Integrating the Treatment of Substance Abuse and Self-Identity in Sexual Minorities: An Outpatient Training Program

Steven P. Euler

A Dissertation Submitted to the Faculty of

The Chicago School of Professional Psychology

In Partial Fulfillment of the Requirements

For the Degree of Doctor of Psychology in Applied Clinical Psychology

January 5, 2015

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

Integrating the Treatment of Substance Abuse and Self-Identity in Sexual Minorities: An Outpatient Training Program

---

A Dissertation Submitted to the Faculty of

The Chicago School of Professional Psychology

In Partial Fulfillment of the Requirements

For the Degree of Doctor of Psychology in Applied Clinical Psychology

---

Steven P. Euler

2015

Approved By:

Jennifer DeFeo, Ph.D., Chairperson
Interim Associate Chair of the MFT Department

Lauren Gavshon, Psy.D., Reader

Acknowledgements

I would like to acknowledge several people and organizations for making this project possible. First I would like to thank the many professionals, friends, and professors that supported and inspired me. I would also like to express my gratitude to the 6 expert reviewers and 10 professional reviewers. Each reviewer took time out of their busy schedule to review this project. I would also like to acknowledge the Substance Abuse and Mental health Services Administration (SAMSHA) for providing a great deal of informative literature free to the public, of which was used in this project. Additionally, I would also like to acknowledge the Gay Alliance organization for the information they provide free to the public, of which was also used in this project. Next, I would like to thank my fiancé, Brandon Zatica, for the many hours of editing and reading for this project. Without his assistance, this project would have taken a lot longer to finish. Finally, I would like to acknowledge Dr. Jennifer DeFeo and Dr. Lauren Gavshon for their continuing support and assistance with this project. Without their attentiveness, speedy correspondence, encouragement, and accountability, this project would have been difficult to complete.

Dedication

This project is dedicated to my loving fiancé, Brandon Zatica. Without his patience, love, and support, I would have had a more difficult time finishing this project. Additionally, I would like to express gratitude towards my parents, Bruce and Elva Beyer. Without their love, encouragement, and support, I would not have made it through nine years of college.

Abstract

Sexual minorities often face challenges. Many of those challenges include discrimination and self-hatred or internalized homophobia which may impede or cause conflict in the formation of their sexual identity. Those who are questioning their sexual identity may abuse or misuse drugs to avoid confrontation and discrimination, admittance of their identity, and as a coping mechanism. Treatment of a substance use disorder is typically through an organization, facility, or agency, while those working with sexual minorities in formulating their sexual identities are predominantly LGBTQ centers or county funded LGBTQ support programs. Many programs do not address both issues at the same time and location, though one may affect the other. An outpatient program that integrates the treatment of substance abuse and self-identity in sexual minorities is one possible means of bridging this gap. To meet this need, the author created an outpatient training program that provides information about the treatment of substance use disorders, identity formation within sexual minorities, and a potential relapse model. This program was reviewed by a panel of six experts who are licensed or registered mental health clinicians and 10 professional reviewers who were comprised of graduate students working toward their degree or licensure. Overall, results from both the expert review and professional review indicated that the outpatient training program is an appropriate medium to be integrated in organizations, facilities, or agencies.

Table of Contents

List of Tables

Chapter 1: Introduction

Despite the removal of homosexuality as a mental disorder from the Diagnostic and Statistical Manual of Mental Disorders in 1986, American society still struggles to recognize the need to support sexual minorities. According to Crowley, Harré, and Lunt (2007), being among peers where they are the majority is very important to sexual minorities, provided they have the feeling of equality and the ability to act and speak freely. However, sexual minorities face a life of discrimination and a constant need to be aware of their surroundings to ensure their safety. Additionally, the fear of losing essential support during their developmental upbringing can be an added stressor. Within the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) community, escape and socialization is predominantly done through the means of a club-like atmosphere (Jordon, 2000). Within this restrictive means of socialization, exposures to substances are common and substances are generally used to escape from the negative aspects of reality. The current support for sexual minorities is minimal, with the exception of LGBTQ community centers. The support for those within the LGBTQ community who have substance use disorders is even more limited. Cochran, Peavy, and Robohm (2007) stated that specialized treatment services are more effective and are important to the field. Moreover, prevention and intervention programs geared toward sexual minorities may have been overlooked.

Research supports that sexual minority youth have higher risks of substance abuse than do heterosexual youth (Green & Feinstein, 2011; Jordon, 2000; Marshal, Friedman, Stall, & Thompson, 2009; Rotheram-Borus, Rosario, Meyer-Bahlburg, & Koopman, 1994). They face many barriers that are different from those faced by heterosexual youth at almost all developmental stages of life (Marshal et al., 2009). They have additional stressors coping with their sexual orientation including discrimination and the feeling of being marginalized by society

(Jordon, 2000; Rotheram-Borus et al., 1994). In addition, those who identify as homosexual are more prone to leaving home as a result of parental conflict than those identifying as bisexual. This may be due to the certainty of their sexual orientation (Rew, Whittaker, Taylor-Seehafer, & Smith, 2005). There is a lack of social resources for sexual minority youth and their relations to subcultures (i.e., gangs and other problematic groups) may lead to more of an exposure to substance use (Jordon, 2000). Green and Feinstein (2012) stated that being out (openly identifying as LGBTQ) to a larger population will provide exposure to LGBTQ-specific stressors, which contributes to an elevated risk of substance use. Substance use and abuse may be linked to feelings of isolation, depression, and the continual stress of having limited grasp on self-identity (Jordon, 2000). Marshal, Stall, and Thompson (2009) discussed that the implementation of efforts to prevent substance abuse in sexual minority youth could have long-lasting effects into adulthood. This study begins the development of a program geared toward incorporating issues surrounding the coming out process in with the treatment of substance abuse.

Chapter 2: Literature Review

Introduction

According to the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (2001), the exact rate of substance abuse among sexual minorities is not fully known, however a variety of studies suggest rates may be between 20-30%. The Substance Abuse and Mental Health Services Administration (2001) stated that roughly 3 to 10% of the general population has a substance abuse issue. Sexual minority youth have been shown to have a higher risk of substance abuse than heterosexual youth (Jordon, 2000; Marshal, Friedman, Stall, & Thompson, 2009; Green, & Feinstein, 2012; Rotheram-Borus, Rosario, Meyer-Bahlburg, & Koopman, 1994). At almost every developmental stage of life, sexual minority youth face hurdles different from heterosexual youth (Marshal et al., 2009). Coping with their sexual orientation and fearing discrimination, they have additional stressors including the feeling of being marginalized by society (Jordon, 2000; Rotheram-Borus et al., 1994). Sexual minorities may be more prone to exposure to substance use due to a lack of social resources and the relations to a subculture (i.e., gangs and other problematic groups (Jordon, 2000). Green and Feinstein (2012) suggested that women who identify as lesbian and bisexual report more alcohol-related issues than heterosexual women, while gay men are likely to have more alcohol and illicit drugs issues than heterosexual men.

Openly identifying as lesbian, gay, or bisexual contributes to an elevated risk of substance use due to the exposure to sexual minority-specific stressors (Green & Feinstein, 2012). Having a limited grasp of self-identity, feelings of isolation, depression, and the need for relief of continual stress may be linked to the use and abuse of substances (Jordon, 2000). There is also a lack of research to understand factors that lead to a successful outcome of substance

abuse treatment of sexual minorities (Cochran, Peavy, & Cauce, 2007). Special attention is needed from those within the mental health profession to help implement intervention programs for sexual minorities (Jordon, 2000).

Meeting the needs of sexual minorities should be a main focus in substance abuse treatment (Cohran, Peavy,& Cauce, 2007). Cohran et al. (2007) stated that there is very little research in this area and many studies involving substance abuse treatment fail to integrate sexual orientation, which may contribute to treatment development. Sereich (2010) explained that clinical literature implies that the treatment needs of sexual minorities developing substance abuse disorders are not being met by many chemical dependency treatment programs (Sereich, 2010).

Isolation Among Sexual Minorities

One of the most important aspects of development for an adolescent into adulthood is coming to terms with his or her own sexuality (Kottman, Lingg, & Tisdell, 1995). Youth sexual minorities are considered to be almost nonexistent to the general population and are left without support in working through this important issue (Kottman et al., 1995). Adolescence is an important period of developmental growth. The ability to develop independence along with building a strong relationship among peers is a strong indicator of good psychological health. In contrast, feelings of social isolation may contribute to poor psychological health (Hall-Lande, Eisenberg, Christenson, & Neumark-Stzainer, 2007; Harrison, 2003). The process of building connections with other peers is particularly stressful for homosexual youth (Harrison, 2003). The correlation between related protective factors, social isolation, and psychological health for sexual minorities is poorly understood by the general population (Hall-Lande et al., 2007)

Among youth sexual minorities, the fear of being labeled abnormal, or facing rejection by their peers and families, pressures them to hide their sexual identities (Harrison, 2003; Kottman, et al., 1995). With these fears looming over them, they quickly learn how to conceal their sexual identity. As they conceal this secret, feelings of self-hatred about their sexual orientation can surface (Harrison, 2003). In addition to dealing with their own feelings, sexual minority youth face discrimination commonly known as homophobia. The general attitude towards gay and lesbian identifying individuals is frequently hostile and negative (Kottman et al., 1995). In many situations, friends and families share the attitude towards sexual minority youth and conditionally accept or reject them (Harrison, 2003; Kottman et al., 1995). In suppressing their identities, they are incapable of establishing positive role models (Kottman et al., 1995). This suppression can contribute to feeling of having to pass as "normal" and can lead to a fear of discovery, creating feelings of isolation (Harrison, 2003).

Self-Identity Among Sexual Minorities

There is minimal doubt that understanding self is conscious: however, in order to gain a better understanding of self, an exploration of thought that is outside of conscious experience must be examined. If people cannot be introspective, then only outside influences can tell them what people believe is true (Rudman & Spencer, 2007). To further understand this, Keba (2004) explained that self-identity can be examined in two distinct ways: People can determine what kind of beings they are and how it is they should live, or they can attempt to comprehend others and begin to make judgments about responsibility, character, and worth. This being said, identity is formed through self-reflection (Keba, 2004).

Conforming to societal norms in public, which may be for sexual minorities a combination of concealed and negatively sanctioned behaviors, promotes a behavior known as

passing. It is assumed that *passing* is a more desirable social identity. Those who know they are passing admit that this contradicts with their true identity (Lever, Kanouse, Rogers, Carson, & Hertz, 1992; Cass, 1979). Cass (1979) explained that passing in certain situations can be easier to continue old patterns of behaviors rather than having a public image of homosexuality. Cass (1979) further stated there are four ways a person uses a passing strategy. These strategies include (a) avoiding threatening situations, (b) controlling personal information (i.e., selecting only aspects that construe the image of heterosexuality), (c) continually presenting and cultivating the image of heterosexuality or asexuality, and (d) distancing themselves from homosexuality in a way conveys detachment from homosexuality (Cass, 1979).

The changing conceptions of self-identity are said to be linked to discourses of addiction. Discourses of addiction have been developed over the last century and been incorporated into social policy. The concept of discourse implies how people understand the relationship between body and mind, conceptualize power, and understand themselves (Bailey, 2005).

The Coming Out Process

Marshal et al. (2009) explained that sexual minorities face many barriers different from heterosexual youth at almost every developmental stage of life and into young adulthood. Cass (1984) described this developmental process in six stages, which may be described according to a number of affective, behavioral, and cognitive dimensions. The stages can be distinguished by these dimensions in their degree of importance. For example, the factors of alienation would have little or no relevance to Stage 6 (Identity Synthesis). Similarly, the factors of disclosure and acculturation would not be an important aspect to Stages 1 (Identity Confusion) and 2 (Identity Comparison), as the factor of professional contact is not applicable to Stages 5 (Identity Pride) and six (Identity Synthesis; Cass, 1984).

Baily (2005) stated that the changing conceptions of self-identity are linked to discourses of addiction. In reviewing Cass's (1984) stages of homosexual identity formation, Stages 5 and 6, may not be linked as strongly to discourses of addiction as Stages 1 through 4. Additionally, Cass (1979) explained that the length of time it can take an individual to progress through the stages will differ from person to person and an individual's age has a major influence on his or her mode of coping with the developmental process.

Homosexual Identity Formation (Cass, 1984)

Stage 1: Identity Confusion

According to Cass (1984), in the first stage, an individual begins to question whether his or her actions, thoughts, and feelings could be defined as homosexual. At this stage, the individual begins to question his or her sexual orientation and becomes confused about his or her identity.

Stage 2: Identity Comparison

As an individual consciously becomes aware of or coming into terms with identifying themselves as homosexual, feelings of alienation between oneself and others becomes transparent. During this stage, contemplation of making social contact with homosexuals is used as a means to lessen feelings of alienation (Cass, 1984).

Stage 3: Identity Tolerance

As he or she becomes committed to the homosexual self-image, the individual seeks to fulfill social, sexual, and emotional needs. During this stage there is more of a tolerance of the homosexual self-image, rather than accepting oneself as a homosexual. Two separate images are created; a public image (heterosexual) and another private image that is exhibited only in the presence of other homosexuals (Cass, 1984).

Stage 4: Identity Acceptance

Cass (1984) stated that exposure to others within the homosexual subculture promotes a more positive outlook of homosexuality, which gradually increases the development of homosexual friends. In this stage selected people are informed of the individual's sexual preference or identity. Typically, this would include close friends and relatives.

Stage 5: Identity Pride

Individuals feel extreme loyalty to homosexual groups and an immense pride toward sexual identity. These homosexual groups are seen as creditable and important while they discredit and devalue heterosexuals. Cass (1984) described that in order to promote equality of homosexuality and validity through disclosure, anger develops about societal stigmatization of the homosexual lifestyle, as well as confrontation with heterosexuals.

Stage 6: Identity Synthesis

The inaccurate division of bad heterosexuals and good homosexuals helps create positive relationships with nonhomosexuals. Anger and pride retained within Identity Pride lessen and a homosexual identity becomes less overwhelming. According to Cass (1984), individuals in this stage see themselves as having many aspects to their identity and not just one related to homosexuality. Disclosure is no longer hidden and an integration of the dichotomy of private and public images cease to exist. Feelings of stability and peace emerge and the process of identity formation completes.

Substance Abuse, Substance Use Disorders, and Addiction

There is a distinction between substance abuse, substance use disorders, and addiction. Substance abuse implies that a particular person is abusing a substance, whether it is alcohol or other drugs. Substance abuse doesn't necessarily mean people are addicted to the substance.

Green and Feinstein (2012) stated that substance abuse, according to social learning theory, is the behavior that is controlled by triggered stimuli and behavior-specific consequences. This behavior is learned through observation and imitation. Substance use disorders, which are derived from the Diagnostic and Statistical Manual of Mental-Fifth Edition (DSM-5), are an array of cognitive, behavioral, and physiological symptoms in which an individual uses the substance despite it causing significant impairment in their lives (American Psychiatric Association, 2013). Generally, the treatment of substance use disorders includes a closer look at the individual's social network (Green & Feinstein, 2012). According to Yucel, Lubman, Solwij, and Brewer (2007), the word *addiction* is taken from the Latin verb *addicere*, which means to enslave. Characteristics include the loss of control and autonomy of one's actions (Yucel et al., 2007).

Within the sexual minority community, many social activities have been centered on the use of drugs and drinking (Jordon, 2000; Rotheram-Borus et al., 1994). This trend could be an indicator that sexual minorities have a higher rate of substance use than heterosexual individuals. This may also provide difficulties for those sexual minorities to avoid addictive substances. Additionally, stress related to being a sexual minority, may contribute to a higher use of substances (Green & Feinstein, 2012; Rotheram-Borus et al., 1994).

According to Marshal, Friedman, Stall, and Thompson (2009), sexual minority youth reported higher rates of substance use compared to heterosexual youth. Marshal, Friedman, Stall, King, Miles, Gold, Bukstein, and Morse (2008) conducted a meta-analysis review on sexual orientation and adolescent substance use. They found that sexual minority youth reported higher rates of substance use compared to heterosexual youth (overall odds ration=2.89, Cohen's d=0.59). When they converted the Cohen's d ratio to odds, they found that substance use for

sexual minority youth were 190% higher than for heterosexual youth. Additionally, the rates of use within sexual minority youth increased faster over time (Marshal, et al., 2009). Marshal et al., (2009) stated that these results suggest that, early in life, sexual minority youth are more vulnerable and are at higher risk for substance abuse. They also suggested that early intervention that focuses on substance use behavior among youth might serve to reduce the risk into adulthood (Marshal et al., 2009).

Rosario, Schrimshaw, and Hunter (2004) found that the coming-out process showed significant correlation with changes over a period of time in both marijuana and alcohol use. They found an increase of substance abuse was positively associated during the introduction to gay-related activities. However, the rate declined as gay-related activities increased over time (Rosario, et al., 2004).

Alcoholism

The key period for developing a substance use disorder that can continue into adulthood, is adolescence. According to Botvin and Griffin (2007), the percentage of high school seniors who reported being drunk at least once is 58%. After high school, there is a decline in the amount of illicit drugs used. Botvin and Giffin (2007) explained that the first phase of alcohol abuse begins with experimentation and that alcohol is readily available because it is legal for adults. Positive messages sent about drinking through the media are often a motivator for experimentation (Ahlstrom & Huntanen, 2007; Botvin & Griffin, 2007). However, during the early stages of experimentation, social situations with same age and slightly older peers are a main contributor. As social relationships solidify with peers who drink, a greater concern of being accepted within the group contributes to continued drinking. Over time with these peers structures, the risks associated with alcohol abuse often becomes minimalized. Some of these

risks affect people's ability to properly evaluate a pattern of use, leading to faulty feelings of being in control of themselves (Botvin & Griffin, 2007). It is important to understand that adolescents often drink to avoid social alienation, to get perceived social rewards, and to enhance positive mood, while reducing negative mood (Coffman, Patrick, Palen, Rhoades, & Ventura, 2007). Eventually over time, persistent use of alcohol during this experimentation stage leads to abuse. This may lead to the trial of illicit drug use. Fortunately, many adolescents do not develop more serious addictions to illicit drugs (Botvin & Griffin, 2007).

Treatment of Alcoholism and other Drug Abuse

There are many treatments of substance abuse for young adults; however, many are not effective (Friend & Stout, 2007; Galanter, Glickman, & Singer, 2007). With the pressure from health insurance companies to produce positive treatment outcomes and a considerable amount of federal grants available, many treatment approaches have not shown much success (McNeese-Smith et al., 2007). Many different forms of intervention have been evaluated. Brief intervention generally involves a primary care provider (marriage family therapist, psychologist, alcohol and drug counselor, etc.), usually a professional who has experience within the field of substance abuse. The professional can assist in bridging gaps between the communities, the primary care provider and the world of substance abuse and addiction treatment. The main technique that is used is motivational interviewing, which emphasizes the young adult's ability to enhance self-efficacy and the motivation to change (Galanter et al., 2007). Galanter et al. (2007) reviewed outpatient treatment for young adults. One particular treatment reviewed was long-term recovery-oriented treatment. This approach is generally reserved for more severe forms of addictions. It is an eclectic mixture of approaches and professionals that is developed on an

individual basis. Additionally, this approach plans for continual care. Some of these approaches include the admission to a 12-step program (Galanter et al., 2007).

The most common traditional 12-step model used is known as Alcoholics Anonymous (AA; Tonigan, 2007; Magura, 2004). This model was developed during a time when treatment options were limited and alcoholics, were considered to be untreatable. The creators of AA envisioned that AA be used in close cooperation with medical treatment. The AA meetings are peer led and community based. The meetings are generally a good starting point for those who are transitioning from an admitted inpatient hospitalization for detox, due to withdrawal symptoms. The 12-step program is based on the sharing of experiences among the group members and is commonly spiritual and some argue religious. It is a framework that can be said to be a Christian model of healing, in which the sinner confesses his or her sins and pleads for God's grace. Whether or not AA is prominently religious, is debatable (Magura, 2004). It is important to note that not all AA or 12-step models are religiously affiliated. There are meetings, though not as common, where the religious aspect has been removed. These meetings are generally known as atheist 12-step recovery meetings. While this may be the best option for those who aren't religious, having an atheist 12 –step recovery meeting for sexual minorities would be difficult to find or non-existent. Despite the possible benefits, AA may not be suited for young adults. The groups are geared towards the general population with more severe addictions and many may feel discomfort with the religious/spiritual emphasis. According to researchers, treatment programs need to adapt to young adults is necessary (Kelly & Myers, 2007).

Conflicts between Religion and Sexuality

The importance of religion in the lives of Americans is evident in the ways it is incorporated into everyday life (Halkitis et al., 2009). Halkitis et al. (2009) stated that a majority of adults in the United States self-describe as being religious, 70% of individuals attend religious services at least once a year, and 90% of individuals are engaged in some private act of prayer or something similar. Communities and individuals that are religious can vary in their views of homosexuality (i.e., casting homosexuality as sinful, deviant, or normal), as well as to the degree in which they embrace homosexuality (Halkitis et al., 2009; Ganzevoort, van de Laan, & Olsman 2011). Sexual minorities who are a part of welcoming faith communities may experience little or no conflict within their religious beliefs (Halkitis, et al., 2009; Sherry, Adelman, Whilde, & Quick, 2010). Halkitis (2009) suggested that sexual minorities being exposed to non-affirming hostile religious rhetoric leads sexual minorities to have conflict between their sexuality and religiosity and to struggle with internalized homophobia. According to Halkitis (2009), sexual minorities' faiths are changed by their experience within unwelcoming and hostile religious communities. Some individuals abandon organized religion, some self-describe as atheists, while others practice privately and reject public religious life (Halkitis 2009).

Risks among Sexual Minorities

Few researchers have explored risk factors experienced by younger sexual minorities in predicting problem behaviors and emotional stress. Risk factors are shared with heterosexual youth; however, sexual minorities face psychosocial challenges (Elze, 2002). Some of the psychosocial challenges that sexual minority youth face can be experienced from childhood and may include sexual, physical, and verbal abuse (Rew, Whittacker, Taylor-Seehafer, & Smith, 2005). Rew et al. (2005) found that 73% of homosexual youth and 26% bisexual youth who left

home did so due to issues with their parental figures about their sexual orientation. Moreover, they found that more gay and lesbian youth left home due to sexual abuse than did heterosexual and bisexual youth. Additionally, negative familial attitudes, stigmatization, and victimization about sexual identity contribute to these risk factors (Elze, 2002).

Suicide

Risk factors and reasons for suicide have been examined in heterosexual young adults, however very little research has examined risk factors and suicidality in younger sexual minorities. Sexual minority youth are two to three times more likely to commit suicide than heterosexual youth. More specifically, 30 % of all completed youth suicides correlate to issues of sexual identity (Proctor & Groze, 1994). Researchers believe that it is not a youth's sexual identity that leads to suicidiality, but family, peer, and institutional discrimination and harassment. Common stressors are being rejected by peers and running away from abusive families. A commonly used coping mechanism includes substance abuse to "numb the pain" or to avoid further emotional pain (Savin-Williams & Ream, 2003). According to Savin-Williams and Ream (2003), same-sex attraction does not cause one to be suicidal; rather it is due to the environmental stressors of being a sexual minority. These environmental stressors are similar to what heterosexual youth face; although the amplification of these stressors due to developmental process they experience (McFarland, 1998).

Espositio-Smythers, Spirito,Kahler, Hunt, and Monti (2011) stated that alcohol and other drug use disorders (AOD) and suicidal behavior parallel each other. They found that rates of any AOD were from 27% to 50% among adolescents who died due to suicide and those who attempted suicide ranged from 12% to 50%. Moreover, Esposito-Smythers (2011) suggested that AOD increases the risk for suicide, especially in the presence of other mental health problems.

Grant, Stinson, Dawson, Chou, Dufour, Compton, Pickering, and Kaplan (2004), stated that substance use disorders and depression often coexist. They found that in the United States, about 20% of those who meet the criteria for the past-12 month substance use disorder also met the necessary criteria for a mood disorder. (Grant et al., 2004)

Support

Many sexual minority youth seek therapy for many reasons, but common reasons are family rejection, school problems, low self-esteem, and the effects of isolation due to a lack of peer support. In adolescence, developmental tasks such as achieving intimacy, developing social skills, and building a sense of self, are important aspects in the peer system (Robinson, 1991; Crowley, Harre, & Lunt, 2007). In sexual minority youth, social development is difficult due to a social stigma. The experience of these youth is very similar to that of other minority groups; however, other minorities receive positive socialization about their subculture in early childhood. The unique problem sexual minority youth face leaves them with limited or no support (Jacobs & Freundlich, 2006; Robinson, 1991; Munoz-Plaza, Quinn, & Rounds, 2002; Detrie & Lease, 2007). Within the family system, many parents express concerns that these youth are too young to make sexual identity decisions. Robinson (1991) believed that all youth are capable of identifying their sexual preference by of 12-14 years of age.

Creating a supportive environment validates sexual minority individuals, which lessens the effects of both internalization and externalization of homophobia. Support groups for sexual minority youth provide an equal footing and an opportunity to develop social skills and gain positive gay-affirming information (Robinson, 1991; Elze, 2002).

Conclusion

The need for support for sexual minority individuals is consistent across studies researched. However, many studies fail to connect isolation, self-identity, and substance abuse within young adult sexual minorities. Harrison (2003) argued that suppression can create feelings of isolation, but did not link self-identity and the potential risks of substance abuse. Within the discussion of self-identity, few studies link isolation as a contributor to substance abuse.

With the rate of substance abuse rising within the sexual minority community, not enough has been done to develop a sexual minority specific intervention. Many studies lack resources geared specifically towards support for young adult sexual minorities (Robinson, 1991). Moreover, clinical literature implies that the treatment needs of sexual minorities developing substance abuse disorders are not being met by many of the chemical dependency treatment programs (Sereich, 2010). The most commonly used treatment, Alcoholics Anonymous, is geared for the general population and can have a religious/spiritual emphasis (Kelly & Myers, 2007). Since many faiths view homosexuality to be evil and morally wrong, many may feel discomfort attending such programs (Kelly & Myers, 2007; McFarland, 1998). Moreover, the unique problem young adult sexual minorities face leaves them with limited or no support (Jacobs & Freundlich, 2006; Robinson, 1991; Munoz-Plaza, et. al., 2002; Detrie & Lease, 2007). The need to link self-identity and isolation to substance abuse within sexual minorities is evident. Additionally, substance abuse treatment programs that focus on the unique issues facing sexual minority young adults are needed.

Chapter 3: Method

The purpose of this chapter is to describe the development of the program that bridges the treatment of substance abuse and the development of self-identity within sexual minorities. For sexual minorities the availability of support is sometimes limited thus making it more difficult to find services to be treated for substance abuse issues along with the development of their self-identity. Many of the mental resources available to sexual minorities do not specialize in substance abuse and many substance abuse resources do not specialize in working with the developmental process of self-identity in sexual minorities. The purpose of this chapter is to assist in the development of a bridge program for sexual minorities with a substance use issue from the ages of 18-29. For the purpose of this project, participants ages 18-29 will be defined as young adults who are not in need of detoxification or other hospitalization for severe mental disturbances. The program is based upon peer reviewed research and key concepts from the organizations and facilities within the LGBTQ community and alcoholism and drug abuse community.

Design

To design the outpatient training program, the author had to first choose the scope of information to be included in the outpatient program curriculum. Below is a summary of the concepts the author opted to include in the outpatient program. The author included information related to the basics in working those diagnosed with a substance abuse use disorder, as well as a basic understanding of the many drugs and the effects they have on the individual. Treatment interventions and strategies for treating individuals with a substance use disorder will be elaborated. Resources used are listed in the Draft Development section. Additionally, the author included information related to the basics in working with individuals that are sexual minorities.

This included a detailed understanding the stages of sexual identity. Treatment interventions and strategies were elaborated. Resources used are also listed in the Draft Development section. Finally, the author decided to conclude the program with the creation of a potential relapse risk chart. A list of terms used for both substance abuse and sexual minorities were provided in Appendix B and C.

After deciding the concepts to include, the author developed a format in which to present the information. The goal was to create a very organized, user-friendly design. The author broke the outpatient training program into three sections. One section focused on information pertaining to working with and treating individuals with a substance use disorder. Another section focused on information pertaining to working with individuals that are sexual minorities. The third section discusses the integration of working with sexual minorities that have substance abuse issues. Within each section, the author included chapters to further break down concepts into smaller and understandable clusters. For each chapter, the author used the following: an explanation of concepts and an explanation of terms of used, to assist in the treatment process.

Draft Development

After thorough research, the author was able to make an informed decision about which information to include in the outpatient training program. As previously stated, the training program was be broken into three sections. A preface and an introduction were included prior to the first section. The preface described the background of the author, the intended audience for the outpatient training program, why the outpatient training program was created, and the limitations, as well as the cautions the reader should consider prior to implementation. The introduction included a brief description of the purpose of both treating substance use disorders and working with the client on self-identity, the historical background of sexual minorities, and

how to work with and treat both collaboratively. The section titled "Prior to beginning…" informed readers that the outpatient program is not a complete comprehensive overview of both the substance abuse community and LGBTQ community, encourages clinicians, agencies, and/or organizations to continue education and support in both areas (e.g., workshops, continuing education courses, local resources, other experts within the fields). It is also encouraged for clinicians, agencies, and/or organizations to fully implement the outpatient program as it is intended. A detailed description of what each section and chapter contains was included.

The final portion of the outpatient training program provides a list of references that were researched prior to the program being created. References/Sources have granted permission to make mention of their work or implement their ideas as long as proper attribution was given.

Design Features

The outpatient training program was designed to be easily understood by professionals in the mental health field. Treatment intervention strategies, terminology, and key concepts were defined with simple language, as well as terms used, and strategies. In addition, since it may be difficulty to ask clarifying questions about the program, questions were provided at the end of the program so that reader can establish whether or not they understand the material. The answers were provided in Appendix A at the end of this research.

Expert Reviewers

After the first draft of the program was created, the author consulted with the following experts: at least five individuals who are licensed and/or certified in marriage and family therapy, clinical psychology, or substance abuse counselors, and work at both non-public and public agencies or organizations that provides services to sexual minorities and/or individuals with substance abuse issues.

Professional Reviewers

The outpatient program was reviewed by at least 10 professionals. Each professional had experience in mental health and/or in a substance abuse clinic, agency, or organization. Each professional had experience working with sexual minorities and/or the substance abuse community. The individual was either a student in a graduate program leading to licensure, and have some experience with either substance abuse or working with sexual minorities.

Recruitment Procedures for Expert Review and Professional Review

The author recruited five expert reviewers. The outpatient training program, expert reviewer survey, and informed consent was sent via e-mail to the reviewers to complete the survey. Each potential expert reviews had the option to opt out of the process. The author knew which reviewer completed which survey because reviewers will provide their names and other relevant information on the survey.

Additionally, the outpatient program was reviewed by at least 10 professional reviewers. The author handed out the outpatient program, expert reviewer survey, and informed consent to each expert reviewer. The expert reviewer had the option to opt out of the survey. In order to promote honest responses, the author did not require the professional reviewer to list their names on the survey, however asked for their e-mail address. The author will not know which person completed which survey.

Evaluation of Outpatient Training Program Manual

The first part of the evaluation process was to evaluate the pool of experts who completed the expert review survey, created by the author. The first part of the survey asked the reviewers to identify their educational and professional background, certifications and/or licenses, and experience treating or working with alcoholism and drug abuse, as well as, treating and/or

working with sexual minorities. Next, the survey contained 10 questions regarding the accuracy, relevancy of program and case vignettes, clarity of the program, length, intended audience, scope of information provided, and any information that should be removed or added. Expert reviewers answered questions with a "yes" or "no" (with the exception of the question that pertains to the length of the program, for which they chose from the following options: "too long," "too short," and "just right"). After each question, they were provided with space to provide additional feedback. After reviewing the results, the author took into account the revisions recommended. The results of this survey and the revisions made were explained and included in detail in the results section.

