Cultural Responsiveness in Serving LGBT Individuals and Families

CE-0001
3 Hours Continuing Education

This course provides three (3) hours of continuing education credit and is intended as an introductory level training for alcohol and drug abuse counselors and mental health professionals involved in alcohol and other drug abuse prevention, treatment, and recovery support services. To obtain a continuing education certificate, please fill out the form at the end of the document and Fax to (415) 501-9141. The document and issuance of a certificate is available for free during the term of Gil Gerald & Associates, Inc. contract with the California Department of Alcohol and Drug Programs as a provider of technical assistance and training services. A processing fee of $30 will be required after September 30, 2010.

This course meets the qualifications for 3 hours of continuing education credit for MFTs and LCSWs as required by the California Board of Behavioral Sciences, provided by Gil Gerald & Associates, Inc., PCE 4584. This provider is also approved by CFAAP/CAADAC, #4C-08-582-0312, for Certified Alcohol and Drug Abuse Counselors. This course was developed through funding from the State of California Department of Alcohol and Drug Programs, Contract No. 07-00135. The opinions, findings, and conclusions herein stated are those of the author and not necessarily those of the State of California, Department of Alcohol and Drug Programs.

Michele J. Eliason, PhD, Associate Professor
HSS 320, Department of Health Education
San Francisco State University, 1600 Holloway
San Francisco, CA 94132
meliason@sfsu.edu

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INTRODUCTION

The substance abuse treatment field has historically ignored the needs of lesbian, gay, bisexual, and transgender clients. In recent years, however, with growing recognition of health disparities based on race/ethnicity, class, gender, and sexual orientation, the health professions in general have increasingly acknowledged the need for cultural competency training. There is an increasing consensus and understanding that providing generic care means that many clients receive inadequate or culturally inappropriate care, and that failing to address health disparities means that some clients do not enter treatment doors until their problems are far advanced, because they fear poor treatment or fear that staff will lack understanding of their life situations.

The purpose of this course is to provide a general introduction to LGBT substance abuse, not to provide a manual for how to provide specific treatment for subgroups of LGBT individuals. More advanced training is offered by Gil Gerald & Associates, Inc. and the more advanced courses should be taken after this introductory one. This course will assist you to increase your knowledge and understanding of the basic terminology involved in serving LGBT individuals and of the impact of stigma in particular. It is not possible to cover all of the subject matter related to cultural responsiveness in serving LGBT people, nor all of the issues related to the whole LGBT community in a three-hour course. The content is based on an extensive review of the literature and footnoted herein. Additional information and courses are available at the Gil Gerald & Associates, Inc. website www.gilgerald.com.

This course has the following goals:

1. To inform substance abuse professionals about the needs of LGBT clients
2. To assist substance abuse professionals in understanding the role of stereotypes and bias in the treatment experience
3. To describe steps that an agency can take to become welcoming and inclusive

By the end of the course, you should:

1. Have tools for self-reflection to identify your own biases and misconceptions
2. Be able to name at least three ways that LGBT communities are diverse
3. Recognize the potential treatment needs of LGBT clients
4. Identify at least three ways that you personally can become more welcoming and inclusive of LGBT clients in the work that you do

TERMINOLOGY/DEFINITIONS

Sexual Identity Terms

Most people are familiar with the sexual identity terms "lesbian," "gay" and "bisexual." However the meanings are not always consistent from one person to another and not all people use these labels.

In regards to bisexual, some use a definition of "sexual and affectional attractions to men and women" whereas others prefer to define bisexual as not dependent on the potential partner's sex/gender (Miller, Andre, Ebin, & Bessanova, 2007).

The term "gay" sometimes is used to refer to all people with same-sex identities, but more often today the term LGBT is used. This acronym stands for Lesbian, Gay, Bisexual and Transgender, and sometimes the letters QQI are added to include "queer," "questioning" and "intersex." It is not unusual to see the term LGBT written as GLBT.

The term homosexual entered the English language around 1869 and was originally defined as "an abnormal and excessive interest in people of the same sex." What many people don't know is that the term heterosexual did not appear in the language until later, 1892, and originally was defined as "an abnormal and excessive interest in people of the opposite sex." That is, both were originally defined as mental disorders. Over the years, heterosexual became the normative term, and homosexual continued to have a taint of mental illness until 1973, when homosexuality was removed from the Diagnostic and Statistical Manual for Mental Disorders. Because of the association with mental illness, many people in the community rejected the term and adopted language of our own choosing. In the 1970s, "gay" was the umbrella term, but today, LGBT is more commonly used (Eliason, Dibble, de Joseph, & Chinn, 2008; Katz, 1995).

Sexual Identity Terms

- ***Lesbian*** refers to a woman whose primary sexual and affectional attachments are to other women.
- ***Gay*** refers to a man whose primary sexual and affectional attachments are to other men.
- ***Bisexual*** is usually used to describe a person who has sexual and affectional attachments to people that are not based on sex/gender.
- ***Homosexual*** is a clinical term that refers to people with same-sex orientations. Some LGBT people use this term but others find it offensive.
- ***Heterosexual*** refers to people whose primary sexual and affectional attachments are to other sex partners.
- ***Queer*** is a derogatory term used to insult people. However, 'queer' is also a term appropriated by some LGBT people, especially youth, and it is used as a self description.
- ***Gender Queer*** is a term used mostly by youth. The term refers to a blending of gender and sexual difference and is expressed in a variety of ways.

Gender Identity Terms

- **Gender Identity** is one's psychological sense of being male or female (or a different sex/gender), and masculine/feminine.
- ***Transgender*** is a person whose gender identity does not fit their biological body. This is the umbrella term that can contain many forms of gender variance, including:
  - ***Transsexual*** is the medical term for people who seek to change their body to match their gender identity. Some transsexual people identify as male or female; others as transgendered. Not all transgender people seek surgery.
  - ***Cross-dresser*** is a person who dresses in clothing and adopts the characteristics of the other sex on a part-time basis. This term is usually used to refer to heterosexual men (the medical term is transvestites)
  - Gay men who occasionally cross-dress are typically called "***drag queens***" and women who occasionally cross-dress are called "***drag kings.***"

(continued below)

Some people challenge whether it is possible to re-appropriate hateful language, such as queer, by using it as a term of empowerment. All oppressed minority communities deal with these issues of language. Many youth, and some adults today use the term queer to describe themselves, but professionals should avoid the term.

Youth who are challenging both gender and sexuality norms may use the term gender queer. As a new term, it has quite diverse meanings, so it is important to ask any client who uses it to explain what is meant by the term.

