ridicule or antigay violence.

### **Stigma, Identity, and Risk**

LGBT youth have the same developmental tasks as their heterosexual peers, but they also face additional challenges in learning to manage a stigmatized identity. This extra burden puts LGBT youth at increased risk for substance abuse and unprotected sex and can intensify psychological distress and risk for suicide.

Sexual orientation evolves over a period of time. However, studies have documented a decreasing age of identity development and coming out among lesbian and gay youth, with initial awareness of same-sex attraction at, on average, age 10; first same-sex experiences at 13 to 15; and first self-identifying as lesbian or gay (initial “coming out”) at around age 15 to 16 (D’Augelli & Herschberger, 1993; Herdt & Boxer, 1993; Rosario et al., 1996). Studies of more recent generations of lesbian and gay youth suggest that the period between becoming aware of same-sex attraction and

self-identifying as lesbian or gay is much shorter than in previous generations (see exhibit 11–1).

Although people may be more aware that an adolescent may be gay, they are generally no more tolerant and may even be less accepting of homosexuality in adolescents. In fact, violence and harassment against LGBT youth appear to be increasing. For those youth who choose to self-disclose or are found out, coping with this stressful life event is most challenging. Adolescents at this point in their lives have not developed coping strategies and are more likely than adults to respond poorly to these stressors. These youth must adapt to living in a hostile environment and learn how to find positive environments (Hunter & Mallon, 1999).

**Exhibit 11–1:  
Sexual Identity: Age of Onset**

Behavior/ Identity	Gender	Earlier Studies* Average Age (Years) Event Occurs	More Recent Studies** Average Age (Years) Event Occurs
First awareness of same-sex attraction	Males	13	9
First awareness of same-sex attraction	Females	14–16	10
First same-sex experience	Males	15	13–14
First same-sex experience	Females	20	14–15
First self- identified as lesbian or gay	Males	19–21	14–16
First self- identified as lesbian or gay	Females	21–23	15–16

\*Studies of adults who remembered their experiences as children and adolescents

\*\*Studies of adolescents who described their experiences as they were happening or right after they happened

From very early ages, children and adolescents are exposed to negative stereotypes about homosexuality. They learn to hide same-sex feelings and attractions to avoid rejection and ridicule. As they begin to realize that they might be gay, these negative stereotypes may increase their feelings of conflict, identity confusion, or even self-hate. Adolescents may repress, deny, or attempt to change these feelings through a range of coping behaviors, including heterosexual activity, use of alcohol and drugs, dating the opposite sex, fathering a child or becoming pregnant, and immersing themselves in sports or school activities.

Youth of color face additional stresses and challenges in integrating their sexual, racial, and ethnic identities (Hunter & Schaefer, 1995; Tremble, Schneider & Appathurai, 1989). Racial and ethnic identities are established at early ages, before a person becomes aware of same-sex feelings that may signal a nonheterosexual identity. Adolescents who may be gay have little support for developing an LGBT identity. At the same time, they interact with three separate communities—including their ethnic or cultural community, LGBT communities, and mainstream culture—none of which provide support for all aspects of their multiple identities. Having to manage more than one stigmatized identity increases the adolescent’s level of vulnerability and stress (Greene, 1994). Because ethnic minority communities are important providers of essential emotional and practical support, their LGBT youth are particularly vulnerable to rejection. Openly identifying themselves as gay may jeopardize acceptance by the family and ethnic community of youth. Thus, many youth of color hide their sexual orientation and, as a result, are often less visible than their Caucasian gay peers. Depression and risk for suicide appear to be high for many of these young people (Rotheram-Borus, Hunter & Rosario, 1994).



Most LGBT youth grow up to lead satisfying, productive lives, but some young people are more vulnerable and are at greater risk than others. A past history of abuse and neglect, severe stress, and underlying emotional disorders may influence a young person's ability to cope. Hetrick and Martin (1987) have suggested that adolescents with these histories may account for the majority of gay youth who attempt suicide or who develop serious substance abuse problems.

### **Abuse and Homelessness**

In the National Lesbian Health Care Survey, lesbians who had been sexually abused, sexually assaulted, or victimized reported significantly more depression and alcohol abuse than lesbians who did not report these experiences (Descamps et al., submitted for publication). Other studies show victims of child sexual abuse are at increased risk for substance abuse (Dimock, 1988; Zierler et al., 1991), suicide (Briere et al., 1988), running away from home (Briere et al., 1988), and HIV infection (Bartholow et al., 1994; Zierler et al., 1991).

Homelessness is a particular concern for LGBT youth, because many teens may run away as a result of harassment and abuse from family members or peers who disapprove of their sexual identity. Still others may be thrown out of the home when their parents learn they are gay. Statistics are not available on the actual percentage of street youth who may be lesbian or gay, but youth service providers agree the percentage is very high, and reports from various studies show ranges from 20 percent to 40 percent (Kruks, 1991; Los Angeles County Task Force, 1988; Seattle Commission on Children and Youth, 1988; Stricof et al., 1991).

Homeless youth are at high risk for exploitation. Without an education or job skills, they may become involved with survival sex (exchanging sex for food, drugs, or shelter), drug dealing, or other illicit activities (Clatts & Davis, 1999).

Like their heterosexual peers, LGBT homeless and runaway youth have many health and social problems, often as a result of abuse and neglect. These include serious substance abuse and mental health problems, being at high risk for suicide, sexually transmitted diseases (including being at high risk for HIV/AIDS), pregnancy, and many chronic health problems (Hoffman, Futterman & Myerson, 1999).