The second part of the evaluation process was an evaluation by a pool of professional reviewers who completed a survey created by the author. The first part of the professional reviewer survey was to ask the professional reviewer to provide a brief description of their education and professional background. The survey contained 7 statements regarding the scope, relevancy of case vignettes, relevancy of program, organization, the intended audience, and size of the outpatient program. Professional reviewers were asked to rate statements from 1 to 7 based on a 5-point Likert scale. 1 indicated *strongly disagree*; 2 indicated *disagree*; 3 indicated *neither agree or disagree*; 4 indicated *agree*; 5 indicated *strongly agree*. After the last question, a comment section was given for additional comments. After reviewing the results, the author took into account the revisions recommended. The results of this survey and the revisions made were explained and included in detail in the results section.

Chapter 4: Results

The results of the current doctoral project were obtained using the methods that were described in the methods section. This chapter presents feedback provided from a panel of expert reviewers and professional reviewers regarding the outpatient training program designed by author. The details of feedback are provided below.

Results from Expert Review

The quantitative and qualitative results were favorable and are discussed in detail below. All expert reviewers but one answered "yes" to the question, "Did you find the program applicable to your facility or organization? If NO, please specify why not?" One expert reviewer stated, "we were outpatient counseling and did not do solely substance abuse related services."

For the second, third, and fourth questions, all reviewers answered "yes" to questions, "Did the program explain concepts in a way that was easy to understand?', "Was the case vignette and other examples relevant to the concepts presented and did they help in understanding the concepts?", and "Did the outpatient program encompass relevant topics for the development and process of self-identity in sexual minorities?"

In response to the fifth question, 5 out of 6 reviewers answered "yes" to the question, "Did the outpatient program encompass relevant topics of the treatment of substance abuse?" While on the sixth question, all 6 reviewers answered "yes" to the question, "Do you feel there's a need for a program to treat sexual minorities with substance abuse collaboratively? Please select Yes or No, then explain your answer." In the explanation section, one reviewer stated that "very few resources that treats both the sexuality and the ethnicity." A second reviewer stated "more thorough treatment." Another respondent stated "Placing individuals in recovery without

addressing stressors and issues specific to LGBTQ is ineffective, and many patients avoid recovery programs due to inadequate addressing of these issues." A fourth reviewer explained, "Due to high rate of substance abuse rate in LGT community the necessity of a collaborative approach is clear." The final comment stated, "Emotional connections are paramount to any recovery. We need to understand that we are truly understood and excepted before we can be honest enough with ourselves & others in an effort to achieve recovery."

Moving on to the seventh question, two reviewers answered "too short" and four reviewers answered "just right," to the question "How would you rate the length of the program?" On the eighth question, six reviewers responded with comments to the question, "Is there anything that wasn't included in this program that you feel should have been included? If so, please describe?" Three reviewers stated "no" and one reviewer stated "none." Another reviewer stated "There was no information on Iranian-Americans. Since Farsi is a threshold language in OC, I recommend inclusion of some relevant information in the program." The sixth reviewer commented "Abstinence programs versus Harm Reduction. Specific strategies/concerns/medical interventions for working with Transgender clients, as this is very different."

Analyzing the ninth question, three reviewers answered "No", two reviewers answered "None," and one reviewer answered "Maybe some clarification needed on transgender people versus sexual minorities," to the question "Is there anything that should be taken out of the program? If so, describe?" Lastly, on the 10th question, three reviewers answered either "N/A," "No," or "None," to the question "Do you have any other comments relevant to the program?" In this section, many of the reviewers gave positive reviews of the training program. One reviewer commented "Very in-depth, great work!", while two others commented "I like the manner in

which it addresses religious obstacles that can deter LGBTQ individuals from seeking recovery groups, and the alternatives suggested, as well as the awareness of sexual identity development and its impact on recovery," and " I am 100% in support of a program such as this. I have witnessed less than full acceptance of the LGBTQ population in programs which support mixed populations."

Revisions of Outpatient Training Program Based on Expert Review

Several edits were made to the outpatient training program, however they were mostly grammatical. While two out of the six stated that the program was too short, the program wasn't meant to be a comprehensive. It was recommended and encouraged that those interested in educating themselves more in depth within the LGBTQ cultural, should attend workshops or presentations generally provided by agencies within the LGBTQ community. Additionally, the author struggled with the idea of including gender identity and gender expression, however decided to stay with sexual identity or sexual orientation.

Results of Professional Review

Each individual of the professional review panel had experience in mental health and/or in a substance abuse clinic, agency, or organization. Each professional had experience working with sexual minorities and/or the substance abuse community. The individual was either a student in a graduate program leading to licensure, and have some experience with either substance abuse or working with sexual minorities. Overall, the quantitative results based upon the professional review survey were favorable and are discussed in detail below. For this section, reviewers were asked to rate statements from 1 to 7 upon the following scale: 1 indicated *strongly disagree*; 2 indicated *disagree*; 3 indicated *neither agree nor disagree*; 4 indicated

agree; and 5 indicated *strongly agree*. In addition, qualitative results were favorable and are discussed below.

The professional reviewers were asked to rate 7 statements based upon the Likert scale described above. A summary of these results can be found on Table 1. The reviewers were first asked to rate a statement that stated, "The training program encompasses appropriate topics." The average score for this statement was 4.40, with a standard deviation of .66. Then, the reviewers were asked to rate a statement that said, "The concepts are explained in a way that was easy to understand." The average score for this statement was 4.50, with a standard deviation of .50. The third statement reviewers were asked to rate on, "The outpatient program is well organized," averaged 4.30 with a standard deviation of .64. The fourth statement asked reviewers to rate the statement, "The case vignettes and other examples are relevant to the concepts presented, and they aid in the ability to understand the concepts. The average score for this statement was 4.40, with a standard deviation of .66. The fifth statement asked reviewers to rate the statement, "The Training is appropriate to treat or work with Sexual Minorities (lesbian, gay, and bisexual)." The average score was 4.60, with a standard deviation of .49. The sixth statement the reviewers were asked to rate said, "The Training is appropriate to treat and work with alcoholism and drug abuse (substance abuse)." The average score for this statement was 4.50, with a standard deviation of .50. The last statement, the reviewers were asked to rate whether "The length of the training program is appropriate." The average score was 4.10, with a standard deviation of .54.

After answering all the questions above, the reviewers had the option to provided additional information or feedback. They were asked "Do you have any additionally comments?" The professional reviewers provided no feedback or comments to this question.

Table 1

Results of the Professional Review Survey Form

N=10	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7
PR1	5	5	5	5	5	5	5
PR2	5	5	4	4	5	4	4
PR3	4	4	4	4	4	4	4
PR4	5	5	5	5	5	5	4
PR5	5	5	5	5	5	5	5
PR6	5	5	5	5	5	5	4
PR7	4	4	3	4	5	4	4
PR8	3	4	4	4	4	4	4
PR9	4	4	4	5	4	4	4
PR10	4	4	4	3	4	4	3
Mean	4.40	4.50	4.30	4.40	4.60	4.50	4.10
SD	.66	.50	.64	.66	.49	.50	.54

Notes: PR = Professional Reviewer; *SD* = Standard Deviation

Responses to each item were based on the following 5-point Likert Scale:

1 = Strongly Disagree; 2 = Disagree; 3= Neither Agree nor Disagree; 4 = Agree; 5 = Strongly Agree

Revisions of Outpatient Training Program Based on Professional Review

Not many revisions were made to the training program as a result of the professional review based upon the results on the professional reviewer survey. The author considered increasing the length of the program and adding specific therapeutic interventions based on theoretical orientations; however the author felt that based on the positive feedback provided by the professional and expert reviewers, the author opted not to lengthen it. As stated in the revisions of the outpatient training program based on expert reviewers, the addition of gender identity and gender expression was opted out due to the decision to focus on sexual identity or sexual orientation.

Chapter 5: Summary and Discussion

This project involved many layers. First, through a comprehensive review of literature and personal experience, the author uncovered that many professionals either have limited exposure to the LGBTQ community and/or substance abuse/chemical dependency. Many graduate programs require one or two courses of each through a six or eight to nine years of study. Most require only one course in substance abuse and one in human sexuality that briefly discusses the LGBTQ community. There are no required courses that focus working specifically with sexual minorities and the stages of identification. Therefore, an outpatient training program for professional that work in agencies that provide services to either the substance abuse or LGBTQ community was developed based upon the literature review. This outpatient training program is based upon the most up to date information on the LGBTQ community and substance abuse community. The information from the LGBTQ community was gathered from research and other programs available to the public. This information will need to be updated down the road, as there have been many changes in civil rights for the LGBTQ community. More specifically, same-sex marriage bans in many states have been ruled unconstitutionally and many other laws that provide protection to LGBTQ individuals. The outpatient training program was evaluated by a group of experts that work in the field of substance abuse and/ or working with sexual minorities, as well as a group of professionals that have experience within one or both communities. Overall, results from both the expert review and professional review indicate that the outpatient training program is an appropriate program to integrate into agencies that work with both populations. Below includes a summary of the results from the expert review and professional review, limitations and assumptions of this project. Recommendations for future research, a training dissemination plan, and project conclusions.

Summary of Expert Review and Professional Review

Expert reviewers were asked to comment on the content, scope, structure, clarity, organization, relevancy of case vignettes, and size of the program. All expert reviewers articulated that the outpatient training program explained concepts were accurate and well written. One expert reviewers stated that the program wasn't applicable to their facility or organization because their facility or organization doesn't solely provide substance abuse related services. Another expert reviewer stated that the outpatient program didn't encompass relevant topics to treatment of substance abuse. A third expert reviewer mentioned to expand a section on treating specific ethnic cultures. The author considered expanding the substance abuse section, however felt that it would deter from the main purpose of the program, which was to be brief and not comprehensive. A statement in the beginning of the program explains that the program isn't comprehensive and it encourages further educating from many other resources. Additionally, expanding the program to cover specific ethnic cultures would have required a get deal of research on each culture, rather than its initial intention to generalize it across all ethnic cultures.

The professional reviewers rated the outpatient training program in several areas that pertained to content, scope, structure, clarity, organization, relevancy of examples, size of the program, and intended audience. In each area rated, the scores fell between 3 (*neither agree nor disagree*) and 5 (*strongly agree*), with the majority falling between 4 (*agree*) and 5 (*strongly agree*), indicating favorable results. When considering the combination of results from both the professional and expert reviewers, the author opted not to lengthen the training.

Limitations and Assumptions

Limitations and Assumptions of this project are evident and do exist. The outpatient program assumes that professionals within the field of mental health have knowledge in the area

of therapeutic intervention and are capable of being empathetic in both communities. Professionals that have little or no experience in either field are encouraged to seek out resources that provide more comprehensive detail about specific interventions, changes in techniques, and additions to terminology.

There are limitations regarding the ability to generalize the results of this project beyond the professional reviewers and expert reviewers. The expert reviewers were individuals from southern California and eastern New York. Recruiting individuals from other sources and locations may have helped in the ability to generalize. Additionally, both groups of reviewers were small; there were only six individuals in the expert review and 10 individuals in the professional review. Potentially, having a larger number of reviewers may have provided more reliable results. It should also be noted that one of the requirements of taking the survey required reviewers to read and review a 164 page outpatient training program. Many of the reviewers were limited on time and it is assumed that some briefly reviewed the program and not in its entirety.

The expert reviewers and professional reviewers had or were in the midst of obtaining graduate degrees in working within either or both populations. It is suggested that future research include and be reviewed by those that have had issues with both substance abuse and sexual identity. Despite that the group of experts communicated that they thought the training would be beneficial, this was not empirically tested.

Another limitation of this project is that professionals who utilize this outpatient training program will be able to ask questions for clarification. In lieu of this, many examples are provided, and individuals are able to test their acquisition of knowledge in the “Measure Your

Understanding" section. Finally, this training only incorporates Cass's theoretical model of homosexual identity; it does not consider other identity models.

Recommendations for Future Research and Training Dissemination Plan

More research needs to be conducted the treatment of individuals struggling with sexual identity and risks of substance abuse within those individuals. Research regarding the availability of an integrative approach needs to be done across the nation. The outpatient training program may need to be modified or expanded on working with those in an inpatient setting (Detox facility or hospital setting). The outpatient training program may also need to be expanded in the areas of biological sex, gender expression, gender identity, and sexual behavior. In response to this need, the author would like to potentially publish this outpatient training program and extend the program include the whole LGBTQ community. The current project examines the opinions of several professionals and experts, however lacks the opinions of those individuals that have both a substance abuse and sexual identity issue.

Conclusion

The author discovered the need for an outpatient training program that integrates the treatment of both substance abuse and identity in sexual minorities, based on both personal experiences and literature reviewed. Therefore, an outpatient training program was created based upon current research and literature available to the public. The goal in creating this program was to assist in those that are struggling in coming to terms with their sexual identity and their path to recovery. It is in the hopes of the author that agencies and organization can use this information to treats these individuals simultaneously on both issues. After its creation, the outpatient training program was evaluated by a group of professional and expert and validated by both groups. Results from both reviews suggest that his program has the potential to assist agencies

and organizations that work with both populations in the successful treatment of recovery of substance abuse. It is the author's intention to expand on this program to include other members of the LGBTQ community.

References

Ahlström, S., & Huntanen, P. (2007). The effects of perceived availability of different alcoholic beverages on young people's drinking in Europe: A comparative exploration. *Contemporary Drug Problems*, *34*(4), 559-574.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Bailey, L. (2005). Control and desire: The issue of identity in popular discourses of addiction. *Addiction Research & Theory*, *13*(6), 535-543. doi:10.1080/16066350500338195

Botvin, G., & Griffin, K. (2007). School-based programmes to prevent alcohol, tobacco and other drug use. *International Review Of Psychiatry (Abingdon, England)*, *19*(6), 607-615.

'Coming-out' process related to substance use among gay, lesbian and bisexual teens. (2005). *DATA: The Brown University Digest of Addiction Theory & Application*, *24*(6), 3-4.

Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal Of Homosexuality*, *4*(3), 219-235. doi:10.1300/J082v04n03_01

Cass, V. C. (1984). Homosexual identity formation: Testing a theoretical model. *Journal Of Sex Research*, *20*(2), 143-167. doi:10.1080/00224498409551214

Cochran, B. N., Peavy, K., & Cauce, A. (2007). Substance abuse treatment providers' explicit and implicit attitudes regarding sexual minorities. *Journal Of Homosexuality*, *53*(3), 181-207. doi:10.1300/J082v53n03_10

Coffman, D. L., Patrick, M. E., Palen, L., Rhoades, B. L., & Ventura, A. K. (2007). Why do high school seniors drink? Implications for a targeted approach to intervention. *Prevention Science*, *8*(4), 241-248. doi:10.1007/s11121-007-0078-1

Crowley, C., Harré, R., & Lunt, I. (2007). Safe Spaces and Sense of Identity: Views and Experiences of Lesbian, Gay and Bisexual Young People. *Journal Of Gay & Lesbian Psychotherapy*, *11*(1/2), 127-143. doi:10.1300/J236v11n01_09

Detrie, P. M., & Lease, S. H. (2007). The Relation of Social Support, Connectedness, and Collective Self-Esteem to the Psybhological Well-Being of Lesbian, Gay, and Bisexual Youth. *Journal Of Homosexuality*, *53*(4), 173-199.

Elze, D. E. (2002). Risk factors for internalizing and externalizing problems among gay, lesbian, and bisexual adolescents. *Social Work Research*, *26*(2), 89.

Esposito-Smythers, C., Spirito, A., Kahler, C. W., Hunt, J., & Monti, P. (2011). Treatment of co-occurring substance abuse and suicidality among adolescents: A randomized trial. *Journal Of Consulting And Clinical Psychology*, *79*(6), 728-739. doi:10.1037/a0026074

Friend, K. B., & Stout, R. L. (2007). Studying treatment quality in outpatient drug abuse clinics. *DATA: The Brown University Digest Of Addiction Theory & Application*, *26*(12), 8.

Galanter, M., Glickman, L., & Singer, D. (2007). An overview of outpatient treatment of adolescent substance abuse. *Substance Abuse: Official Publication Of The Association For Medical Education And Research In Substance Abuse*, *28*(2), 51-58.

Ganzevoort, R. R., van der Laan, M. M., & Olsman, E. E. (2011). Growing up gay and religious. Conflict, dialogue, and religious identity strategies. *Mental Health, Religion & Culture*, *14*(3), 209-222. doi:10.1080/13674670903452132

Gay Alliance. (2013). SafeZone Certification Program: Creating sustainable SafeZone Programs in your workplace or school.

Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, P., Dufour, M. C., Compton, W., & ... Kaplan, K. (2004). Prevalence and Co-occurrence of Substance Use Disorders and Independent Mood and Anxiety Disorders: Results From the National Epidemiologic

Green, K., & Feinstein, B. (2012). Substance use in lesbian, gay, and bisexual populations: an update on empirical research and implications for treatment. *Psychology Of Addictive Behaviors: Journal Of The Society Of Psychologists In Addictive Behaviors*, *26*(2), 265-278.

Hall-Lande, J. A., Eisenberg, M. E., Christenson, S. L., & Neumark-Sztainer, D. (2007). Social isolation, psychological health, and protective factors in adolescence. *Adolescence*, *42*(166), 265-286.

Harrison, T. (2003). Adolescent homosexuality and concerns regarding disclosure. *The Journal Of School Health*, *73*(3), 107-112.

Halkitis, P. N., Mattis, J. S., Sahadath, J. K., Massie, D., Ladyzhenskaya, L., Pitrelli, K., & ... Cowie, S. E. (2009). The meanings and manifestations of religion and spirituality among lesbian, gay, bisexual, and transgender adults. *Journal Of Adult Development*, *16*(4), 250-262. doi:10.1007/s10804-009-9071-1

Jacobs, J., & Freundlich, M. (2006). Achieving permanency for LGBTQ youth. *Child Welfare*, *85*(2), 299-316.

Jordan, K. M. (2000). Substance Abuse Among Gay, Lesbian, Bisexual, Transgender, and Questioning Adolescents. *School Psychology Review*, *29*(2), 201.

Keba, A. (2004). The Concept of Self-Identity and Moral Conflicts. *Politicka Misao: Croatian Political Science Review*, *41*(5), 134-148.

Kelly, J., & Myers, M. (2007). Adolescents' participation in Alcoholics Anonymous and Narcotics Anonymous: review, implications and future directions. *Journal Of Psychoactive Drugs*, *39*(3), 259-269.

Kottman, T., Lingg, M., & Tisdell, T. (1995). Gay and lesbian adolescents: Implications for Adlerian therapists. *Individual Psychology: Journal Of Adlerian Theory, Research & Practice*, *51*(2), 114-128.

Lever, J., Kanouse, D. E., Rogers, W. H., Carson, S., & Hertz, R. (1992). Behavior Patterns and Sexual Identity of Bisexual Males. *Journal Of Sex Research*, *29*(2), 141-167.

Magura, S. (2007). The Relationship Between Substance User Treatment and 12-Step Fellowships: Current Knowledge and Research Questions. *Substance Use & Misuse*, *42*(2-3), 343-360. doi:10.1080/10826080601142071

Marshal, M. P., Friedman, M. S., Stall, R., King, K. M., Miles, J., Gold, M. A., & ... Morse, J. Q. (2008). Sexual orientation and adolescent substance use: A meta-analysis and methodological review. *Addiction*, *103*(4), 546-556.

Marshal, M., Friedman, M., Stall, R., & Thompson, A. (2009). Individual trajectories of substance use in lesbian, gay and bisexual youth and heterosexual youth. *Addiction (Abingdon, England)*, *104*(6), 974-981.

McFarland, W. P. (1998). Gay, lesbian, and bisexual student suicide. *Professional School Counseling*, *1*(3), 26.

McNeese-Smith, D., Nyamathi, A., Longshore, D., Wickman, M., Robertson, S., Obert, J., & ... Wenzel, S. L. (2007). Processes and Outcomes of Substance Abuse Treatment Between Two Programs for Clients Insured Under Managed Care. *American Journal Of Drug & Alcohol Abuse*, *33*(3), 439-446. doi:10.1080/00952990701315186

Munoz-Plaza, C., Quinn, S., & Rounds, K. A. (2002). Lesbian, Gay, Bisexual and Transgender Students: Perceived Social Support in the High School Environment. *High School Journal*, *85*(4), 52.

Proctor, C., & Groze, V. (1994). Risk factors for suicide among gay, lesbian, and bisexual youths. *Social Work*, *39*(5), 504-513.

Rew, L., Whittaker, T., Taylor-Seehafer, M., & Smith, L. (2005). Sexual health risks and protective resources in gay, lesbian, bisexual, and heterosexual homeless youth. *Journal For Specialists In Pediatric Nursing: JSPN*, *10*(1), 11-19.

Robinson, K. (1991). Gay youth support groups: an opportunity for social work intervention. *Social Work*, *36*(5), 458-459.

Rosario, M., Schrimshaw, E., & Hunter, J. (2004). Predictors of substance use over time among gay, lesbian, and bisexual youths: an examination of three hypotheses. *Addictive Behaviors*, *29*(8), 1623-1631.

Rotheram-Borus, M., Rosario, M., Meyer-bahlburg, H. L., Koopman, C., Dopkins, S. C., & Davies, M. (1994). Sexual and Substance Use Acts of Gay and Bisexual Male Adolescents in New York City. *Journal Of Sex Research*, *31*(1), 47-57.

Rudman, L. A., & Spencer, S. J. (2007). The implicit self. *Self & Identity*, *6*(2/3), 97-100. doi:10.1080/15298860601128271

Savin-Williams, R., & Ream, G. (2003). Suicide attempts among sexual-minority male youth. *Journal Of Clinical Child And Adolescent Psychology: The Official Journal For The Society Of Clinical Child And Adolescent Psychology, American Psychological Association, Division 53*, *32*(4), 509-522.

Senreich, E. (2010). Are specialized LGBT program components helpful for gay and bisexual men in substance abuse treatment?. *Substance Use & Misuse*,*45*(7-8), 1077-1096. doi:10.3109/10826080903483855

Tonigan, J. (2007). Spirituality and Alcoholics Anonymous. *Southern Medical Journal*, *100*(4), 437-440.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (2012). A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals. *Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment*

Yücel, M., Lubman, D., Solowij, N., & Brewer, W. (2007). Understanding drug addiction: a neuropsychological perspective. *The Australian And New Zealand Journal Of Psychiatry*, *41*(12), 957-968.

Appendix A: Program Manual

Integrating the process of self-identity in sexual minorities with the treatment of substance abuse:

An Outpatient Training Program Manual

Integrating the Process of Self-Identity in Sexual Minorities with the Treatment of Substance Abuse: An Outpatient Training Program

By Steven Euler, M.A., MFTI, LAADC-R

Preface

Throughout my life, I have observed peers that have faced discrimination among those in the community, including experiencing it firsthand. It has been my experience that those that have faced discrimination have isolated themselves. Generally, this would suppress or delay many developmental steps for self-identity and growth. Moreover, I'd found that those within the sexual minority are more prone to the use of recreational drugs during the early stages of identity formation and have the ability to abuse or become addicted to those substances.

After many years of experience in the mental health field, it has been my experience that many people within this field do not either have experience or interest in working with substance use disorders. Throughout my research, I've found minimal resources with the Southern California that provide treatment for those that are coming into term with their sexual identity and those that are suffering from a substance use disorder. Some sources stated that they are friendly or will except any individual without discrimination. While that provides hope for sexual minorities, it may be beneficial for mental health facilities and clinicians to have a better understanding of identity formation and obstacles that sexual minorities face that are using recreational drugs and substances.

The purpose of this article is to close that gap or better yet, bridge it. I've found that certain facilities or programs offer substance abuse treatment under one roof and mental health services under another. Yet, if someone identifies as a sexual minority or LGBTQ and has a substance abuse issue, under which roof would they be treated and/or helped? Additionally, many facilities offer substance abuse treatment, however have limited understanding and knowledge of the stages of coming out, history, barriers faced, resources available, and how to treat those that identify as sexual minority and as having an issue with substances. How do they

interact with each and if one or the other is ignored or less emphasis is placed on one, how does it affect the treatment as a whole?

The following is a training program for outpatient facilities. The program is designed to assist in integration and to bridge treatment for substance use disorders within sexual minorities.

Contents

*Please note that the page numbers listed below have been changed to correspond with the page numbers in this project.

Introduction

Why integrate a substance abuse program with self-identity of sexual minorities?

Despite the removal of homosexuality as a mental disorder, from the Diagnostic and Statistical Manual of Mental Disorders, in 1986, American society still struggles to recognize the need to support sexual minorities. According to Crowley, Harré, and Lunt (2007), being in a place where they are the majority is very important to sexual minorities are, providing they have the feeling of having equality and the ability to act and speak freely. However, sexual minorities face a life of discrimination and a constant need to be aware of their surroundings to ensure their safety. Additionally, the fear of losing essential support during their developmental upbringing can be an added stressor. Within the lesbian, gay, bisexual, transgender, & questioning (LGBTQ) community, escape and socialization is predominantly done through the means of a club-like atmosphere (Jordon, 2000). Within the restrictive means of socialization, the exposures to substances that are generally used to escape from the negative aspects of reality. The current support for sexual minorities is minimal, with the exception of LGBTQ community centers. The support for those within the LGBTQ community who have substance use disorders is limited. Cochran, Peavy, and Robohm (2007) stated that specialized treatment services are more effective and are important to the field. Moreover, prevention and intervention programs geared towards sexual minorities may have been been overlooked.

Research supports that sexual minority youth have higher risks of substance abuse than of heterosexual youth (Jordon, 2000; Marshal, Friedman, Stall, & Thompson, 2009; Green, & Feinstein, 2011; Rotheram-Borus, Rosario, Meyer-Bahlburg, & Koopman, 1994). They face many barriers that are different from those faced by heterosexual youth at almost all developmental stages of life (Marshal et al., 2009). They have additional stressors coping with

their sexual orientation including discrimination and the feeling of being marginalized by society (Jordon, 2000; Rotheram-Borus, et al., 1994). In addition, those who identify as homosexual are more prone to leaving home as a result of parental conflict than those identifying as bisexual. This may be due to the certainty of their sexual orientation (Rew, Whittaker, Taylor-Seehafer, & Smith, 2005). There is a lack of social resources for sexual minority youth and their relations to subcultures (i.e., gangs and other problematic groups) may lead to more of an exposure to substance use (Jordon, 2000). Green and Feinstein (2012) stated that being out (openly identifying as LGBTQ) to a larger population will provide exposure to LGBTQ-specific stressors, which contributes to an elevated risk of substance use. Substance use and abuse may be linked to the feelings of isolation, depression, and the continual stress of having limited grasp on self-identity (Jordon, 2000). Marshal, Stall, and Thompson (2009), discussed that the implementation of efforts to prevent substance abuse in sexual minority youth could have long-lasting effects into adulthood. This research begins the development of a program that integrates issues surrounding the coming out process with the treatment of substance abuse.

Prior to beginning…

This outpatient training program is not a complete comprehensive overview of both the substance abuse community and LGBTQ community. It is encouraged that clinicians, agencies, and/or organizations, continue education and support in both areas of substance abuse and information concerning the LGBTQ community (e.g., workshops, continuing education courses, local resources, other experts within the fields). It is also encouraged that clinicians, to implement the outpatient training program as it is intended.

Please note that organizations that already have training in substance abuse and addiction may choose to begin the program on Part 1b and may skip Part 1a. Those organizations that already have training and knowledge of identity formulation and issues within sexual minorities may begin the program on Part 1a.

Part 1a: Working with Substance Abuse, Addiction, and Substance Use Disorders

The first part of this training is dedicated to help understand the basics of substance abuse, addiction, and the treatment of both. While some may have knowledge in this area, I found it necessary to help those that do not have much experience with substance abuse and addiction.

Chapter 1: What is Substance Abuse?

Alcoholism and drug dependence and addiction, known as substance use disorders, are complex problems. People with these disorders once were thought to have a character defect or moral weakness; some people mistakenly still believe that. However, most scientists and medical researchers now consider dependence on alcohol or drugs to be a long-term illness, like asthma, hypertension (high blood pressure), or diabetes. Most people who drink alcohol drink very little, and many people can stop taking drugs without a struggle. However, some people develop a substance use disorder—use of alcohol or drugs that is compulsive or dangerous (or both).

Why Do Some People Develop a Problem but Others Don't?

Substance use disorder is an illness that can affect anyone: rich or poor, male or female, employed or unemployed, young or old, and any race or ethnicity. Nobody knows for sure exactly what causes it, but the chance of developing a substance use disorder depends partly on genetics— biological traits passed down through families. A person's environment, psycho-logical traits, and stress level also play major roles by contributing to the use of alcohol or drugs. Researchers have found that using drugs for a long time changes the brain in important, long-lasting ways. It is as if a switch in the brain turned on

at some point. This point is different for every person, but when this switch turns on, the person crosses an invisible line and becomes dependent on the substance. People who start using drugs or alcohol early in life run a greater risk of crossing this line and becoming dependent. These changes in the brain remain long after a person stops using drugs or drinking alcohol.

What Are the Symptoms of Substance Use Disorders?

One of the most important signs of substance addiction or dependence is continued use of drugs or alcohol despite experiencing the serious negative consequences of heavy drug or alcohol use.

Often, a person will blame other people or circumstances for his or her problems instead of realizing that the difficulties result from use of drugs or alcohol. For example, someone may believe he was fired from jobs because his bosses didn't know how to run a business. Or they may believe she got a ticket for driving under the influence of alcohol because the police were targeting her. Perhaps they have even blamed someone else. People with this illness really may believe that they drink normally or that "everyone" takes drugs. These false beliefs are called denial, and denial is part of the illness.

Other important symptoms of substance use disorders include:

- Tolerance—A person will need increasingly larger amounts of alcohol or drugs to get high.
- Craving—A person will feel a strong need, desire, or urge to use alcohol or drugs, will use alcohol or a drug despite negative consequences, and will feel anxious and irritable if he or she can't use them. Craving is a primary symptom of addiction.
- Loss of control—A person often will drink more alcohol or take more drugs than he or she meant to, or may use alcohol or drugs at a time or place he or she had not planned. A person also may try to reduce or stop drinking or using drugs many times, but may fail.
- Physical dependence or withdrawal symptoms—In some cases when alcohol or drug use is stopped, a person may experience with-drawal symptoms from a physical need for the substance. Withdrawal symptoms differ depending on the drug, but they may include

nausea, sweating, shakiness, and extreme anxiety. The person may try to relieve these symptoms by taking either more of the same or a similar substance.

Chapter 2: What is Substance Abuse Treatment?

Who Provides Treatment?

Many different kinds of professionals provide treatment for substance use disorders. In most treatment programs, the main caregivers are specially trained individuals certified or licensed as substance abuse treatment counselors. About half these counselors are people who are in recovery themselves. Many programs have staff from several different ethnic or cultural groups. Most treatment programs assign patients to a treatment team of professionals. Depending on the type of treatment, teams can be made up of social workers, counselors, doctors, nurses, psychologists, psychiatrists, or other professionals.

What Will Happen First?

Everyone entering treatment receives a clinical assessment. A complete assessment of an individual is needed to help treatment professionals offer the type of treatment that best suits him or her. The assessment also helps program counselors' work with the person to design an effective treatment plan. Although clinical assessment continues throughout a person's treatment, it starts at or just before a person's admission to a treatment program. The counselor will begin by gathering information about the person, asking many questions such as those about

- Kinds, amount, and length of time of substance or alcohol use
- Cultural issues around use of alcohol or drugs
- Effects of drug or alcohol use on the person's life
- Medical history
- Current medical problems or needs
- Current medications (including pain medication)
- Mental health issues or behavioral problems

- Family and social issues and needs
- Legal or financial problems
- Educational background and needs
- Current living situation and environment
- Employment history, stability, problems, and needs
- School performance, problems, and needs, if relevant
- Previous treatment experiences or attempts to quit drug or alcohol use.

The counselor may invite family members to answer questions and express their own concerns as well. Be honest—this is not the time to cover up one's behavior. The counselor needs to get a full picture of the problem to plan and help implement the most effective treatment. It is particularly important for the counselor to know whether the individual has any serious medical problems or whether you suspect that he or she may have an emotional problem. They may feel embarrassed answering some of these questions or have difficulty completing the interview, but remember: the counselor is there to help. The treatment team uses the information gathered to recommend the best type of treatment. No one type of treatment is right for everyone; to work, the treatment needs to meet individual needs. After the assessment, a counselor or case manager is assigned. The counselor works with the person (and possibly his or her family) to develop a treatment plan. This plan lists problems, treatment goals, and ways to meet those goals. Based on the assessment, the counselor may refer to a physician to decide whether he or she needs medical supervision to stop alcohol or drug use safely.