It is important to know the terms that are used in the communities you serve. There are regional, age, group, racial/ethnic, and other differences in terminology. For example, in some African American communities, the term "same-gender loving" may be used. In some indigenous people of the Americas, the term "two-spirit" is used to denote the presence of both masculine and feminine spirits in one body (Fieland, Walters, & Simoni, 2007; Savin-Williams, 2005; Malebranche et al, 2004).

Gender Identity Terms

Gender identity refers to one's inner sense of being male or female and placement on a masculine/feminine continuum.

Most people experience continuity from their birth sex as male or female to their sense of gender as men or women. However, LGBT people are more variable in how gender is expressed through clothing choices, accessories, hair styles, attitudes, and behaviors.

Transgender is the overall term to describe people for whom birth sex and psychological gender are not the same. Many variations of gender can be contained under this label.

The tip of the iceberg of the transgender population are those the medical profession calls "transsexuals."

More Gender Identity Terms

- ***Transgender*** terms also include:
  - ***Androgynous:*** people who are not clearly male or female in their appearance or behavior.
  - ***Gender queer:*** a term used by youth.

Note: some people in all of the above transgendered categories identify as transgendered and some do not. There is no consensus. Some are LGB, some heterosexual.

- ***Intersex:*** a wide variety of conditions, disorders, or differences that affect genitals, hormones, and/or internal reproductive organs. People with intersex conditions vary in their gender and sexual identities. For more information, see the website of the Intersex Society of North America (www.isna.org).

In the transgender community, terms such as Male-to-Female (MTF or MtF or trans woman) and Female-to-Male (FTM, FtM, trans man) are common. These are people who take some steps to change their bodies to align with their psychological gender. Not all will consider surgery. This group lives fulltime as their psychological gender (Hanssman, Morrison, & Russian, 2008).

Cross-dressers (the medical term is "transvestite") are people who adopt the dress and mannerisms of the other sex on a part-time basis. They are usually heterosexual men.

When gay, lesbian, or bisexual people cross dress for entertainment, political reasons, or just for fun, they are called drag queens or drag kings.

Androgynous people are those who through their "natural" body type or the choices they make in clothing, hair style, mannerisms, and so on, do not present clearly as male or female.

Gender queer is a term often used by youth, who may be experimenting or playing with the concepts of gender. These presentations are quite diverse.

The term transgender has only been used for about 20 years, and there is no consensus on what it means. Some people in any of the categories just described will use the term transgender and others will not.

Gender does not predict sexual identity: some people in these categories identify as heterosexual and others as lesbian, gay, bisexual, queer or some other sexual identification (Hanssman, Morrison, & Russian, 2008).

Intersex refers to dozens of medical conditions or variations of human physical development that affect our biological markers of sex, such as genitals, hormone levels, or internal reproductive organs.

Some people with intersex conditions identify as LGBT, but most do not. However, some align with LGBT political organizations because of the shared stigma related to one's sexuality or gender.

The Intersex Society of North America website contains great information about intersex conditions, treatments, and politics (Liao & Boyle, 2004; Navarro, 2004).

LGBT: In talking about the community as a whole, LGBT is used as a short-hand. However, more specific terms should be used as warranted, and this approach is also followed in this course.

In this course, there is discussion about LGBT identities, but it is important to keep in mind that identity and behavior are not always congruent. The AIDS epidemic that began in the 1980s taught us that health risks are associated with behavior, not identity.

The health literature tends to use behavioral terms such as MSM (men who have sex with men) and WSW (women who have sex with women). In referring to groups who are behaviorally bisexual, terms like MSMW and WSWM are more accurate (Miller, Andre et al, 2007); Young & Meyer, 2005).

Which terms you use, and how you assess your clients depends on the setting. If you deal with sexually transmitted infections (STIs), pregnancy risk, or do HIV prevention education, then behavior might be more important.

In substance abuse treatment groups, sexual and gender identities may be more important because of their implications for daily living, and because identity implies access to a community. Whenever possible, assess both identity and behavior.

LGBT people may be seen as a group but it is important to recognize that group and individual differences are very important.

Men and women in our society are socialized differently, and have different health risks. Transgender people have different health needs than do LGB people. Race, ethnicity, socioeconomic status and education also all have roles in differentiating groups and individuals and what their needs are.

Identity and Behavior

- ***LGB*** are sexual identities, but identity and behavior are not always congruent.
    - ***MSM:*** (men who have sex with men) is a term developed to describe the behavior of men who engage in same-sex sexual behavior, whether they identify as gay, bisexual or not.
- The difference between identity and behavior has clinical implications:
    - In settings where you deal with sexually transmitted infections (STI), pregnancy risk, or provide HIV prevention education, behavior may be the most important.
    - In other settings, like substance abuse treatment, sexual identities (LGBT) may be more important. Identity implies access to a community.
    - It is helpful to assess both identity and behavior.
    - Behavioral interventions used in HIV prevention targeted at specific groups do incorporate sexual and other identities as well.

Other Basic Definitions

- ***Sexual orientation or identity*:** How people label their sexuality. The terms include heterosexual, gay, lesbian, bisexual, queer, asexual, or a host of other terms.
- ***Gender identity:*** How people label their gender, such as male, female, or transgender, masculine, feminine, androgynous, or butch, femme, queen, or similar terms.
- Many youth use the term "***gender queer***" for fluidity in both gender and sexual difference.

However, when you focus on the commonalities the common experience is stigma in one form or another. The stigma of being different has similar consequences on employment, families, relationships, and health risks. Keep in mind, however, that LGBT people are diverse in every other way as well, and many have multiple experiences of stigma (Eliason, Dibble, et al, 2008).

Other Basic Definitions

To sum up the definitions section, sexual orientation or identity includes lesbian, gay, or bisexual. Gender identity includes transgender or any other terms that fall under the umbrella of transgender. Identities are psychological facts and may not be visible.

People who have had to question their sexuality often must question their gender as well, regardless of whether they identify as transgender. Stigma is based on perceived deviation from gender roles more so than perceived sexual difference (most people are beaten up for "looking gay" not for being gay). The questioning of gender leads to wide variation in gender expressions among LGBT people (D'Augelli et al., 2006; Friedman et al, 2006).

Gender Expression Among LGBT People

Examples of gender expression in the transgender spectrum include RuPaul (Rupaul Andre Charles) who is a gay man who has a "drag queen" persona, RuPaul, for entertainment purposes. On the other hand, Kate Bornstein and her partner Barbara Correlis are transgender women. Both were born male and transitioned to living fulltime as women.

Gender expression examples in lesbian, gay, and bisexual people include some people who fit

What About Gender Differences?