LGBT youth are at high risk for antigay violence such as physical attacks, verbal and physical abuse, and harassment (D'Augelli & Dark, 1995; Dean, Wu & Martin, 1992). Youth of color and those who are openly or stereotypically gay are more likely to be victimized, and anecdotal reports suggest that transgender youth may be at greatest risk. Antigay attacks heighten an adolescent's feelings of vulnerability, often intensify a young person's own inner conflict with his or her sexual identity, and may cause the youth and others to perceive the attacks as a punishment for being gay. Lesbians who are victims of hate crimes report significantly higher levels of stress, depression, and alcohol and drug abuse than those who were not victimized (Descamps et al., submitted for publication).

Ironically, while coming out to peers and adults may reinforce adolescents' feelings of comfort about their sexual identity, it greatly increases their risk for violence and harassment, even by their families (D'Augelli, Hershberger & Pilkington, 1998).

## Assessment and Treatment

LGBT youth experience countless challenges in attempting to manage their stigmatized identity. Assessment and treatment should address the adolescents' social environment, sexual identity development, stage of coming

out, gender identity, support network, impact of multiple identities (such as gender, ethnic, and cultural identities), level of disclosure about their sexuality, and knowledge and use of safer sex practices. Providing safety and giving support are essential elements in prevention and treatment of substance abuse in LGBT youth.

### Case Study

David is a 16-year-old gay youth who identified himself as gay at age 12 but did not “come out” to others until he met another gay youth on the Internet last year. His father was a heavy drinker and physically abused David and his mother. His father left home when David was 11. Since then, David has been raised by his mother, a restaurant manager, in a medium-sized city in the Midwest.

David began drinking beer with friends in seventh grade and smokes marijuana when he can get it. Alcohol helps him relax in social situations and makes it easier to pretend that he's straight. It helps reduce feelings of isolation and depression. David was afraid to come out to friends at school and had not told anyone he was gay until he found a gay youth Web site last year. Through the Web site, he connected with other gay teens who provide emotional support. This is David's only source of support and has helped reduce his feelings of isolation, but none of these youth live nearby. His mother usually works on weekends, and David has been able to drink without anyone finding out. His drinking has increased during the last 2 years, and his grades have begun to drop. He has become increasingly irritable, and arguments with his mother are escalating. David was dropped from the track team last year for failing to attend morning practice, but no one at school or home noticed the early warning signs of substance abuse.

David began having sex with young men he met in a public park when he was 14. He did not know how to meet other gay people until he heard someone joking about a park across town. David feels more comfortable having a few drinks before he has sex and rarely uses condoms.

David's experiences are common for gay youth who use alcohol and drugs to cope with loneliness and social adjustment and to medicate themselves for depression and anxiety. Potentially, his substance abuse problem could be identified by a perceptive teacher, school counselor, or pediatrician. In many cases, however, adolescent substance abuse is not identified until youth get into trouble or alcohol and drug use escalates. In David's case, early intervention could help prevent more severe dependency and could help him develop social and interpersonal skills, including the capacity for chemical-free intimacy and for discussing risk reduction with his sexual partners.

### Suggested Interventions

Finding drug treatment programs for teens like David is a challenge. Very few resources for drug treatment and aftercare exist for LGBT youth. Hunter and Haymes (1997, p. 156) noted: “With few exceptions, appropriate models for this population have not been designed. And those that exist have not been evaluated. Consequently, these youth are continually forced into straight, traditional drug treatment programs, which almost always fail to meet their needs.” Youth care providers and counselors caution that LGBT youth may be harmed by programs that lack appropriate content or experience.

## Chapter 12 Related Health Issues

*Dennis J. Ghindia, Ph.D., Rhode Island College School of Social Work, Providence, RI*

*Susan Hart, LICSW, C.A.C., AIDS Action Committee, Boston, MA*

*Harvey Gochros, University of Hawaii at Manoa School of Social Work, Honolulu, HI*

*William J. Pellicio, LICSW, LCDP, Addiction Technology Transfer Center of New England, Providence, RI*

### What providers will learn from this chapter:

- The health concerns of substance-abusing LGBT individuals
- Some of the mental health issues that substance-abusing LGBT individuals face
- What is currently known about interpersonal violence and substance abuse in the LGBT community

### Introduction

Once a client begins to address his or her substance abuse problem, he or she may face a variety of additional health problems, some of which may be due to poor self-care. Lesbian, gay, bisexual, and transgender (LGBT) people in recovery have similar health concerns and face many of the same physical and mental health crises as anyone else in recovery. This chapter provides a brief introduction to some of the health problems facing LGBT individuals as they begin their recovery from substance abuse. Health assessments and interventions for substance-using LGBT clients should include the same components as those for other clients and some additional components that are unique to or more common among LGBT individuals.

Many people who abuse substances have co-occurring mental health disorders, such as affective disorders, eating disorders, or other psychiatric illnesses. Substance abuse clouds judgment and contributes to hazardous behaviors that can lead to illness, such as HIV/AIDS, sexually transmitted diseases (STDs), hepatitis, and injuries. People who abuse substances may have neglected their health and nutrition and may smoke cigarettes. Some may have been the victims of domestic violence or hate crimes resulting in posttraumatic stress disorder. When considering these factors, providers of substance abuse treatment for LGBT clients should, as with any client, screen for other

health problems—for possible co-occurring mental disorders, poor nutrition, poor dental care, liver disease, STDs, HIV/AIDS, violence, sexual abuse, and incest. In this way, substance abuse treatment providers can assist their LGBT clients in accessing appropriate medical care and treatment for their health and mental health concerns.

The abuse of alcohol and other mood-altering substances can also affect the treatment of HIV/AIDS. For example, substance abuse and its associated mental impairments can interfere with clients' ability to comply with very complicated medicine regimens. Strict adherence is crucial to the effectiveness of the powerful new medications used to combat HIV. Substance abuse also affects clients' ability to take their medication properly.