Medically supervised withdrawal (often called detoxification or detox) uses medication to help people withdraw from alcohol or drugs. People who have been taking large amounts of opioids (e.g., heroin, OxyContin7, or codeine), barbiturates or sedatives ("downers"), pain

medications, or alcohol— either alone or together—may need medically monitored or managed withdrawal services. Sometimes, alcohol withdrawal can be so severe that people hallucinate, have convulsions, or develop other dangerous conditions. Medication can help prevent or treat such conditions. Anyone who has once had hallucinations or seizures from alcohol withdrawal or who has another serious illness or (in some cases) a mental disorder that could complicate detoxification may need medical supervision to detoxify safely. Medically supervised withdrawal can take place on a regular medical ward of a hospital, in a specialized inpatient detoxification unit, or on an outpatient basis with close medical supervision. Detoxification may take several days to a week or more. During that time, the person will receive medical care and may begin to receive education about his or her disease. Not everyone needs inpatient medically supervised detox. People with mild withdrawal symptoms from alcohol or drugs and people using cocaine, marijuana, opioids, or methamphetamine do not generally need to be hospitalized for detoxification. However, they may need out-patient medical care, a lot of support, and someone to ensure their well-being.

Social detoxification can meet this need. Sometimes social detoxification centers are part of a residential treatment program; other times they are separate facilities. Social detoxification centers are not hospitals and seldom use medication, but the person does stay there from several days to 1 week. The social detoxification staff includes nurses and coun-selors. The staff watches each person's medical condition closely, and counselors are available to help him or her through the most difficult part of withdrawing from alcohol and drugs. It is important to know that detoxification is not treatment; it is a first step that can prepare a person for treatment.

What Types of Treatment Programs Are Available?

Several types of treatment programs are available:

- Inpatient treatment
- Residential programs
- Partial hospitalization or day treatment
- Outpatient and intensive outpatient programs
- Methadone clinics (also called opioid treatment programs).

Inpatient treatment, provided in special units of hospitals or medical clinics, offers both detoxification and rehabilitation services. Several years ago, many hospital-based treatment programs existed. Today, because of changes in insurance coverage, inpatient treatment is no longer as common as it used to be. People who have a mental disorder or serious medical problems as well as a substance use disorder are the ones most likely to receive inpatient treatment. Adolescents may also need the structure of inpatient treatment to make sure a full assessment of their substance use and mental disorders can be done.

Residential programs provide a living environment with treatment services. Several models of residential treatment (such as the therapeutic community) exist, and treatment in these programs lasts from a month to a year or more. The programs differ in some ways, but they are similar in many ways.

Residential programs often have phases of treatment, with different expectations and activities during each phase. For example, in the first phase, an adult's contact with family, friends, and job may be restricted. An adolescent may be able to have contact with his or her parents but not with friends or with school. This restriction helps the person become part of the treatment community and adjust to the treatment setting. In a later phase, a person may be able to start working again, going "home" to the facility every evening. If your loved one is in a residential treatment program, it is important that you know and understand the program rules

and expectations. Often residential programs last long enough to offer general equivalency diploma (GED) preparation classes, training in job-seeking skills, and even career training. In residential programs for adolescents, the participants attend school as a part of the program. Some residential programs are designed to enable women who need treatment to bring their children with them. These programs offer child care and parenting classes.

Residential programs are best for people who do not have stable living or employment situations and/or have limited or no family support. Residential treatment may help people with very serious substance use disorder who have been unable to get and stay sober or drug free in other treatment.

Partial hospitalization or day treatment programs also may be provided in hospitals or free-standing clinics. In these programs, the person attends treatment for 4 to 8 hours per day but lives at home. These programs usually last for at least 3 months and work best for people who have a stable, supportive home environment.

Outpatient and intensive outpatient programs provide treatment at a program site, but the person lives elsewhere (usually at home). Outpatient treatment is offered in a variety of places: health clinics, community mental health clinics, counselors' offices, hospital clinics, local health department offices, or residential programs with outpatient clinics. Many meet in the evenings and on weekends so participants can go to school or work. Outpatient treatment programs have different requirements for attendance. Some programs require daily attendance; others meet only one to three times per week.

Intensive outpatient treatment programs require a person to attend 9 to 20 hours of treatment activities per week. Outpatient programs last from about 2 months to 1 year. People who do best in an outpatient program are willing to attend counseling sessions regularly, have

supportive friends or family members, have a place to live, and have some form of transportation to get to treatment sessions (some programs will provide transportation if needed).

Opioid treatment programs (OTPs), sometimes known as methadone clinics, offer medication-assisted outpatient treatment for people who are dependent on opioid drugs (such as heroin, OxyContin, or Vicodin). These programs use a medication, such as methadone or LAAM, to help a person not use illicit opioids. OTPs provide counseling and other services along with the medication.

What Actually Happens in Treatment Programs?

Although treatment programs differ, the basic ingredients of treatment are similar. Most programs include many or all elements presented below.

Assessment

As we discussed earlier, all treatment programs begin with a clinical assessment of a person's individual treatment needs. This assessment helps in the development of an effective treatment plan.

Medical Care

Programs in hospitals can provide this care on site. Other outpatient or residential programs may have doctors and nurses come to the program site for a few days each week, or a person may be referred to other places for medical care. Medical care typically includes screening and treatment for HIV/AIDS, hepatitis, tuberculosis, and women's health issues.

A Treatment Plan

The treatment team, along with the person in treatment, develops a treatment plan based on the assessment. A treatment plan is a written guide to treatment that includes the person's goals,

treatment activities designed to help him or her meet those goals, ways to tell whether a goal has been met, and a timeframe for meeting goals.

The treatment plan helps both the person in treatment and treatment program staff stay focused and on track. The treatment plan is adjusted over time to meet changing needs and ensure that it stays relevant.

Group and Individual Counseling

At first, individual counseling generally focuses on motivating the person to stop using drugs or alcohol. Treatment then shifts to helping the person stay drug and alcohol free.

The counselor attempts to help the person

- See the problem and become motivated to change
- Change his or her behavior
- Repair damaged relation-ships with family and friends
- Build new friendships with people who don't use alcohol or drugs
- Create a recovery lifestyle.

Group counseling is different in each program, but group members usually support and try to help one another cope with life without using drugs or alcohol. They share their experiences, talk about their feelings and problems, and find out that others have similar problems. Groups also may explore spirituality and its role in recovery.

Individual Assignments

People in treatment may be asked to read certain things (or listen to audiotapes), to complete written assignments (or record them on audiotapes), or to try new behaviors.

Education about Substance Use Disorders

People learn about the symptoms and the effects of alcohol and drug use on their brains and bodies. Education groups use videotapes or audiotapes, lectures, or activities to help people learn about their illness and how to manage it.

Life Skills Training

This training can include learning and practicing employment skills, leisure activities, social skills, communication skills, anger management, stress management, goal setting, and money and time management.

Testing for Alcohol or Drug Use

Program staff members regularly take urine samples from people for drug testing. Some programs are starting to test saliva instead of urine. They also may use a BreathalyzerTM to test people for alcohol use.

Relapse Prevention Training

Relapse prevention training teaches people how to identify their relapse triggers, how to cope with cravings, how to develop plans for handling stressful situations, and what to do if they relapse. A trigger is anything that makes a person craves a drug. Triggers often are connected to the person's past use, such as a person he or she used drugs with, a time or place, drug use paraphernalia (such as syringes, a pipe, or a bong), or a particular situation or emotion.

Orientation to Self-Help Groups

Participants in self-help groups support and encourage one another to become or stay drug and alcohol free. Twelve-Step programs are perhaps the best known of the self-help groups. These programs include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous, and Marijuana Anonymous. Other self-help groups include SMART (Self-Management and Recovery Training) Recovery7 and Women for Sobriety.

Members themselves, not treatment facilities, run self-help groups. In many places, self-help groups offer meetings for people with particular needs. You may find special meetings for young people; women; lesbian, gay, and bisexual people; newcomers; and those who need meetings in languages other than English. Internet chat groups and online meetings are also available for some groups. Many treatment programs recommend or require attendance at self-help groups. By attending, many people make new friends who help them stay in recovery. The number of meetings required varies by treatment program; many programs require participants to attend "90 meetings in 90 days," as AA and NA recommend. Some treatment programs encourage people to find a "sponsor," that is, someone who has been in the group for a while and can offer personal support and advice. Self-help groups are very important in most people's recovery. It is important to understand, however, that these groups are not the same as treatment. There are self-help groups for family members, too, such as Al-Anon and Alateen.

Treatment for Mental Disorders

Many people with a substance use disorder also have emotional problems such as depression, anxiety, or post-traumatic stress disorder. Adolescents in treatment also may have behavior problems, conduct disorder, or attention deficit/hyperactivity disorder. Treating both the substance use and mental disorders increases the chances that the person will recover. Some counselors think people should be alcohol and drug free for at least 3 to 4 weeks before a treatment professional can identify emotional illness correctly. The program may provide mental healthcare, or it may refer a person to other sites for this care. Mental health care often includes the use of medications, such as antidepressants.

Family Education and Counseling Services

This education can help with understanding the disease and its causes, effects, and treatment. Programs provide this education in many ways: lectures, discussions, activities, and group meetings. Some pro-grams provide counseling for families or couples. Family counseling is especially critical in treatment for adolescents. Parents need to be involved in treatment planning and follow-up care decisions for the adolescent. Family members also need to participate as fully as possible in the family counseling the program offers.

Medication

Many programs use medications to help in the treatment process. Although no medications cure dependence on drugs or alcohol, some do help people stay abstinent and can be lifesaving. Medication is the primary focus of some programs, such as the medication-assisted OTPs discussed earlier. Methadone is a medication that prevents opioid withdrawal symptoms for about 24 hours, so the person must take it daily. Taken as directed, it does not make a person high but allows him or her to function normally. In fact, methadone blocks the "high" a person gets from an opioid drug. Some people stay on methadone for only 6 months to 1 year and then gradually stop taking it; most of these people relapse and begin to use opioids again. However, others stay on methadone for long periods of time or for life, which is called methadone maintenance treatment. People receiving this treatment often have good jobs and lead happy, productive lives.

If the individual is taking medications for HIV infection or AIDS or for any other medical condition, it is important that OTP staff members know exactly what he or she is taking. Mixing some medications with methadone or LAAM may mean that your family member will need special medical supervision.

Buprenorphine is another medication that may be used to treat opioid dependence and is sometimes used by OTPs. Buprenorphine recently was approved for treatment by primary care doctors in their offices. A doctor treating a patient with buprenorphine generally will provide or refer the patient for counseling, also. Disulfiram (Antabuse7) is a medication that causes a bad reaction if people drink alcohol while taking it. The reaction is flushing, nausea, vomiting, and anxiety. Because people know the medication will make them very ill if they drink alcohol, it helps them not to drink it. Antabuse is taken daily.

Q: If substance use disorder is a disease, why aren't there medicines that will help?

A: There are medicines that will help, though only for some addictions. No "magic pill" exists to cure substance use disorders, but medicines can often be an important part of the treatment. Medications are used to detoxify a person, to prevent him or her from feeling high from taking drugs, to reduce cravings, or to treat a person's mental disorder.

Another medication, naltrex-one (ReVia7), reduces the craving for alcohol. This medication can help keep people who drink a small amount of alcohol from drinking more of it. Programs also sometimes use naltrexone to treat heroin or other opioid dependence because it blocks the drug's effects. It is important for people who use heroin to go through detox first, so they are heroin free before starting to take naltrexone.

Because it is very difficult for a person to detoxify from opioid drugs, many people don't make it that far; buprenorphine is sometimes used to help people make that transition. If a person does detoxify from opioids and begins to take naltrexone, it still will not work well for this purpose unless a person has a strong social support system, including someone who will make sure that he or she continues to take the medication regularly. When an adolescent is taking

naltrexone to treat opioid dependence, it is particularly important that parents provide strong support and supervision.

Follow-up Care (Also Called Continuing Care)

Even when a person has successfully completed a treat-ment program, the danger of returning to alcohol or drug use (called a "slip" or relapse) remains. The longer a person stays in treatment, including follow-up, the more likely he or she is to stay in recovery. Once a person has completed basic treatment, a program will offer a follow-up care pro-gram at the treatment facility or will refer him or her to another site. Most programs recommend that a person stay in follow-up care for at least 1 year. Adolescents often need follow-up care for a longer period.

Follow-up care is very important to successful treatment. Once a person is back in his or her community, back in school, or back at work, he or she will experience many temptations and cravings for alcohol or drugs. In follow-up care, an individual will meet periodically with a counselor or a group to determine how he or she is coping and to help him or her deal with the challenges of recovery.

For some people, particularly those who have been in residential treatment or prison-based programs, more intensive forms of follow-up care may be helpful. Halfway houses or sober houses are alcohol- and drug-free places to live for people coming from a prison-based or residential program. People usually stay from 3 months to 1 year, and counseling is provided at the site or at an outpatient facility.

Supportive living or transitional apartments provide small group living arrangements for those who need a sober and drug-free living environment. The residents support one another, and involvement in outpatient counseling and self-help groups is expected.

Source: Center for Substance Abuse Treatment. What Is Substance Abuse Treatment? A Booklet for Families. DHHS Publication No. (SMA) 08-4126. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004, reprinted 2005, 2006, 2007, and 2008.

Part 1b

Treating LGBT Clients

The second part of this training is dedicated to help understand the basics of working with and understanding culture issues, legal issues, in treating LGBT clients. While some may have knowledge in this area, I found it necessary to help those that do not have much experience or knowledge in working with sexual minorities.

Chapter 3: An Overview for Providers Treating LGBT Clients

Introduction

For substance abuse treatment providers to deliver skilled care to lesbian, gay, bisexual, and transgender (LGBT) clients, they need to be aware of issues specific to the LGBT community. This chapter presents an overview of the use and abuse of substances in the LGBT community and a brief introduction to the concepts of gender identity, sexual orientation, homophobia, and heterosexism.

Substance Use and Abuse in the LGBT Community

In a discussion of the epidemiology of substance use and abuse among LGBT individuals, the following two questions are of interest to providers:

- What is the epidemiology of substance use and abuse among LGBT individuals?
- Do LGBT individuals use or abuse more substances than heterosexuals or the general population?

Epidemiology is the study of the patterns of disease and health problems in populations and the factors that influence these patterns. Prevalence refers to the number of people in a given population who are affected by a particular disease at a certain time; it is frequently expressed in percentages. Incidence refers to the number of new cases of a disease or condition, such as alcoholism or drug abuse, in a given population over a specified time (such as a year).

Rates of substance use and abuse vary from population to population. The numerous reasons for the varying rates include biological, genetic, psychological, familial, religious, cultural, and historical circumstances. The LGBT population is similar to the general population in that numerous factors predispose its members to substance abuse. However, some clinicians argue that the additional stigma and resulting tension of being a member of a marginalized

community such as the LGBT community cause some members of the marginalized community to seek to manage these additional stressors by using mind-altering substances.

The precise incidence and prevalence rates of substance use and abuse by LGBT individuals have been difficult to determine for several reasons. Reliable information on the size of the LGBT population is not available. Scientific studies of LGBT individuals' substance abuse do not always clearly define the difference between substance use and substance abuse, making it difficult to compare studies. Many studies have methodological flaws, such as the use of convenience samples that only infer or estimate substance abuse among the LGBT population. However, several promising studies are under way that, it is hoped, will provide additional information. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) will continue to report the results of these studies as they are completed.

To provide background information for this publication, the authors conducted a review of the epidemiological literature, and 16 studies were chosen to highlight the extent of substance use or abuse problems in the LGBT population. The table in appendix D, Studies on LGBT Substance Abuse, presents a comparison of the studies. Studies were included if they focused on the LGBT population and substance abuse but did not focus primarily on the human immunodeficiency virus (HIV). These studies are considered classics and have been cited in numerous articles about LGBT individuals' substance abuse. The summary is by no means exhaustive; however, it provides the context for exploring the issue and has implications for future research.

Publication dates of articles about the selected studies range from 1970 to 2000. Of the 16 studies, 10 focused primarily on substance abuse in the lesbian population, 3 focused on both

lesbians and gay men, 1 focused exclusively on gay men, 1 focused exclusively on men who have sex with men (MSM), and focused on transgender individuals. Eleven of the studies used convenience samples, and five used population-based data. Most of the studies reported on alcohol use.

These studies generally state that gay men and lesbians have greater substance abuse problems than non-LGBT men and women. In seven studies, comparisons between the LGBT population and the heterosexual population could not be made. Studies by Saghir and colleagues (1970); Fifield, DeCrescenzo, and Latham (1975); Lewis, Saghir, and Robins (1982); and Morales and Graves (1983) found that approximately 30 percent of all lesbians have an alcohol abuse problem. Studies that compared gay men or lesbians with heterosexuals (Stall & Wiley, 1988; McKirnan & Peterson, 1989; Bloomfield, 1993; Skinner, 1994; Skinner & Otis, 1996; Hughes & Wilsnack, 1997) found that gay men and lesbians were heavier substance and alcohol users than the general or heterosexual population. From these studies, it is clear that substance abuse treatment is needed and that providers need to know more about this community to provide competent treatment.

Types of Substances Abused

Over the past several years, the concerns about the epidemic of HIV-related conditions have led to an increased number of studies of both gay and bisexual men and injection drug users. Although LGBT persons use and abuse alcohol and all types of drugs, there are certain drugs seem to be more popular in the LGBT community than in the majority community.

Woody and colleagues (1999) compared a convenience sample of MSM at high risk for HIV who participated in a vaccine preparedness study with a nationally representative sample of men from the 1995 National Household Survey on Drug Abuse (NHSDA). The study found that

these MSM were 21 times more likely to use nitrite inhalants. They were also much more likely (four to seven times) to use hallucinogens, stimulants, sedatives, and tranquilizers than the men in the NHSDA sample. The study also found that weekly use by this MSM sample was 2 times more likely for marijuana, cocaine, and stimulants and 33 times more likely for inhalant nitrites.

A study by Cochran and Mays (2000) found that people with same-sex partners were more likely to use substances than were people with opposite-sex partners. Closer examination of the data (Cochran et al., in press) comparing MSM with heterosexual men and comparing lesbians with heterosexual women showed little difference between MSM and heterosexual male substance abuse but showed that rates of alcohol use were much higher for lesbians than for heterosexual women. For example, lesbians used alcohol twice as often in the past month, were five times more likely to use alcohol every day, were more than twice as likely to get intoxicated, and were four times more likely to get intoxicated weekly than heterosexual women.

Another study of lesbians using self-reported data stated that rates of alcohol use in the lesbian population were higher than those in the general population, but not as high as rates in other studies, and that the most significant predictor of alcohol use was reliance on bars as a primary social setting (Heffernan, 1998).

Designer Drug Use

Abuse of methamphetamine, also known as meth, speed, crystal, or crank, has increased dramatically in recent years (Drug Abuse Warning Network, 1998; Derlet & Heischober, 1990; Morgan et al., 1993; National Institute on Drug Abuse, 1994; Gorman, Morgan & Lambert, 1995; CSAT, 1997b), particularly among gay men but also among male-to-female (MTF) transgender individuals and, increasingly, among some groups of lesbians.

What makes the current epidemic so discon-certing is its relationship to the HIV epidemic

(Ostrow, 1996; Gorman et al., 1997).

Amphetamines and methamphetamine currently are the most popular synthetic stimulants in the United States, and abuse of them can lead to significant dependence and addiction. The drugs may be drunk, eaten, smoked, injected, or absorbed rectally. They have a half-life of approximately 24 hours. They work by releasing neurotransmitters, and users suffer the same addiction cycle and withdrawal reactions as those suffered by crack cocaine users. These substances increase the heart rate, blood pressure, respiration rate, and body temperature. They cause pupil dilation and produce alertness, a sense of euphoria, and increased energy. After prolonged use, users often experience severe depression and sometimes paranoia. They may also become belligerent and aggressive.

Methamphetamine use appears to be integral to the sexual activities of a certain segment of gay men, especially in some urban communities. The so-called party drugs, such as MDMA (methylenedioxymethamphetamine) (also known as ecstasy or X-T-C), “Special K” or ketamine, and GHB (gamma hydroxybutyrate), are increasingly popular at dances and celebrations, such as circuit parties and raves.

MDMA is a synthetic drug with hallucinogenic and amphetamine-like properties. The effects are reminiscent of lysergic acid diethylamide-25 (LSD). Ketamine, a white crystalline powder that is soluble in water and alcohol, is a dissociative anesthetic, a synthetic drug that produces hallucinations, analgesia, and amnesia and can cause euphoria. Users can experience impaired thought processes, confusion, dizziness, impaired motor coordination, and slurred speech. Liquid X (GHB) possesses euphoric properties, and overdoses can cause electrolyte imbalances, decreased respiration, confusion, and hypertension, as well as seizure-like activity and vomiting.

Party drugs can impair judgment and increase sexual risk taking. Research has shown a connection between use of nitrite and high-risk sexual behavior (Ostrow et al., 1993), and there is compelling evidence that HIV and hepatitis C infections are linked with methamphetamine use. Studies in several cities indicate that gay and bisexual men who used speed, alone or in combination with other drugs, appear to have much higher seroprevalence rates than either heterosexual injection drug users or gay and bisexual men who do not use these drugs (Harris et al., 1993; Diaz et al., 1994; Gorman, 1996; CDC [Centers for Disease Control and Prevention], 1995; Hays, Kegeles & Coates, 1990; Waldorf & Murphy, 1990; Paul, Stall & Davis, 1993; Paul et al., 1994). This finding is particularly apparent for individuals who inject these drugs and who share needles or injecting equipment. Although most LGBT meth users probably snort, ingest, or smoke the drugs, a sizable number also report histories of injection drug use. Within the substance-abusing population in general, and the LGBT population in particular, injection drug users represent an often hidden and stigmatized group. Public health efforts have targeted mostly heterosexual injection drug users of heroin. A number of injection drug users inject methamphetamine, and a number of these are LGBT individuals.

Information on the needle hygiene of methamphetamine users or LGBT injection drug users is lacking. Some HIV-positive individuals appear to be self-medicating for depression or specific HIV-related symptoms by using methamphetamine because it reduces lethargy, raises libido, and can be an antidepressant. Mixing these drugs can be dangerous, and some deaths have been documented from using party drugs while taking protease inhibitors.

Definition of Terms and Concepts Related to LGBT Issues

Understanding how certain terms are used is essential to understanding homosexuality. It is important to recognize the difference between sexual orientation and sexual behavior as well as the differences among sexual orientation, gender identity, and gender role.

Sexual orientation may be defined as the erotic and affectional (or loving) attraction to another person, including erotic fantasy, erotic activity or behavior, and affectional needs. Heterosexuality is the attraction to persons of the opposite sex; homosexuality, to persons of the same sex; and bisexuality, to both sexes. Sexual orientation can be seen as part of a continuum ranging from same-sex attraction only (at one end of the continuum) to opposite-sex attraction only (at the other end of the continuum).

Sexual behavior, or sexual activity, differs from sexual orientation and alone does not define someone as an LGBT individual. Any person may be capable of sexual behavior with a person of the same or opposite sex, but an individual knows his or her longings—erotic and affectional—and which sex is more likely to satisfy those needs. It is necessary to draw a distinction between sexual orientation and sexual behavior. Not every person with a homosexual or bisexual orientation, as indicated by his or her fantasies, engages in homosexual behavior. Nor does sexual behavior alone define orientation. A personal awareness of having a sexual orientation that is not exclusively heterosexual is one way a person identifies herself or himself as an LGBT person. Or a person may have a sexual identity that differs from his or her biological sex—that is, a person may have been born a male but identifies and feels more comfortable as a female. Sexual orientation and gender identity are two independent variables in an individual's definition of himself or herself.

Sexual identity is the personal and unique way that a person perceives his or her own sexual desires and sexual expressions. Biological sex is the biological distinction between men and women.

Gender is the concept of maleness and masculinity or femaleness and femininity. One's gender identity is the sense of one's self as male or female and does not refer to one's sexual orientation or gender role. Gender role refers to the behaviors and desires to act in certain ways that are feminine by a particular culture.

A culture usually labels behaviors as masculine or feminine, but these behaviors are not necessarily a direct component of gender or gender identity. It is common in our culture to call the behaviors, styles, or interests shown by males that are usually associated with women "effeminate" and to call the boys who behave this way "sissies." Women or girls who have interests usually associated with men are labeled "masculine" or "butch," and the girls are often called "tomboys."

Transgender individuals are those who conform to the gender role expectations of the opposite sex or those who may clearly identify their gender as the opposite of their biological sex. In common usage, transgender usually refers to people in the transsexual group that may include people who are contemplating or preparing for sexual reassignment surgery— called preoperative—or who have undergone sexual reassignment surgery—called postoperative. A transgender person may be sexually attracted to males, females, or both.

Transvestites cross dress, that is, wear clothes usually worn by people of the opposite biological sex. They do not, however, identify themselves as having a gender identity different from their biological sex or gender role. The motivations for cross dressing vary, but most transvestites enjoy cross dressing and may experience sexual excitement from it. The vast

majority of transvestites are heterosexual, and they usually are not included in general discussions about LGBT people.

Gender identity disorder (GID) was introduced in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV) (American Psychiatric Association, 1994). Although GID is listed as a mental ill-ness, most clinicians do not consider individuals who are confused or conflicted about their biological gender and their personal sense of their gender identity to be mentally ill. Considerable work needs to be done to augment the small amount of research available on the development of a transgender identity—that is, how a person becomes aware of a sexual identity that does not match his or her biological sex or gender role.

Estimates of the Number of LGBT Individuals

The true number of people who identify themselves as LGBT individuals is not known. Because of a lack of research focusing on the LGBT population and the mistrust that makes many LGBT people afraid to be open about their identity, reliable data are difficult to obtain. The popular estimate that 10 percent of the male population and 5 to 6 percent of the female population are exclusively or predominately homosexual is based on the Kinsey Institute data (Kinsey, Pomeron & Martin, 1948; Kinsey et al., 1953) addressing sexual behavior. Kinsey proposed the Kinsey Scale, a continuum that rated sexual behavior on a scale from zero to six. Zero represented exclusive heterosexual behavior and six represented exclusive homosexual behavior. The survey reported that 37 percent of American men had at least one homosexual experience after adolescence; 5 to 7 percent had bisexual experiences but preferred homosexual ones; and 4 to 5 percent had homosexual experiences exclusively.

These data illustrate how widespread male homosexual behavior is, not necessarily the number of gay men. The same research indicated that the majority of those surveyed reported

behavior in a range Kinsey termed bisexual. Again, the classification is based only on reported behavior. For many minority populations, bisexuality—but not homosexuality—is acceptable (or at least admittable on surveys). For example, in the 1989 Centers for Disease Control and Prevention 8-year review of acquired immunodeficiency syndrome (AIDS) cases among gay or bisexual men, 54.2 percent of African Americans were reported to be bisexual, 44.2 percent of Hispanics were reported to be bisexual, and 11.3 percent of Caucasians were reported to be bisexual.

Michaels (1996) thoroughly analyzed the limited available data and concluded that determining prevalence rates of sexual orientations is extremely difficult because the data are widely disparate. He estimates that in the United States, 9.8 percent of men and 5 percent of women report same-gender sexual behavior since puberty; 7.7 percent of men and 7.5percent of women report same-gender desire; and 2.8 percent of men and 1.4 percent of women report a homosexual or bisexual identity.

The data on the number of transgender people are even more limited. Some psychiatric literature estimates that 1 percent of the population may have had a transgender experience, but this estimate is based only on transgender people who might have sought mental health services (Seil, 1996).

Homophobia and Heterosexism

Having a general understanding of heterosexism, homophobia, and antigay bias is important for substance abuse treatment providers working with LGBT individuals. Alport (1952) defined prejudice as a negative attitude based on error and overgeneralization and identified the three interdependent states of acting out prejudice as verbal attacks, discrimination, and violence. Verbal attacks can range from denigratory language to pseudoscientific theories

and findings, which serve as a foundation for discrimination and violence. Following this theory, prejudice and discrimination against LGBT individuals is formed, in part, by misinformation such as the following:

- All gay men are effeminate, and all lesbians are masculine.
- LGBT persons are child molesters.
- LGBT individuals are unsuitable for professional responsibilities and positions.
- LGBT persons cannot have fulfilling relationships.
- LGBT persons are mentally ill.

Once negative generalizations are formed about a group of people, some members of the majority group feel that they can treat the other group differently. As the acceptance of negative stereotypes spreads, discrimination and violence can result.

Heterosexism and homophobia are used to describe the prejudice against LGBT people. Heterosexism is a prejudice similar to racism and sexism. It denies, ignores, denigrates, or stigmatizes any nonheterosexual form of emotional and affectional expression, sexual activity, behavior, relationship, or socially identified community. Heterosexism exists in everyone—LGBT individuals as well as heterosexuals—because almost everyone is brought up in a predominately heterosexual society that has little or no positive recognition of homosexuality or bisexuality. Heterosexism supports the mistaken belief that gay men— because they are attracted to men—are in some way like women, and lesbians, in turn, are in some way like men.

Homophobia, although a popular term, lacks precise meaning. Coined in 1972 to describe fear and loathing of gay men and lesbians, it also has been used by gay men, lesbians, and bisexuals to describe self-loathing, fear, or resistance to accepting and expressing sexual orientation (Weinberg, 1983). Antigay bias is another phrase to describe the first concept, and

internalized homophobiais another phrase for the latter. Internalized homophobia is a key concept in understanding issues facing gay men, lesbians, and bisexuals in substance abuse treatment.

Examples of heterosexism in the United States include the following:

- The widespread lack of legal protection for individuals in employment and housing
- The continuing discrimination on lesbian and gay military personnel
- The hostility and lack of support for lesbian and gay committed relationships as seen in the passage of Federal and State laws against same-gender marriages
- The enforcement of outdated sodomy laws that are applied to LGBT individuals but not applied to heterosexual individuals.

Examples of heterosexism in the substance abuse treatment setting are as follows:

- Gay-bashing conversations
- Cynical remarks and jokes regarding gay sexual behaviors
- Jokes about openly LGBT staff members
- Lack of openly LGBT personnel
- Lack of inclusion of LGBT individuals' family members or significant others in treatment processes.

Substance abuse treatment providers should remember that LGBT clients do not know the reaction they will receive when mentioning their sexual orientation. For example, public opinion measures indicate that homosexuality is not widely accepted. In 1996, Gallup Poll data showed 50 percent of respondents reported that homosexuality was unacceptable and only 45 percent found homosexuality an acceptable lifestyle. In addition, Herek (1989) found that as

many as 92 percent of lesbians and gay men reported that they have been the target of threats, and as many as 24 percent reported physical attacks because of their sexual orientation.

It is likely that all substance abuse treatment programs have LGBT clients, but staff members may not be aware that they are treating LGBT clients. Most treatment programs do not ask about sexual orientation, and many LGBT people are afraid to speak openly about their sexual orientation or identity. Treatment programs also may not realize that they have LGBT staff members, who can be a great resource for treating LGBT clients.

How Heterosexism Contributes to Substance Abuse

When treating LGBT clients, it is helpful for providers to understand the effect of heterosexism on their LGBT clients. The role of heterosexism in the etiology of substance abuse is unclear. Heterosexism instills shame in LGBT individuals, causing them to internalize the homophobia that is directed toward them by society (Neisen, 1990, 1993). Some LGBT individuals may use intoxicants to cope with shame and other negative feelings. Some LGBT individuals learn to devalue themselves and value only heterosexual persons instead. The negative effects of heterosexism include the following:

- Self-blame for the victimization one has suffered
- A negative self-concept as a result of negative messages about homosexuality
- Anger directed inward resulting in destructive patterns such as substance abuse
- A victim mentality or feelings of inadequacy, hopelessness, and despair that interfere with leading a fulfilling life
- Self-victimization that may hinder emotional growth and development.