- Gender Matters:
  - Transgender people have different issues than do LGB people.
  - Lesbian and bisexual women have different issues than gay/bisexual men, due to both biology and socialization.

stereotypes, such as Rudy Galindo, a male ice skater and Martina Navritalova, a female athlete and tennis star. Others are contrary to stereotypes, such as John Amechi, a gay professional basketball player, and Gia, a lesbian fashion model.

COMMON QUESTIONS PEOPLE HAVE ABOUT LGBT PEOPLE

How Many LGBT People Are There?

Many people want to know how many people in the population are LGBT individuals. This question is hard to answer, and depends on whether you ask people about their identities, their behavior or their attraction.

Surveys in the past 20 years have found that around 2-3% of the population call themselves lesbian, gay, or bisexual. However, at least twice as many people have had a same-sex experience, and up to 40-50% have had a same-sex attraction (Laumann, Gagnon, Michael, & Michaels, 1994; Ziyadeh, Prokop, Fisher et al, 2006).

There is no way of knowing how accurate the numbers are, because there is still tremendous stigma associated with sexual and gender diversity. Many people will not accurately report LGBT identities, behaviors, or attractions because of the stigma.

It may be even harder to answer the question about how many transgender people there are. For one thing, most data collection systems, like the census and population health surveys, ask only if respondents are male or female. Even if there is an “other” option, many transgender people will check the box that indicates their psychological gender.

You would have to ask about both birth sex and current gender identification to be able to count transgender people.

The Diagnostic and Statistical Manual of Mental Disorders states that 1 in 30,000 people in the population are male-to-female transsexuals and 1 in 100,000 are female to male transsexuals. These figures do not count other people within the transgender spectrum.

A recent study suggested that the numbers are much higher, about 1 in 3000 in the U.S. population seek surgical gender reassignment surgery. Obviously, this is the tip of the iceberg, because the majority of transgender people do not seek surgery (Horton & Goza, 2007).

Is Sexual Orientation Inborn or Caused by Factors in the Environment?

The next big question that many people ask is whether sexual orientation is inborn or caused by factors in the environment. There have been a number of studies in the past two decades aimed at addressing that question, including studies of brain structures, hormones, genes and family history on the inborn side, and studies of childhood traumas, parenting, and dysfunctional families on the environment side. So far, none of these have been conclusive.

Two studies that got a lot of press in the 1990s were said to be "proof" that sexual orientation is biologically hard-wired. Here is more information about them:

Simon LeVay (1991) found some differences in the size of one tiny cell in the hypothalamus of gay men who died of AIDS—it was smaller than the same cell in the brains of presumed heterosexual men (most of whom did not have AIDS). Was it AIDS or sexual orientation that caused the cell to be smaller? In addition, we do not know the function of that cell—is it related to sexual orientation, sexual drive, or something else? Others who have repeated the study have not found differences.

Dean Hamer et al. (1993) studied families with gay twins for gene markers in common and found that about 60% of them did indeed share some genetic markers. These markers however, were not the gene for sexual orientation. And 40% of the twin pairs did not share these markers. Lesbian women do not appear to share these markers. So far, studies trying to replicate this finding have failed.

All one can conclude from these studies, and the attempts to replicate them, is that sexuality has some biological basis, but there is no "proof" of any biological cause for gay or lesbian identity. Thus far, no one has attempted biological studies of bisexuality. The world of science, like most of western society, generally considers gender and sexuality as dichotomous (opposite pairs). One must be male or female, gay or straight. That is why there is less study of the options that fall in between the extremes, even though most behavior in nature is on a continuum (Stein, 2007; LeVay, 1991; Hamer et al., 1993).

The most logical conclusion we can make is that sexual orientation is multifaceted. There are probably multiple pathways to developing any sexual orientation that involves combinations of biological and environmental factors (and psychological, social, cultural, and spiritual reasons as well).

The bottom line question is: why does it matter? The important issue is: Why are some people treated differently because of their sexual identities? Does it matter whether they are biological or influenced by the environment in deciding if LGBT people deserve civil rights? Religion is not inborn, yet we protect people's rights to practice the religion of their choice. Political viewpoints are not inborn, yet they are protected by law.

Similar studies have been done of transsexual people, attempting to find a biological reason, but like the studies on sexual orientation, they have not been conclusive. There are no physiological, hormonal, or brain structure finds that prove why some people are transsexual, and virtually no studies have been done of the many other people on the transgender spectrum (Gooren, 2006).

Ironically, we don't know why people are heterosexual either. Sexual orientation and gender identity are probably like other complex human behaviors (such as language, cognition, aggression, personality): they are influenced by many factors.

Throughout history, left handed people have made up about 10 percent of the human population. In the middle ages, left-handers were burned as witches and heretics. This stemmed from Bible passages interpreted to mean that being on the "right hand" of God was better than being on the "left hand." For decades scientists tried to identify a cause for left-handedness and were not very successful. For decades, parents and teachers tried to re-educate left-handers to be right-handed, sometimes with compassion and sometimes with great cruelty. These attempts were rarely successful. Now we accept left-handedness as a normal variant of human behavior, although it can still be challenging to be a left-hander in a right-handed world. There is still a right-handed bias in the world.

Can a Person's Sexual Orientation be Changed?

Another question of great interest to many is whether or not you can change someone's sexual orientation. These efforts have been called reparative or conversion therapy. There are a handful of psychiatrists and psychologists who claim to be able to change people's sexual orientation with therapy, and there are ex-gay ministries in many churches in the U.S. that offer religious programs of conversion. These therapies are based on the erroneous assumptions that LGBT people failed to bond properly with their same-sex parent and their gender identity was disrupted as a result.

Most research claiming that people can change their sexual orientation, or gender identity, is seriously flawed. Better designed studies have failed to show that people can really change. People can change their short-term behavior for a while, but not deep-seated attractions or identities. Some LGBT people choose to be celibate or miserable, and in fact, attempting to change sexual orientation can result in serious psychological harm to the individual, including suicide attempts.

On the other hand, supportive and affirmative therapy can be very helpful for LGBT people who have been rejected by family, church, community, and internalized negative stereotypes. Therapy used to help people toward self-acceptance is very useful (Drescher & Zucker, 2006; Shidlo, Schroeder, & Drescher, 2002). Nearly every professional, medical and psychological association has denounced reparative therapy as unethical.

COMING OUT AS AN LGBT PERSON

Coming out is a term used by LGBT people to describe the process of forming a sexual or gender identity and revealing it to others. The process can start at any age or stage in life, but a very common pattern is for people to report that they felt different as children. Most of us do not have labels for this difference until later in life, although crushes and same-sex attractions often begin around the age of 8-9 (for all kids—straight and gay). Although some LGBT youth experiment with their sexuality in adolescence, many do not feel safe to disclose their identities to others at that age. They are still dependent on family and fear risking family rejection, and peers at school can be extremely cruel to LGBT youth. For many, they wait until young adulthood when the consequences of rejection have been lessened somewhat.