### **Gay and Bisexual Men**

Gay and bisexual men who are sexually active with multiple partners are more susceptible to STDs and HIV/AIDS. Substance-abusing gay and bisexual men may be at an even greater risk for infection than non-substance-abusing gay and bisexual men if their substance abuse disinhibits safe sex practices. Moreover, even when men refrain from high-risk activities, such as unprotected anal sex, they may engage in other activities, such as unprotected oral sex, that likewise increase their risk for STDs, such as gonorrhea and chlamydia. Gay and bisexual men may be exposed to STDs at multiple sites, such as the pharynx and rectum, and may be at risk for anal trauma or the human papilloma virus. Thus, screening these men for all STDs and HIV is recommended. Screening for syphilis is recommended as well because it is often asymptomatic and is increasing in incidence.

Gay men are at higher risk for hepatitis A and hepatitis B through sexual contact. Hepatitis C also may be spread by sexual contact, although transmission via infected needles is probably a far more significant route and is of

concern to all injection drug users. All clients should be referred for vaccination for hepatitis A and hepatitis B as a public health measure.

Because so much of the focus for gay and bisexual men is on STDs and HIV, other significant health risks often are neglected. However, as for all men, cancer and heart disease remain the most significant causes of death and morbidity. High stress and smoking may increase these risks. It is especially important to advise clients of these risks and the importance of prevention and regular medical screening for these conditions.

### **Lesbian and Bisexual Women**

Even though research about the health issues of lesbian and bisexual women has increased during the past decade, knowledge of many of their health concerns, including substance abuse, is still limited. It is known that substance-abusing lesbian and bisexual women have many medical risks similar to those of substance-abusing heterosexual women. Alcoholic women tend to have higher rates of fatty liver disease, alcoholic hepatitis, and cirrhosis (Woolf, 1983), as well as a higher risk of muscle weakness, muscular pain, and osteoporosis (Woolf, 1983). Because the majority of lesbians have had heterosexual intercourse—often without birth control or protection against STDs—they are at risk for both pregnancy and STDs (O'Hanlan, 1995). Research information is limited, but some STDs, such as the human papilloma virus, bacterial vaginosis, and *Trichomonas*, can be transmitted among women, although female-to-female transmission of HIV is extremely rare (only two cases have been reported). Lesbian and bisexual women who use injectable drugs are at high risk for hepatitis B, hepatitis C, and HIV/AIDS and should be screened for these diseases. Some lesbian and bisexual women may be sex workers and may have been exposed to STDs, HIV, and trauma.

For lesbians, negative experiences with health care providers and the lack of providers who are knowledgeable about lesbian issues may have been a barrier to proper diagnosis and treatment. In addition, some experts speculate that lesbians may have an increased risk for specific health problems, such as cancers of the breast, colon, and ovaries; endometriosis; and bacterial vaginitis. These higher risks are based on factors such as a higher fat intake, alcohol abuse, not bearing children, and inconsistent medical care (O'Hanlan, 1995). Providers may not test for STDs and pregnancy, incorrectly assuming that lesbians do not have sex with men. Moreover, lesbians may be offered pap smears less often than heterosexual women, presumably because doctors assume they do not need them as often (Kerner, 1995).

### **Transgender Individuals**

The health concerns of transgender individuals are numerous. A study of 500 transgender individuals in San Francisco (Clements et al., 1998) showed a 35-percent HIV prevalence rate among male-to-female (MTF) transgender individuals and a 65-percent HIV prevalence rate among African-American MTF transgender individuals. More than 15 additional studies showed similar high rates of HIV infection in transgender individuals who were primarily MTFs in the sex industry and also at high risk for substance use. These findings underscored the great need for prevention and appropriate care for this underserved population.

MTF and FTM (female-to-male) transgender individuals also face the risks associated with hormones, alcohol, and drugs. A particular concern is FTM hormonal use, because male hormones are injected. The use of needles raises the risk of hepatitis C and ovarian cystic syndrome and may increase the risk of injectable substance relapse. Hormones can damage liver function and, with the added effects of alcohol and drugs, the combinations

may be even more harmful. Indeed, increased risks of liver cancer and cirrhosis have been noted in the medical literature regarding hormones and alcohol and drugs.

### **Common Barriers to LGBT Individuals Receiving Adequate Health Care**

LGBT individuals have been marginalized by some segments of the health professions. Historically, their sexual orientations and gender diversity were labeled deviant or pathological by many in the medical and psychiatric community. As a result, many gays and lesbians do not disclose their sexual orientation to their health care providers (Cochran & Mays, 1988). Consequently, many LGBT individuals, particularly transgender individuals, are reluctant to use mainstream health care services and are medically underserved. However, LGBT health advocates and professionals have lobbied for changes in mainstream professional organizations that have resulted in policy statements addressing the needs of LGBT clients and the formation of official LGBT affiliates, such as the American Psychological Association's Task Force on the Status of Lesbian and Gay Psychologists and the American Psychiatric Association's Committee on Gay, Lesbian, and Bisexual Issues. Although these changes have been important steps in establishing ethical guidelines for appropriate care, many health and mental health treatment providers remain uncomfortable with sexual diversity and continue to discriminate against LGBT clients.

A 1994 survey of the membership of the American Association of Physicians for Human Rights (now called the Gay and Lesbian Medical Association) (1994) found that, of 711 members, 52 percent had observed the denial of care or the provision of suboptimal care to lesbian and gay clients. Eighty-eight percent heard colleagues make disparaging remarks about their lesbian and gay clients. However, 64 percent of the members stated that it is

important for clients to reveal their sexual orientation but also noted they risk receiving substandard care when doing so. Transgender individuals are even more marginalized and are often denied care, and LGBT individuals of color may experience racial bias in addition to homophobia. Thus, sensing these prejudices, many LGBT persons have not used the health care system adequately.