Recognizing that heterosexism is a type of victimization helps the counselor and client draw a parallel with recovery from other types of victimization, whether they are culturally or

individually based. It is crucial that counselors and clients recognize that these effects result from prejudice and discrimination and are not a consequence of one's sexuality. It is not surprising to find that many LGBT individuals in therapy report feeling isolated, fearful, depressed, anxious, and angry and have difficulty trusting others. Meyer (1993) reports that the victimization of gay males in our society results in mental health consequences for individuals. A skilled substance abuse treatment counselor should be attentive to the negative effects that prejudice produces when working with LGBT clients.

Perspectives on Homosexuality

Homosexuality, as a specific category, was not described in the medical or psychiatric literature until the early 1870s. The fledgling psychoanalytic movement regarded homosexuality as a topic of special interest. Sigmund Freud believed a person's sexual orientation, in and of itself, did not impair his or her judgment or cause problems, and Freud set a positive tone when he supported homosexual colleagues in medical and psychiatric societies. Even so, European psychoanalytic organizations did not welcome gay men and lesbians as members in the early years of psychiatry, and many American psychiatrists and psychoanalysts promoted the attitude that homosexuality was a mental disorder.

Bieber and colleagues (1962) proposed that childhood influences and family upbringing were responsible for producing male homosexuality and described the classic combination of a distant, uninvolved father and an overinvolved mother. They did not consider biology or genetics as playing a role. Other psychoanalytic writing also refuted a biological component to female homosexuality, seeing it as caused primarily by early developmental disturbances.

Alfred Kinsey introduced new perspectives on homosexuality with his studies of sexual behavior (Kinsey, Pomeron & Martin, 1948; Kinsey et al., 1953). Although his studies have been

criticized for a variety of reasons, such as poor sampling methods, the studies greatly increased Americans' awareness of sexuality and the range of sexual behavior.

The psychologist Evelyn Hooker (1957) demonstrated that no discernible differences existed between the psychological profiles of gay men and those of heterosexual men, effectively beginning the debunking of the theory that homosexuality is a mental illness. Psychiatrist Judd Marmor (1980) recognized that homosexuality could not be explained in a single dimension and helped support exploring the biological, genetic, psychological, familial, and social factors involved in the formation and expression of a homosexual orientation.

In 1973, the American Psychiatric Association, after extensive scientific review and debate, stopped classifying homosexuality as a mental illness. Homosexuality is now seen as a normal variation of human sexual and emotional expression, allowing, it is hoped, a nonpathological and nonprejudicial view of homosexuality as well as of LGBT people. LGBT people and homosexual and bisexual behavior are found in almost all societies and cultures in the world and throughout history

(Herdt, 1996). But the degree of tolerance and acceptance of them has varied considerably in different periods of history and from country to country, culture to culture, and community to community. Anthropological studies that have observed homosexual behavior in other cultures may help put homosexuality in global perspective and may contribute to understanding some of the issues facing American LGBT individuals who are from ethnic or cultural minority groups, such as African Americans (Jones & Hill, 1996), Asian Americans (Nakajima, Chan & Lee, 1996), Latinos/ Latinas/Hispanics (Gonzalez & Espin, 1996), and Native Americans (Tafoya, 1996).

The genetic and biological contributions to sexual orientation have been studied increasingly in recent years. Unfortunately, the biological studies often grow out of the confusion between sexual orientation and gender identity. Many studies have tried to demonstrate that physical traits in gay men resemble those of women or have tried to identify traits in lesbians that resemble those of males. These views are based on the belief that, if a man wishes to be with a man, he must somehow be like a woman, and a woman wishing to be with a woman must, in some way, be like a man.

The Kinsey Institute has supported surveys and studies of both sexual behavior and sexual orientation and concluded that homosexuality must be innate, that is, inborn, and is not influenced developmentally by family upbringing (Bell & Weinberg, 1978; Bell, Weinberg & Hammersmith, 1981; Weinberg & Williams, 1974). The studies noted the diversity and variety of gay men and lesbians, recognizing that there was no uniform way to be or become gay or lesbian in our society.

Lesbianism and female homosexuality have also been studied from a nonpathological perspective. Magee and Miller (1998) reviewed these efforts and found no psychodynamic etiologies to female homosexuality and that each lesbian is unique and without stereotypic characteristics.

Studies of intersexual people, that is, people with sexually ambiguous genitalia or true hermaphrodites, are often analyzed. Hermaphrodites have both male and female reproductive organs. These studies ultimately are about gender role expectations and do not contribute to our understanding of homosexuality.

The most promising areas of study involve genetics and familial patterns. Although the gene has not been identified, Hamer and Copeland (1994) have reported a linkage on the X

chromosome that may influence homosexual orientation. The genetic and familial patterns studied by Pillard, Bailey, and Weinrich and their colleagues (Bailey et al., 1993; Bailey & Pillard, 1991; Pillard, 1996) have demonstrated the most consistent and verifiable data. Pillard found that gay men are much more likely to have gay or bisexual male siblings than heterosexual males—based on the incidence of homosexuality—but are not more likely to have lesbian sisters than are heterosexual males. Lesbians are more likely to have lesbian sisters but are not more likely to have gay brothers.

Combined with other twin and heritability studies, this research helps explain the probable genetic substrate of sexual orientation, with different genetic influences for male homosexuality, male heterosexuality, female homosexuality, female heterosexuality, and, possibly, bisexuality. Although the complex set of behaviors and feelings of homosexuality could not be explained by a single factor, a genetic basis seems to be the foundation on which other complex biological, familial, and societal influences work to shape the development and expression of sexual orientation (LeVay, 1996).

Perspectives on Bisexuality

Bisexuality has also existed throughout recorded history. Freud believed in innate bisexuality and that an individual evolves into a heterosexual or a homosexual, rarely a bisexual (Freud, 1963). Many bisexuals still find themselves contending with this lack of acknowledgment that a bisexual orientation can be an endpoint in itself and not just a step toward heterosexuality or homosexuality.

It is helpful for providers to know that the clinical issues facing bisexuals often are problems resulting from the difficulty of acknowledging and acting on a sexual orientation

that is not accepted by the heterosexual majority but also not accepted by many gay men and lesbians.

Some people of color in the United States or people from different cultures may define themselves as bisexual, even if they focus exclusively on people of the same sex (Gonzalez & Espin, 1996). This perspective may be their way of coping with the stigma of homosexuality. Reviews that discuss theory and clinical issues include those by Weinberg, Williams, and Pryor (1994); Klein and Wolfe (1985); and Fox (1996).

Sexual Orientation over Time

Although this chapter presents sexual orientation as belonging to one of three categories—homosexual, bisexual, or heterosexual—clearly sexual feelings, sexual behaviors, and sexual orientation may vary over time. As Kinsey found, sexual behavior ranges over a continuum from sexual activity with people of the same sex exclusively to sexual activity with people of the opposite sex exclusively, and most people's behavior falls somewhere in between. Sexual orientation also follows the same continuum—from sexual interest in people of the same sex exclusively to sexual interest in people of the opposite sex exclusively.

The mapping of sexual orientation over time has not been well studied. It seems that most people have a fairly stable and fixed sexual orientation, once they become aware of their sexual orientation. Nevertheless, some people's sexual orientation may vary. Women's orientation may be more changeable than men's, possibly because of society's homophobia and because men are more uncomfortable with a non-heterosexual identity. Some people may not become fully aware of their orientation for years and may seem to change sexual orientation when, in fact, they are just becoming conscious of their true orientation. This knowledge may help providers support

their LGBT client whose confusion about sexual issues is interfering with recovery from substance abuse.

Some types of therapies claim to be able to change a person's sexual orientation. These conversion therapies or reparative therapies are often practiced by religiously based therapists or by some psychoanalysts who still consider homosexuality a mental illness. These therapies treat people who are uncomfortable with being gay, lesbian, or bisexual and—rather than helping an individual become comfortable with his or her inborn and natural sexual orientation—make the individuals even more uncomfortable and ashamed about being different. These attempts to change orientation may result in a temporary change of behavior. A gay man may stop having sex with other men or have sex with women, but his actual sexual orientation, expressed in his sexual fantasies, desires, or thoughts, possibly will not change. Almost all major mental health and medical organizations have condemned these therapies as ineffective and potentially harmful because they make the person feel guilty and ashamed (Haldeman, 1994).

Assessing Sexual Orientation

If a substance abuse treatment provider is concerned that a client is confused about his or her sexual orientation, some evaluation tools are available to help assess a client's feelings. Coleman (1987) devised a relatively simple assessment tool to help map out or identify the sexual orientation of clients. The questionnaire considers the combination of sexual behavior, fantasies, feelings, and self-identification that contributes to sexual orientation. This tool may be a useful way to introduce a discussion about sexual orientation with clients who are uncomfortable with the topic. It may also help people under-stand the complexity of sexual expression and their comfort level with it. However, providers should be sensitive to the individual situation of the client in both administering and interpreting the instrument.

Life Cycle Issues

LGBT individuals face many of the same issues all people face as they progress through life. However, LGBT youth may have an especially difficult time. During adolescence, teens are under pressure to conform, and extraordinary effort and courage may be required for an LGBT teenager to "come out" to peers and family. Gay and lesbian youth may be subject to sexual abuse or exploitation sometimes related to their insecurity and low self-esteem. LGBT youth may face significant stress in coping with the attitudes of peers, teachers, and parents.

Older adolescent and young adult LGBT people focus on identity development through school, career choices, and sexual exploration and relations. Their social life often revolves around bars or other settings that promote drug and alcohol use (D'Augelli, 1996). When LGBT adolescents come out to their family, the result can range from understanding and support to verbal and physical abuse. Some youth run away from home and live on the streets (Savin-Williams, 1994).

Many LGBT people consider becoming part of a couple an important part of life. Although there are no legal sanctions for such relationships, the majority of gay people are in relationships, and many are as committed as traditional heterosexual couples (Klinger & Cabaj, 1993). Some LGBT people are parents; they have had or adopted children (Patterson, 1995). LGBT clients belong to a family of origin. Depending on the circumstances, the relationship may be healthy or strained. Some LGBT people create their own family of choice consisting of a close network of friends that serves the needs often met by traditional families. Treatment providers need to consider an LGBT client's partner, children, family of origin, and family of choice when providing care.

Older LGBT individuals may experience a sense of loss related to the aging process and associated changes in their physical attractiveness and capacities. This state may be further compounded by the lack of a partner or a legally sanctioned relationship. Consequently, their sense of a purpose and a future may become hazy and may be expressed in emotional and substance abuse problems (Kertzner & Sved, 1996).

Older LGBT people face the same concerns as other older persons regarding living arrangements and loss of loved ones and social supports. These concerns may be exacerbated for some LGBT people by HIV-related losses and limited familial support, that is, not having children and being isolated from their family of origin. Some people in this age group may need treatment for substance abuse or emotional issues avoided or ignored over the years (Berger & Kelly, 1996).

Summary

It is hoped that the information helps providers improve their ability to provide competent and effective treatment. Treatment can be enhanced by a substance abuse treatment provider who is knowledge-able about the unique needs of LGBT clients. A provider who understands and is sensitive to the issues surrounding sexual and gender identity, homophobia, and heterosexism can help LGBT clients feel comfortable and safe while they confront their substance abuse and start their journey of recovery.

Cultural Issues in Working with LGBT individuals

Introduction

This chapter presents information to help providers understand cultural issues relevant to treating lesbian, gay, bisexual, and transgender (LGBT) clients. To provide culturally competent

treatment, providers must possess attitudes that reflect openness to other cultures, values, and belief; willingness to assess and change their own beliefs; and the ability to appreciate diversity. Providers need to know about the social and cultural context in which their clients live and abuse substances and be receptive to information that may differ from their personally held views (CSAT [Center for Substance Abuse Treatment], 1998a)

Providers can play an important role in the healing process of LGBT individuals by being aware of the community, traditions, and heritage of their LGBT clients. The information that follows includes broad generalities intended as starting points for providers in their work with individual clients. It is not intended as a thorough discussion of the topic.

Definitions of terms

Culture refers to the customary beliefs, social norms, and material traits of a racial, religious, or social group. It affects the group Cultural Issues in working with LGBT Individuals members' viewpoints: how they act; how they think; and how they see themselves in relation to the rest of the world. Culture is transmitted through language, symbols, and rituals.

Ethnicity describes a population or group having a common cultural heritage that is distinguished by customs, characteristics, language, and common history.

Diversity refers to differences in geographic location (rural, urban), sexual orientation, age, religion or spiritual practice, socioeconomic status, and physical and mental capacity.

Important reference materials on cultural competency include the following:

- CSAT's publication Cultural Issues in Substance Abuse Treatment, 1999b
- CSAT's Technical Assistance Publication (TAP) 21 Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice,1998b.

Cultural Competency Overview

Cultural competency is a set of academic and interpersonal skills that assists individuals in increasing their understanding and appreciation of cultural differences and similarities within, among, and between groups (Woll, 1996). It requires willingness and an ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports. A culturally competent pro- gram is defined by CSAT (1994a) as one that demonstrates sensitivity and understanding of cultural differences in treatment and program design, implementation, and evaluation. Within the treatment setting, cultural competency is a fundamental component that helps individuals develop trust as well as an understanding of the way members of different cultural groups define health, illness, and health care (Gordon, 1994).

Substance abuse treatment providers may use their understanding of the client and the client's cultural context to develop a culturally appropriate assessment, identify problems, and choose appropriate treatment strategies for the client. A culturally competent model of treatment acknowledges the client's cultural strengths, values, and experiences while encouraging behavioral and attitudinal change. Treatment services that are culturally responsive are characterized by the following:

- Staff knowledge of the client's first language
- Staff sensitivity to the cultural nuances of the client population
- Staff backgrounds representative of those of the client population
- Treatment modalities that reflect the cultural values and treatment needs of the client population
- Representation of the client population in decision making and policy implementation.

These aspects alone do not constitute cultural competency, nor do they automatically create a culturally competent system. Culturally competent systems include both professional behavioral norms for treatment staff and the organizational norms that are built into the organization's mission, structure, management, personnel, program design, and treatment protocols. In other words, culturally competent systems need to implement cultural competency in attitudes, practices, policies, and structures (Mason, 1995).

Interpreting behavior without considering its cultural context can lead to poor, sometimes detrimental, treatment outcomes. The covert prejudice of the treatment staff and language cultural Issues in working with LGBT Individuals and cultural differences undermine efforts to help clients recover from substance abuse (CSAT, 1999b). However, if practitioners are to move from accommodation to inclusion in their helping practices, they must alter practices to meet the needs of their clients.

Assimilation and Acculturation

Assimilation and acculturation are key concepts in cultural competency. The extent of a person's assimilation or acculturation influences individual behavior and may affect the treatment outcome. When working with LGBT people from minority populations, providers must assess their level of acculturation and assimilation.

- Assimilation is adaptation to a new culture by taking on a new identity and abandoning the old cultural identity.
- Acculturation refers to accommodation to the rules and expectations of the majority culture without entirely giving up cultural identity.

The four interpersonal styles represented below may be exhibited by clients in treatment and should be assessed by counselors during substance abuse treatment (Bell, 1981). These

styles are fluid, meaning individuals can move among them depending on the context or stage of their development or both.

Assimilated individuals consciously or subconsciously reject their culture of origin in favor of their adopted culture. These clients may resist placement in a group with clients of their own ethnicity or may prefer a clinician from their adopted culture.

Bicultural, or multicultural, individuals are proud of their cultures and can function in, fulfill their needs through, and be proud of the dominant culture. Their emotional, educational, economic, and spiritual needs are usually fulfilled in a diverse, integrated living environment that honors two (or more) cultures. A bicultural or multicultural client is likely to be comfortable in any clinical setting with relative ease. However, one of the difficulties of this interpersonal style is cultural or racial schizophrenia (Bell, 1981): the feeling of not belonging to either community. These clients face special challenges that may need to be addressed in treatment.

Culturally immersed individuals have rejected mainstream culture, and their emotional and spiritual needs are met exclusively in their ethnic community or in the gay community. The effectiveness of their treatment may depend on the ability of the provider to be supportive as clients work through issues related to being a person from a minority group.

Traditional individuals are defined as carriers of the community ethos. They neither overtly accept nor reject their ethnic identity. Traditional persons have most of their emotional, spiritual, and, to some degree, educational needs met through their ethnic community and have limited contact with the dominant culture or any outside communities. Their economic needs are met primarily in the context of the majority culture and sometimes involve power imbalances that increase their distrust of other groups. For traditional individuals, entering into a mainstream

treatment program is usually a frighteningly foreign experience that calls for sensitivity by treatment staff.

The heterogeneity of ethnic culture emphasizes the need for providers to appreciate clients' cultural context and individuality. This emphasis allows for more culturally appropriate interventions and focuses on the importance of matching client and provider according to interpersonal styles rather than ethnicity alone.

Source: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (2012). A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals. *Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment*

Chapter 4: Cultural Issues in Working with LGBT Individuals

General Issues in Cross-Cultural Treatment

Our culture guides how we act and think as well as how we come to understand who we are and how we fit into the world. Cultural norms are rules of conduct that are internalized by the members of the group and embody the fundamental expectations of the group. Cultural rules resemble family rules often the strongest are the ones not spoken. Because cultural rules are usually reinforced by parents or special people in one's life, the rules are hard to defy. In addition to cultural norms, five general aspects of culture need to be considered if cross-cultural treatment is to be effective. They are as follows:

Values of a culture play an important role in determining how one behaves. Cultural values vary among different groups. For example, some cultures admire assertive behavior, but some Asian cultures consider such behavior rude or disrespectful. In American Indian culture, silence is highly valued—a difficulty for counselors who are trained to assess commitment by verbal expression.

Language is the primary tool for our work. Certainly, a client whose native language is not spoken in treatment is at an extraordinary disadvantage. All languages are complex, and immigrants find adjusting to the nuances of a new language difficult. The meaning of many words or phrases varies depending on context, tone, audience, and intended message. For some clients, using bilingual services and staff greatly increases the effectiveness of treatment. However, translation into the client's primary language is not enough. Materials or oral translations need to be adapted to be culturally appropriate for the intended audience. Historical factors such as discrimination and how a person interprets another's actions also impact communication and need to be considered. Counselors should verify with the client that the

message is understood as meant. This verification should be done in a sensitive manner that does not embarrass the client.

Nonverbal behavior is extraordinarily powerful. Interpretations of touches, gestures, and eye contacts are shaped by personal experience and culture. For instance, a person in a prison community does not use direct eye contact because it is a sign of disrespect in that circumstance. In the Latino culture, touching the person being addressed is a sign of attentiveness. It is important for counselors to be sensitive to a client's style of nonverbal communication and to consider the degree of familiarity and the context of the contact. Counselors should ask clients about any nonverbal behavior they do not understand. If counselors question clients in a nonthreatening way, the clients usually are willing to explain.

Learning styles vary among individuals and cultures. Typically, treatment programs use a Western learning style of formal, often written instruction. For example, many treatment centers require that clients read literature from Alcoholics Anonymous and write out the step work without assessing whether the clients understand the information. Non-literate clients or those with low reading comprehension would be better served if culturally appropriate audiotapes or videotapes also were used. Clients from a cultural group with a tradition of storytelling also may welcome alternative forms of communication and the use of a variety of methods to transmit information.

Healing is the essential task of treatment. With all clients, counselors need to create an environment where clients can heal. It is critical for counselors to assess each client's sources of comfort, to understand the individual's beliefs and customs around healing—what will make the client feel better—and to understand the person's definitions of illness and health.

The Western health care tradition tends to compartmentalize health issues and assumes. Cultural Issues in Working with LGBT Individuals that healing should be left to those who know best—medical personnel. However, this assumption is being challenged by some people and health care providers who are seeking alternative treatment methods such as folk medicines, acupuncture, herbs, and massage. Some health care providers and patients are also forming new treatment partnerships instead of the authoritarian model of physician-patient. Substance abuse counselors need to determine what the client believes will make him or her healthy and what needs to be included in the treatment plan. This determination is particularly important because what a person believes will make him or her healthy has a great impact on the recovery process. Clients' resistance to a particular treatment method can sometimes be traced to their healing belief system.

Dimensions of Culture

Many people experience some form of discrimination, prejudgment, bias, close mindedness, or other exclusionary attitudes because of their race, ethnic origin, gender, sexual orientation, religion, or class. Discrimination toward minority groups can come from those of the majority culture; toward other minority groups or the majority culture, from a minority person or group; or toward an LGBT individual, from someone in the majority culture, other ethnic groups, and the individual's own ethnic group.

Little research has been done on the interactions among ethnic diversity, homosexuality, and substance abuse. Providers need to remember that LGBT clients from ethnic minority groups may have additional problems that will affect their recovery from substance abuse. LGBT members of an ethnic minority group need to learn the norms of the mainstream culture, their own minority culture, and gay culture—norms that may conflict. Juggling the demands of these

norms may be confusing and problematic, and the substance abuse treatment provider may need to help the client negotiate the confusing and contradicting norms while the client is in treatment. An LGBT individual may have a stronger connection to his or her ethnic group than to the LGBT com- munity, or the dominant allegiance may be to the LGBT community. It is important that providers invite clients to explain their cultural context and how they feel about their place in society, assess with clients their placement on the continuum from assimilated to traditional, and explore the meaning of these variables in their clients' recovery. It is of utmost importance for counselors to be aware of how their own cultural values, biases, and attitudes influence their practice and how they affect their behavior toward coworkers and clients.

Introduction to the LGBT Community and Culture

Substance abuse treatment providers need to be aware that LGBT persons do not fit the prevalent stereotype of well-dressed, middle-class urban dwellers; drag queens; or masculine dressed females. LGBT people live and work in all segments of society. They are from every minority, cultural, racial, and ethnic group. They are members of every nationality, religion, and age group and are from every educational and socioeconomic level. Although some urban centers have populations that are more accepting of LGBT lifestyles than others, and thus are magnets for LGBT persons, LGBT people live in rural, urban, and suburban areas and in every State. LGBT clients can ask for substance abuse treatment services anywhere in the country and not only in large urban areas.

The LGBT minority group differs from other minority groups in that LGBT persons do not come from a common geographic area or have certain physical characteristics in common.

Gay Culture

There is a lively debate in the LGBT community over what constitutes gay culture. Is it several cultures within one culture? Do lesbian, gay, bisexual, and transgender people each have their own cultures? Gay culture is as diverse as all its members. However, there is no question that many LGBT individuals experience a way of life that is considered a culture. Although lesbian, gay, bisexual, and transgender individuals from different backgrounds experience their communities differently, they share the belief in the legitimacy of their way of life. Substance abuse treatment providers should understand that the gay community possesses common knowledge, attitudes, and behavioral patterns and has its own legacy, argot, folklore, heritage, and history.

Gay culture is different in the degree to which it is submerged within other cultures and in the way that these cultures tend to affect it. LGBT people's behavior is still stigmatized, and because there is usually no way of identifying LGBT people apart from their own disclosure or identification with gay culture, gay culture is essentially hidden in the larger community.

In contrast to how members of ethnic cultures are marginalized, LGBT individuals may receive disapproval and censure from those whom they most trust and rely on—parents, relatives, religious leaders, teachers, and friends. Most members of ethnic minorities can escape discrimination by returning to a supportive family or neighborhood. This is not always true for LGBT persons. When they are growing up, their positive role models are not easy to identify. This isolation sets LGBT minority members apart from ethnic minority group members who are usually in close proximity to other members. The LGBT culture is one that is not developed, taught, or transmitted by families.

Although homosexuality has existed throughout the ages and in many different cultures, gay culture as it is known today began to emerge in 1969, when the New York City police raided a popular gay bar, the Stonewall Inn. At the time, raids of gay bars were conducted regularly with little resistance. However, that night the event erupted into a violent protest as the crowd fought back. The protests that followed, known as the Stonewall Riots, gave birth to the gay rights movement. Before Stonewall, public expression of LGBT life and experience was rare.

The gay rights movement spawned calls for gay pride and civil rights. Since Stonewall, some aspects of gay culture have blossomed. Gay media, books, magazines, movies, newspapers, and Internet sites abound. Attention is lavished on gay heroes—public figures who are "out" and who work to improve the lives of LGBT individuals. Many large companies market their products or services to the lesbian and gay community. Several LGBT organizations exist, and many companies have LGBT employee organizations.

Part of gay culture is a celebration of being gay. Gay pride celebrations are held in June to mark the anniversary of the Stonewall Riots. At gay pride celebrations, the invisible LGBT minority makes themself visible and celebrates its uniqueness, the struggle for civil rights, the cultural gains, and its heroes. The event usually consists of a parade, musical entertainment, and art events showcasing LGBT authors and performing artists and is attended by representatives of LGBT social and service organizations. Gay pride celebrations provide an opportunity for substance abuse treatment providers to reach out to the LGBT community.

An aspect of the debate within the gay community about gay culture involves gay rights. Because public acceptance is important, many LGBT persons want to advance the message that LGBT individuals are no *Individuals different from non-LGBT persons.* Some LGBT persons worry that highlighting the similarities and the positive aspects of gay culture will mean the loss

of that culture as the LGBT community is accepted into mainstream culture. Some believe that the gay community should try to transform mainstream society rather than join it. Another aspect of the debate involves some LGBT individuals who believe there is only one way to be gay and do not honor LGBT persons with other lifestyles or opposing views. Bisexuals have complained that lesbians and gay men do not accept bisexuality as a legitimate sexual orientation but regard it as a developmental phase on the way to acceptance of lesbianism or homosexuality exclusively. Substance abuse treatment providers should keep in mind that this disagreement may be very confusing to clients who are questioning their sexual orientation or to self-identified LGBT clients who may feel unaccepted by the LGBT community because they have a different lifestyle.

Values

Compassion and authenticity are important ideals for LGBT individuals. The abilities to invent their own relationships, cultivate the arts, build a community, and create a culture are sources of pride in the LGBT community.

Language

Some LGBT individuals disapprove of the words used to describe them, and the reasons can be helpful in understanding LGBT clients. For some LGBT people, the term "homosexual" overemphasizes sexuality and seems to indicate that the sex act is more important to homosexuals than it is to heterosexuals. It also resurrects memories of when homosexuality was considered a psychiatric disorder. Hence, the words "homo," "bi," "queer," or "gay" are preferred by some LGBT persons. However, some LGBT per- sons are offended by the term "queer." Some lesbians may prefer to be called dyke or gay, instead of lesbian. Transgender persons may prefer the less clinical term "trans." It is important to call a transgender client by his

or her preferred name and always to use the gender designation that the client has chosen. Given these conflicting opinions, providers should ask a self-identified LGBT client what he or she prefers to be called. The choice is a conscious and sometimes rather emotional decision and should be honored. A provider's sensitive use of language can be an important sign of respect and can help create a healing environment for LGBT clients. When clients are confused and questioning their sexual orientation, the provider should be sensitive to the clients' confusion.

LGBT individuals have a creative vocabulary on the subject of sexual orientation because they may often use code words for safety reasons. For example, a gay man or lesbian uses the following to acknowledge someone with a same-sex preference: one of us, family, member of the church, cousin, colleague, or brother or sister. The vocabulary varies, and providers should listen carefully and ask questions about the meaning and use of unfamiliar terms.

Nonverbal behavior

LGBT individuals rely tremendously on nonverbal cues to establish whether the situation is safe for them to be themselves. As they walk into a treatment center, they will be looking for evidence that they are accepted and welcome. Do they see a rainbow-colored flag? A "Straight But Not Narrow" bumper sticker? Is there a mission statement that includes a commitment to honoring diversity or a commitment to treating LGBT clients? Do they see gay or lesbian staff members? Until the LGBT client feels a degree of safety, he or she will be guarded. A provider who is unaware of this may believe that he or she is seeing the client's real personality when, in fact, the client is on alert and hiding it from the provider. It is important for providers to signal respect, open-mindedness, and acceptance by using appropriate gestures and vocabulary.

Learning styles

Much of what is taught by institutions and teachers does not reflect the personal experiences of many LGBT people. Experiential learning techniques such as role-plays may be more appropriate, and peers with similar experiences are likely to have influence. Any materials used in treatment that acknowledge the LGBT experience will be more effective than those that do not mention it.

Healing

LGBT individuals may distrust the medical establishment and may be somewhat more likely than the general population to rely on the personal experiences of those they trust or other LGBT persons to select providers and treatments.

Ethnic Minority Groups

The cultural norms and beliefs of an ethnic group can have a significant impact on an LGBT person's feelings about his or her sexual orientation or gender identity, his or her ability to express that identity, and how other members of the ethnic group treat the LGBT person. Although an LGBT orientation conflicts with mainstream cultural values, it may be just as, or even more, unacceptable in some ethnic minority groups. Many ethnic groups value strong family ties and traditional gender roles and expect that their children will carry on the family name and traditions through marriage and children. Some families see LGBT behavior as arising from a decadent Western society and as a rebellion against the family and traditional beliefs, instead of as a part of a person's identity. Consequently, LGBT behavior is difficult for family and friends to understand and tends to become invisible.

Some LGBT individuals of color may be accepted by their parents but feel alienated from their ethnic community. Some may distance themselves from their cultural communities and turn

to the LGBT community for support and validation. Support groups for LGBT African Americans, Latinos, and Asian/Pacific Islanders are active in large cities, but many LGBT individuals of color find themselves in predominantly white, middle-class LGBT communities. It is assumed that the LGBT community with its experience of discrimination would be tolerant of diversity. However, ethnic minorities are discriminated against by some LGBT individuals. LGBT people of color may feel they have double minority status that may compound negative consequences such as a poor self-image, low self-esteem, inadequate coping mechanisms, and substance abuse. LGBT ethnic minorities face greater challenges than their counterparts in mainstream society, and it is important for substance abuse treatment providers to validate these experiences and challenges.

American Indian/Alaska Natives

The number of LGBT individuals in American Indian and Alaska Native communities is not definitely known, although it is believed to resemble the parameters of the dominant population. From self-reports and the small amount of research findings available, American Indians and Alaska Natives in gay or lesbian relationships report a higher degree of bisexuality than do their Caucasian counterparts.

Historically, some American Indian and Alaska Native communities viewed the role of a native person who was different from other community members as having a strong spiritual component. Being different was seen as a result of a spiritual experience and a path chosen by the Creator or the Spirits for that person. Many American Indian and Alaska Native communities used the term "two-spirited" to describe LGBT individuals. Traditionally, American Indian and Alaska Native nations were taught to celebrate the differences and to see all their members as sacred beings fashioned by the Creator. At least 168 of the more than 200 Native American

languages still spoken today have terms for genders in addition to male and Cultural Issues in Working with LGBT Individuals female. Many LGBT people prefer the term "two-spirited" because it expresses their sense of combining a male and female spirit. It is also considered empowering for a person to choose what to be called as opposed to accepting a label given by another. This may be particularly true for this group. In the past, the culture, language, and religion of American Indian and Alaska Native people were oppressed by the majority culture. Christian missionaries used their influence in converting many traditional rituals into Christian rituals. Many native children were sent to government-run boarding schools and were prohibited from speaking their native languages and practicing their native customs. Along with erasing traditional roles, the traditional respect for two-spirited people also was diminished.

While American Indian and Alaska Native clients are in treatment, it is important to deter- mine their level of acculturation, their tribal affiliation, and the degree to which their sexual or gender identity is accepted by their tribal community and family. In many communities, being accepted by one's family is a measure of health and connectedness. If the family has difficulty accepting the client's sexual orientation, recovery from substance abuse may be hindered. Reintegrating the individual into his or her family may help in the recovery process. Becoming reconnected with family is seen as necessary for health in native tradition. Achieving awareness of one's sexual orientation or identity may occur in a different way for native men and women than for their non-Indian LGBT counterparts.

Values

Some common tribal values are the importance of sharing and generosity, allegiance to one's family and community, respect for elders, noninterference, and orientation to the present time, and harmony with nature. Respect for individual autonomy within the community, respect

for family, and honoring the earth are entwined, and each person depend on others for meaning and existence. Traditional beliefs support the existence of a Supreme Creator and the view that each human has many dimensions such as the body, mind, and spirit. Like humans, plants and animals are part of the spirit world that coexists and intermingles with the physical world.