Although this is a common pattern, some people do not have same-sex attractions or engage in same-sex behaviors until much later in life. The experience is quite different for someone who is 60 than for someone who is 16 (Eliason & Schope, 2007; Savin-Williams, 2005).

Research suggests that women come out a little later than men. Perhaps this is because women have more freedom to be intimate with their girlfriends than are men with their male friends, making the process less clear-cut. Bisexual and transgender people also come out a little later, probably because there has been a lot less media attention and societal discussion about these identities, making it harder for people to find labels for their feelings.

The very limited research on racial/ethnic diversity in sexual and gender identification suggests that LGBT people of color might be more likely to identify as bisexual than white LGBTs, and might be less likely to come out to family and community. It makes sense if those communities are support for living in a racist society that some LGBTs of color would not want to jeopardize that support (Harper et al, 2004; Rosario, Schrimshaw, & Hunter, 2004).

Transitioning is the term that transgender people use for altering their bodies and appearance to align with their psychological gender. Transitioning includes a wide diversity of activities, some considered medical practices, such as taking hormones, having cosmetic surgeries, and having gender reassignment surgery. Others include electrolysis, speech therapy, and learning how to dress, accessorize, do one's hair, walk, talk, and act like members of the gender they choose to be. This means overcoming years of socialization as the birth sex (Israel & Tarver, 2003; Lombardi, 2001).

One term that has different meanings for LGB people and transgender people is "passing."

Passing for LGB people is usually derogatory, and refers to people who are hiding their sexuality and passing for heterosexual. It often refers to those people who are hypocritical, such as public figures who engage in denouncing LGB people while secretly carrying on same-sex lives behind the scenes. Sometimes these people are "outed" by others.

Passing for transgender people means the ability to go through daily life as the gender of choice without being detected (or "read"). It means being successful at transitioning, therefore is a positive term. To pass is safer than to be read as a person in transition (Eliason, et al., 2008).

STEREOTYPES OF LGBT PEOPLE

There are many negative stereotypes about LGBT families, including the idea that LGBT people are incapable of having stable relationships, that they cannot be good parents, because children need both male and female parents to be "normal," and the idea that LGBT people are not interested in having children or traditional families. These stereotypes underlie much of the resistance to same-sex marriage and the laws about foster care and adoption rights of LGBT people.

The reality is that all LGBT people have some form of family. Some of those are very traditional looking family relationships, and others are more unique. LGBT people might have children through the usual heterosexual sex method, or via modern practices such as using sperm donors and surrogates, or through adoption and fostering.

Recently a lot of media attention has been paid to transgender parenting. Trans men, who still have uteruses can give birth. They must go off of testosterone prior to getting pregnant, but there is nothing to interfere with normal childbirth (Kurdek, 2004; Patterson, 2005; Weston, 1991).

RACIAL, ETHNIC AND CULTURAL DIVERSITY IN THE LGBT COMMUNITY

LGBT people are found among all nationalities, race and ethnic groupings. It is important to know the LGBT communities you work with, because the terminology of the community and the acceptability of open discussions about sexuality and gender may differ depending on underlying cultural differences.

One difference may be in the tendency to disclose sexuality or gender to a "professional." White LGBT's may be more likely to do this, based on an assumption that knowledge of sexuality and gender is important to get adequate care.

Other cultural beliefs may be related to sexuality and gender being private concepts, not appropriate to reveal to a western health care professional. Some LGBT people who belong to other oppressed minority groups may have had experiences of poor quality of care already and not want to risk further discrimination by coming out as LGBT (Harper et al, 2004; Malebranche et al, 2004; Battle & Crum, 2007; Wilson & Yoshikawa, 2007).

There is a widespread misconception that LGBT people are mostly white and more affluent than the general population. This myth stems from volunteer bias found in most research studies. The typical kind of recruitment methods used in research studies without a lot of resources is a convenience sample—researchers study the people they have the easiest access to. This turns out to be well-educated white people.

However, even those well-educated LGBT white people tend to make less money than their heterosexual counterparts. Studies show that gay and bisexual men earn 10-32% less than comparable heterosexual men. In most studies lesbians earn about the same as heterosexual married women, but consider that when two women are in a relationship together, their household income is likely to be less than gay male couples or heterosexual couples. Transgender people are the most likely to be unemployed and the few studies conducted on trans populations reports that 22-64% earn less than $25,000 per year (Badgett, 2001. Badgett, Lau, Sears, & Ho, 2007).

Groups of the population that are often reported to be the most negative about LGBT people are also more likely to belong to very conservative religions. For example, African Americans are more likely to belong to conservative protestant religions and Latinos to belong to Catholic churches, both of which are likely to be negative about LGBT people.

The down-low is increasing understood to be a derogatory term applied mostly to African American men in relationships with women who have sex with men on the side. The reality is that men and women of any ethnic group sometimes have sexual relations other than with their spouses. It is no better or worse when done by African American men, so the term down-low represents the pernicious overlap of racism and homophobia (Miller, Andre et. al, 2007). Additionally, much of the contemporary use of the term is used in the context of HIV/AIDS with the concern for HIV transmission from men on the down low to African American women. While such transmission occurs, so called men on the down low are not the reason for the disparity in HIV/AIDS incidence in African American women.

THE EFFECTS OF STIGMA ON LGBT INDIVIDUALS

Stigma: the word comes from the Greek for tattoo—a mark of difference. Stigma explains how and why LGBT people are treated differently. In western societies, negative attitudes about LGBT people have come primarily from two sources:

(1) Religious beliefs
(2) The concept of biological “normality:” the idea that heterosexuality is biologically normal and all else is abnormal.

Both viewpoints suggest that society can only be preserved through upholding a heterosexual standard.

Both religion and science have contributed to the stereotypes about LGBT people, religion contributing the moral value judgments and science the sickness/disease judgments. Both contribute to the idea of gender as only male or female.

Hate Crimes

Examples of LGBT people who were murdered recently because of their identities include:

Matthew Shepard – tortured to death at age 22 for being gay by two men who offered him a ride home from a lounge (Wyoming, 1998)

Gwen Araujo – beaten and strangled to death at age 17 by four men, two with whom she had been sexually intimate, after they learned she was transgender (California, 2002)

Sakia Gunn – murdered at age 15 by a man she declined to have sex with because she was a lesbian (New Jersey, 2003)

Lawrence King – shot to death at age 15 while at school, after he gave a valentine to a boy who bullied him for being gay (California, 2008)

Hate crimes include acts other than murder, and these are often not reported because LGBT people fear negative repercussions, including secondary victimization from police and other authorities, or further discrimination or violence from the perpetrators, as in high school

students. What if the perpetrators are family members on whom you depend for financial support?