Their hesitation to seek health care may result in later diagnoses of illnesses, which results in poorer treatment outcomes. Many physicians are ignorant of the special health concerns of LGBT individuals, such as the possibility of anal warts in gay men or the surgical and hormonal treatment options for transgender individuals.

### **Common Mental Health Issues That LGBT Individuals May Face**

Substance-using LGBT clients struggle with mental health concerns and illnesses similar to those of their heterosexual counterparts. They suffer from affective disorders, posttraumatic stress disorder (PTSD), sexual trauma, suicidal ideation and behaviors, eating disorders, and the full range of mental disorders.

However, LGBT individuals have the added stress of struggling to consolidate stigmatized sexual or gender identities, making choices about coming out to family and friends, fear of prejudice, and being at increased risk of violence. In general, researchers suggest that individuals who feel more comfortable about their sexuality and gender identity are more resilient, have better coping skills, and are better able to articulate their mental health needs. However, many clients in substance abuse treatment may not be out and may be very uncomfortable with their identity. This presents several stumbling blocks for the counselor and the client, including the possibility of inappropriate counseling and an increased risk of relapse. Research on the mental health needs of

lesbians and gay men has increased substantially during the past two decades. However, significant gaps still exist. The process of coming out as a lesbian or gay man can be extremely stressful, yet there is virtually no research on effective ways of coping with this process, and there has been even less research on the mental health of lesbians and gay men who are nonwhite, adolescent, elderly, or coping with disabilities (Rothblum, 1994). There is also very little research on bisexual and transgender individuals. However, some suggest that many transgender individuals struggle with low self-esteem, depression, and fear about the reality of their vulnerability to personal violence.

Past sexual abuse and trauma may well lead to other mental illnesses, such as PTSD, and complicate treatment for substance abuse. For example, an outcome study of lesbians and gay men who had completed inpatient substance abuse treatment found that 44 percent had been sexually abused (37 percent of males and 67 percent of females) and abstinence was much more likely among those who had not experienced abuse (Ratner, Kosten & McLellan, 1991).

### **Interpersonal Violence in the LGBT Community**

Historically, differences in philosophy and terminology have blocked collaborative care for clients involved in both interpersonal violence and substance abuse (CSAT [Center for Substance Abuse Treatment], 1997c). Interpersonal violence has been defined as the use of intentional verbal, psychological, sexual, or physical force by one intimate partner to control another (CSAT, 1997c). Nonetheless, a marked link between interpersonal violence and substance abuse is well documented (Pernanen, 1991; Windle et al., 1995; Bennett, 1995). Up to one-half of the men who commit acts of interpersonal violence also have substance abuse problems (Gondolf, 1995;

Leonard & Jacob, 1987; Faller, 1988), and women who abuse alcohol and other substances are more likely to be the victims of interpersonal violence (Miller, Downs & Gondolfi, 1989; Bureau of Justice Statistics, 1994; Stark & Filcraft, 1988; Gorman et al., 1995).

Less is known about the relationship between substance abuse and interpersonal violence in the LGBT community. Perhaps the LGBT community has been reluctant to call attention to the issue of interpersonal violence out of concern for reinforcing the stereotype that homosexuality is inherently dysfunctional. Fortunately, the seriousness of interpersonal violence has finally been acknowledged by the LGBT community over the past decade (Elliot, 1996). The first account of lesbian battering was published in 1986 (Lobel). Experts estimate that interpersonal violence occurs at about the same rate in same-sex relationships as in heterosexual relationships (Island & Letellier, 1991; Lobel, 1986). Rates of partner violence range from 8 to 46 percent (Elliot, 1996). The National Lesbian Health Care Survey (Bradford, Ryan & Rothblum, 1994) showed an 8-percent rate of partner violence in a diverse, nonclinical sample of nearly 2,000 lesbians. In a study of 90 lesbian couples, 46 percent of the couples experienced repeated acts of violence in their relationship (Coleman, 1990). And of 1,000 gay men surveyed in the Northstar Project, 17 percent reported having been in a physically violent relationship (Gay and Lesbian Community Action Council, 1987).

In a study of 228 gay male perpetrators, Farley (1996) found the following contributing to gay interpersonal violence:

- 40 percent abused drugs.
- 87 percent had previous mental health treatment.

- 93 percent reported physical abuse as a child, and 67 percent reported sexual abuse as a child.
- 53 percent reported physical abuse as an adult.
- 40 percent reported alcohol abuse in their family of origin.
- 80 percent had a previous history of being an abuser in an adult relationship.

### Assessment

Substance abuse in the LGBT community has been exacerbated by internalized homophobia (Ghindia & Kola, 1996) so that many LGBT individuals feel isolated and victimized. The isolation may be intensified further by mistrust of treatment providers and a lack of civil rights protection. Seeking professional or legal help for interpersonal violence is equivalent to coming out (Elliot, 1996). These barriers may make it more difficult to identify LGBT victims or perpetrators of interpersonal violence. Consequently, LGBT clients in substance abuse treatment should be screened to identify both batterers and survivors of interpersonal violence (CSAT, 1997c). Indicators of interpersonal violence include the presence of physical injuries, especially in visible areas, inconsistent or evasive answers regarding injuries when questioned, a history of relapse or noncompliance with substance abuse treatment goals, and stress-related conditions and illnesses (CSAT, 1997c).

As with all clients, practitioners should gather information about the partner's treatment of the client. Interpersonal violence may be a factor if the client states that the partner tries to isolate him or her socially, tries to prevent him or her from attending treatment or self-help programs, threatens to abandon him or her, or damages property.