Language

Words are to be honored and not wasted. Language is used to impart knowledge, often through stories. The legends and stories often have specific meanings and involve intricate relationships. Use of symbol- ism, animism, subtle humor, and metaphors is important. Direct questioning is not as important. Practitioners need to be aware of both their language and nonverbal behavior when communicating with this group.

Nonverbal behavior

Their emphasis on observant, reflective, and integrative skills leads American Indian and Alaska Natives to behavior patterns of silence, listening, non-verbal cues, and learning by example. Some traditional natives would view a firm handshake as intrusive and rude; eye contact is used minimally; and a passive demeanor is appropriate.

Learning styles

Historically, their survival depended on learning the signs of nature, so observation is central to American Indians and Alaska Natives. Learning is accomplished by watching and listening and through trial and error. Cultural norms and values are passed from generation to generation through rituals, ceremonies, and the oral tradition of story-telling. The relationship with a teacher is important, but trust needs to be established.

Healing

Wellness is harmony of the mind, body, and spirit, and native people feel they are responsible for their own wellness. Healing is interconnected with the whole person and rooted in spiritual beliefs connected to the earth and nature. Some traditional practices are the talking circle, sweat lodge, four circles, vision quest, and sun dance and involve community. *Individuals healers, elders, and holy persons (CSAT, 1999b).*

African Americans

Homophobia in the African-American community is often more intense than in the dominant community. In the past, the sexual orientation of African-American lesbians and gay men was often known by the community although it was not discussed. Many African-American individuals, particularly men, call themselves bisexual instead of gay. Many African-American LGBT individuals operate in separate spheres and may perform community service in the African-American community, but they primarily socialize within the African-American LGBT community. Identifying oneself as an LGBT individual publicly may put an African American at risk for losing his or her most important support system—the African-American community.

Many LGBT African Americans say that they do not feel welcome or comfortable in predominantly Caucasian LGBT settings (e.g., clubs, bars, pride events), and racist incidents have been reported. Diversity in the LGBT service provider community is essential to accommodate for the distrust between African Americans and Caucasians. Many service provider agencies targeting African Americans were formed during the height of the HIV/AIDS epidemic.

Focus groups consisting of African-American gay men and lesbians conducted in California by Michael Browning of Day One in Pasadena, a member of this publication's

Steering Committee, clearly stated that they did not want to be called queer and considered it a negative term. Substance abuse treatment counselors need to refrain from using the term, especially if they are working with African Americans. Focus group members stated that religion remains important to many gays and lesbians in African-American communities, even though some have had negative experiences with organized religious groups. Many treatment programs have some religious context (whether spoken about or not), and focus group members felt that including spiritual activities, music, and practices that are more indigenous to African-American communities would be helpful in treatment.

Values

Interpersonal relationships are highly valued, and the identity of African Americans is tied to their group identity. The self is considered an extended self, and this group orientation contrasts with the wider cultural norm of individualism. The community, social organizations, neighborhoods, and kinship relationships provide aid and support. African-American families vary from nuclear to extend. Female-headed households predominate in some socioeconomic levels, but marriage is still highly valued. Rearing children is considered a communal responsibility.

Language

Language is passionate and full of action. Dialects and slang are used in some geographic locations and need to be understood by providers. “Same-gender-loving” is a term used by many African-American LGBT individuals. The appropriate form of address is by title (e.g., Ms., Dr., Rev., and Mrs.) rather than first name, unless permission is given to use the more informal address.

Nonverbal behavior

Body language is expressive and used extensively to help communicate. Movement, thought, and nonverbal behavior are spontaneous, and many African Americans are highly aware of nonverbal cues. Touch is important; however, observing personal space is one key to whether a person feels respected and providers needed to follow the client's lead.

Learning styles

Learning styles tend to be relational rather than analytical. Oral communication predominates in knowledge transmission. Tradition is highly valued over the visual and the written word. Teachers and students need to develop a trusting relationship. Storytelling is used to teach about life and pass on cultural values. The use of storytelling and African proverbs can enhance insights into treatment.

Healing

Healing occurs through lying on of hands, prayer, herbs, and the like. One is sick when one cannot do for oneself any longer, and recovery from illness usually is seen as possible with the help of God. For many, God and the spiritual community are based in the Christian church and organized religion.

Asian/Pacific Islanders

Asian/Pacific Islanders consist of more than 60 culturally distinct groups, practice several types of religion, and speak more than 100 languages and dialects. Their degree of acculturation and assimilation varies. The Asian/Pacific Islander cultures have few characteristics in common. For some Asian/Pacific Islander groups, "the traditional Asian/Pacific Islander approach to health and illness centers around balance and harmony. The ultimate goal is to attain a perfect balance among systems of the individual, society, and the universe at large" (Wong et al., 1998).

Cohesiveness of the group is an important value, and because of this, shame is a frequently used social constraint to control or deter expressions of homosexual behavior (Wong et al., 1998).

Some Asian/Pacific Islander cultures believe that if one is vigilant in maintaining balance in one's relationships, then one cannot become ill. It is only when one is out of balance that disease occurs. In addition, prevention as conceptualized by most Asian/Pacific Islanders dictates that, as long as primary prevention behaviors are practiced, there is no reason for secondary prevention efforts, such as making regular visits to a physician (Wong et al., 1998). Providers need to understand this cultural value and adapt their prevention and treatment efforts accordingly.

Values

This culture is heavily based on interdependence, and family is central. The individual is expected to subsume his or her needs to those of the larger group—family, community, or other groups. Varying from one's prescribed role can cause shame and loss of face for the family. Authority and age are highly respected and honored; thus, there may be discomfort in addressing providers, particularly older ones, by their first names.

Language

Some of the languages spoken by Asian/Pacific Islanders do not have words for lesbian, gay, bisexual, or transgender. Without descriptive words, the formation of an LGBT identity may be precluded and an ambiguous social role for LGBT individuals may result. In other words, the behaviors may be practices that lack social legitimacy and may not be discussed. Thus, communication may be indirect, particularly about personal issues or sexual behavior. Initial communication during treatment may need to be indirect with a gradual increase in directness about the issue.

Nonverbal behavior

Nonverbal behaviors are as varied as the communities themselves. In some groups, bowing is important, as are related behaviors such as using both hands to present a business card to a colleague, the elderly, and people in authority. Same-sex touching (e.g., holding hands) is not uncommon in most Asian/Pacific Islander cultures; it is a gesture of affection, not sexual feeling.

Learning styles

Hierarchical societies support deference to authority (e.g., physicians, health care providers, teachers, and the elderly). The learning style is likely to be traditional; information is disseminated or transmitted in one direction, from teacher to student.

Healing

Self-reflection through meditation is one traditional way to confront personal issues and increase self-knowledge. Ethics, as outlined by philosophers such as Lao Tzu and Confucius, provide standards for human behavior and regaining a healthy balance. Asian Americans who are Muslim, Christian, or Hindu may have very different beliefs. Eastern medicine is complex, and many recently arrived Asian Americans may still use traditional cures.

Hispanic Americans/Latinos

Hispanic Americans (also called Latinas and Latinos) are defined as individuals of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultures or origins, regardless of their race (CSAT, 1999b). LGBT Hispanics, regardless of the differences among the nationalities represented, have many common values, including strong religious faith, altruism, family values, and spirituality. They contribute greatly to their community, regardless

of the fact that they may come from diverse and separate cultural systems and socioeconomic realities.

In treating Hispanic clients, the family is the cornerstone. The support network consists of the family and a host of other individuals who may or may not be related. For new immigrants, the stress of learning a new language, new cultural norms and behavior, and the sense of loss from leaving family and other loved ones behind can be overwhelming.

Homosexuality may be privately acknowledged, but it is usually not discussed openly. Hispanics may be more reluctant to self-identify as LGBT than members of the mainstream culture. The perception of sexuality as an indication of identity is often overridden by identification with the community. Mainstream culture tends to label a person who has a sexual encounter with someone of the same gender as gay, bisexual, or lesbian. In Hispanic culture, some men who have sex with men do not consider themselves gay if they play the dominant role in the sexual act. When treating Hispanic clients, providers should respect this distinction.

Values

Group needs and objectives, family values and ties, and trust (confianza) are respected. Traditional values, some of which are rooted in the Catholic faith, are honored. Many Hispanic Americans consider religion central to their lives. Latino/Latina clients appreciate recognition of the emotional, family, and spiritual challenges related to substance abuse problems. Clients likely will maintain a high level of privacy about subjects of a personal nature (illness, addiction, sexual behavior).

In most families, the family respects strong gender roles. Machismo, the strong sense of masculine pride or exaggerated masculinity, and other traditional male attitudes can be barriers to seeking treatment for substance abuse and to coming out. Males are the center of the family,

and many gay, bisexual, and transgender men find it difficult to acknowledge their sexual and gender identities.

Drinking is a socially accepted behavior in some families, and young children are allowed to drink beer and tequila as a rite of passage. Caseres and Cortifias (1996) report that for gay Latinos "the bar can be a surrogate home where they can find their other family, who fulfill[s] some of their needs of emotional support in a nonjudgmental context . . . the bar life nurtures, relieves guilt, and becomes an emotional shelter where they can find a new, positive, and valuable world."

Language

Using nonscientific, nontechnical terms and descriptions applicable to the client's cultural background (Mexican, Colombian, Puerto Rican, etc.) is recommended. The use of Latino, Chicano, or Hispanic differs among groups and communities. An interpreter may be necessary to successfully treat some Hispanic clients or their families, and bilingual staff members are an excellent resource.

Nonverbal behavior

A professional and respectful physical contact, such as shaking hands at every greeting, helps create a safe space for the client. Maintaining eye contact denotes attention and understanding.

Learning styles

Family members, especially heads of families, are a source of guidance, counseling, and instruction. It is important to empower individuals to learn about their situation and to know that they can seek support within their own community. It is necessary to remember that for most Hispanic Americans the learning process is based in the context rather than the process. Using a

hypothetical third person when giving examples to avoid embarrassment and discomfort about intimate subjects, is an effective approach.

Healing

Healing is influenced by strong religious beliefs that are often based on traditional Catholicism, although other practices may be followed. Spirituality and religious beliefs are generally very strong and can influence the decision making or behavioral-change processes.

Summary

The information in this chapter is only a skeletal framework to introduce providers to the complex issues of cultural competency, ethnicity, and gay culture. Providers can help their LGBT clients by understanding their struggle and creating a safe and supportive treatment space. Cultural values and norms are powerful forces, and providers should be mindful that often it is hard for clients to abandon long-held cultural beliefs, even if they are harmful. The experience of expanding their knowledge of the cultural backgrounds of their clients can be rewarding and worthwhile for providers.

Chapter 5: Legal Issues for Programs Treating LGBT Clients

Lesbian, gay, bisexual, and transgender (LGBT) individuals with substance abuse problems are doubly stigmatized. As substance abusers, they are viewed by many as weak in character and moral fiber. As lesbian, gay, bisexual, and transgender individuals, they are reviled by some as deviant and immoral. They may encounter bigotry from employers, human service workers, criminal justice officials, the general public, and even their own families.

Two Federal (and a number of State) statutes protect recovering substance abusers from many forms of discrimination. However, in most areas of the country, LGBT individuals have no legal protection against discrimination in employment, housing, or access to social services. Protections fought for and won by women, racial minorities, and individuals with disabilities simply are not available for LGBT persons. Disclosure of sexual orientation can lead to an individual's being fired or being denied access to housing and social services—all with legal impunity. LGBT individuals may even lose custody of their children if their sexual orientation becomes known during a custody dispute.

Even in those States that have enacted statutes prohibiting discrimination on the basis of sexual orientation, LGBT individuals have sometimes been denied protection. Little wonder that LGBT individuals regard protecting information about their sexual orientation and substance abuse histories as critically important. Programs that treat this special population need to be particularly sensitive about maintaining clients' confidentiality, for the consequences of an inappropriate disclosure can be far reaching. (For a compendium of the law regarding discrimination against LGBT individuals, see http://www.lambdalegal.org.)

This chapter examines ways programs can safeguard information about clients' substance abuse histories, sexual orientation, and HIV status. It then describes how the lack of legal

protection against discrimination can affect LGBT individuals in a variety of areas and how programs can help these clients protect them- selves. Finally, the chapter outlines the laws protecting clients with histories of substance abuse and/or HIV/AIDS from discrimination.

Protecting the Confidentiality of LGBT Individuals in Substance Abuse Treatment Programs

Confidentiality Requirements

Concerned about the adverse effects stigma and discrimination have on clients in recovery and how stigma and discrimination might deter people from entering treatment, Congress passed legislation (42 U.S.C. §290dd-2) and the U.S. Department of Health and Human Services issued a set of regulations (Vol. 42 of the Code of Federal Regulations [CFR], Part 2) to protect information about clients' substance abuse treatment.

The Federal law and regulations severely restrict communications about identifiable clients by "programs" specializing, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for substance abuse problems (42 CFR §2.11). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid, such as tax-exempt status or State or local government funding coming (in whole or in part) from the Federal Government.

The regulations for communications are more restrictive in many instances than, for example, either doctor-patient or attorney-client privilege. They protect any information about an individual who has applied for or received any substance abuse-related assessment, treatment, or referral services from a program. They apply from the time the individual makes an appointment and apply to former clients as well. They apply to any information that would identify the individual either directly or by implication as a substance abuser. They apply whether or not the person seeking information already has that information, has other ways of getting it, has some

form of official status, is authorized by State law, or comes armed with a subpoena or search warrant. Violating the regulations is punishable by a fine of up to $500 for a first offense and up to $5,000 for each subsequent offense (§2.4).

Programs can find detailed information about compliance with the regulations in Technical Assistance Publication 13 Confidentiality of Patient Records for Alcohol and Other Drug Treatment(CSAT [Center for Substance Abuse Treatment], 1999a), available from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Publications Ordering Web page at: http://store.samhsa.gov. What follows is a brief description of some of the regulations' major provisions.

When May Confidential Information Be Shared With Others?

The confidentiality regulations permit disclosure without the client's consent in several situations, including medical emergencies, reporting child abuse, and communications among program staff. (For a full discussion of these exceptions, see CSAT, 1999a.)

Consent: Rules About Obtaining Consent To Disclose Treatment Information

The most frequently used exception to the regulations' general rule prohibiting disclosure is client consent. (Parental consent must also be obtained in some States. See below.) The regulations' requirements regarding consent are strict and somewhat unusual and must be carefully followed.

Most disclosures are permissible if a client has signed a valid consent form that has not expired or been revoked (§2.31). To be valid, a consent form must be in writing and must contain each of the items specified in §2.31:

1. The name or general description of the program (s) making the disclosure
2. The name or title of the individual or organization that will receive the disclosure

3. The name of the client who is the subject of the disclosure
4. The purpose or need for the disclosure
5. How much and what kind of information will be disclosed
6. A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
7. The date, event, or condition upon which the consent will expire if not previously revoked
8. The signature of the client (and, in some States, his or her parent)
9. The date on which the consent is signed (§2.31(a))

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable.

A number of items on this list deserve further explanation and are discussed under the bullets below.

- *The purpose of the disclosure and how much and what kind of information will be disclosed.*

These two items are closely related. All disclosures must be limited to information that is necessary to accomplish the need or purpose for the disclosure, and this purpose or need must be specified on the consent form. It would be improper to disclose everything in a client's file if the recipient of the information needs only one specific piece of information.

Once the purpose or need has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the specified need or purpose. That, too, must be written into the consent form.

As an illustration, if a client needs to have his or her participation in counseling verified in order to be excused from school early, the purpose of the disclosure would be "to verify treatment so that the school will permit early release," and the amount and kind of information to be disclosed would be "times and dates of appointments." The disclosure would then be limited to a statement saying, "Susan Taylor (the client) is receiving counseling at XYZ Program on Tuesday afternoons at 3 p.m."

- *The client's right to revoke consent*

The client may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, acting in reliance on the client's signed consent, it is not required to try to retrieve the information it has already disclosed.

The regulations also provide that "acting in reliance" includes the provision of services while relying on a consent form permitting disclosures to a third-party payer. (Third-party payers are health insurance companies, Medicaid, or any party other than the adolescent's family that pays the bills.) Thus, a program can bill the third-party payer for services provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third-party payer does so at its own financial risk.

- *Expiration of consent form*

The form must also contain a date, event, or condition on which it will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a) (9)). Depending upon the purpose of the consented disclosure, the consent form may expire in 5 days, in 6 months, or in a longer period.

The consent form does not have to contain a specific expiration date but may instead specify an event or condition. For example, if an adolescent has been placed on probation at school on the condition that she attends counseling at the program, the consent form can be drafted to expire at the completion of the probationary period. Or, if a client is being referred to a podiatrist for a single appointment, the consent form should stipulate that consent will expire after he or she has seen "Dr. X." (See below for further discussion about making referrals.)

- *The signature of the client (and the issue of parental consent)*

A minor must always sign the consent form in order for a program to release information even to his or her parent or guardian. The program must get the signature of a parent, guardian, or other person legally responsible for the minor in addition to the minor's signature only if the program is required by State law to obtain parental permission before providing treatment to a minor (§2.14).

In other words, if State law does not require the program to get parental consent in order to provide services to a minor, then parental consent is not required to make disclosures (§2.14(b)). If State law requires parental consent to provide services to a minor, then parental consent is required to make any disclosures.

Note that the program must always obtain the minor's consent for disclosures and cannot rely on the parent's signature alone. (For a full discussion of this issue and what programs can do when minors applying for treatment refuse to consent to parental notification in those States requiring parental consent to treatment, see "Legal and Ethical Issues," in Treatment Improvement Protocol 32 Treatment of Adolescents With Substance Use Disorders (CSAT, 1999c).

Where LGBT minors are concerned, the issue of parental consent can be a particularly delicate matter. Minors in States requiring parental consent for treatment can specify on the written consent form that their sexual orientation will not be disclosed to parents (see exhibit 3–1).

- *Required notice against redisclosing information*

Once the consent form has been properly completed; there remains one last formal requirement. Any disclosure made with patient consent must be accompanied by a written statement that the information is protected by Federal law and that the recipient cannot further disclose or release such information unless permitted by the regulations (§2.32).

This statement, not the consent form itself, should be delivered and explained to the recipient of the information at the time of disclosure or earlier. (Of course, a client may sign a consent form authorizing a disclosure.)

Using Consent Forms

The fact that a client has signed a valid consent form authorizing the release of information does not mean that a program must make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b)(1); 2.61(a)(b)). In most cases, the decision whether to make a disclosure authorized by a client's signed consent is up to the program, unless State law requires or prohibits a particular disclosure once consent is given. The program's only obligation under the Federal regulations is to refuse to honor a consent that is expired, deficient, or other- wise known to be revoked, false, or incorrect (§2.31(c)).

In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose for disclosing the information.

- *Using consent forms to seek information from collateral sources*

Making inquiries of families, partners, schools, employers, doctors, and other health care providers might, at first glance, seem to pose no risk to a client's right to confidentiality. But it does.

When a program that offers assessment and treatment for substance abuse asks a family member (including a parent), partner, employer, school, or doctor to verify information it has obtained from the client, it is making a disclosure that the client has sought help for substance abuse. The Federal regulations generally prohibit this kind of disclosure unless the client consents.

How then is a program to proceed? The easiest way is to get the client's consent to contact the family member (including a parent), partner, employer, school, health care facility, etc. In fact, the program can ask the client to sign a consent form that permits the very limited disclosure that he or she has sought assessment or treatment services in order to gather information from any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or name of the organization" for each collateral source the program may contact. If program staff are making inquiries by telephone, they must inform the parties at the other end of the line orally and then by mail about the prohibition on redisclosure.

Of course, the program should never disclose information about the client's sexual orientation to a collateral source, unless the client specifically consents to disclosure to that particular person or agency. The consent form provided in exhibit 3–1 allows the client to choose whether to consent to disclosure of this information.

- *Using consent forms to make periodic reports or coordinate care*

Programs serving LGBT individuals may need to confer on an ongoing basis with other agencies, such as mental health or child welfare programs. Again, the best way to proceed is to get the client's consent (as well as parental consent when State law requires). Take care in wording the consent form to specify the purpose of the communication and the kind and amount of information to be disclosed. For example, if the program needs ongoing communications with a mental health provider, the "purpose of the disclosure" would be "coordination of care for Simon Green" and "how much and what kind of information will be disclosed" might be "treatment status, treatment issues, and progress in treatment."

If the program is treating a client who is on probation at work and whose continued employment is contingent on completing treatment, the "purpose of disclosure" might be "to assist the patient to comply with the employer's mandates" or to "supply periodic reports about attendance," and "how much and what kind of information will be disclosed" might be "attendance" or "progress in treatment."

Note that the kinds of information that will be disclosed in these two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider if that would help in coordinating care. Disclosure to an employer should be limited to a brief statement about the client's attendance or progress in treatment. Disclosure of detailed clinical information to an employer would, in most circumstances, be inappropriate.

The program should also give considerable thought to the expiration date or event the consent form should contain. For coordinating care with a mental health program, it might be appropriate to have the consent form expire when treatment by either agency ends. A consent

form permitting disclosures to an employer might expire when the client's probationary period ends.

Programs should exercise great care about sharing information about clients' sexual orientation. Disclosure of such information might be therapeutically important when a substance abuse program is coordinating a client's care with a mental health provider. It would not be appropriate to disclose this information to a client's employer. Programs should get clients' consent in writing before making any disclosures about sexual orientation.

- *Using consent forms to make referrals*

Programs treating LGBT individuals may need to refer clients to other health care or social service agencies. The program can, of course, give the client the name and telephone number of an outside gynecologist, psychologist, or training program and allow him or her to initiate the call. However, if a staff member at the program makes the call to set up an appointment, he or she must keep in mind that such a call may result in disclosure that the client has a substance abuse problem. If the staff member identifies the client as attending a substance abuse treatment program, directly or by implication, the referral requires the client's consent in writing (as well as parental consent in States requiring it).

Unless the client has consented, the program should not disclose the client's sexual orientation when making a referral.

HIV and Confidentiality

Almost all States now have laws protecting information about individuals' HIV status. The laws vary widely in the strength of the protection they offer. All allow for disclosure of HIV-related information in certain circumstances. Administrators should educate themselves about the HIV confidentiality protections offered by their individual States.

Discrimination Against LGBT Individuals

In much of the United States, discrimination against individuals because of their sexual orientation is legal. Although some States have extended their laws against racial and gender discrimination to cover discrimination on the basis of sexual orientation, in most places LGBT individuals can be denied employment or fired, barred from housing, and excluded from health and social services.

LGBT individuals are disadvantaged legally in other areas as well. In most States, same-sex couples in a committed relationship are prohibited from marrying. This means that same-sex partners must make special arrangements if they wish to bequeath their assets to each other after death. Few jurisdictions provide unmarried partners of employees the health insurance benefits married partners take for granted; even fewer require private employers to offer unmarried partners these benefits. Partners may have difficulty visiting their loved ones in hospitals that have "family only" policies. LGBT individuals are often denied the right to adopt children.

Because of the lack of protection under the law, LGBT individuals may suffer severe or painful consequences if their sexual orientation becomes known. They risk losing custody of their own children in disputes with former spouses or families of origin because of their sexual orientation. (A diagnosis of substance abuse can be yet another strike against them in such cases.) In addition, LGBT individuals can be discharged from the military if their sexual orientation becomes known.

Thus far, only one State has enacted legislation that recognizes what it terms "civil union" between two individuals of the same sex. The statute was passed in response to a decision of the Supreme Court of Vermont (Baker state of Vermont) finding that the State's denial of marriage licenses to same-sex couples "effectively excludes them from a broad array of legal

benefits and protections incident to the marital relation, including access to a spouse's medical, life, and disability insurance, hospital visitation and other medical decision making privileges, spousal support, intestate succession, homestead protections, and many other statutory protections." The court held that "the State is constitutionally required to extend to same-sex couples the common benefits and protections that flow from marriage under Vermont law."

The Vermont Supreme Court did not order the State to offer marriage licenses to same-sex couples. Rather it required the State legislature to "craft an appropriate means of addressing this constitutional mandate [through any one] potentially constitutional statutory scheme from other jurisdictions [that provide] an alternative legal status to marriage for same-sex couples, impose similar formal requirements and limitations, create a parallel licensing or registration scheme, and extend all or most of the same rights and obligations provided by the law to married partners." Ultimately, the State legislature chose to enact a "civil union" (cu) statute, and same-sex couples in Vermont have already been "cued." (It remains unclear whether other States will recognize such unions between individuals who travel to Vermont for the purpose of being cued.)

The Vermont Supreme Court based its decision squarely on the common benefits clause of the Vermont constitution, a provision it interpreted as offering stronger protection to Vermont citizens than the Federal equal protection clause. The advantage of the court's resting its decision on the Vermont constitution is that the U.S. Supreme Court cannot review or overturn the decision. The disadvantage is that other States lacking a similar clause are less likely to adopt the court's reasoning.

For up-to-date information on the laws regarding discrimination against LGBT individuals, see http://www.lambdalegal.org.

What Can Be Done To Help LGBT Clients?

There are a number of ways that programs can adjust their policies and procedures to protect clients, educate them, and help them deal with the discrimination they may face.

1. Confidentiality

Programs should establish written policies that ensure that information about sexual orientation is confidential. The policy should prohibit disclosure of such information to anyone outside the program, unless the client consents. Any exceptions to this rule should be approved in advance by the program director.

2. Caution on Self-Disclosures

As part of the recovery process, substance abuse treatment programs often encourage clients to acknowledge to others that they have abused alcohol and drugs. Of course, disclosure of this information is not always advisable. While there are laws protecting alcoholics and former drug abusers from discrimination in employment, housing, and access to health care (see below), it is not always easy to enforce those legal protections. Clients should be advised to think carefully before disclosing information about their substance abuse histories.

LGBT clients should also be cautioned to think carefully before disclosing their sexual orientation to others. Such disclosures will rarely be advisable unless clients are fairly sure how the information will be received. Because LGBT clients often have no legal protection against discrimination on the basis of sexual orientation, they should continue to share this information only with those they are confident will respect them and their privacy.

3. Education

Programs should educate staff and clients about State and local laws and regulations regarding LGBT persons. Some jurisdictions have enacted statutes protecting LGBT individuals

from some forms of discrimination. Other jurisdictions have enacted statutes designed to make life more difficult for LGBT individuals. The confidentiality afforded HIV-related information also varies from place to place. Programs should use the resources listed at the end of this chapter to educate themselves and their clients about LGBT legal issues. The Web site maintained by the Lambda Legal Defense and Education Fund is particularly informative.

4. Legal Inventory

Programs can help their clients review their employment, marital, and parental statuses and assess what steps they might take to protect themselves and their rights.

Example 1: Barbara A., a 23-year-old lesbian, is contemplating a divorce. She has three young children and very much wants to retain custody. She worries that her spouse will use her sexual orientation (and/or treatment his- tory) when the issue of child custody arises. The program should encourage Barbara to share information about her sexual orientation and substance abuse treatment with her attorney. Depending on Barbara's relationships with her spouse and the children's grandparents, her attorney may advise her to consider seeking a negotiated custody agreement. Information about her sexual orientation (and substance abuse history) is less likely to be used against Barbara in this context than during a heated court battle.

Example 2: Harry B. is in a committed relationship with Stephen C. Harry is worried about what might happen if his high blood pressure causes him to have a stroke. What if he becomes unable to make decisions about his own medical care? He feels very strongly that he would not want to prolong his life following a massive stroke. He wonders whether Stephen will be allowed to make medical decisions for him.

The program can help Harry explore the options available to him, which may include (depending upon State law) signing "advance directives" about his health care and/or signing a

legal document appointing Stephen his proxy, enabling him to make health care decisions should Harry become incapacitated. This legal document is often called a "health care proxy" or a "medical power of attorney."

Example 3: Ellen W. and Jean C. have grown old together. Ellen has a considerable fortune she inherited from her father; Jean has few assets. Ellen wants to make sure Jean will inherit her property.

State law generally controls rules of inheritance. However, in most (although not all) instances these rules can be overridden once an individual makes a will naming a beneficiary or establishes a trust for the benefit of a named individual. In this respect, LGBT individuals are no different from heterosexuals who are unmarried and have only distant blood relatives. They, too, must make a formal will or set up a trust if they do not want a third cousin to inherit their assets.

5. Respect for LGBT Clients

Programs treating LGBT individuals should take steps to ensure that staff and other clients respect the privacy, safety, and humanity of this population.

- Programs should screen staff members to ensure that they are willing to work with LGBT individuals. Written descriptions of job responsibilities should include treatment of LGBT individuals.

- Program rules should require that clients exhibit respect for one another without regard to race, gender, religion, national origin, or sexual orientation. Programs should establish grievance procedures for clients who want to complain about violation of the rules. All complaints should be handled promptly.

- Programs should treat the partners of LGBT clients as they do members of traditional families. Many LGBT clients are alienated from their families of origin and will not want them to visit. However, visits by a partner may be welcomed.

For a comprehensive list of "Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual, and Transgendered Clients," see the Web site maintained by the Gay, Lesbian, Bisexual, and Transgender Health Access Project at http://www.glbthealth.org .

6. Program Safety for LGBT Individuals

All clients should be informed at admission that the program will not tolerate sexual harassment or sexual overtures between persons of the same or different gender. Programs should establish effective grievance procedures and respond to any violations of the rules promptly.

Written personnel policies should include prohibition of harassment in the workplace, including harassment of LGBT staff by other staff and sexual harassment between persons of the same (or different) gender. Programs should establish effective disciplinary procedures and respond to complaints promptly.

Programs treating minors should be particularly attentive to this issue, as an incident involving a minor can result in serious legal consequences. The minor's parents may sue a program that is negligent in this area, and child protective services may intervene if there is an allegation of abuse.

7. Affirmative Action/Cultural Competency

Providing effective treatment for LGBT individuals requires programs to make every effort to employ LGBT individuals in visible jobs. Personnel policies should include a

nondiscrimination hiring clause that encompasses LGBT persons (see chapter 14, Policies and Procedures), and programs should offer domestic partner benefits whenever possible.

Do LGBT Individuals in Substance Abuse Treatment Have Any Legal Protections?

Yes, in areas unrelated to sexual orientation, they do. The Federal Rehabilitation Act (29 U.S.C. §791 et seq.(1973)) and the Americans with Disabilities Act (ADA) (42 U.S.C. §12101 et seq.(1992)) prohibit discrimination against individuals with "disabilities," a group defined as including individuals who are alcoholics or have a history of drug abuse. Together, these laws prohibit discrimination based on alcoholism or a history of drug abuse in the services, programs, or activities provided by:

• State and local governments and their departments, agencies, and other instrumentalities (29 U.S.C. §794(b) and 42 U.S.C. §§12131(1) and 12132)

• Most providers of "public accommodations," including hotels and other places of lodging, restaurants and other establishments serving food or drink, places of entertainment (movies, stadiums, etc.), places the public gathers (auditoriums, etc.), sales and other retail establishments, service establishments (banks, beauty shops, funeral parlors, law offices, hospitals, laundries, etc.), public transportation depots, places of public display or collection (museums, libraries, etc.), places of recreation (parks, zoos, etc.), educational establishments, social service centers (day care or senior citizen centers, homeless shelters and food banks, etc.), and places of exercise and recreation (42 U.S.C. §§12181(7) and 12182).

The Rehabilitation Act and ADA (Rehabilitation Act and key implementing regulations: 29 U.S.C. §793 and 29 CFR Part 1630; §794(a), (b)(1), (b)(3)(A) and 45 CFR Part 84; Americans with Disabilities Act and key implementing regulations: 42 U.S.C. §§12111(2) and

(5)and 12112 and 28 CFR Part 35, Subpart C, and 29 CFR Part 1630) also provide protection against discrimination by a wide range of employers, including:

• Employers with Federal contracts worth more than $10,000

• Employers with 15 or more employees

• Federal, State, and local governments and agencies

• Corporations and other private organizations and individuals receiving Federal financial assistance

• Corporations and other private organizations and individuals providing education, health care, housing, or social services and parks and recreation sites

• Labor organizations and employment committees.