The experiencing of a hate crime, or having a friend or community affected by hate crimes can lead to post-traumatic stress disorder (PTSD) and other stress reactions, and make the person more vigilant. We know that PTSD and its milder manifestations are risk factors for substance use to self-medicate the anxiety.

Partner Violence

LGBT people experience intimate partner violence at the same rate as heterosexual couples, or perhaps at even higher rates because of the increased levels of stress on relationships. The reasons for the domestic violence are often the same as in heterosexual relationships—power and control, manipulation, financial issues, etc. The two main differences are:

(1) There are fewer resources for LGBT people who are victims of domestic violence. Battered women shelters are geared toward heterosexual women and may not accept others; professionals may not believe men who say they are victims.

(2) One strategy the abuser uses to manipulate the partner is the threat of outing them to family, employer, religious community etc.; and/or using internalized oppression messages to keep the partner isolated and feeling powerless (Rohrbaugh, 2006).

Coming Out to Health Professionals

Coming out to healthcare professionals can be very difficult. People who are in need of physical or mental health care services often feel highly vulnerable and fear that a disclosure might adversely affect the quality of their care. There have been a few studies that asked about disclosure to medical personnel like doctors and nurses, and those studies often report that about ½ to ¾ of LGBT people disclose.

In the study cited here (Eliason & Schope, 2001), some LGB people actively disclosed, and about the same number assumed that their health care provider knew, when they had not actually told them (they used indirect methods such as bringing along a partner or wearing a t-shirt/button with an LGBT slogan on it).

In another study, two-thirds of LGBT youth (Meckler) said they wished that physicians and other health care professionals would ask them directly. This would take the burden off of them having to bring up the topic (Eliason & Schope, 2001; Meckler, et al., 2006; van Dam et al, 2001).

Reasons that LGBT people might or might not come out in a substance abuse treatment agency may be explained by:

- The environment (Are there signs of welcome or inclusion? Is confidentiality assured?)
- The staff members (Do they use inclusive language? Are some of the staff openly LGBT?)
- The client (factors over which you have no control or knowledge—their degree of internalized homophobia/transphobia/biphobia; their past experiences with disclosure; their fears about negative treatment; and so on).

Staff has control over the environment and how they talk to clients. You do not have control over the client factors, but can keep in mind that many have had negative experiences and will enter the relationship with you with mistrust—do not personalize the client's hypervigiliance (Eliason & Schope, 2001).

High Rates of Stress-related Disorders

Living with stigma is stressful, and stress takes its toll on both physical and mental health. LGBT people have higher rates of all the stress-related disorders, such as depression and anxiety disorders, which for many underlie suicide ideation and attempts. Most research suggests that risk for a suicide attempt is at least double in LGBT than the general population.

Substance abuse, including smoking is often a response to chronic stress, and used as self-medication for stress itself, or depression or anxiety. Along with these mental health disorders can be physical conditions, such as lung diseases related to smoking, liver disease related to drinking, and so on (Cochran & Mays, 2007; Meyer, 2007).

LGBT people like substance abuse clients in general, often have co-occurring disorders, and depression and substance abuse is one of the most common combinations (Cochran, Mays, & Sullivan, 2003; Gilman et al, 2001)

SUBSTANCE ABUSE PROBLEMS IN LGBT PEOPLE

Substance Abuse Patterns

There is a growing body of research on substance use and abuse patterns among LGBT people, although much more of the research has focused on lesbians and gay men than on bisexuals or transgender people. Here are some of the consistent themes found in this literature:

- Fewer LGBT people than heterosexuals are abstainers from alcohol (those who do abstain have a much higher rate of people in recovery than abstainers in the general population)

- LGBT people may have telescoped development of problems—that is, even when the levels of heavy drinking are about the same in LGBT and heterosexual groups, the LGBT samples tend to report they have had more negative consequences from drinking. The combination of stress from stigma with the impact of substances on the body may accelerate the course of the alcohol or drug disorder.

- LGBT people show a different life course for drinking (discussed later).

- LGBT people are more likely to report lifetime use of virtually every substance of abuse compared to heterosexual people.

- Gay, Bisexual, and MSM report higher use of stimulant drugs than do lesbians and bisexual women and heterosexual men. For some men, substance abuse and sexual behaviors become linked, making sex a relapse trigger for drug use. Methamphetamine is one of the most common sexual enhancing drugs used by MSM.

- Lesbians are more likely than heterosexual women to any drug use, but most commonly report alcohol and marijuana.

- Transgender women who are sex workers also report high levels of stimulant abuse. In the absence of legitimate, transition-related health care, some may inject oils (silicone, vegetable, even motor oils) to achieve more feminine curves. This practice is extremely dangerous.

The literature on the topic of substance abuse in LGBT people includes Hughes & Eliason, 2002, which is a review of the risk and protective factors. Other recent sources include: Drabble & Trocki, 2005; Eisenberg & Weschsler, 2003; Greenwood & Gruskin, 2007; Marshal et al, 2008; Skinner, 1994; Ziyadeh et al., 2006; Clements et al., 2001; Drabble & Trocki, 2005; Xavier, 2000. Visit www.glma.org for a meth and MSM report.

Research has provided examples of the differences in drinking across the lifespan. Among heterosexuals, drinking rates are highest in late adolescence and early adulthood, but as people get married, have children, and take on responsibilities at work, their drinking declines.

LGBT people do not have as pronounced a decline in drinking rates over time. Most are unable to marry, fewer have children, and many stay in communities where drinking at bars and parties is the most common social outlet. The longer a person maintains heavy drinking, the greater the likelihood of progression to alcohol dependence (Hughes et al, 2000; For men, see McKirnan & Peterson, 1988).

Gay and bisexual men have only slightly higher rates of alcohol dependence than heterosexual men, but triple the rate of drug dependence. Lesbian and bisexual women have four times

higher rates of alcohol dependence than heterosexual women, and triple the rates of drug dependence (Cochran & Mays, 2000). (It should also be pointed out that in this study roughly 90% of LGB men and women reported no drug or alcohol dependence, significantly lower than among heterosexuals but still the overwhelming majority of the LGB population.)

Smoking often accompanies drug and alcohol use. A study from a random population survey in the states of Washington and Oregon shows that LGBT people have about double the rates of smoking compared to the general population (Dilley et al, 2006; see also Tang et al., 2004).

So far there is only one study that reports on the characteristics of people entering mainstream substance abuse treatment facilities. Washington is one of the few places that collects information about sexual orientation on their mandated intake/state surveillance forms. California does not.