The practitioner should ask questions in an affirming and culturally sensitive manner. Establishing rapport and trust is critical in accurately gathering sensitive information. Care in selecting words and phrases that reflect sensitivity to LGBT issues is imperative. Potentially difficult questions should not be raised too quickly or the client may feel overwhelmed or threatened and refuse to cooperate.

Clients should always be interviewed about interpersonal violence in private, even if the client requests the presence of another individual who is not the batterer (CSAT, 1997c). Putting the client at risk by interviewing him or her in the presence of others should be avoided because batterers may manipulate family members and others.

Practitioners should include questions about sexual abuse that reflect their sensitivity to LGBT concerns. Questions about the client's family of origin should be posed in a way that helps the client speak openly. When working with LGBT individuals, the service provider should help clients feel safe and assure them that confidentiality is respected. These issues frequently provoke great discomfort in all clients, and LGBT clients may feel additional discomfort because of some apprehension about mental health practitioners in the LGBT community.

Screening of possible batterers should be conducted with the same emphasis on confidentiality, safety, and cultural sensitivity. The practitioner should ask clients about abusive behavior using the technique of circumstantial violence (Kantor & Strauss, 1987). Simply put, this involves using a third-person example so as not to personalize the question, thereby making the client defensive. For example, "Some people think that under the right circumstances, it's okay to hit your partner. Under what conditions do you think violence might be justified?" (CSAT, 1997c).

Then the practitioner could begin personalizing the questions assessing self-control. For example, "If you were confronted with overwhelming stress, do you think you could keep your cool? Faced with that, what do you think you would do?" (CSAT, 1997c).

Questions should be supportive and affirming, thereby encouraging genuine responses. Gradually, the practitioner should ask specific questions about the relationship, e.g., "Have you ever hurt your partner?" It is critical to recognize that denial, rationalization, and minimization are strong mechanisms used for both interpersonal violence and substance abuse. Thus, it is critical that the practitioner guard against being manipulated or misled by excuses and that batterers be held responsible for their actions (CSAT, 1997c).

Finally, the treatment provider should avoid colluding with clients in denying the implication that substance abuse causes interpersonal violence. Practitioners should watch for clients who blame others for their battering or substance abuse. For successful treatment outcomes, clients must take full responsibility for their behavior.

### Interventions

If a client is identified as either a batterer or a survivor of interpersonal violence, he or she should be referred to a support group, to a batterers' intervention program, and for ongoing consultation with an expert in the treatment of domestic violence (CSAT, 1997c). Exactly how to refer survivors depends on the situation. If immediate danger is present, suspend the interview. The provider should be familiar with deescalation methods and have established links with other treatment providers and police (CSAT, 1997c). The practitioner should be aware of available resources with expertise in interpersonal violence and LGBT issues.



Past trauma has been associated with subsequent substance abuse. For many in the LGBT community, trauma not only results from childhood physical and sexual abuse but also from internalized homophobia, cultural heterosexism, and gay bashing. It is important for the practitioner to consider these issues as LGBT clients move toward abstinence because they can be powerful relapse triggers.

Just as substance abuse does not cause or excuse violent interpersonal behavior, HIV infection does not cause battering. Unfortunately, many in the LGBT community who are assaulted by their HIV-infected partners blame the stress of HIV infection for the violent behavior (Letellier, 1996). Treatment providers should not collude in this denial of responsibility and should consider the comorbidity of HIV infection, interpersonal violence, and substance abuse in planning assessments and interventions.

The treatment for both substance abuse and interpersonal violence should be conducted concurrently. The fundamental goal of treatment for both is to create, nurture, and

strengthen the individual's capacity to maintain intimate relationships that are free of violence (Byrne, 1996) and substance abuse.

The skills used in assessing substance abuse are useful for assessing interpersonal violence, regardless of the client's sexual orientation. A practitioner is likely to encounter the same defensive strategies (e.g., denial, defensiveness, blame). Assessment and intervention strategies do not require new theoretical approaches or skills. However, the practitioner must consider the safety of the victim and perhaps the practitioner's own safety when intervening. The same competencies and approaches can be used with LGBT individuals. Successful treatment outcomes for LGBT individuals depend on creating an open and trusting atmosphere, taking care not to make heterosexist assumptions, and having an understanding of the importance of confidentiality and disclosure issues. Working with LGBT individuals requires a thorough knowledge of the effects of cultural heterosexism on the LGBT client and the use of existing empirically derived practice skills.

**Case Example**

Ron, a 34-year-old African-American male, presents to your substance abuse treatment agency at the insistence of his employer for alleged difficulties at work. Apparently, he has come to work late on numerous occasions with alcohol on his breath. During his assessment, he informs you that he has been drinking excessively over the past few months and, as a result, has been unable to get to work on time. He also vaguely reports engaging in high-risk sexual behaviors. During the assessment, you notice black and blue marks on Ron's arms and neck. He tells you that for about 3 years he has been living with another man who recently has been diagnosed with HIV and now has symptoms.

How would you proceed with the assessment? What questions would you ask and how would you ask them?

**Suggested Interventions**

- Conduct a standard substance abuse assessment.
- Attempt to connect interpersonal violence, the stress of being in a relationship with someone with HIV, and substance abuse using LGBT-sensitive language. This may help the client gain insight and create an environment conducive to further discussion.
- Include questions about a history of family abuse or posttraumatic stress disorder and current relationship issues such as ways of expressing anger and frustration, issues of power and control, and issues of gender roles.
- After establishing sufficient rapport, mention that interpersonal violence is not uncommon in relationships. Do not assume because the client has a bruise that he or she is the victim.
- Take steps to ensure the safety of the client if he or she is in danger.
- Conduct interventions for substance abuse and interpersonal violence concurrently, if possible, within the same organizational structure.
- Ensure that a female batterer of a lesbian in a women's shelter cannot gain access to the shelter.
- Refer clients promptly to a practitioner or an agency that has expertise in interpersonal violence and that is sensitive and knowledgeable about LGBT issues.