The Rehabilitation Act and ADA also classify individuals with HIV/AIDS as individuals with disabilities and prohibit employers, government agencies, and places of public accommodation from discriminating against them on the basis of seropositivity. Because gay men, other men who have sex with men and injection drug users constitute the largest portion of persons diagnosed with AIDS in the United States, this protection is important. For a detailed discussion of the scope of protection offered and how these statutes have been applied in cases of individuals with HIV/AIDS, see Treatment Improvement Protocol 37Substance Abuse Treatment for Persons With HIV/AIDS(CSAT, 2000), available at SAMHSA's Publications Ordering Web page. Many States also have laws protecting people with HIV/AIDS from dis- crimination. Local HIV/AIDS and gay and lesbian advocacy groups and resource centers are often able to provide information and advice about both Federal and State laws in this area.

These laws can be helpful to LGBT clients and the programs treating them. If a program refers a client to a vocational rehabilitation training program or a dentist and he or she is rejected

because of a history of drug abuse or HIV positivity, there is legal recourse. Programs should also be aware that they, too, are most likely covered by these laws; for example, they may not discriminate against clients with HIV/AIDS or against job applicants or employees with HIV/AIDS or histories of substance abuse. (Note that ADA specifically excludes "transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, and gender identity disorders not resulting from physical impairments, and other sexual behavior disorders" from the definition of "disability." Psychoactive substance use disorders resulting from current illegal use of drugs are also excluded.)

Recommendations

The following are some recommendations for improving substance abuse treatment for LGBT clients.

1. Improve knowledge among staff members about the laws affecting LGBT individuals with substance abuse histories. These include:

    a. Federal and State antidiscrimination laws protecting individuals with disabilities that apply to alcoholics and individuals with histories of drug abuse

    b. Federal and State antidiscrimination laws protecting individuals with disabilities that apply to individuals with HIV/AIDS

    c. Federal confidentiality laws and regulations

    d. State laws protecting HIV-related information

    e. State and local laws that apply to LGBT individuals.

2. Ensure that staff members respect LGBT clients by:

    a. Establishing written job descriptions that require treatment of all clients without regard to their sexual orientation

b. Screening out job applicants who express overt bias

c. Establishing clear, written program policies requiring equal treatment of clients without regard to their sexual orientation and enforcing program policy through a disciplinary process

d. Providing staff members with training to increase their awareness of and sensitivity to LGBT issues

e. Establishing a procedure for clients to complain about bias.

3. Ensure that clients respect LGBT individuals by:

a. Establishing program rules requiring respect for clients without regard to their race, gender, religion, national origin, or sexual orientation

b. Providing clients with education and information about LGBT individuals

c. Establishing grievance procedures for clients wishing to lodge complaints

d. Enforcing program rules promptly.

4. Ensure that LGBT staff and clients are safe while attending the program by:

a. Establishing personnel policies prohibiting harassment in the workplace, including harassment of LGBT staff by other staff and sexual harassment by persons of the same or a different gender

b. Informing clients at admission that the program does not tolerate sexual harassment or sexual overtures or activities by persons of the same or a different gender

c. Enforcing the rules promptly d. Establishing grievance procedures for both staff and clients who may wish to complain about harassment and responding promptly to complaints.

5. Take all steps necessary to ensure the confidentiality of information about clients' substance abuse treatment as well as their sexual orientation by:

a. Providing staff with training about the Federal confidentiality regulations

b. Establishing written policies about the confidentiality of information about sexual orientation and instructing staff about those policies

c. Educating clients about the importance of respecting the confidentiality of their fellow clients.

6. Establish personnel policies that attract and retain LGBT staff by:

a. Actively recruiting such individuals

b. Offering such individuals' partners the same benefits offered married couples.

7. Educate LGBT clients about:

a. The confidentiality protections they enjoy (and those they lack)

b. The antidiscrimination laws that protect them, as well as the ways in which their rights are not protected

c. The steps they can take to protect themselves.

Source: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (2012). A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals. *Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment*

Part II

Integrating the treatment of Substance Abuse, Addiction, and Substance Use Disorders for Sexual Minorities.

Treating LGBT Clients

The third part of this training is dedicated to help understand working with substance use disorders and understanding treatment approaches, modalities, and issues of accessibility in the continuum of care. Additionally, Cass's homosexual identity model, the developmental model of recovery and the potential risk relapse, will be covered.

Chapter 6: Overview of Treatment Approaches, Modalities, and Issues of Accessibility in the Continuum of Care

Introduction

This chapter advises providers on approaches, modalities, and accessibility in the continuum of care relevant to the lesbian, gay, bisexual, and transgender (LGBT) populations seeking substance abuse treatment services. Although the issues discussed may be similar to those of the larger population, some differences exist. This chapter provides information about accessibility and attributes of programs that are helpful for LGBT clients.

Substance abuse treatment for LGBT individuals is the same as that for other individuals and primarily focuses on stopping the substance abuse that interferes with the well-being of the client. However, some LGBT clients will need to address their feelings about their sexual orientation and gender identity as part of their recovery process. For some LGBT clients, this will include addressing the effects of internalized homophobia. Clinicians sometimes see relapses in LGBT persons with lingering negative feelings about their sexual orientation or gender identity.

Substance use, especially alcohol use, is woven into the fabric of the lives of many LGBT individuals. The greater use and presence of alcohol and drugs in settings where LGBT people socialize (in conjunction with the denial produced by the use of these substances) may help to explain the greater predisposition to substance abuse among LGBT individuals.

Even if the LGBT individual is open about his or her identity, it is virtually impossible to deny the effects of society's negative attitudes, which can result in feelings of doubt, confusion, fear, and sorrow (Diamond-Friedman, 1990). Often referrals or appropriate treatment are difficult to secure due to the lack of understanding of these issues by treatment program

administrators and staff. Finding a program that can both address LGBT clients' treatment needs and be supportive of them as individuals can be very difficult.

Members of the LGBT community often face problems in traditional health care systems and are stigmatized within programs by staff and other clients (Mongeon & Ziebold, 1982). Service providers should develop a basic understanding of how they can best serve these populations to help ensure successful treatment outcomes. In addition, due to the multicultural and varied backgrounds of LGBT clients, treatment approaches and modalities may need to be tailored to meet the needs of these individuals.

The growing body of literature on working with LGBT substance abusers can help clinicians understand the issues and improve treatment (Cabaj, 1996; Finnegan & McNally, 1987; Gonsiorek, 1985; Ziebold & Mongeon, 1985).

Approaches

Abstinence-based and treatment-readiness approaches to substance abuse disorders are the two major approaches presented in this chapter. For the purpose of this publication, treatment readiness refers to the level of readiness that individuals may exhibit relating to changing alcohol and drug use behaviors. When undergoing treatment for substance abuse, LGBT individuals have many of the same issues as the larger population, but they may have additional issues as well. LGBT clients may be coping with coming out; their sexual orientation and gender identity; societal stigmas; HIV/AIDS; death and dying; discrimination; same-sex relationships; and homophobic family members, employers, and work colleagues. At times, these issues have a negative impact on a person's ability to change his or her alcohol and drug use patterns and other harmful behavior.

Providers need to understand that a part of substance abuse recovery for many LGBT individuals is accepting themselves as gay, lesbian, bisexual, or transgender and finding a way to feel comfortable in society.

Levels of Care

Levels of care refers to the intensity and duration of services being provided by a program to clients, including inpatient, residential, therapeutic, partial hospitalization or day treatment, intensive outpatient, outpatient, aftercare and followup, and monitoring services.

LGBT substance abusers should be assessed to determine the range of services and levels of care they require. The type of drug and the amount used by a client, the danger of a medically complicated withdrawal, the difficulty with withdrawal and craving, and the need to be away from social and psychological stressors will help a counselor determine the level of care a client needs. Whatever the planned treatment, it should be LGBT sensitive and supportive.

Although they abuse alcohol and some of the same substances as non-LGBT substance abusers, certain LGBT individuals may abuse other drugs that influence the level and duration of care they need. For example, methamphetamine abuse is nearly epidemic in gay men in some parts of the United States (Freese et al., 2000). Abuse of this drug often results in strong cravings and frequent relapses and may require extensive and highly focused treatment.

Outpatient care will serve the vast majority of LGBT substance abusers, just as it does non-LGBT substance abusers. Many larger urban communities have residential programs for LGBT people as well as LGBT-supportive inpatient or outpatient recovery programs.

Continuum of Care

The continuum of care refers to continuing available services and may include provision of additional services while individuals are in the program; ongoing support and services after

discharge (regardless of treatment completion); followup and monitoring activities; and outreach, recruitment, and retention. Some of these services may be different for LGBT clients due to factors such as the health status of the clients or their partners, their living arrangements, the type and stability of their employment, their work hours, their level of openness about their sexual orientation/sexuality, and their experience with previous service providers or systems.

Accessibility

Due to the homophobia and discrimination they experience, LGBT individuals may find it difficult, and sometimes uncomfortable, to access treatment services. Substance abuse treatment programs are often not equipped to meet the needs of this population. Heterosexual treatment staff may be either uninformed about LGBT issues, insensitive to their concerns, or antagonistic toward such individuals. These attitudes may be based on misperceptions or personal beliefs. A harmful result of this insensitivity is that some professionals or other clients may falsely believe that an LGBT person's sexual orientation/gender identity caused his or her alcohol and drug use. One's sexual orientation/gender identity should not be viewed as in need of changing. Such factors become barriers when the LGBT population seeks access to appropriate treatment.

Some LGBT individuals may express difficulty in participating in non-LGBT focused treatment, stating that heterosexuals may not understand LGBT issues and problems. This can be problematic for the treatment staff, but it does not have to impede services. This attitude may be a defense mechanism, or the person may have experienced problems with heterosexual treatment providers in the past. Whatever the cause, it should be managed in a therapeutic manner. Encourage individuals to discuss previous experiences or why they have these feelings or attitudes toward heterosexuals. It is also important for counselors not to assume that they know

why such statements are made or that they completely understand these experiences. Be sensitive to the LGBT individual's experience and facilitate these issues within a therapeutic context.

Often negative feelings or attitudes are based on real experiences and should be acknowledged as such. Making the program accessible to the LGBT community may require some changes. Programs that use observers to administer urine screens need to consider the clients' concerns and ask which gender observer they prefer. Staff may not know what gender the client considers herself or himself, and this could result in uncomfortable situations.

If possible, designate a separate, non-gender-specific toilet and shower facility for some LGBT clients, particularly in residential treatment settings. Transgender individuals may be in the process of change or may be living as the gender opposite the one they were born with, which may result in these individuals using rest rooms different from what one would expect.

Heterosexual staff and clients should not assume that LGBT individuals are any more likely to flirt or act out sexually than their heterosexual counterparts. Rules regarding sexual interactions, flirting, and dating in treatment settings should be the same for LGBT persons as for heterosexual individuals.

Degrees of LGBT Sensitivity

In addition to addressing issues of accessibility, it is important for program administrators and staff to create a supportive environment for LGBT individuals. The impact on the client of anti-LGBT bias and internalized homophobia should be considered when developing the treatment plans of LGBT people with substance abuse problems. Few programs provide education to staff about LGBT people, and many programs may be unaware that they have LGBT clients. Some LGBT clients may be too frightened to come out during treatment or feel they have been given permission to be open about their sexual identity (Hellman et al., 1989).

Staff attitudes are crucial in helping clients feel comfortable and safe; training counselors about homosexuality will help clients feel safe.

Substance abuse treatment programs can be rated on a spectrum from LGBT-hostile to LGBT-affirming. Exhibit 4–1, which was adapted from Neisen (1997), provides a brief overview of the components identified on the spectrum.

It is hoped that only a few programs are openly hostile toward LGBT people; it is essential that any LGBT individuals seeking help for substance abuse problems are not treated at these programs. Unfortunately, many substance abuse treatment programs are unaware of the importance of sexual orientation and operate as if everyone is heterosexual—unaware that LGBT people exist. In such settings, LGBT people most likely will not talk about their sexual orientation or gender identity and will not be able to integrate their sexuality and acceptance of a gay, lesbian, bisexual, or transgender identity into recovery. Internalized homophobia/transphobia and coping with anti-LGBT societal bias most likely will not be discussed.

Some substance abuse treatment programs may be LGBT tolerant, that is, aware that LGBT people exist and use their services. Such awareness is usually due to an LGBT staff member. Even so, accepting one's sexual orientation and dealing with homophobia most likely will not be addressed.

LGBT-sensitive programs are aware of, knowledgeable about, and accepting of LGBT people. Many well-established programs are training staff about LGBT concerns to make them LGBT sensitive. The material in this document is part of that effort. LGBT-sensitive programs acknowledge the existence of LGBT people and treat them with respect and dignity. These programs usually care for LGBT people in the same way that they treat other clients but

recognize the difficulties and challenges facing LGBT people in recovery. Some programs may also have specific therapy groups for LGBT people.

Fewer programs are LGBT affirmative—that is, they actively promote self-acceptance of an LGBT identity as a key part of recovery. These programs affirm LGBT individuals' sexual orientation, gender identity, and choices; validate their values and beliefs; and acknowledge that sexual orientation develops at an early age. An LGBT-affirmative program, the Pride Institute, released data showing a very successful treatment rate when acknowledging one's sexual orientation is considered a key factor in recovery (Ratner, Kosten & McLellan, 1991). At a 14-month followup with verified reports, 74 percent of all patients treated 5 or more days abstained from alcohol use continuously, and 67 percent abstained from all drugs. These data can be compared with data from four similar, sometimes LGBT-sensitive but non-LGBT-affirmative treatment programs with unverified reports taken at followups ranging from 11 months to 24

months after treatment, which had abstinence rates of 43, 55, 57, and 63 percent.

Exhibit 4–1:
LGBT Sensitivity Model

Anti-LGBT Treatment	Traditional Treatment	LGBT-Naive Treatment	LGBT-Tolerant Treatment	LGBT-Sensitive Treatment	LGBT-Affirming Treatment
No LGBT sensitivity	No LGBT sensitivity	No LGBT sensitivity	Minimal LGBT sensitivity	Moderate level of LGBT sensitivity	Highest level of LGBT sensitivity
Antagonistic toward LGBT individuals	No realization that there are LGBT clients	Realization that there are LGBT clients	Recognition that there are LGBT clients	Several clients and/or staff are open with their LGBT identity	Program primarily targets LGBT population
Treatment focuses exclusively on heterosexuals and excludes LGBT clients	No acknowl-edgment or discussion of LGBT issues; it is assumed everyone is heterosexual	As an agency, has not yet begun to address the special issues of the LGBT population	Some staff may verbalize that it is okay to be an LGBT individual; however, such discussions are limited to individual sessions	Several workshops and/or groups focus on LGBT issues; they may have LGBT groups or a "track" for LGBT issues; groups are generally mixed	All workshops specifically for LGBT clients; workshops and groups affirm the LGBT individual, have LGBT-specific materials, etc.; groups and work-shops are not mixed with heterosexuals
No specific LGBT treatment components	No specific LGBT treatment components	No specific LGBT treatment components	No specific LGBT treatment components	Some specific LGBT treatment components	All treatment components are LGBT specific

Adapted from Neisen, 1997

Specific Issues

Substance abuse and sexual identity formation, which includes awareness and acceptance of sexual orientation and gender identity, are often enmeshed for many LGBT people. Some counselors and clinicians working with LGBT clients' substance abuse see addressing these issues as essential to recovery, and failure to do so may result in a difficult recovery process.

Substance abuse treatment programs that are LGBT sensitive are more likely to have more successful outcomes with LGBT clients.

Exhibit 4–2 presents principles of care that are appropriate for any client. Program administrators and staff need to be aware of issues that may be specific to the LGBT population with respect to the continuum of care, including outreach, identifying the extent of alcohol and drug use, and discharge planning.

Exhibit 4–2:
Principles of Care

Principles of care that should be part of any substance abuse treatment program for LGBT populations are listed below. These principles are adapted from a mental health care practical guide to developing programs for working with people living with or affected by HIV/AIDS (Acuff et al., 1999).

Be flexible and client centered
Clients will present with a wide range of substance use and psychosocial needs. While some clients may benefit from group modalities, others may need individual counseling or may benefit from supportive treatment. To meet the individual's needs, services need to be flexible but consistent and thorough.

Be coordinated, integrated, and comprehensive
Service systems should establish formal linkages and networks to enhance service coordination and integration. Likewise, providers working in a multidisciplinary setting should use a team approach to meet each client's needs.

Be consistent with each client's cultural needs and expectations
Programs may need to employ multilingual and multicultural staff as well as individuals representing LGBT populations. Sensitivity training is essential for staff members who are not culturally matched with the client base.

Promote self-respect and personal dignity
Effective service delivery depends on recognizing an individual's self-worth and contributions to his or her community. Society and the traditional health care system, along with substance abuse treatment programs, typically may have stigmatized LGBT clients and left them with little sense of self-respect or dignity. Programs must ensure that staff and the service delivery system do not stigmatize the clients further.

Promote healthier behaviors
Service providers can work with clients to practice healthier behaviors, to practice safer sexual behaviors, to strengthen supportive relationships, and to comply with medication regimes for HIV and psychotropic communities—or other professionals and agencies may provide positive examples for clients currently in treatment or receiving services.

Empower persons in substance abuse treatment to make decisions in collaboration with the service provider
Service providers must not assume that they know what is best for individuals but must include clients in treatment planning. All segments of the community, including consumer and advocacy groups, should be involved in the process of establishing, delivering, and improving services.

Reduce barriers to services for hard-to-reach populations
LGBT populations are varied, which can cause difficulties in reaching segments of the community. Individuals may be homeless, work as street hustlers/prostitutes, be in jail/prisons, or come from a variety of cultural/ethnic backgrounds, thus creating the need to develop effective outreach and retention mechanisms.

Develop and deliver services that are clinically informed and research based
It is important not to assume that services that are effective for the larger population will be as effective or appropriate for the LGBT populations; clinical issues often are different and need to be acknowledged and treated. Evaluations of current clinical services for the LGBT community may need to be undertaken, or research from other such undertakings can be used to develop appropriate services.

Work to create a treatment/recovery community
Programs can play a role in developing a community of individuals, agencies, and organizations that work in partnership to develop a treatment/recovery community. Making use of individuals who have successfully completed treatment (alumni), individuals in the recovery communities, or other professionals and agencies may provide positive examples for clients currently in treatment or receiving services.

Identifying the extent of alcohol and drug use is an issue that is important to all individuals entering substance abuse treatment regardless of their sexual orientation. Traditional assessment forms may need to be modified or redeveloped for the LGBT populations to include more inclusive language (refer to Coleman's Assessment Tool in chapter 1).

Without culturally competent training, the assessor may be uncomfortable and miss biopsychosocial information important to effective treatment planning. Also, collecting collateral information may be different for the LGBT population: Some LGBT clients may not have close relationships with their family of origin; it may be clinically appropriate to gather collateral information from a partner and close friends (who may be identified by clients as their family of choice). However, it cannot be assumed that all LGBT clients are estranged from their families of origin. Many have supportive and close families. It may be helpful to include these individuals in treatment to expand clients' recovery support system.

Special Assessment Questions

In formulating a treatment plan for LGBT individuals with a substance abuse problem, some additional factors may need to be assessed. Following are a sample.

- Determine the individual's comfort with being an LGBT person. Evaluate the person's comfort level with his or her sexuality and expression of sexual feelings. If the person is a transgender individual, determine his or her level of comfort with, and acceptance of, that identity.
- If appropriate, determine the stage where the individual is in the coming-out process (whether as a gay, lesbian, bisexual, or transgender person). Learn about his or her experience and the consequences of coming out.

- Determine the extent of the individual's support and social network, including whether there are any current relationships or past relationships and the individual's relationship with his or her family of origin.
- Determine whether there are any health factors of concern, including the individual's HIV status.

The substance abuse counselor can ask the same questions about alcohol or drug use as he or she uses for non-LGBT individuals. Specific information about the patterns of, and situations involved in, the use of alcohol and drugs by LGBT individuals can be helpful in planning treatment and preventing relapse. For example:

- Look at the most recent alcohol and drug use: Was it with family, friends, a significant other, a lover, or a date? With work colleagues? Where was it? At a circuit party? Alone? At a sex club or bathhouse? At a lesbian, gay, bisexual, or transgender bar or at a straight bar?
- Is there current or past intravenous or injection drug use? If so, what drugs are used? Are amphetamines (speed, crystal, crank) used? Are amphetamines used to enhance sexual intensity?
- What is the frequency of the alcohol and drug use? Does it correlate with the socializing?
- What is the drug of choice—the drug the client enjoys or seeks most? What does it seem to do or accomplish? Provide relaxation? Provide freedom from guilt? Enhance sexual behavior?
- If the client has a significant other, does that person believe there is a problem? Does he or she have his or her own substance abuse problems?

- Has the client had legal problems due to his or her use of alcohol and drugs, including driving under the influence? Has the client ever had legal problems related to sexual behavior or police harassment?
- Has the client ever been attacked or assaulted (gay bashed) because he or she was thought to be an LGBT person?
- Has the client had social problems or lost partners, family, or friends because of alcohol and drug use? Has there been domestic violence? Was it by a same-sex lover?
- Has the client had treatment in the past for substance abuse? If so, was his or her sexual orientation or sexuality discussed?
- What is the longest time the client did without alcohol and drug use, and what allowed that to happen?

Modalities

Typical modalities for substance abuse treatment include individual, group, couples, and family counseling, but LGBT individuals can face other unique problems if they are treated by traditional programs through group, couples, or family modalities.

The group modality may be difficult for LGBT individuals if heterosexism/homophobia is demonstrated by staff and other group members. Groups should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns. If a group combines heterosexuals and LGBT individuals, provide sensitivity training relating to LGBT issues and concerns; ensure that all clients are aware that groups will be mixed. Placing LGBT individuals in therapy groups with homophobic clients may lead to difficult situations and/or hostility toward the LGBT individuals.

Staff need to ensure that LGBT clients are treated in a therapeutic manner and should provide a strong verbal directive that homophobia and hostility will not be tolerated. If it does occur, staff must take strong action on behalf of LGBT clients. LGBT clients should not be required to discuss issues relating to their sexuality or sexual orientation in mixed groups if they are uncomfortable. On the other hand, in a mixed group setting led by adequately trained, culturally competent, and LGBT-supportive staff, LGBT clients may have the powerful experience of gaining acceptance and affirmation from peers. The acceptance and care that can come from members of groups could be healing for LGBT persons.

Often, intensive programs provide groups for special populations (e.g., women, professionals, those with HIV/AIDS, racial/ethnic minorities) to address their multidimensional needs (CSAP [Center for Substance Abuse Prevention], 1994). If a program has enough LGBT clients, it may start an additional or separate group for them. This may provide a safe or more cohesive venue for discussing issues specific to LGBT clients. However, attendance should be voluntary. When LGBT-or gender-specific groups are held, therapists should regularly direct attention to safe-sex practices and sexual feelings about and experiences with same-sex individuals.

Family counseling can be difficult due to issues relating to the client's sexual identity/ orientation, substance abuse, and, in some cases, HIV/AIDS diagnosis, which have caused distance and alienation. LGBT clients are more likely to seek support for their partners if they view the program as LGBT sensitive.

If a program provides treatment primarily through an individual modality, many of these issues may not be relevant. Providing one-to-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood that

heterosexism/homophobia will become an issue. LGBT individuals will be able to discuss issues revolving around their sexual orientation/identity without fearing that non-LGBT individuals will be hostile, will be insensitive, or will minimize LGBT issues.

Discharge planning

Specific concerns related to the discharge planning process for LGBT clients may include an enhanced analysis of their social support, their living arrangement/environment, their employment status or type of employment, and ongoing issues that clients have identified related to their sexual orientation/identity. Social support involves the amount of support available to clients, which can increase their likelihood of remaining abstinent or in recovery. Social support often includes the family of origin and family of choice (e.g., sexual partner, friends, or others) and should focus on individuals who support clients' efforts to create such significant changes. LGBT individuals may live in an environment that is not conducive to their ongoing abstinence/recovery (e.g., they have a partner or roommate who actively uses alcohol and drugs, or they live in close proximity to drug dealers or open air drug markets). Although these issues or concerns may be similar to those individuals from the larger population may face, it is important to assess and provide appropriate referrals for LGBT clients. Clients' employment status or type of employment may also interfere with their ongoing abstinence/recovery. Specific issues may be the type of work the individuals perform (e.g., bartender, sex industry worker) or status (e.g., not in stable employment, disabled). Issues related to their sexual orientation/ identity may interfere with their recovery after discharge if ongoing support or counseling is not provided to meet needs indentified by clients.

Aftercare/Recovery

Aftercare and support for recovery may be a problem, depending on the geographic location and any difficulties the client may have expressed concerning acceptance of his or her sexual orientation (there may be no LGBT-sensitive counselors or programs in the client's community).

Twelve-step recovery programs and philosophies are, of course, the mainstays in recovery and in staying clean and sober. As an organization, Alcoholics Anonymous (AA) clearly embraces LGBT individuals as it embraces anyone concerned about alcohol problems and has literature specifically for LGBT individuals. Although open to all, AA meetings involve a random group of people and may reflect the perceptions and prejudices of those individuals and the local community and not be supportive of openly gay members (Kus, 1989). Many communities now have LGBT-specific AA, Narcotics Anonymous (NA), and Al-Anon meetings. Many LGBT people, however, mistakenly link AA and religion and resist attending since many religious institutions denounce or condemn homosexuality. For example, because of the moral condemnation of some religious bodies, references to a higher power or God in the 12-step model may, in fact, create fear of prejudice rather than assurance of support. While AA advises same-sex sponsors, recovering LGBT individuals require some flexibility, in that same-sex sponsorship may create problems. Many times AA respects this need. In locations where they are available, counselors should consider exposing their LGBT clients to LGBT-specific 12-step meetings so that any problems or issues relating to those meetings can be addressed while the clients are in treatment.

Some groups similar to AA have formed to meet the needs of LGBT people, such as Alcoholics Together. Many large cities sponsor "roundups"—large, 3-day weekend gatherings

focused on AA, NA, lectures, workshops, and alcohol and drug-free socializing. Some LGBT people entering recovery, however, may not have come out publicly or may not feel comfortable in such meetings, especially if a discussion of sexual orientation was not part of the early recovery process.

Twelve-step programs such as AA and NA recommend avoiding emotional stress and conflicts in the first 6 months of recovery. However, for LGBT persons, the risk of a relapse may be increased if they cannot begin to work through these issues. Discussions about sexual orientation and learning to live comfortably as an LGBT person are essential for recovery, even if these topics are emotionally stressful.

On the other hand, waiting 6 months to deal with this issue may be helpful. The client will have the increased confidence that 6 months of sobriety brings as well as a clear head. Just like many other people in recovery, LGBT individuals may find some of the suggestions and guidelines of AA, NA, and some treatment programs difficult to follow. Giving up or avoiding their old friends, especially fellow LGBT substance users, may be difficult when clients have few other contacts. Staying away from bars, parties, or circuit parties may be difficult if those are their only social outlets. The counselor may need to provide special help on how not to drink or use drugs in such settings or, better yet, help clients find social environments that support recovery. Clients will need to learn how to adjust to clean and sober socializing, without the use of alcohol or drugs to hide their social anxiety.

Many localities now have LGBT health, mental health, or community centers, almost all of them with a focus on recovery and substance abuse treatment. National organizations, such as the National Association of Lesbian and Gay Addiction Professionals, the Association of Gay and Lesbian Psychiatrists, the Gay and Lesbian Medical Association, the Association of Lesbian

and Gay Psychologists, the National Association of Alcoholism and Drug Abuse Counselors' LGBT Special Interest Group, and National Gay Social Workers, may help with appropriate referrals.

Additional things the newly sober client should learn are how to have safer sex while clean and sober, how to deal with the damaging effects of substance abuse on employment and relationships, and the adjustment to recovery couples must make that will heal the client and avoid the negative impact of codependent relationships.

Case Example

Ruth is a 47-year-old African-American lesbian living in a large midwestern city. She is currently in an inpatient substance abuse treatment program that is gay sensitive. She has talked openly about being lesbian, and her partner of the past 25 years has been part of the treatment program.

Ruth was admitted for help with her crack cocaine use. She grew up in a very poor part of the city but had developed supports and strengths at her local Baptist church. Ruth and her mother went to regular services and many social functions, and she developed many friendships. She did well in school and liked sports. She was surprised one day in the ninth grade when she read a story about a lesbian teacher and felt a sudden awareness of sexual feelings for other women. She went home to talk about it with her mother, who said she should talk to the minister. When Ruth told him about her feelings, he became very upset, said she was an abomination before God. Although some clergy are LGBT supportive, this minister asked Ruth's mother to keep Ruth away from the church until she "recovered her senses." Ruth's mother agreed.

Very upset and confused, Ruth ran away from home. She became homeless and discovered that she could escape her feelings by using crack cocaine. To get money for food and drugs, she began to work as a streetwalker. At a special celebration for a homeless center a few years later, she met a city worker who happened to be black and lesbian. They formed an improbable relationship, and her partner brought Ruth off the streets and into a loving living arrangement. In the last 25 years, Ruth went back to school and worked as a substance abuse counselor. She has been clean and sober most of that time. She relapsed recently after her mother died and the old minister refused to let her attend the funeral in her old Baptist church.

Her lover was still supportive but was getting frustrated and angry. The lover had a history of severe depression and was treated with psychotherapy and medications; she again sought help from a therapist. That therapist convinced the lover to bring Ruth in for couples counseling. After being suspended from work for absenteeism, Ruth finally agreed. The therapist helped Ruth accept that she had relapsed and that she needed to get clean and sober. The couple's therapy work was suspended while Ruth entered an out-of-town inpatient treatment program. Ruth said she was too embarrassed to seek help locally since she might run into her fellow counselors and current or former clients.

Suggested Interventions

This case presents a unique situation but touches on several important themes: treatment level, location, and type; racism and homophobia; mental health or emotional stresses and relapse; and religion. A counselor working with Ruth will have many challenges.

- Relapse is possible at any time. LGBT people in long-term recovery may be very embarrassed about relapsing and use that as an excuse to avoid 12-step or other interventions. LGBT substance abuse counselors may feel that they have even fewer treatment options, especially if they wish to preserve a sense of personal confidentiality. In Ruth's case, the out-of-town location may not have been necessary from a clinical point of view (that is, the treatment at a local site may have been just as good as the site chosen), but the client accepted the intervention and referral. Since getting back on the path of recovery is so important, this concession made perfect sense.

- Relapse can be triggered by many things. Though nothing like a death or a reaction to prejudice causes the substance abuse, the emotional reaction to such events may be the trigger that brings on a relapse. Ruth will have to face several emotional challenges in her early recovery, and her substance abuse counselor will need to help her pace the rate at which she confronts the issues to help her remain clean and sober. The death of her mother, the homophobia of her church, her concern about the effect of her behavior on her lover, her return to work, and revisiting her own internalized homophobia all will be part of her long-term recovery.

- Religion and spirituality may play a very important part in recovery from substance abuse for many LGBT people. If the client's church is an issue, the counselor may need to help the client find an LGBT-accepting church or a different church branch. Some organized religious groups and churches have congregations for LGBT people. Most religious groups will have some LGBT-sensitive, if not even openly LGBT, clergy who may be very helpful. Counselors will need to know the difference between religion and spirituality and help the LGBT client understand that difference. Such a client may find spiritual comfort even if he or she cannot find religious comfort.

- Psychotherapy usually does not work for substance abusers who are actively using. In Ruth and her lover's case, couples therapy would probably not have been helpful. The therapist was very aware of the need to recognize this fact and used the couple's meetings to help the lover shape an intervention, which led to Ruth beginning treatment. After Ruth is clean and sober for several months, the couple could start therapy if it is still needed. Meanwhile, the lover can continue to seek the help she needs to manage her own depression.

- Ruth herself will also need to see how much of her life has been affected by racism and homophobia. If it has not been explored in past counseling, it will need to be looked at to help shore up her recovery. In the same way that not acknowledging the effects of homophobia may make relapse more likely, so, too, will not addressing the impacts of racism.

- Since the lover is so involved in Ruth's life and recovery, she should play a role in the early recovery process. Ruth's inpatient treatment counselor will need to include her just as she would the significant other of a non-LGBT person.