LGBT people entering treatment programs in Washington had a greater frequency of mental health problems, were more likely to be homeless, reported higher rates of domestic violence, and were higher frequency users of drugs than heterosexual people entering treatment. This might be evidence of the telescoped development of adverse effects of substance use, or be related to delayed entry to treatment because of stigma (Cochran & Cauce, 2006).

Reason for Comparatively Higher Substance Abuse Rates

There are a number of possible reasons for the higher rates of substance use and abuse. Some of these factors we have already mentioned, and some of the factors are the same things that bring heterosexual people to treatment, such as heredity, having substance abusing parents, experiencing stressful life events, being depressed, and so on. LGBT people have all of those risk factors, plus

- Living with stigma or minority stress;
- The role of gay bars in many LGBT communities;
- Higher rates of depression and anxiety with the concomitant risk for self-medicating those negative symptoms;
- Targeted advertising and community sponsorships by alcohol and tobacco companies;
- LGBT community norms about alcohol, tobacco, and drug use (which is often a libertarian approach—whatever consenting adults do in privacy is fine), and
- Lack of substance free activities and role models in LGBT communities (Hughes & Eliason, 2002).

One factor that is important for substance abuse treatment professionals to know about is internalized stigma. As we grow up and are exposed to all the negative stereotypes before we can understand them cognitively, they are embedded in our emotional responses. If we grow up believing the stereotypes to be true, and have no accurate information to counteract them, then the experience of feeling different will result in shame, guilt, and self-doubt. In its

extreme form internalized stigma results in self-hatred, mental health problems, and suicide attempts. That self-hatred can also result in destructive behaviors like substance abuse and unsafe sexual behaviors.

An important component of treatment for LGBT clients is assessment for internalized stigma and providing supportive treatment toward self-acceptance. Some of the older treatment literature suggested that self-acceptance was a necessary precursor for recovery, at least for gay men (Amadio, 2006; Kus, 1988; Meyer, 2007).

Role of Gay Bars

- Historically, gay bars have served a primary social function in LGBT lives, for there were few other accepting social outlets where people could be themselves.
- Bars encourage smoking and drinking.
- People who meet their friends/partners through bars are more likely to have heavy drinking and smoking friendship networks than people who meet friends/partners elsewhere.
- Today there is declining bar attendance, but other venues are increasing, such as circuit parties, LGBT weekends, cruises, etc.

Many LGBT people have more than one stigmatized identity. What happens when you have overlapping and intersecting sources of stress? Vickie Mays and her colleagues from UCLA found that lesbians of color reported higher rates of smoking and alcohol use than their heterosexual counterparts, demonstrating the additive effects of racism, sexism, and homophobia. Data from the Mays study shows rates of drinking 3 or more drinks at a time on a drinking day. For all three ethnic groups studied, lesbians reported higher rates of drinking than their heterosexual counterparts.

As mentioned earlier, gay bars have played an important role in LGBT communities. In some communities or subsets of communities, the majority of social life has revolved around gay bars, making it difficult to find clean and sober social outlets for the person in recovery. This is particularly true if clients meet their partners and their best friends through bars—acquiring a social network through gay bars means that the norms of the social group may include heavy drinking and drugging. The entire social network may need to be included in the recovery/aftercare plan.

Many LGBT communities also have large social events that center around drinking and drug use. These circuit parties or LGBT weekends, cruises, and other celebrations such as pride festivals, often include heavy alcohol and drug use. These events are often sponsored by alcohol and tobacco industry funding. There are few other funding sources to sustain LGBT community events, so the alcohol and tobacco marketers take advantage of that fact (Warwick, et al., 2003).

One way the industries target LGBT communities is through advertising. For some people who have never seen themselves reflected in the media, this targeted advertising is very powerful.

Alcohol and tobacco companies often do promotions in gay bars, such as giving away free products, or implying that they care about LGBT communities whereas other corporations do not (Drabble, 2000; Smith & Malone, 2003; Smith, Offen, & Malone, 2005).

Treatment Issues

Some substance abuse counselors have misconceptions about LGBT people and treatment. Some of these myths include:

- One myth is that LGBT people do not benefit from treatment. There is a perception that LGBT people cannot recover, or are harder to treat than heterosexual people. This is particularly said about MSM and methamphetamine. There is no evidence to support this—LGBT people can and do recover, and methamphetamine can be treated as effectively as any other drug.
- Another myth is that LGBT people must have separate LGBT-specific treatment or they will not recover. The majority of LGBT people in recovery have recovered in mainstream treatment programs, through AA/NA and other self-help groups, or on their own, just like heterosexual people. There are only a handful of LGBT-specific treatment programs in the U.S. so most LGBT people who seek treatment must use mainstream services.
- Another myth is that LGBT people use their sexuality or gender issues to avoid dealing with the hard issues related to substance abuse. Of course, many clients might on occasion try to take the heat off of themselves by raising less

Alcohol Industry Targeted Marketing

- **Advertising**
  - Tobacco and alcohol advertisers target their messages to specific audiences. Being validated in the media is a powerful influence for some individuals who feel stigmatized in other aspects of their life.
  - Alcohol and tobacco industries sponsor events in LGBT communities (one of the few and more readily available corporate sponsors)

Treatment Myths Related to LGBT Clients

- **LGBT people**
  - Do not benefit from treatment
  - Must always have separate treatment
  - Use their sexual orientation or gender identity issues to avoid dealing with substance abuse
  - Are in treatment because of their sexual orientation or gender identity

sensitive issues, but most of the time, LGBT people are talking about how sexuality and gender have impacted their use of substances or their recovery. They are legitimate issues.

- Finally, some counselors think that sexual orientation or gender identity is the cause of the substance abuse. For some LGBT clients, stigma related to their gender or sexuality is one of the causes, for others it is not (Eliason, 2000; Finnegan & McNally, 2002).

Substance Abuse Treatment Provider Attitudes

- The knowledge and attitudes of over 300 counselors in Iowa and Chicago were studied.
- Knowledge: the majority were unaware of the basic issues that affect LGBT people (homophobia, discrimination, harassment, legal issues, and family issues).
- Chicago providers had more education and experience with LGBT clients than Iowa providers but had similar attitudes.

There are two studies that have examined the knowledge and attitudes of substance abuse treatment professionals about LGBT clients. Over 300 counselors from rural Iowa and from urban Chicago were surveyed. Even though Chicago providers had more experience working with LGBT clients, they were no more knowledgeable about LGBT issues such as the effects of stigma, the legal issues, the coming out process, health issues, and family structures, than were rural providers.

The Chicago providers also had more formal education about LGBT issues, but their attitudes were not more positive than the rural providers. This shows that knowledge alone does not always change deeply held attitudes, particularly if those attitudes are derived from religious beliefs (Eliason, 2000; Eliason & Hughes, 2004).