**Case Example**

Deedee, a 52-year-old African-American lesbian, reported to her substance abuse treatment counselor that she found a painful lump in her breast. The counselor knew that Deedee had not seen a doctor in more than 5 years and that she was extremely tense around health care providers. Deedee has a history of childhood sexual abuse and is not comfortable with anyone touching her. She has had bad experiences with health care providers and has been treated disrespectfully because of her lesbian identity. Her counselor was quite concerned about the pain Deedee was experiencing but unsure what to do.

**Suggested Interventions**

Health care workers and substance abuse counselors should recognize that some of the health care concerns of LGBT individuals are a product of past bad experiences with health care providers. There are a number of ways that helping professionals can address these problems with their clients. For example:

- The counselor should ensure that Deedee is aware of the importance of being evaluated and treated for her potentially life-threatening condition.
- Substance abuse treatment programs should develop partnerships with LGBT-sensitive primary care physicians and clinicians, therapists, and psychiatrists for referring clients to other practitioners who provide sensitive care.

Other suggestions include:

- Help LGBT clients be more comfortable in disclosing their sexual identity.
- Integrate LGBT-inclusive language and lifestyles into curriculums.
- Use gender-neutral questions, and communicate a nonjudgmental attitude.
- Make sure the health practitioner takes a sensitive but thorough sexual history to determine the appropriate STD screening and treatment if necessary.
- Focus risk-reduction education not only on HIV and other STDs but hepatitis as well.

## Chapter 13

# Counselor Competence in Treating LGBT Clients

Dana G. Finnegan, Ph.D., C.A.C., Naples, FL

Emily B. McNally, Ph.D., C.A.C., Naples, FL

E. Bernard Anderson, Jr., M.S., M.A., NCAC, ICADC, C.C.S., Florida Addictions and Correctional Treatment Services (F.A.C.T.S.), Tallahassee, FL

Candace Shelton, M.S., CADAC, Consultant, Tucson, AZ

### What providers will learn from this chapter:

- How counselors can become more aware of their homophobia and heterosexism, how these biases can lead to mistreatment, and how to monitor and manage their own biases
- How to provide good quality, fair, ethical, and competent treatment to LGBT clients
- How to provide LGBT-sensitive treatment
- What counselors should consider in treating LGBT criminal justice clients

### Introduction

Counselors will encounter and provide treatment to lesbian, gay, bisexual, and transgender (LGBT) clients in all treatment settings: residential, intensive outpatient, outpatient, crisis intervention, and the criminal justice system.

The Center for Substance Abuse Treatment (CSAT) published a Technical Assistance Publication (TAP) in 1998 titled *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, in which the professional addictions counseling field, represented by leaders of national counseling organizations, identified eight practice dimensions. The dimensions are (1) clinical evaluation, (2) treatment planning, (3) referral, (4) service coordination, (5) counseling, (6) client, family, and community education, (7) documentation, and (8) professional and ethical responsibilities. Proficient knowledge and skill in each of the dimensions is necessary for effective practice (CSAT, 1998b). The development of effective counseling practices in the field of addictions depends on the presence of attitudes in which openness to alternative approaches, appreciation of diversity, and willingness to change are present and consistently practiced (CSAT, 1998b).

In the counseling competencies model, a counselor needs to respect the client and his or her frame of reference; recognize the

importance of cooperation and collaboration with the client; maintain professional objectivity; recognize the need for flexibility and be willing to adjust strategies in accordance with client characteristics; appreciate the role and power of a counselor as a group facilitator; appreciate the appropriate use of content and process therapeutic interventions; and nonjudgmentally and respectfully accept the client's cultural, behavioral, and value differences. These best practice methods are critical when working with LGBT clients.

The most important ethical issue in counseling is the protection of clients' well-being and safety, based on an "ethos of care" and a "covenant of trust" between clients and counselors (Peterson, 1992). In this capacity, counselors acknowledge and manage the power accruing to them so that they can use that power constructively and ethically (Gartrell, 1994). Thus, counselors need to be aware of how clients who have been or are being discriminated against may respond to others' power. Clients who have been traumatized may be overly passive and accepting or very oppositional. These behaviors are important information for the counselor, and an aware counselor will provide a safe environment for the client in which to work through his or her feelings. Counselors need to be aware of and monitor their use of authority so that they do not push or force clients to do something they are not ready to do. In the case of LGBT clients, counselors should not "out" or push a client to share his or her sexual orientation or gender status in the name of honesty and good treatment.

At the same time, the counselor should help create a safe environment for clients who are ready to come out in treatment to do so. Counselors need to use their authority to ensure their LGBT clients' safety when it is necessary to protect LGBT clients from overt expressions of homophobia (or biphobia or transphobia) by other clients or staff. Most

clients who present for treatment have to deal with the shame and guilt of their drug-using behavior. It is important for counselors to remember how their words can activate clients' shame; this is especially important when working with LGBT clients, who have been traumatized by both their alcohol or drug abuse and the heterosexist attitudes and behavior they must deal with.

### **Counselor's Professional Responsibility**

In the counseling competencies model, a counselor is responsible for self-monitoring, obtaining proper supervision, and adhering to professional and ethical standards. Establishing the proper ethos of care for LGBT clients requires that counselors be aware of and work through their own feelings about these clients.

**Self-monitoring** is the means for accomplishing this task. Counselors should be aware of countertransference. Countertransference is the process of counselors seeing themselves in their clients, overidentifying with their clients, meeting their personal needs through their clients, or reacting to a client because of unresolved personal conflicts (Corey, 1991).