Source: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (2012). A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals. *Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment*

Chapter 7: Homosexual Identity Model

The Coming out Process for Lesbians and Gay Men

Marshal et al. (2009) explained that sexual minorities face many barriers different from heterosexual youth at almost every developmental stage of life and into young adulthood. Cass (1984) described this developmental process in six stages, which may be described according to a number of affective, behavioral, and cognitive dimensions. The stages can be distinguished by these dimensions in their degree of importance. For example, the factors of alienation would have little or no relevance to Stage 6 (Identity Synthesis). Similarly, the factors of disclosure and acculturation would not be an important aspect to Stages 1 (Identity Confusion) and 2 (Identity Comparison), as the factor of professional contact is not applicable to Stages 5 (Identity Pride) and six (Identity Synthesis; Cass, 1984).

Baily (2005) stated that the changing conceptions of self-identity are linked to discourses of addiction. In reviewing Cass's (1984) stages of homosexual identity formation, Stages 5 and 6, may not be linked as strongly to discourses of addiction as Stages 1 through 4. Additionally, Cass (1979) explained that the length of time it can take an individual to progress through the stages will differ from person to person and an individual's age has a major influence on his or her mode of coping with the developmental process.

Homosexual Identity Formation (Cass, 1984)

Stage 1: Identity Confusion

According to Cass (1984), in the first stage, an individual begins to question whether his or her actions, thoughts, and feelings could be defined as homosexual. At this stage, the individual begins to question his or her sexual orientation and becomes confused about his or her identity.

Stage 2: Identity Comparison

As an individual consciously becomes aware of or coming into terms with identifying themselves as homosexual, feelings of alienation between oneself and others becomes transparent. During this stage, contemplation of making social contact with homosexuals is used as a means to lessen feelings of alienation (Cass, 1984).

Stage 3: Identity Tolerance

As he or she becomes committed to the homosexual self-image, the individual seeks to fulfill social, sexual, and emotional needs. During this stage there is more of a tolerance of the homosexual self-image, rather than accepting oneself as a homosexual. Two separate images are created; a public image (heterosexual) and another private image that is exhibited only in the presence of other homosexuals (Cass, 1984).

Stage 4: Identity Acceptance

Cass (1984) stated that exposure to others within the homosexual subculture promotes a more positive outlook of homosexuality, which gradually increases the development of homosexual friends. In this stage selected people are informed of the individual's sexual preference or identity. Typically, this would include close friends and relatives.

Stage 5: Identity Pride

Individuals feel extreme loyalty to homosexual groups and an immense pride toward sexual identity. These homosexual groups are seen as creditable and important while they discredit and devalue heterosexuals. Cass (1984) described that in order to promote equality of homosexuality and validity through disclosure, anger develops about societal stigmatization of the homosexual lifestyle, as well as confrontation with heterosexuals.

Stage 6: Identity Synthesis

The inaccurate division of bad heterosexuals and good homosexuals helps create positive relationships with non-homosexuals. Anger and pride retained within Identity Pride lessen and a homosexual identity becomes less overwhelming. According to Cass (1984), individuals in this stage see themselves as having many aspects to their identity and not just one related to homosexuality. Disclosure is no longer hidden and an integration of the dichotomy of private and public images cease to exist. Feelings of stability and peace emerge and the process of identity formation completes.

Cass (1984) states that 10 researched identity models place emphasis on the varying degrees to behavioral, cognitive, and affective aspects, however it is difficult to compare between other models. Cass (1984) further explains that there has been little effort to detail the changes that occur within each stage of development, creating a poor and vague conceptualization of the process in each developmental stage. Identity is viewed as a cognitive construct, each component accompanied by a unique effect. Additionally, identity is transposed into a psychological behavior, which can result in changes to identity (Cass, 1984). Cass (1984) elaborates that this model differs from other models in which it rejects the assumption that people perceive the attainment of a negative homosexual identity. Moreover, other models that were proposed concentrated on one gender, while this particular model explains the identity formation process for both genders. Within each developmental stage, several different paths can occur (Cass, 1984).

Table 1 Dimensions Used to Describe Stages (Cass, 1984)

Factors	Cognitive	Behavioral	Affective
1. Commitment	-Degree that individual accepts a homosexual and/or heterosexual self-image.		Feelings about accepting a homosexual self-image.

	-Degree of confusion about own self-image regarding sexual orientation. -Degree of acceptance of others' view of self as a homosexual and a heterosexual. -Clarity of perception of homosexual meaning of behavior and self-image.		
2. Disclosure	-Degree of wanting to disclose homosexual behavior/self-image to homosexual/heterosexual others. -Types of homosexual/heterosexual others that individual would like to disclose to. -Perceived elements of relationship between self and others that lead to desire to disclose.	-Degree of disclosure of homosexual behavior/self-image to homosexual/heterosexual others. -Types of homosexual/heterosexual others that individual discloses to. -Elements of relationship between self and others leading to disclosure.	-Feelings about disclosing homosexual behavior/self-image to homosexual/heterosexual others.
3. Generality	-Degree that a homosexual/heterosexual self-image is seen as being a part of self. -The way that individual imagines others perceive the generality of their homosexual self-image.	-Degree that homosexual and/or heterosexual behavior occurs when possible situation arises.	
4. Identity evaluation	-Degree of acceptance for self of negative stereotypes of homosexuals.		-Evaluation of homosexual and/or heterosexual self-image/behavior. -Evaluation of others' view of homosexual/heterosexual self-image behavior.
5. Group identification	-Sense of belonging felt with homosexuals and/or heterosexuals groups. -Degree that individual perceives self as similar to		-Degree of pride felt towards homosexuals as a whole.

	homosexual/heterosexuals. -Degree that homosexual/heterosexual groups are seen to meet own needs.		
6. Social interaction	Perceived quality of interaction with homosexuals and/or heterosexuals.	-Frequency of social contacts with homosexuals/heterosexuals. -Types of settings in which social contacts with homosexuals/heterosexuals take place.	-Degree of satisfaction with interactions with homosexuals and/or heterosexuals.
7. Alienation	-Degree that individual feels different from others, a stranger to self.		-Degree that individual likes feeling different from others.
8. Inconsistency	-Degree that individual's perception of self, behavior, and others' view of self are inconsistent with regard to sexual orientation.		-Degree of discomfort felt about inconsistency between self, behavior, and others' view of self as pertains to homosexuality.
9. Sexual orientation activity	-Degree that individual desires increased/decreased frequency of homosexual of homosexual erotice, emotional, and sexual activity.	-Frequency with which homosexual erotic, emotional, and sexual activity are engaged in.	-Degree of enjoyment felt from homosexual erotic, emotional, and sexual activity.
10. Acculturation		-Forms of homosexual subcultural activities engaged in.	-Degree of comfort felt in participating in homosexual subcultural activities.
11. Deference to others	-Degree of importance attached to opinions of homosexuals/heterosexual. -Types of homosexuals/heterosexuals perceived as important.		
12. Dichotomizatio	-Degree that homosexuals and		

n	heterosexuals perceived as two separate and distinct groups.		
13. Personal control	-Amount of influence that a homosexual identity is seen to have on day-to-day living and on future prospects. -Degree that a homosexual identity is seen to interfere with running of life.		
14. Strategies	-Degree that individual wants to continue using strategies outlined in model.	-Degree that strategies outlined in model are adopted. -Ease with which strategies are carried out. -Types of strategies used.	
15. Personal satisfaction	-Degree that individual is satisfied with current life. -Degree that individual wants to change current life. -Degree that life is perceived as settled and stable.		
16. Professional contact	-Degree that individual wants to see professional for help regarding homosexual behavior/self-image. -Reasons for seeing/wanting to see professional.	-Whether is seeing or has seen professional for help regarding homosexual behavior/self-image.	

Chapter 8: Developmental Model of Recovery

One widely accepted model of recovery, known as the **Developmental Model**, identifies six stages that addicted individuals must undergo for long-term recovery:

1. **Transition**, the period of time needed for the addicted individual to come to grips with the realization that safe use of alcohol or other drugs for them is not possible;
2. **Stabilization**, during which the chemically dependent person experiences physical withdrawal and other medical problems and learns how to separate from people, places and things that promote substance abuse;
3. **Early recovery**, when an individual faces the need to establish a chemical-free lifestyle and build relationships that support long-term recovery;
4. **Middle recovery**, seen as time for the development of a balanced lifestyle where repairing past damage is important;
5. **Late recovery**, during which the individual identifies and changes mistaken beliefs about oneself, others and the world that caused or promoted irrational thinking; and
6. **Maintenance**, the lifelong process of continued growth, development, and managing routine life problems.

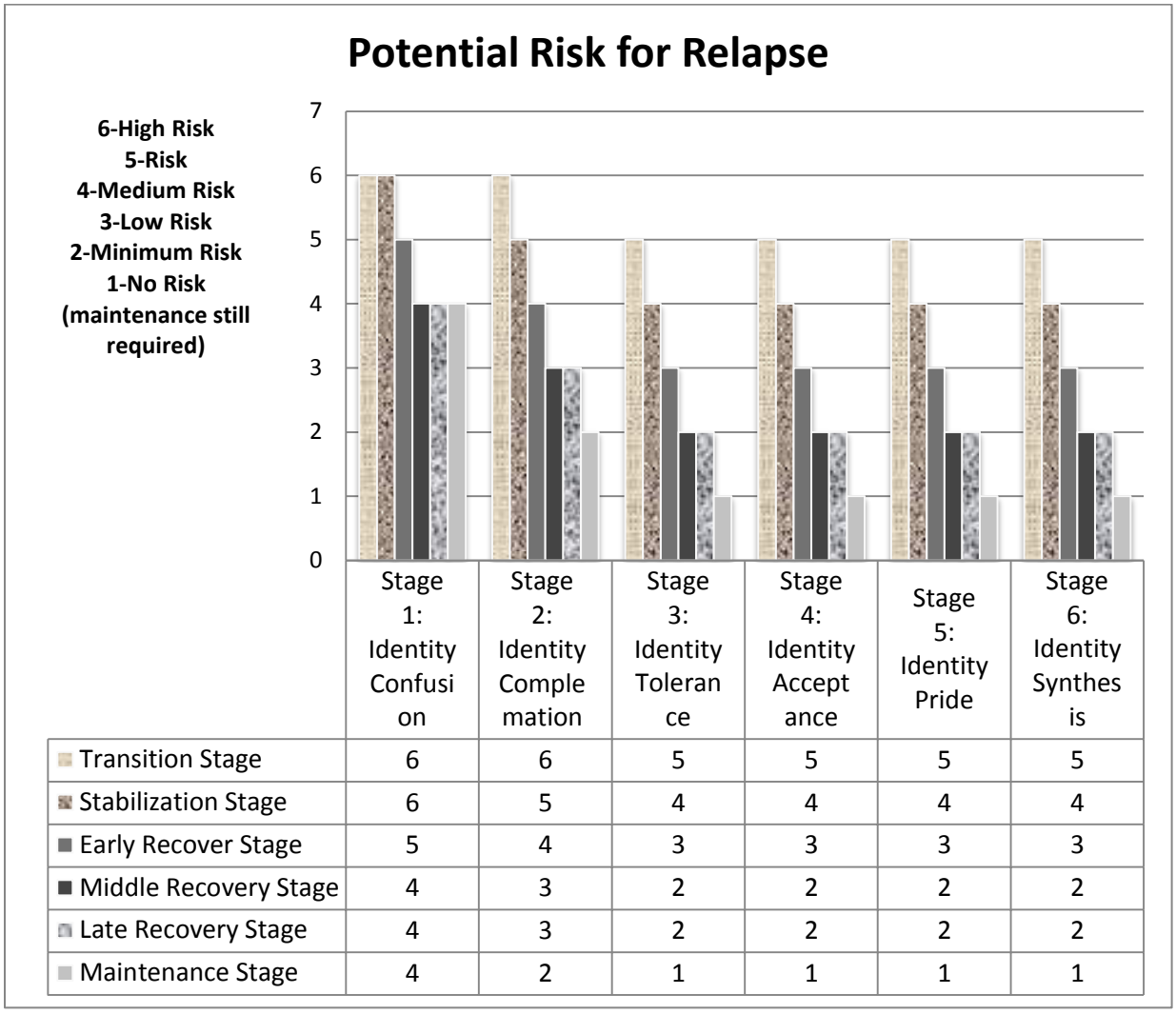
Recovery is very complex, is not exempt from vulnerabilities, and requires a long-term commitment. This important part of the treatment continuum must be taken into account in the design of training programs for providers of substance abuse treatment and those of child welfare services. The complexities of recovery must be understood as well as the compelling need to address the issues of children and addicted parents and other family members. It is often said in the recovery communities that the whole family is in recovery because many changes affecting

the entire family system will necessarily occur as the recovering person embarks on this lifelong journey of well-being.

Source: Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection, April 1999, Chapter 2 - http://aspe.hhs.gov/hsp/subabuse99/chap2.htm

Chapter 9: Potential Risk for Relapse Chart

The following chart is hypothetical and is not based on any research or collected data. Its purpose is to understand that those individuals that are in the beginning stages of identity formation are at higher or greater risk for relapse in treatment. Those individuals that are in stage 6: Identity Synthesis, although a minimum risk, still poses somewhat of a risk. This chart is only to be used for reference and assistance in conceptualization.



	Stage 1: Identity Confusion	Stage 2: Identity Completion	Stage 3: Identity Tolerance	Stage 4: Identity Acceptance	Stage 5: Identity Pride	Stage 6: Identity Synthesis
Transition Stage	6	6	5	5	5	5
Stabilization Stage	6	5	4	4	4	4
Early Recover Stage	5	4	3	3	3	3
Middle Recovery Stage	4	3	2	2	2	2
Late Recovery Stage	4	3	2	2	2	2
Maintenance Stage	4	2	1	1	1	1

Measure Your Understanding!

1. What does “P” in LGBTQQIIAA2-SP Stand for?

a. Paraphilic

b. Pornography

c. Pansexual

d. Photosexual

2. _____ is the essential first step in determining the possible causes of addition for the person and the most appropriate treatment modality for his or her needs.

a. Screening

b. Assessment

c. Intake

d. Orientation

3. Brent is a case manager in an intensive inpatient treatment facility. He recently was assigned a client, Fran, who presents not only with alcoholism but has also identified as a lesbian. To assist Fran in her treatment and recovery needs, Brent would probably need to have knowledge of all of the following areas **EXCEPT**:

a. stage of identity according to Cass’ model

b. past history of discrimination

c. stage of recovery

d. history of sexual relations with opposite sex

4. _____ are various antecedent conditions that lead to individual chemical dependency problems (e.g. conditioning, environment, genetics, etc.)

a. life factors

b. casual factors

c. neuron factors

d. environmental conditions

5. An example of an antagonist (A substance that can nullify another's effects) is:

a. Nasaltine

b. Naltrexone

c. Nicotine

d. Methadone

6. Peter identifies as gay and most recently went on a date with Frank, who identifies as bisexual. Peter explained to Frank that he couldn't be in a relationship with someone that is bisexual, because they can't make up their mind on what they are attracted to. This would be an example of:

a. homophobia

b. genderphobia

c. biphobia

d. social phobia

7. Your client, Ben, discloses to the group that he is homosexual. Another member of the group shifts in his seat and changes the subject, talking about a superficial incident that happened earlier in the day. The facilitator's **MOST** appropriate response would be to:

a. interrupt the second speaker and remind him of the group rules

b. remind Ben that you are here to treat addiction and ask how this relates to his addiction

c. tell Ben that this disclosure is more appropriate for an individual session and you will meet with him later.

d. ask questions which facilitate a group response to Ben's disclosure and elicit more feeling content from Ben

8. During the first session, your client states they are addicted to meth and admits that they are bisexual and has been leaning towards the same sex lately. It is also explained that the stress and internalized homophobia has been creating the urge to use again. While considering the diagnosis, you decide to add one of following, **EXCEPT**.

a. gender identity disorder

b. phase of life problem

c. adjustment disorder

d. no additionally diagnosis necessary

9. Which self-help group would be most appropriate for a mother whose drug and alcohol-abusing son is causing her distress?

a. Alateen

b. ACOA

c. Al-Anon

d. A.A.

10. Because addiction affects so many facets of the addicted person's life, _____ promotes recovery and enables the substance abuse client to fully integrate into society as a healthy, substance-free individual.

a. detoxification and stabilization

b. psychological evaluation and treatment

c. integration into a self-help recovery program

d. a comprehensive continuum of services

Conclusion

It is my hope this training has contributed to your knowledge about the treatment of substance use disorders within sexual minorities. Thank you for allowing me to guide you through this process. There are a few closing statements I would like to leave with you.

First, I want to thank you for taking a step in making your establishment inclusive for sexual minorities. It's okay if some of the concepts still are difficult to grasp. In time there will be more added, which is why it is important to attend workshop or take continuing education units pertaining to these topics. The more you experience with either population, the more comfortable you'll feel. Next, this training is not meant to be completely comprehensive and terminology may need to be adjusted individually. I would encourage you to stay inside the general framework provided; however individualize the treatment as needed.

As a final thought, substance abuse treatment and sexual identity formulation is a complex process; it is very likely that as soon as you are able to understand the basics, another term or new treatment will suddenly be available. All we can do is be as prepared as possible and remember that we are all human and have the same basic needs. Best of Luck!

Appendix A: Answers for "Measuring Your Understanding!'

1. What does "P" in LGBTQQIIAA2-SP Stand for?

a. Paraphilic

b. Pornography

c. Pansexual *

d. Photosexual

2. _____ is the essential first step in determining the possible causes of addition for the person and the most appropriate treatment modality for his or her needs.

a. Screening

b. Assessment*

c. Intake

d. Orientation

3. Brent is a case manager in an intensive inpatient treatment facility. He recently was assigned a client, Fran, who presents not only with alcoholism but has also identified as a lesbian. To assist Fran in her treatment and recovery needs, Brent would probably need to have knowledge of all of the following areas **EXCEPT**:

a. stage of identity according to Cass' model

b. past history of discrimination

c. stage of recovery

d. history of sexual relations with opposite sex *

4. _____ are various antecedent conditions that lead to individual chemical dependency problems (e.g. conditioning, environment, genetics, etc.)

a. life factors

b. casual factors *

c. neuron factors

d. environmental conditions

5. An example of an antagonist (A substance that can nullify another's effects) is:

a. Nalsaltine

b. Naltrexone*

c. Nicotine

d. Methadone

6. Peter identifies as gay and most recently went on a date with Frank, who identifies as bisexual. Peter explained to Frank that he couldn't be in a relationship with someone that is bisexual, because they can't make up their mind on what they are attracted to. This would be an example of:

a. homophobia

b. genderphobia

c. biphobia *

d. social phobia

7. Your client, Ben, discloses to the group that he is homosexual. Another member of the group shifts in his seat and changes the subject, talking about a superficial incident that happened earlier in the day. The facilitator's **MOST** appropriate response would be to:

a. interrupt the second speaker and remind him of the group rules

b. remind Ben that you are here to treat addiction and ask how this relates to his addiction

c. tell Ben that this disclosure is more appropriate for an individual session and you will meet with him later.

d. ask questions which facilitate a group response to Ben's disclosure and elicit more feeling content from Ben *

8. During the first session, your client states they are addicted to meth and admits that they are bisexual and has been leaning towards the same sex lately. It is also explained that the stress and internalized homophobia has been creating the urge to use again. While considering the diagnosis, you decide to add one of following, **EXCEPT**.

a. gender identity disorder*

b. phase of life problem

c. adjustment disorder

d. no additionally diagnosis necessary

9. Which self-help group would be most appropriate for a mother whose drug and alcohol-abusing son is causing her distress?

a. Alateen

b. ACOA

c. Al-Anon *

d. A.A.

10. Because addiction affects so many facets of the addicted person's life, _____ promotes recovery and enables the substance abuse client to fully integrate into society as a healthy, substance-free individual.

a. detoxification and stabilization

b. psychological evaluation and treatment

c. integration into a self-help recovery program

d. a comprehensive continuum of services *

Appendix B: Glossary Terms for Part 1a

Abstinence: Refraining from further drug use

Acetaminophens: Pain relievers (e.g. Tylenol) used to treat headaches, muscle aches, headaches, etc.

Addict: A stigmatizing slang term for an individual with an addictive disorder

Addiction Assessment: A way to determine the prevalence of chemical dependency in a client or the extent of one's addiction (considers sociological, psychological, physical, and family factors, etc.)

Addiction Treatment: Aims to reduce addiction

Addiction: A repeated activity that continuously causes harm to oneself or others (e.g. a substance's continuous presence in the bloodstream).

Addictive Personality: A trait/traits that develops in response to drug use

Adverse Reaction: A detrimental reaction to a drug (not the desired reaction)

Affinity: The strength a drug has that allows it to bind to its receptor

Age at Onset: The age at which one's addictive behavior began; an important factor in addiction assessment

Agonist: A drug that activates a receptor in the brain

Alcoholics Anonymous (AA): A voluntary program concerned with helping alcoholics with recovery and continued sobriety

Alkaloids: Plant-produced organic compounds that are the active ingredients in many drugs

Amphetamine: A behavioral stimulant; also known as pep pills

Analgesic: Medication designed to treat pain

Antagonist: A substance that can nullify another's effects (a drug that does not elicit a response)

AOD: Stands for (Alcohol and Other Drugs)

AODA: Stands for (Alcohol and Other Drug Abuse)

Barbiturate: A class of sedative-hypnotic compounds that are chemically related through a six-membered ring structure

Benzodiazepine: A group of depressants used to induce sleep, prevent seizures, produce sedation, relieve anxiety and muscle spasms, etc.

Bioavailability: A drug's ability to enter the body

Biofeedback: Signal use to control physiological processes that are normally involuntary

Blood Alcohol Level/Concentration: The concentration level of alcohol in the bloodstream (expressed as a percentage by weight)

Buprenorphine: A semi-synthetic partial agonist opioid derived from the brain; used for pain relief (e.g. Buprenex)

Caffeine: An alkaloid that acts as a diuretic and a stimulant (found in coffee, tea, etc.)

Carcinogen: A cancer-causing chemical agent

Causal Factors: Various antecedent conditions that lead to individual chemical dependency problems (e.g. conditioning, environment, genetics, etc.)

Ceiling Effect: Occurs when the dosage of buprenorphine is increased beyond maximum levels and no differences result

Central Nervous System (CNS): The brain and spinal cord

CADC: Certified Alcohol Drug Counselor

Cirrhosis: Chronic liver disease

Clinical Opiate Withdrawal Scale (COWS): Used to determine the severity of opioid withdrawal

Codeine: The pain-relieving sedative agent contained in opium

Codependence: A family member's or friend's suffering that is the result of the side effects of one's addiction; it occurs when one takes responsibility for another's actions and helps that person avoid facing his or her problems directly to maintain the relationship

Cold Turkey: Abruptly quitting a drug by choice in order to try to quit long-term

Compulsion: A physical behavior one repeats involuntarily that can be harmful (e.g., addiction)

Conditioning: A behavioral change that results from an association between events

Craving: A powerful and strong desire/urge for a substance; a symptom of the abnormal brain adaptions that result from addiction

Crisis Intervention: The action taken when one's usual coping resources pose a threat to individual or family functioning

Cross-Dependence: The ability of one drug to prevent the withdrawal symptoms of one's physical dependence on another

Cross-Tolerance: Occurs when one's tolerance for one drug results in their lessened response to another

D.O.C.: This stands for drug of choice.

Denial: One's failure to either admit or realize his or her addiction or to recognize and accept the harm it can cause

Depressants: Sedatives that act on the CNS (e.g. to treat anxiety, high blood pressure, tension, etc.)

Detoxification (Detox): The process of removing a toxic substance (e.g. a drug) from the body

Disease Model: A theory of alcoholism that considers the addiction a disease rather than a social or psychological issue.

Dopamine: A chemical produced naturally by the body; functions in the brain as a neurotransmitter to provide feelings of well-being

Downers: Another name for depressants; these drugs can cause low moods (e.g. alcohol, barbiturates, tranquilizers, etc.)

Drug Misuse: One's use of a drug not specifically recommended or prescribed when there are more practical alternatives; when drug use puts a user or others in danger

Drug Tolerance: A progressive state of decreased responsiveness to a drug

Dual-Diagnosis: Mental patients ' condition when they are also addicted to any mind-altering drug

DUI: Stands for (driving under influence) (of alcohol or another illicit substance that impairs one's ability to drive)

DWI: Stands for (driving while intoxicated)

Dysynergy: An addiction's tendency to cause another (e.g. gateway drugs); an addicted person's tendency to combine substances

Enabling: Helping an addicted person do things they can or should be doing for themselves; causes disease progression

Endogenous Opioid: The opioids that the body naturally produces in order to help us tolerate pain

Endorphins: Opium-like substances produced by the brain; natural painkillers

Ethanol: The beverage type (ethyl) of alcohol

Euphoria: A pleasurable state of altered consciousness; one reason for the preference of one addictive behavior or substance over another

Evidence-based Treatment: Scientifically validated treatment approaches

Excipient: An inactive substance added to a drug to help bind the active ingredient

Fetal Alcohol Syndrome (FAS): Birth defects/abnormalities in babies of alcoholic and alcohol abusing mothers

Fetal Drug Syndrome (FDS): Birth defects/abnormalities in babies of drug abusing mothers

Food and Drug Administration (FDA): Administers federal laws regarding, for example, the safety and effectiveness of drugs

Habit: An outdated term for addiction/physical dependence

Hallucinogen: Chemical substance that distorts perceptions, sometimes resulting in delusions or hallucinations

Harm Reduction: Often the first stage of addiction treatment; reducing therapy instead of stopping the target behavior

Heroin: A full opioid agonist

Hydrocodone: An effective narcotic analgesic first developed as a cough medication

AddictionIllegal/Illicit Drugs: Drugs that are illegal to produce, use, and sell

Induction: Beginning phase of buprenorphine treatment

Inflation: An addiction behavior's tendency to slowly but surely increase in frequency

Intoxication: A state of being drugged or poisoned; results from abuse of alcohol, barbiturates, toxic drugs, etc.

Intrinsic Activity: The extent to which a drug activates a receptor

Legal Drugs: Everyday drugs not for medical use (e.g. alcohol, caffeine, carbohydrates, nicotine, etc.)

Maintenance: Stabilization of a patient who is indefinitely on a drug's lowest effective dose

Medical Model: An addiction theory that considers addiction a medical rather than social issue

Metabolism (of drugs): The chemical and physical reactions carried out by the body to prepare for a drug's execution

Methadone: A long-acting opiate (synthetically produced)

Monotherapy: Therapy using one drug

Morphine: A major sedative/pain reliever found in opium

Mu Agonist: A drug that stimulates physiologic activity on mu opioid cell receptors

Mu Opioid Receptor: Nerve cell receptor that mediates opioid addiction and tolerance through drug-induced activity

Naloxone: An opioid antagonist that blocks the effects of opioid agonists

Naltrexone: A narcotic antagonist that blocks the effects of opioids

Narcotic: A drug that produces sleep/drowsiness and that also relieves pain while being potentially dependence producing

Negative Reinforcement: Repetitive behavior to avoid something unpleasant

Neurotransmitter: The natural chemical a neuron releases to communicate with or influence another

Nicotine: Tobacco's extremely toxic main active ingredient (causes negative CNS stimulation)

Nonopioid: A drug that doesn 't activate opioid receptors

Obsession: A mental behavior one repeats involuntarily that can be harmful (e.g., (needing) an alcoholic drink)

Off-Label Use: Physician-approved use of a drug for uses other than those stated on its label

Opiate: The poppy's natural ingredients and their derivatives (opium, morphine, codeine, and heroin)

Opioids: Opium's synthetic form

Opium: One of the most popular drugs; contained in muscle-relaxers, sleeping pills, and tranquilizers

Over-the-Counter Drugs: Legal non-prescription drugs

Oxycodone: A medicine used for relief of moderate to high pain

Painkillers: Analgesic substances (opioids and nonopioids)

Partial Agonists: Bind to and activate receptors to a lesser degree than full agonists

Pharmacology: Scientific branch dealing with the study of drugs and their actions

Physical Dependence: The body's physiologic adaptation to a substance

Placebo: A substance with no pharmacological elements that may elicit a reaction because of a patient's mindset

Polysubstance Abuse: Concurrent abuse of more than one substance

Post-Acute Withdrawal Syndrome (PAWS): Withdrawal symptoms after initial acute withdrawal

Precipitated Withdrawal Syndrome: Can occur when a patient on full-agonist opioids takes an antagonist

Prescription Drugs: Only available by a physician's order

Psychedelic Drugs: Produce an intensely pleasurable mental state

Psychoactive Drug: A mind- and behavior-altering substance

Psychological Dependence: One's compulsion to use a psychologically based drug for pleasure; may lead to drug misuse

Psychopharmacology: The study of how drugs affect consciousness, mood, sensation, etc.

Psychotropic Drug: Any drug that acts on one's psychic experience or mood behavior

Rapid Detox: Anesthesia-assisted detoxification (injection of high doses of an opiate antagonist, followed by an infusion of naloxone)

Receptor: Protein on a target cell's membrane or cytoplasm with which a drug interacts

Recidivism: One's return to a negative behavior (relapse) (e.g. drug use)

Recovery Rates: The percentage of addicted persons undergoing treatment who partake in abstinence in their first year

Recovery: Reducing or ceasing substance abuse; often followed by one's personal life being turned around by way of a supportive environment

Relapse Prevention: A therapeutic process that interrupts believes and behaviors that result in lifestyle dysfunction

Relapse: Symptom recurrence after a period of sobriety or drug use cessation

Remission: A symptom-free period

Reversed Tolerance: When a lower dose of a drug produces the same desired or observed effect that previously resulted only with higher dosages

Screening: Measurement tool for the extent of one's addiction (e.g., self-completion questionnaire/life-history assessment)

Self-Help Group: Group of individuals dealing with similar issues that meets to support each other and share helpful information (e.g. AA)

Side Effects: Secondary effects of a drug; these are usually undesirable

Societal Denial: Society's denial of the historical value of drug-induced pleasure and euphoria

Steroids: A group of cyclic, solid unsaturated alcohols (e.g. cholesterol)

Stimulant: Drugs that act on the CNS, resulting in alertness, excitation, and wakefulness

Straight-Edge/ Normy: A term for people who don’t use drugs

Sublingual: Drugs that enter the blood through the membranes under the tongue

Substance Abuse (Chemical Dependence): A maladaptive pattern of recurrent substance use that leads to impairment or distress that is clinically significant

Substance Dependence:

Synergism: The greater effect that results when one takes more than one drug simultaneously

Synthetic: Not natural occurring

Therapeutic Dependence: Patients ' tendency to demonstrate drug-seeking behaviors because they fear withdrawal symptoms

Titration: The gradual adjustment of the amount of a drug

Tolerance: Condition in which one must increase their use of a drug for it to have the same effect

Toxicity: A degree of poisonousness

Tranquilizers: A type of drug that can help relieve the symptoms of severe psychosis

Trigger: Anything that results in psychological and then physical relapse

Ups or Uppers: Drugs that produce a euphoric effect (e.g. stimulants, amphetamines)

Urge-Peak Cycle: Ongoing urge-peaks, usually followed by relapse

Urge-Peak: A sudden, unpredictable increase in addiction cravings; they usually involve temporary mental unawareness (e.g. not realizing the amount of drinks one has had)

Urges: Less powerful desires than cravings; can be suppressed by willpower

Withdrawal Symptoms: Severe and excruciating physical and emotional symptoms that generally occur between 4 to 72 hours after opiate withdrawal (e.g., watery eyes, yawning, loss of appetite, panic, insomnia, vomiting, shaking, irritability, jitters, etc.)

Withdrawal Syndrome: Combined reactions or behaviors that result from the abrupt cessation of a drug one is dependent on

Withdrawal: The abrupt decrease in or removal of one's regular dosage of a psychoactive substance

Appendix C: Glossary Terms for Part 1b

*provided by Gay Alliance

Ally: A person who does not identify with a group, but still advocates for that group's rights.

Asexual: A person who has no sexual orientation and/or has a lack of interest in sex.