The researchers looked at whether or not providers have overtly negative or ambivalent attitudes about lesbians, gay men, bisexuals, and transgender clients. The results indicated that one out of three counselors were negative or ambivalent about lesbians and gay men, nearly half were negative/ambivalent about bisexual clients, and over half were negative/ambivalent about transgender clients.

Safety is the first concern of all clients in substance abuse treatment. Do they feel physically, mentally, emotionally, and spiritually safe? What creates a perception of safety in your agency? Safety might be related to the perception of confidentiality. Many clients are concerned about others finding out about their substance abuse.

Some LGBT people are also concerned that their sexuality and/or gender will be revealed to others and have potentially negative consequences for their recovery and for their well being (if they are not out to family, employers, community members, etc). How do you currently protect the confidentiality of sensitive information provided by clients?

Many LGBT people, because there are no legal protections in most states, have legal documents that heterosexual people may not need. These include wills, power of attorney for health care

and finances, guardianship papers, and others. Do you have a place on your intake/admission forms to register whether clients have such documents in the case of an emergency (Eliason et al., 2008; SAMHSA, 2001)?

Other Treatment Issues

HIV/AIDs and other Sexuality Transmitted Infection counseling—many agencies provide this education, as all of their clients are at risk. If your agency provides this education, is it balanced to include same-sex and other-sex behaviors? Is the language inclusive?

Does your agency provide family counseling or family days? If so, are families of LGBT clients welcomed? Is the definition of family sufficiently broad to cover all the kinds of families that clients might have?

Transgender clients have some unique issues that counselors need to know about. One has to do with the injection of oils. Assessments should include questions about use of silicone or other oils, or ask about injection use broadly enough to cover oils. The injection of oils to create more feminine curves is potentially dangerous—the needles might not be clean or people might share the needles, and the practice itself is dangerous. If the oils get in the blood stream they can cause serious infections and even death. The oils will eventually sink to the ankles due to gravity.

Some transgender clients get their hormones on the street, with all of the dangers that entails. Transgender clients may need help finding a reputable health care provider to supply and monitor their hormone use to make sure they are using appropriate doses and not experiencing adverse effects (Lawrence, 2007; Lombardi & van Servellan, 2000; Xavier, 2000).

Another big issue for transgender clients has to do with housing. First, if the treatment is residential, where are transgender clients most safely housed? There is no one right answer to this question. The answer may differ depending on the setting, the client's degree of transition and preferences, and staff and client issues. Wherever they

Treatment Issues

- Safety is the number one issue
- Confidentiality
- Legal Protection—Wills, Power of Attorney for health care and finances, guardianship papers
- HIV/STI prevention
- Family Involvement
    - Family of origin may not be involved
    - Family of choice may include partners, close friends, communities, ex-lovers
    - Children may be involved—biological children or children from adoption, alternative reproductive methods, and children of partners

Treatment Issues Unique to Transgender Clients

- Transgender people face even more societal stigma than LGB people
- They may inject oils
- Hormonal therapy needs to continue during treatment
- Housing issues are a safety issue
- Privacy is important
- The client's choice for pronouns and names needs to be respected

Creating a Welcoming Environment

- Have you advertised you services in the LGBT community centers, newsletters, and social gathering places?
- Do your promotional materials show that you are welcoming and inclusive?
- Do you have a "reputation" in the LGBT community?
- When the client enters the door, is there anything that indicates that you are a welcoming and inclusive place for LGBT clients, such as posters, brochures, etc?
- Do your forms allow for patients to: Indicate their relationships? Disclose sexual/gender identities if they want to? Keep this information confidential if they choose? Record if they have any legal documents for health care decision making?

are placed, privacy is an issue. This also pertains to bathrooms and allowing clients privacy to undress, shower, etc.

Finally, there is the issue of names and pronouns. It is important to respect the client's choices in names and pronouns regardless of where they are in transition and what their legal name or sex might be (Hansmann et al., 2008).

CREATING A WELCOMING ENVIRONMENT

First Impressions

First impressions are very important. How does your agency look to outside observers? There are some things you can do well before clients even find you. These activities include advertising your services, and putting job announcements in LGBT community centers, local newspaper and newsletters, and flyers at social gathering places.

You can examine your promotional materials—the brochures, pamphlets about your services. Is there a statement about being welcoming and inclusive? Is there a human rights statement?

You can find out if you have a reputation in the LGBT community. If you are not sure how to develop a relationship with the LGBT community, Gil Gerald & Associates, Inc. provides training on creating linkages with LGBT communities.

At the time a client enters your door, that client will be scanning the environment for any signs that your agency is a safe place to be. Some of the visible signs of inclusion will be the posters on the wall, the brochures and flyers in the rack, the magazines scattered around the reception area or common room. The simplest thing that you can do is have a client rights or nondiscrimination policy sign prominently displayed.

Forms and Intake Process

Written forms and face-to-face assessments are nerve-racking for all clients—they know they will be asked personal questions. For LGBT clients, the written forms are the first indication of whether the agency has a clue about LGBT issues. They will look for places to indicate their relationships, families, and identities. They will look for information about confidentiality.

A welcoming/inclusive provider is one who:

- Uses appropriate language
- Shows in words and body language that LGBT people are welcome
- Is committed to equal access to treatment for LGBT people and families
- Knows local resources of the LGBT community
- Keeps learning
- Treats every client as a unique individual
- Knows how to take a sexual history and is comfortable talking about sexuality with all clients

Staff Member Characteristics

Welcoming and inclusive providers will use inclusive language and avoid offensive language and slang terms. They will have a relaxed and engaged body language when talking to clients. They are committed to equal access to treatment for LGBT clients and their families, and they know the local resources in the LGBT community.

Local resources include LGBT AA/NA meetings, other sober support systems, LGBT community centers and social service agencies, and LGBT-friendly health care providers. The Gay and Lesbian Medical Association has a health care provider data base searchable by geographic region at www.glma.org .

Welcoming and inclusive providers keep learning, because the issues and the terminology change over time. They treat every client as a unique individual, not reduced to one of their social identities.

Finally, the welcoming and inclusive provider takes a sexual history on all clients and is comfortable talking about sexuality. We have included information in the appendices about conducting a brief sexual history, and offer additional training in assessment and sexual history-taking.

Agency Policies

A welcoming and inclusive agency is one that has a nondiscrimination policy that protects both clients and employees from discrimination based on sexual orientation and gender identity, and enforces the policy. It is displayed prominently, not just buried in a procedures manual. This

agency pays attention to diversity from top to bottom and in all policies, procedures, and activities.