Recognizing the manifestations of countertransference reactions is one of the most essential elements of effective counseling. Unless counselors are aware of their own conflicts, needs, assets, liabilities, beliefs, and values, they might use the counseling process more for their own purposes than for their clients'. This self-monitoring is very important when working with LGBT clients. Counselors need to examine their beliefs about lesbians, gay men, bisexuals, and transgender people because their own beliefs underlie countertransference.

Some important questions counselors need to ask themselves are the following:

- Are there myths and stereotypes about LGBT people that I believe? Do I, for instance, believe that gay men are child molesters? That LGBT people try to recruit others, especially children, to their orientation and lifestyle? That lesbians, gay men, and bisexuals would all choose to be heterosexual if they could? That transgender people want to change genders because they are really homosexual?
- Do I believe that having sex with someone of the same sex or having sexual feelings toward someone of the same sex indicates that the person is lesbian or gay? Do I believe that the sexual act, by itself, constitutes sexual orientation or identity? Do I believe that having a lesbian or gay or bisexual or transgender orientation is unnatural, immoral, sick, or disgusting?

If counselors agree with any of these questions, there is a real need for education, training, supervision, and consultation before they work with LGBT clients because their ability to fairly and competently treat LGBT clients is questionable. Unless these counselors are actively seeking to change or alter these beliefs, they should not treat LGBT clients.

A method of managing countertransference issues, prejudices, and difficult clients is by supervision. Supervision provides the counselor the opportunity for processing experiences with clients that may be problematic and may be creating anxiety that can interfere with the counseling process. If a counselor is aware of negative feelings about LGBT clients, it is imperative that those issues are taken to supervisors and worked through immediately. If a counselor is aware of his or her prejudicial behavior toward an LGBT client, he or she should be willing to behave differently or transfer the client to someone who is comfortable working with that client.

### Helping Clients Heal From the Negative Effects of Homophobia and Heterosexism

Neisen (1993) discusses the process of recovering from shame associated with heterosexism. Counselors who want to help their clients heal from homophobia and heterosexism may find the following steps helpful.

**Breaking the silence** parallels the process of coming out. It is important for LGBT individuals to tell their stories and to address the pain of being different in a heterosexist society. The counselor can:

- Encourage a discussion of how the client hid his or her LGBT feelings from others
- Explore the emotional costs of hiding and denying one's sexuality
- Discuss attempts the client has made to change in an effort to fit in
- Examine negative feelings of self-blame, feeling "bad" or "sick," and the impact of shaming messages on the client
- Foster the client's courage to accept and speak up about who he or she is.

**Establishing perpetrator responsibility** allows clients to understand their struggle in the context of discrimination and prejudice. The counselor can:

- Help clients manage anger in a constructive manner rather than direct it toward themselves
- Help clients understand that anger and a negative self-image are the result of cultural victimization and not a personal defect
- Shift clients' perspective by drawing parallels to the process of recovery from physical or

sexual abuse—recognizing that they have suffered a form of abuse

- Ensure that the treatment environment fosters behavior by staff and clients that is not hostile to LGBT individuals—a difficult task in the case of subtle or covert behaviors.

**Reclaiming personal power** involves helping clients:

- Improve their self-concept and self-confidence
- Identify internalized negative messages that result from cultural victimization and heterosexism
- Change negative messages to positive, affirming statements about themselves
- Find positive, affirming expressions for spirituality to combat any negative messages about their own morality that clients may have received
- Recognize residual shame and a victim mentality and begin to release it
- Integrate public and private identities
- Build a support network of individuals who accept and value them for who they are.

### **Practical Suggestions for Providing Competent Treatment**

How can a counselor self-monitor when treating LGBT clients? The first issue is what counselors and agencies, via construction of psychosocial histories and intake forms, ask or do not ask clients at intake. If clients are routinely asked about partners or significant others, but this question is omitted with LGBT clients, LGBT clients lose the opportunity to tell

their counselor who they really are. Some LGBT clients may not want to reveal their sexual or gender orientation, but if counselors do not ask, they may treat the client's "false self" (Winnicott, 1965), that is, the self that is presented to the world to protect the identity that is repressed and stigmatized. Treating the false self, by not asking about sexual orientation in an accepting and nonjudgmental way, is acting unethically and does a disservice to the client.

Following are some guidelines, or "do's and don'ts," for counselors who are or who wish to be sensitive to the needs and feelings of their LGBT clients and improve their own treatment and counseling skills.

#### **Do's**

- Do create safety for LGBT clients. This can include clearly stating what you can and will hold in confidence and what you will share with your team or your supervisor; assuring clients of your own supportive attitudes; and protecting LGBT clients from others' homophobia.
- Do know the population. Read about LGBT people. Get to know LGBT people, especially those in self-help groups and nonclients. Know what LGBT resources are available for clients and how to access them. Recognize that it is easy to shame LGBT clients because of their internalized homophobia and their substance abuse.
- Do create an atmosphere that is supportive. On forms and in all verbal interchanges, use inclusive language. For example, instead of asking about marital status, ask who the partner or significant other is. Instead of asking for the names of next-of-kin in case of emergency, ask for the name of the responsible party and that person's relationship to the client.

- Do acknowledge clients' significant others and encourage their participation in the treatment. Hang pictures and posters of known LGBT people (e.g., athletes, historical figures); have books about LGBT subjects on tables and in waiting rooms; post lists of LGBT-friendly Alcoholics Anonymous/ Narcotics Anonymous/Al-Anon/Adult Children of Alcoholics meetings in visible places.
- Do be guided by your LGBT clients. Listen to what they say is comfortable for them. Support them in making decisions about coming out, self-disclosing, or accepting their identity.
- Do get training to help you become less heterosexist and increase your knowledge and understanding.