Biphobia: Negative feelings, attitudes, actions, or behaviors against people who are, or are perceived to be, bisexual or pansexual. It may also be a fear of one's own bisexual or pansexual attractions.

Bisexual: A person who is sexually attracted to men and women.

Cisgender: The state of not being transgender. Someone who is comfortable with the gender they were assigned at birth.

Cissexism: The systems of advantages bestowed on people who are cisgender. It can also be the assumption that all people are, or should be, cisgender.

Crossdresser: A person who dresses in clothing deemed inappropriate by society for the gender assigned them at birth. The purpose is usually emotional comfort or erotic fulfillment.

Demisexual: A person who is only sexually attracted to people after a strong emotional bond has been formed.

Drag King & Drag Queen: A person who crossdresses as a means of performance or entertainment.

Gay: While most often associated with men, in its broadest meaning, this is a person who is sexually attracted to people of the same sex.

Gender: The range of characteristics associated with men and women and the masculine and feminine attributes assigned to them by society.

Gender Expression: The part of a person's sexual identity that is about expressing masculinity or femininity as influenced by society, culture and individual expectations. It is sometimes referred to as gender role.

Gender Identity: The part of a person's sexual identity that is about their sense of self as male or female, neither or both.

Genderqueer: A person who does not identify as a man or a woman. They might identify as both, neither or somewhere between.

Heteronormative: A term that describes the marginalization of non-heterosexual relationships and reinforces the binary system of viewing gender.

Heterosexism: The systems of advantages bestowed on people who are heterosexual. It can also be the assumption that all people are, or should be, heterosexual and gender-conforming.

Heterosexual: A man who is only sexually attracted to women or a woman who is only sexually attracted to men; also known as straight.

Homophobia: Negative feelings, attitudes, actions, or behaviors against LGBTQ people or people perceived to be LGBTQ. It may also be a fear of one's own same-sex attractions.

Homosexual: An outdated clinical term used to describe someone who is gay or lesbian. Many people dislike the term since it was used to denote a mental illness.

Intersex: A person whose biological anatomy and/or genes vary from the expected male or female anatomy and/or genetics.

Lesbian: A woman who is sexually attracted to other women.

LGBTQQIAA2SP: Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Ally, Asexual, Two-Spirit, Pansexual

MSM: An abbreviation for men who have sex with men. They may or may not identify as gay, bisexual or pansexual.

Omnigender: Possessing all genders. The term is used to oppose the idea that there are only two genders.

Out of the Closet: Living openly and honestly by not hiding one's sexual orientation or gender identity. The term is sometimes shortened to being "out."

Pansexual: A person who is sexually attracted to people regardless of their gender identity, gender expression or biological sex. The term pansexual goes beyond a gender binary. Some people prefer the term Omnisexual.

Polyamory: Having more than one romantic partner with the consent and knowledge or all individuals.

Queer: A simple label to explain sexual orientations, gender identities and/or gender expressions that do not conform to societal expectations. Some LGBT community members view this as a term of empowerment and others strongly dislike this term.

Questioning: A person who is unsure about their sexual orientation or gender identity.

Same-Gender Loving (SGL): A cultural term used most frequently in communities of color that affirms the same-sex attraction of individuals. The term may be preferred over lesbian, gay or bisexual.

Sex: The identification of the biological/physical gender most often categorized as male or female.

Sexual Behavior: Actions that express a person’s desire, love, romance and affection.

Sexual Orientation: The part of our sexual identity related to whom we are sexually attracted. Sexual orientation can be broken into three distinct orientations: affectional, romantic and erotic.

Trans*: An inclusive term that encourages people to remember all of the identities under the transgender umbrella, including: transsexual, crossdresser, genderqueer, genderfluid, two-spirit, etc.

Transgender: In its broadest meaning, this umbrella term encompasses anyone whose self-identity, behavior or anatomy falls outside of societal gender norms and expectations.

Transphobia: Negative feelings, attitudes, actions, or behaviors against transgender people or people perceived to be transgender. It may also be a fear of one's own gender non-conformity.

Transsexual: A person whose gender identity is not congruent with their biological sex. Transsexuals may or may not pursue hormonal or surgical means to bring congruency to themselves.

Two-Spirit: A Native American term for LGBTQ individuals with dual or multiple genders. It can mean having both a masculine and a feminine spirit. It has different meanings in different communities.

Appendix D: References for Outside Resources

Federal Government

Resources

-Substance Abuse and Mental Health Services Administration's (SAMHSA's) Substance Abuse Treatment Facility Locator

www.findtreatment.samhsa.gov/facilitylocatordoc.htm

-SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI)

-SAMHSA's NCADI offers thousands of publications (most of them are free) and runs a 24-hour helpline (English and Spanish) for SAMHSA. Helpline operators can answer questions about substance use disorders, suggest written resources, and make treatment referrals using the national Substance Abuse Treatment Facility Locator.

P.O. Box 2345

Rockville, MD 20847-2345

Helpline: 800-729-6686

Local number: 240-221-4017

TDD: 800-487-4889

www.ncadi.samhsa.gov

-SAMHSA's National Mental Health Information Center

800-789-2647

TDD: 866-889-2647

www.mentalhealth.samhsa.gov

-SAMHSA's Center for Substance Abuse Treatment (CSAT)

www.csat.samhsa.gov

-SAMHSA's Center for Substance Abuse Prevention (CSAP)

www.csap.samhsa.gov

Other Resources:

The following is a sampling, not a complete list, of available resources. Inclusion on this list does not imply endorsement. Most State and local governments have an office on substance

abuse issues that can be an excellent resource. There also may be an office of the Council on Alcoholism and Drug Dependence in your area; consult your local telephone book.

-Adult Children of Alcoholics
World Service Organization, Inc.
P.O. Box 3216
Torrance, CA 90510
310-534-1815
www.adultchildren.org

-Al-Anon Family Group Headquarters, Inc. (Al-Anon and Alateen)
1600 Corporate Landing Parkway
Virginia Beach, VA 23454-5617
888-4AL-ANON (meeting information line)
www.al-anon.alateen.org
Spanish Web site:
www.al-anon.org/alaspan.html

-Alcoholics Anonymous
P.O. Box 459
Grand Central Station
New York, NY 10163
212-870-3400
www.aa.org

-Cocaine Anonymous World Services (CAWSO)
3740 Overland Avenue, Suite C
Los Angeles, CA 90034
310-559-5833
www.ca.org

-Co-Dependents Anonymous (CoDA®)
P.O. Box 33577
Phoenix, AZ 85037-3577
602-277-7991
www.codependents.org

-Dual Recovery Anonymous (DRA)
Central Service Office
P.O. Box 8107
Prairie Village, KS 66208
877-883-2332
www.draonline.org

-Jewish Alcoholics, Chemically Dependent

Persons and Significant

Others (JACS)

850 Seventh Avenue

New York, NY 10019

212-397-4197

www.jacsweb.org

-Join Together

One Appleton Street

Fourth Floor

Boston, MA 02116-5223

617-437-1500

www.jointogether.org

-Marijuana Anonymous

World Services

P.O. Box 2912

Van Nuys, CA 91404

800-766-6779

www.marijuanaanonymous.org

-Nar-Anon

22527 Crenshaw Boulevard

Suite 200 B

Torrance, CA 90505

310-547-5800

-Narcotics Anonymous

World Services Office

P.O. Box 9999

Van Nuys, CA 91409

818-773-9999

www.na.org

-National Asian Pacific

American Families

Against Substance

Abuse (NAPAFASA)

340 East Second Street

Suite 409

Los Angeles, CA 90012

213-625-5795

www.napafasa.org

-National Association for

Children of Alcoholics

(NACoA)

11426 Rockville Pike

Suite 100

Rockville, MD 20852

888-554-COAS

www.nacoa.org

-National Association for
Native American Children of Alcoholics
(NANACOA)
c/o White Bison, Inc.
6145 Lehman Drive, Suite 200
Colorado Springs, CO 80918
719-548-1000
www.whitebison.org/nanacoa

-National Association on
Alcohol, Drugs and
Disability (NAADD)
2165 Bunker Hill Drive
San Mateo, CA 94402-3801
650-578-8047

-National Black
Alcoholism & Addictions
Council (NBAC)
5104 North Orange Blossom
Trail, Suite 207
Orlando, FL 32810
407-532-2747
www.nbacinc.org

-National Clearinghouse on Families and
Youth (NCFY)
P.O. Box 13505
Silver Spring, MD 20911-3505
301-608-8098
www.ncfy.com

-National Families in
Action (NFIA)
2957 Clairmont Road N.E.
Suite 150
Atlanta, GA 30329
404-248-9676
www.nationalfamilies.org

-Nicotine Anonymous
419 Main Street, PMB 370
Huntington Beach, CA 92648
415-750-0328
www.nicotine-anonymous.org

-Parents, Families and
Friends of Lesbians and
Gays (PFLAG)
1726 M Street, N.W.
Suite 400

Washington, DC 20036

202-467-8180

www.pflag.org

-Secular Organizations for Sobriety/Save Our Selves (SOS) Clearinghouse

4773 Hollywood Boulevard

Hollywood, CA 90027

323-666-4295

www.secularsobriety.org

-SMART Recovery

7537 Mentor Avenue

Suite #306

Mentor, Ohio 44060

440-951-5357

www.smartrecovery.org

-Su Familia: The National Hispanic Family Health Helpline

866-SuFamilia (783-2645)

-Women for Sobriety, Inc.

P.O. Box 618

Quakertown, PA 18951-0618

215-536-8026

www.womenforsobriety.org

Appendix E: Sample of Integrative Intake Form

COUNSELING INTAKE FORM

Sample form

Note: This information is confidential.

Demographic Information:

Name:	Date:
Date of Birth:	Relationship Status:
Age:	Sexual Orientation*:*
# of Dependents:	Gender Identity:
Home/Mobile Phone:	Is it ok to leave a message for you at this number? Y / N
Work Phone:	Is it ok to leave a message for you at this number? Y / N
Mailing Address:	
E-mail Address:	
Current Employer:	Position Title:
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):	
How long on this Job:	Do you enjoy your job?
Education Level:	Special Trainings:
Hobbies:	Military Background:
Talents:	
Emergency Contact Name:	

ER Contact Relationship:	Emergency Contact Phone:
How were you referred?	If online, which website?

Physical Health Data:

Describe your Physical Health: Excellent: ____Good:

____Average____Poor_____Weight:_____Height:____

Are you now under a doctor's care? _____If yes, name of doctor_____

Reason for doctor's care_____

Hospitalizations and

Reasons:_____

_____

Have you ever been hospitalized for a mental illness?____ Describe_____

Have you ever suffered from an eating disorder, such as bulimia, anorexia or obesity?_____

Recent major illnesses or surgeries_____

Do you have any current concerns about your physical health? Please specify:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Do you get regular exercise? If so, what type and how often?

Check any of the following that apply to you:

	Never	**Rarely**	**Frequently**	**Very Often**
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens				
Diarrhea				
Compulsive Exercise				
Use Laxatives				
Heart problems				
Nausea				
Vomiting				
Insomnia				
Headaches				
Backaches				
Early morning				

awakening				
Fitful sleep				
Binge / Purge				
Poor appetite				
Eat "junk foods"				
Lack of interest in activities				
Constipation				
High blood pressure				
Allergies				

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

Family Data:

Birthplace: _____

FATHER: age now if living: _____Age at Death_____Cause: _____Your age then:_____

MOTHER: age now if living _____Age at Death _____Cause: _____Your age then:_____

Do your parents live together? Yes _____No_____Were Parents Divorced? Yes _____No_____

Do you feel closest to your Mother _____Father _____Neither_____

Your Marital Status_____ #of marriages _____

Spouse's Name_____

Living with a partner _____How long _____Partner's Name_____

CHILDREN: (O=other) #1 M/F/O Age_____ #2 M/F/O Age_____ #3 M/F/O Age_____#4 M/F/O Age____

SIBLINGS: Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M/F/O Age____ #2 M/F/O Age____ #3 M/F/O Age____ #4 M/F/O Age____ #5 M/F/O Age____

Family Alcoholism or Domestic Violence?_____ Sexual Addictions or Abuse?_____

Parents divorced? _____If yes, your age at the time_____

Any step-parents? _____If yes, describe your relationship with them_____

_____

If raised by someone other than your birth parents, describe:_____

_____

Legal Data:

Have you ever been incarcerated (Jail or Prison)? Yes _____No_ _____Dates_____

Reason_____Where_____

Have you ever had a DWI (Driving While Intoxicated)? Yes _____No_____How Many:_____

Are you currently on Probation? Yes _____No_____Explain_____

Religious Data:

Current Religious Preference:_____

In Childhood:_____

List 3 Strengths you believe you have:

1._____

2._____

3._____

List 3 Weaknesses you believe you have:

1._____

2._____

3._____

List 3 Support Systems you have in your life right now:

1._____

2._____

3._____

Behavior – circle any of the following behaviors that apply to you:

Overeat Suicidal attempts Can't keep a job Take drugs Compulsions

Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Are there any specific behaviors, actions, habits that you would like to change?

_____

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

For Clients Seeking Substance Abuse Treatment

Chemical Dependency Data:

Have you ever been in treatment for Chemical Dependency/Addiction? Yes_____No_____

If Yes, Where:_____

Treatment was for what chemical: _____

Are you involved in a recovery program? Yes _____No_____

Do you attend meetings? Yes ____No ____

Have you completed a 12-step program? Yes ____No _____When _____

Do you have a sponsor? Yes_____ No_____

Alcohol and Drug History:

Have you ever felt you should cut down on your drinking and/or drug use? Yes_____ No_____

Have people annoyed you by criticizing your drinking and/or drug use? Yes_____ No_____

Have you ever felt bad or guilty about your drinking and/or drug use? Yes_____ No_____

Have you ever used alcohol or drugs in the morning to steady your nerves or get rid of a hang-over? Yes_____ No_____

Have you ever had any drug or alcohol related arrests? Yes_____ No_____

Have you ever had any D.T.'s? (Delirium tremens) Yes_____ No_____

Have you experienced any blackouts from drugs or alcohol? Yes_____ No_____

Have you ever injected drugs? Yes_____ No_____

Please check which of the following substances you have used or currently are using:

Substance	When use began?	Used in past year?	How often?
Alcohol			
Inhalants			
Marijuana			
Amphetamines			
Barbiturates			
Valium, Xanax, etc			
Psychedelics			
Cocaine			
Heroin			
Other:			

References

Ahlström, S., & Huntanen, P. (2007). The effects of perceived availability of different alcoholic beverages on young people's drinking in Europe: A comparative exploration. *Contemporary Drug Problems*, *34*(4), 559-574.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Bailey, L. (2005). Control and desire: The issue of identity in popular discourses of addiction. *Addiction Research & Theory*, *13*(6), 535-543. doi:10.1080/16066350500338195

Botvin, G., & Griffin, K. (2007). School-based programmes to prevent alcohol, tobacco and other drug use. *International Review Of Psychiatry (Abingdon, England)*, *19*(6), 607-615.

Center for Substance Abuse Treatment. *Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders.* COCE Overview Paper 2. DHHS Publication No. (SMA) 06-4164 Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2006.

Center for Substance Abuse Treatment. *What is Substance Abuse Treatment? A Booklet for Families.* DHHS Publication No. (SMA) 08-4126. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004, reprinted 2005, 2006, 2007, and 2008.

Center for Substance Abuse Treatment. *Screening, Assessment, and Treatment Planning for Persons With Co-Occuring Disorders.* COCE Overview Paper 2. DHHS Publication No. (SMA) 06-4164 Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2006.

Coming-out process related to substance use among gay, lesbian and bisexual teens. (2005). *DATA: The Brown University Digest of Addiction Theory & Application*, *24*(6), 3-4.

Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal Of Homosexuality*, *4*(3), 219-235. doi:10.1300/J082v04n03_01

Cass, V. C. (1984). Homosexual identity formation: Testing a theoretical model. *Journal Of Sex Research*, *20*(2), 143-167. doi:10.1080/00224498409551214

Cochran, B. N., Peavy, K., & Cauce, A. (2007). Substance abuse treatment providers' explicit and implicit attitudes regarding sexual minorities. *Journal Of Homosexuality*, *53*(3), 181-207. doi:10.1300/J082v53n03_10

Coffman, D. L., Patrick, M. E., Palen, L., Rhoades, B. L., & Ventura, A. K. (2007). Why do high school seniors drink? Implications for a targeted approach to intervention. *Prevention Science*, *8*(4), 241-248. doi:10.1007/s11121-007-0078-1

Crowley, C., Harré, R., & Lunt, I. (2007). Safe Spaces and Sense of Identity: Views and Experiences of Lesbian, Gay and Bisexual Young People. *Journal Of Gay & Lesbian Psychotherapy*, *11*(1/2), 127-143. doi:10.1300/J236v11n01_09

Detrie, P. M., & Lease, S. H. (2007). The Relation of Social Support, Connectedness, and Collective Self-Esteem to the Psybhological Well-Being of Lesbian, Gay, and Bisexual Youth. *Journal Of Homosexuality*, *53*(4), 173-199.

Elze, D. E. (2002). Risk factors for internalizing and externalizing problems among gay, lesbian, and bisexual adolescents. *Social Work Research*, *26*(2), 89.

Esposito-Smythers, C., Spirito, A., Kahler, C. W., Hunt, J., & Monti, P. (2011). Treatment of co-occurring substance abuse and suicidality among adolescents: A randomized trial. *Journal Of Consulting And Clinical Psychology*, *79*(6), 728-739. doi:10.1037/a0026074

Friend, K. B., & Stout, R. L. (2007). Studying treatment quality in outpatient drug abuse clinics. *DATA: The Brown University Digest Of Addiction Theory & Application*, *26*(12), 8.

Galanter, M., Glickman, L., & Singer, D. (2007). An overview of outpatient treatment of adolescent substance abuse. *Substance Abuse: Official Publication Of The Association For Medical Education And Research In Substance Abuse*, *28*(2), 51-58.

Ganzevoort, R. R., van der Laan, M. M., & Olsman, E. E. (2011). Growing up gay and religious. Conflict, dialogue, and religious identity strategies. *Mental Health, Religion & Culture*, *14*(3), 209-222. doi:10.1080/13674670903452132

Gay Alliance. (2013). SafeZone Certification Program: Creating sustainable SafeZone Programs in your workplace or school.

Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, P., Dufour, M. C., Compton, W., & ... Kaplan, K. (2004). Prevalence and Co-occurrence of Substance Use Disorders and Independent Mood and Anxiety Disorders: Results From the National Epidemiologic

Green, K., & Feinstein, B. (2012). Substance use in lesbian, gay, and bisexual populations: an update on empirical research and implications for treatment. *Psychology Of Addictive Behaviors: Journal Of The Society Of Psychologists In Addictive Behaviors*, *26*(2), 265-278.

Hall-Lande, J. A., Eisenberg, M. E., Christenson, S. L., & Neumark-Sztainer, D. (2007). Social isolation, psychological health, and protective factors in adolescence. *Adolescence*, *42*(166), 265-286.

Harrison, T. (2003). Adolescent homosexuality and concerns regarding disclosure. *The Journal Of School Health*, *73*(3), 107-112.

Halkitis, P. N., Mattis, J. S., Sahadath, J. K., Massie, D., Ladyzhenskaya, L., Pitrelli, K., & ... Cowie, S. E. (2009). The meanings and manifestations of religion and spirituality among lesbian, gay, bisexual, and transgender adults. *Journal Of Adult Development*, *16*(4), 250-262. doi:10.1007/s10804-009-9071-1

Jacobs, J., & Freundlich, M. (2006). Achieving permanency for LGBTQ youth. *Child Welfare*, *85*(2), 299-316.

Jordan, K. M. (2000). Substance Abuse Among Gay, Lesbian, Bisexual, Transgender, and Questioning Adolescents. *School Psychology Review*, *29*(2), 201.

Keba, A. (2004). The Concept of Self-Identity and Moral Conflicts. *Politicka Misao: Croatian Political Science Review*, *41*(5), 134-148.

Kelly, J., & Myers, M. (2007). Adolescents' participation in Alcoholics Anonymous and Narcotics Anonymous: review, implications and future directions. *Journal Of Psychoactive Drugs*, *39*(3), 259-269.

Kottman, T., Lingg, M., & Tisdell, T. (1995). Gay and lesbian adolescents: Implications for Adlerian therapists. *Individual Psychology: Journal Of Adlerian Theory, Research & Practice*, *51*(2), 114-128.

Lever, J., Kanouse, D. E., Rogers, W. H., Carson, S., & Hertz, R. (1992). Behavior Patterns and Sexual Identity of Bisexual Males. *Journal Of Sex Research*, *29*(2), 141-167.

Magura, S. (2007). The Relationship Between Substance User Treatment and 12-Step Fellowships: Current Knowledge and Research Questions. *Substance Use & Misuse*, *42*(2-3), 343-360. doi:10.1080/10826080601142071

Marshal, M. P., Friedman, M. S., Stall, R., King, K. M., Miles, J., Gold, M. A., & ... Morse, J. Q. (2008). Sexual orientation and adolescent substance use: A meta-analysis and methodological review. *Addiction*, *103*(4), 546-556.

Marshal, M., Friedman, M., Stall, R., & Thompson, A. (2009). Individual trajectories of substance use in lesbian, gay and bisexual youth and heterosexual youth. *Addiction (Abingdon, England)*, *104*(6), 974-981.

McFarland, W. P. (1998). Gay, lesbian, and bisexual student suicide. *Professional School Counseling*, *1*(3), 26.

McNeese-Smith, D., Nyamathi, A., Longshore, D., Wickman, M., Robertson, S., Obert, J., & ... Wenzel, S. L. (2007). Processes and Outcomes of Substance Abuse Treatment Between Two Programs for Clients Insured Under Managed Care. *American Journal Of Drug & Alcohol Abuse*, *33*(3), 439-446. doi:10.1080/00952990701315186

Munoz-Plaza, C., Quinn, S., & Rounds, K. A. (2002). Lesbian, Gay, Bisexual and Transgender Students: Perceived Social Support in the High School Environment. *High School Journal*, *85*(4), 52.

Proctor, C., & Groze, V. (1994). Risk factors for suicide among gay, lesbian, and bisexual youths. *Social Work*, *39*(5), 504-513.

Rew, L., Whittaker, T., Taylor-Seehafer, M., & Smith, L. (2005). Sexual health risks and protective resources in gay, lesbian, bisexual, and heterosexual homeless youth. *Journal For Specialists In Pediatric Nursing: JSPN*, *10*(1), 11-19.

Robinson, K. (1991). Gay youth support groups: an opportunity for social work intervention. *Social Work*, *36*(5), 458-459.

Rosario, M., Schrimshaw, E., & Hunter, J. (2004). Predictors of substance use over time among gay, lesbian, and bisexual youths: an examination of three hypotheses. *Addictive Behaviors*, *29*(8), 1623-1631.

Rotheram-Borus, M., Rosario, M., Meyer-bahlburg, H. L., Koopman, C., Dopkins, S. C., & Davies, M. (1994). Sexual and Substance Use Acts of Gay and Bisexual Male Adolescents in New York City. *Journal Of Sex Research*, *31*(1), 47-57.

Rudman, L. A., & Spencer, S. J. (2007). The implicit self. *Self & Identity*, *6*(2/3), 97-100. doi:10.1080/15298860601128271

Savin-Williams, R., & Ream, G. (2003). Suicide attempts among sexual-minority male youth. *Journal Of Clinical Child And Adolescent Psychology: The Official Journal For The Society Of Clinical Child And Adolescent Psychology, American Psychological Association, Division 53*, *32*(4), 509-522.

Senreich, E. (2010). Are specialized LGBT program components helpful for gay and bisexual men in substance abuse treatment?. *Substance Use & Misuse*,*45*(7-8), 1077-1096. doi:10.3109/10826080903483855

Tonigan, J. (2007). Spirituality and Alcoholics Anonymous. *Southern Medical Journal*, *100*(4), 437-440.

U.S Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (2012). A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals. Rockville, MD: Author.

Yücel, M., Lubman, D., Solowij, N., & Brewer, W. (2007). Understanding drug addiction: a neuropsychological perspective. *The Australian And New Zealand Journal Of Psychiatry*, *41*(12), 957-968.

Appendix B: Expert Review Survey

Name:_____

Date:_____

1. Please describe your educational background, certifications and/or licenses, and experience treating or working with alcoholism and drug abuse.

_____

_____

_____

2. Please describe your educational background, certifications and/or licenses, and experience treating or working with sexual minorities (LGBTQ individuals).

_____

_____

_____

3. (Circle one) **YES NO** Did you find the program applicable to your facility or organization? If not, please specify why not?

_____

_____

_____

4. (Circle one) **YES NO** Did the program explain concepts in a way that was easy to understand?

5. (Circle one) **YES NO** Was the case vignette and other examples relevant to the concepts presented and did help in understanding the concepts?

6. (Circle one) **YES NO** Did the outpatient program encompass relevant topics for the development and process of self-identity in sexual minorities?

7. (Circle one) **YES NO** Did the outpatient program encompass relevant topics of treatment of substance abuse?

8. (Circle one) **YES NO** Do you feel there's a need for a program to treat sexual minorities with substance abuse collaborately? Please select Yes or No, then explain your answer.

9. **TOO LONG, TOO SHORT, JUST RIGHT** How would you rate the length of the program? Please circle one and then elaborate below.

_____

_____

_____

10. **YES** **NO** Is there anything the wasn't included in this program that you feel should have been included? If so, please describe?

_____

_____

_____

11. **YES** **NO** Is there anything that should be taken out of the program? If so, describe?

_____

_____

_____

12. Other comments:

_____

_____

_____

Appendix C: Expert Review Verbatim Responses

Please describe your educational background, certifications and/or license, and experience treating or working with alcoholism and drug abuse.

(verbatim responses):

- Licensed Marriage Family Therapist, PhD in Clinical Psychology, Certified in Trauma Focus, Certified Domestic Violence & Grief, Designated 5150 for County of Orange.
- Doctorate in Clinical Psychology, Licensed Psychologist in 1991 in state of Hawaii in 1992 in State of CA. Training in MediCal, county agencies in treatment of Alcohol and substance abuse in adults and teens in which I also provided treatment services to dual diagnosis populations and was group leader for PC1000 drug diversion programs. Also served as counselor for inpatientdrug and alcohol rehabilitiation hospital for teens for five years, and currently work with dual diagnosis and those in continuing recovery in private practice.
- PsyD in clinical psychology MA in counseling psychology I work in health care agency with Co-occurring diagnosis individuals.
- MSW at Adelphi University, Licensed Certified Social Worker with R# in NYS. 16 years in School District(7 years has been in High School) Member of NASW for past 16 years.
- Masters in Social Work - clinical work with substance abuse studied, Harm Reduction studied, BA in Women's Studies -substance abuse studied NYS Licensed School Social Worker, NYS State Education Dept Certified School Social Worker, FirstAid/CPR Crisis Management Certification.
- I have an MA in Counseling Psychology & am certified with CCAPP as a CADA-II pending test results. I specialize in Cooccurring disorders and the vast majority of my clients have a substance abuse/addiction problem. In addition, I work with foster agencies, addicted pregnant mothers, & children who were born with and are still effected by in utero drug addiction. I have been treating clients for 3.5 years.

Please describe your educational background, certifications and/or licenses, and experience treating or working sexual minorities (LGBTQ individuals).

- I have worked with LGBTQ population for 5 plus years.
- I work with LGBT community on a regular bases.
- 7+ years working with LGBTQ clients 3 in LGBTQ specific organization . Specialization in working with Transgender clients.
- Presenter at national transgender health conferences. Masters Degree in Social Work - LGBT specific work studied, NYS license, NYS Edu Certification.

- Education in treatment of LGBTQ populations included several courses in my graduate program including sexuality and cultural diversity, as well as continued education in sexuality with certified sexologist. Training experiences included sexual assault and trauma treatment with specific populations, including LGBTQ, and personally treated three individuals undergoing various levels of sex reassignment under supervision of a psychologist who specialized in LGBTQ and sex reassignment candidates.
- Working in a high school I have worked with sexual minorities and if necessary referred the students to outside agencies.
- Education and certifications are the same as those noted above. In the specific populations I work with, approximately 20% of my clients can be identified as LGBTQ individuals. I have been treating clients for 3.5 years.

Did you find the program applicable to your facility or organization?

- we were outpatient counseling and did not do solely substance abuse related services 1

Do you feel there's a need for a program to treat sexual minorities with substance abuse collaborately? Please select Yes or No, then explain your answer.

- Very few resources that treats both the sexuality and the ethnicity.
- more thorough treatment.
- Yes
- Placing individuals in recovery without addressing stressors and issues specific to LGBTQ is ineffective, and many patients avoid recovery programs due to inadequate addressing of these issues.
- Due to high rate of substance abuse rate in LBGT community the necessity of a collaborative approach is clear.
- Emotional connections are paramount to any recovery. We need to understand that we are truly understood and excepted before we can be honest enough with ourselves & other in an effort to achieve recovery.

Is there anything that wasn't included in this program that you feel should have been included? If so, please describe?

- No
- No
- No

- None
- There was no information on Iranian-Americans. Since Farsi is a threshold language in OC, I recommend inclusion of some relevant information in the program.
- Abstinence programs versus Harm Reduction. Specific strategies/concerns/medical interventions for working with Transgender clients, as this is very different.

Is there anything that should be taken out of the program? If so, describe.

- Maybe some clarification needed on transgender people versus sexual minorities.
- No
- No
- No
- None
- None

Do you have any other comments relevant to the program?

- N/A
- No
- None
- Very in-depth, great work!
- I like the manner in which it addresses religious obstacles that can deter LGBTQ individuals from seeking recovery groups, and the alternatives suggested, as well as the awareness of sexual identity development and its impact on recovery.
- I am 100% in support of a program such as this. I have witnessed less than full acceptance of the LGBTQ population in programs which support mixed populations.

Appendix D: Professional Review Survey

Please provide a brief description of your education and professional background.

_____

_____

_____

For questions 1 through 6, please use the following scale to answer each question:

1=Strongly Disagree; 2=Disagree; 3=Neither Agree nor Disagree; 4=Agree; 5=Strongly Agree

1. The training program encompasses appropriate topics.

1 2 3 4 5

2. The concepts are explained in a way that was easy to understand.

1 2 3 4 5

3. The outpatient program is well organized.

1 2 3 4 5

4. The case vignettes and other examples are relevant to the concepts presented, and they aid in the ability to understand the concepts.

1 2 3 4 5

5. The Training is appropriate to treat or work with Sexual Minorities (Lesbian, gay, and bisexual).

1 2 3 4 5

6. The Training is appropriate to treat or work with Alcoholism and Drug Abuse (Substance Abuse).

1 2 3 4 5

7. The length of the training is appropriate.

1 2 3 4 5

Comments:

_____

_____

_____

_____

Appendix E: Professional Review Verbatim Responses

Please provide a brief description of your education and professional background.

- MA, IMF.
- MFT Intern with 2,600 hours from an LGBT Center.
- Psy.D Clinical Psychology Doctoral Student.
- Third year clinical psychology student.
- M.S. Clinical Psychology -MFT Trainee at The Center OC (LGBTQ community center in Orange County, CA) -Sexual Assault and Victim Services Advocate/Volunteer for Orange County's Victim/Witness Program (CSP, Inc).
- MS in Experimental Psch MA in Clinical Psych Psyd in Clinical Psych (2015) Experience with substance abuse, inpatient, assessment, and various sexual orientations.
- I have a BS from San Diego State University in Child Psychology and MFT from University of Phoenix. Through practicum and internship, I have experience with clients of domestic violence, a variety of mental health issues, juvenile hall high security unit involving gangs and drugs. I have specialized in child behavioral issues. I have been a child care provider for 28 years.
- B.A. psychology M.A. child and adolescent psych Psy.D. in progress community counseling setting school district setting inpatient setting.
- I'm currently in a Clinical PsyD program. I have worked in approximately 4 or 5 mental health agencies that serve minorities.
- Currently a pre-doctoral forensic psychology intern at the Orange County Health Care Agency - Juvenile Drug Court. B.S. & M.S. in Criminal Justice M.A. in Forensic Psychology, 4th year student in a Clinical Forensic Psychology Doctoral program.

Do you have any additionally comments?

No verbatim responses left.