Linkages to LGBT Resources in the Community

The welcoming and inclusive agency has links to the local LGBT community; has openly LGBT people on staff, on the board of directors, and/or as volunteers, mentors, or sponsors.

Finally, this agency does not automatically refer all LGBT people only to the openly LGBT staff, but knows that all staff members have been trained to provide appropriate services. Sometimes it is most appropriate to refer to the openly LGBT staff, but not always.

Steps You Can Take Today:

- Examine your knowledge and skills
  - Do you know what you need to know to help your LGBT clients?
- Examine your own attitudes and beliefs
  - Where did they come from?
  - How do they affect your behavior with clients?
- Review the policies of your agency
  - Do you have a nondiscrimination policy that includes sexual orientation and gender identity?
- Review the written forms
  - Are they inclusive?
- Examine your use of terminology/language in taking a client's history
  - Do you offer safe places for clients to disclose?

Steps Individuals and Agencies Can Take to Become More Inclusive

There are a number of steps you can take today to start becoming more welcoming and inclusive of your LGBT clients. First you can examine your own knowledge and skills. Do you need more information? What about your own attitudes and belief systems? Where did they come from? Were they from accurate sources? Do your current attitudes affect your behavior with clients, and if so in what ways?

Other steps you can take today include a review of the agency policies and procedures to make sure LGBT people are included and the language is appropriate. You can examine all the written forms. For this you should consult some of Best Practices Reports available at the Gil Gerald & Associates, Inc. website (www.gilgerald.com), including one with the title: Standards for Culturally Responsive Services for Sexual and Gender Variant Clients and Communities.

Finally, you can think about the language you use when assessing clients, counseling individuals, or running treatment groups. Do you offer safe places for LGBT people to disclose and to talk about their treatment issues? In groups, how do you create safety for all clients?

Additional resources are offered in the next section of this document, and at the Gil Gerald & Associates, Inc. website, (www.gilgerald.com). If you want more detailed information about working with LGBT people from a therapeutic standpoint, a recommended resource is Counseling LGBT Substance Abusers from Haworth Press, by Dana Finnegan and Emily McNally (2002).

Resources

Go to the website of the Gay and Lesbian Medical Association (GLMA) (www.glma.org). Resources at this site include a brochure on creating a welcoming environment with ideas about inclusive language for forms and history-taking. Also available at GLMA is the Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual and Transgender (LGBT) Health (http://www.glma.org/_data/n_0001/resources/live/HealthyCompanionDoc3.pdf).

The federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) developed and published in 2001 A Provider's Introduction to Substance Abuse Treatment for LGBT, and it is available at http://kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf.

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APPENDICES

Components of a Brief Sexual History

COMPONENT	SAMPLE QUESTIONS
Coming Out: Sexual Identity Formation	• Do you identify as: heterosexual or straight, gay, lesbian, bisexual, questioning or unsure, other • Are you questioning your sexuality? If yes, tell me more about that. • If LGB, how "out" are you about it? • When did you first identify as LGB or know you were LGB? • Is your substance use in any way related to being LGB?
Coming out: Gender Identity Formation	• Are you questioning any aspect of your gender at this time? • If yes, tell me more about that. Is there anything we need to know to make your treatment experience better?
Internalized Oppression	• Do you ever feel ashamed or guilty about your sexuality or gender? • If yes, how have you dealt with those feelings?
Sexual/Gender Stigma	• How did your family react to your coming out? If not out to them, how do you think they would react? • How well accepted are you at work? • Do you feel safe in your neighborhood? • Have you experienced harassment or discrimination based on your sexuality or gender? • Have you ever experienced violence because of your sexuality or gender?

Relationships	• Are you currently in a relationship?
	• Is it monogamous, long-term? Is your partner male, female or other?
	• Is your partner a user/drinker?
	• If LGBT:
	  ○ How "out" is your partner?
	  ○ Does your family accept your relationship?
	  ○ How often do you feel you have to hide your relationship?

Relationship Between Sex and Substances	• Do you use drugs/alcohol to enhance your sexual life?
	• If LGBT, relationship to gay bars
	  ▫ How often do you socialize in gay bars?
	  ▫ Do you meet your friends, partners in gay bars?

COMPONENT	SAMPLE QUESTIONS
	▫ How easy would it be for you to stop going to gay bars? ▫ Do you meet casual sexual partners in bars?
Abuse History	Have you ever experienced • Sexual abuse as a child/adolescent • Physical or emotional abuse as a child/adolescent • Sexual abuse as an adult • Physical or emotional abuse as an adult
Intimate Partner Violence	• Do you feel safe in your relationship? • Have you felt controlled, manipulated, or abused by your partner? • Have you ever felt forced by your partner to have sex when you did not want to? • How often were substances involved in situations of abuse from your partner?
Current Sexual Behavior and HIV/AIDS/STI prevention	• Are you currently sexually active? • Are you satisfied with your sexual life? • Have you ever had sex sober? Are you worried about your sexual life after treatment? • How often did you use stimulant drugs for sexual purposes? Describe. • How many different partners did you have in the past year? How many were men? How many women? • How often do you practice safer sex? What does being safe mean to you? • Have you ever been diagnosed with a sexually transmitted infection? If yes, describe. • Have you been tested for HIV? When, what was the result?

CONTINUING EDUCATION TEST

Please print out this form, complete it, and **FAX to Gil Gerald & Associates, Inc., at (415) 501-9141**. We will contact you with the results of the exam and provide additional information for submission of the processing fee and receipt of a certificate for individuals who achieve a passing grade of 70% or higher.

Name: _____

Street Address: _____

City, State and Zip Code: _____

Email address: _____

Please keep me informed of course offerings: Yes _____ No _____

Phone #: _____

If Applicable, California Board of Behavioral Sciences License # _____

If Applicable, California Drug and Alcohol Counselor Certification # _____

Please answer the following questions true (T) or false (F):

1. Sexual identity and sexual behavior are the same thing.
   T F
2. Gay and bisexual men are more likely to use stimulant drugs than heterosexual men.
   T F
3. LGBT identities are caused by biological differences in the genetic code and brain.
   T F
4. Most substance abuse treatment agencies include sexual and gender identity assessments.
   T F
5. Lesbians, like heterosexual women, show a decline in drinking as they age.
   T F
6. The alcohol and tobacco industries have targeted LGBT people in their ads.
   T F
7. A welcoming and inclusive agency automatically refers all LGBT clients only to staff who are openly LGBT.
   T F
8. An agency's written forms are among the clues that indicate to LGBT people that they are possibly welcome or not.
   T F
9. It is important to respect the client's choices in names and pronouns regardless of where they are in transition and what their legal name or sex might be.
   T F
10. The pronouns and names to be used are those indicated by the client.
    T F