### **Don'ts**

- Don't label your clients. For example, when a client says he is in a long-term relationship with another man, do not say, "Oh, then you must be gay." It is for the client to label himself or herself.
- Don't pressure clients to come out. Respect their sense of where they are in this process and their need to feel safe.
- Don't ignore significant others and family members. Don't assume because people are not related by blood or marriage that they are not extremely important to the client.
- Don't interpret on behalf of the client by saying "It must be hard being a lesbian," or "You must be angry because your parents don't accept your being a person of transgender experience." Follow the client's lead. A comment that is empathetic in one context may be invasive in another.

### **Treating LGBT Clients in the Criminal Justice System**

Treating LGBT clients in the criminal justice system presents special challenges for the counselor who has to balance security protocols with maintaining his or her professional and ethical responsibilities. It is especially important that counselors present themselves in a manner that gains clients' trust so that the clients can process issues that may involve their sexuality or gender identity.

In the correctional institution setting homophobia, transphobia, and heterosexism are even more prevalent than in society in general. Stigmatization is more intense, resulting in extreme "closeting" on the part of many incarcerated LGBT offenders. The LGBT offender's sexuality, if known, may be considered an attribute of his or her criminality. This is an issue that should be processed appropriately in treatment.

Some incarcerated LGBT offenders express themselves by clear and flagrant presentation while others choose to hide their sexual orientation or gender identity to avoid punitive consequences from other prisoners. LGBT couples may state to their fellow inmates that they are strongly committed to each other and are monogamous.

Treatment documentation and security of records are important. Counselors may find it helpful to inform their immediate clinical supervisor about LGBT cases and provide progress reports and assistance in managing issues such as clients who are used to being out and open but are forced while incarcerated to hide their identities.

A history of rape, family-of-origin issues, and unresolved grief are prevalent in incarcerated LGBT clients. Due to the homophobia/transphobia/heterosexism of institutional staff and the other offenders, incarcerated LGBT



clients may have trouble bonding with other LGBT offenders. These clients usually present with profound feelings of isolation, fear, depression, and anxiety and have difficulty trusting others.

Most correctional facilities endorse the traditional 12-step model of treatment in conjunction with “therapeutic community” treatment. In most of the settings, an LGBT-specific 12-step support group will not be available for the LGBT client. Rational-emotive therapy is also utilized in many correctional

settings, and counselors should not give the impression that LGBT clients’ sexual orientation is a negative “behavior” that needs to be “changed.”

Before an LGBT client is released, his or her counselor may be the only professional who can adequately provide the specific referrals needed by the client for community reentry. This is a case management function, and the referrals and recommendations made by the counselor are crucial to helping the LGBT client reenter society and stay clean and sober.

#### Case Example #1

Yoko was out as a lesbian while going through treatment in a 14-day inpatient facility. Because some of the other clients were homophobic, she was subjected to ridicule, vicious insults, and some threats. Although Yoko managed to stick it out and get some help with her addiction, she was clearly harmed by her experience, both by the direct homophobia of her fellow clients and by the staff’s homophobic attitudes and inability to help and protect her. Not only did this experience harm Yoko, but it also affected Sally, a closeted lesbian. Sally observed the abuse perpetrated on Yoko but was too terrified to help. She felt terrible about herself for not speaking out, but she was confused by her anger at Yoko for making treatment more difficult.

#### Suggested Interventions

The counselors should have addressed the homophobia of the other clients and helped them look at it and stop the antigay behavior. Such prejudice and bad feelings are harmful not only to the recipient and the identifying bystander but also to those harboring and acting on such malicious feelings.

#### Case Example #2

John is a 43-year-old male who acknowledged his homosexuality several years ago after years of trying to deny his sexual attractions to other men. When John was a child, his parents suspected he was gay because he did not show much interest in “male” activities. When he was 15 years old, his parents sent him to a prestigious hospital hoping that he would be “cured” of his homosexuality. John returned to school and did what was expected of him: He played sports and dated. He thought that perhaps his psychiatrist was right, that his homosexuality “was just a phase.” He was a good student and had a small group of friends. He dated several girls, but he never felt romantically or sexually attracted to them. After graduation, he attended college and found his attraction to men was intensifying. John married in his senior year in college, thinking that maybe if he “met the right girl and settled down,” these feelings would go away. Over the years, he and his wife had two children. Nevertheless, John’s same-sex attractions increased. John began to secretly frequent gay bars to meet gay men. On a number of occasions, he had sex with these men, but only after first getting drunk. He dated one man for 6 months. However, this man left him because of John’s alcohol abuse and because he was still in the closet. John’s alcohol abuse and his shame about his homosexuality have deeply affected his emotional well-being and all aspects of his life. John recently separated from his wife. He arrived in treatment stating he knows he is gay, but because he still has difficulty accepting himself, he engages in substance abuse to hide his pain.

**Suggested Interventions**

It is important for the counselor to assure John that he is safe to share his story and his pain. John needs validation that, in spite of his parents' good intentions, it was inappropriate to "cure him of his homosexuality." John is likely to be too vulnerable to share his pain in a group setting at this time. John needs the opportunity to discuss, in individual counseling sessions, the prejudice and pain he has endured and how it is related to his substance abuse. Although only the beginning of John's healing, it should not be ignored. It is a critical part of his therapy in early sobriety. Because John is at high risk for relapse while his self-esteem and self-acceptance are low, the counselor can assist John when he senses the time is right by identifying gay Alcoholics Anonymous meetings as one means to help John meet gay people who accept themselves. The counselor can also help by referring John to a therapist after he finishes treatment so that he can continue working on issues of self-acceptance.