BEST PRACTICES REPORT

The Importance of Collecting Data Relevant to Sexuality and Gender: Written Forms

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Most substance abuse treatment and prevention programs do not include information about sexual identity on their written documents, and limit questions about gender to checking the box that says male or female. Few states include sexual identity and none include gender variation on their statewide data collection forms. Cal-OMS does not currently collect this information, although San Francisco and Los Angeles counties do have questions about sexuality and gender. Many staff members would like to gather this information, but have never had any training on how to ask the questions. There is no one right way to assess sexuality and gender, so feel free to modify this information to fit your own agency needs, individual interviewing style and the characteristics of the clients you serve. This report focuses on written documents, particularly intake forms.

Why Ask Questions about Sexuality or Gender?

Reasons given for not including questions about sexual orientation and gender identity on written intake forms include: the myth that LGBT people make up such as small number of the population as to make the questions irrelevant; the assumption that questions about sexuality and gender might offend some clients; the idea that staff members do not know what to do with such information if it is revealed; and the idea that it is the responsibility of LGBT people to disclose to staff members if they want to, rather than the responsibility of staff to elicit this information.

In regards to the number of LGBT people, public polls and research generally finds that only 1-3% of the population self-identify as LGBT, depending on the format of the survey (telephone, face-to-face show lower numbers than online surveys). However, that number may be an underestimate because of the great stigma attached to this disclosure. Research shows that more than twice as many people report that they have had same-sex sexual experiences, but don't call themselves LGBT. Many more have same-sex desires or fantasies that they have not acted on because of societal stigma. If stigma were reduced, the numbers might be much greater. The reality, however, is that some LGBT people still fear job discrimination, rejection by family, harassment by strangers, and violence from acquaintances and strangers. If you count all people who are impacted by LGBT people—those who have LGBT parents, children, siblings, best friends, ex-partners, and coworkers, then nearly everyone has an interest in raising visibility for LGBT people by openly discussing the issues. Also, LGBT people have higher rates of substance abuse than the general population, so it is likely that they will show up in treatment programs in rates that exceed their representation in society. Hypothetically, if 3% of the general population self-identifies as LGBT, that number may be at least 6% in substance abuse treatment. If 10% of the general population has same-sex experiences without adopting a label of LGBT, then 20% of those in substance abuse treatment would report same-sex behaviors.

Some people think that it may be offensive to heterosexual clients to ask these questions. However, if all forms included these questions, they would become routine. In the meantime, offering people the choice of skipping the question should be sufficient to avoid discomfort.

If you as a staff member never ask clients about their sexuality or gender variance and the forms do not provide any space to indicate their identities, how will they know that it is safe to disclose? On top of the stigma of sexuality and gender variance, is the stigma of substance abuse, and clients often have a situation of realistic paranoia and doubt. LGBT people may fear negative judgments from those who hold the resources for their recovery. In a couple of recent studies of health care settings, the majority of LGBT people indicated that they wanted providers to ask the questions (Lucas et al, 1992; Meckler et al., 2006).

Most forms in all types of health and social service settings are heterosexist—that is, they assume all people are heterosexual and completely ignore other possibilities. They are also gender normative, assuming that all people are born male or female and stay the same gender their entire lives.

Basic Concepts Related to Sexuality and Gender

Forms do not allow for LGBT people to reveal their identities demonstrate how strong societal expectations are that everyone is heterosexual and that everyone is male or female. We call these concepts heterosexism and gender normativity (Eliason et al., 2008). They deny the very existence of LGBT people. How would you feel if the forms you complete in a reception area of a human service agency had no indication that you exist?

- When you ask questions of clients about their backgrounds, as in taking a history or assessing their current problem, do you ask directly about gender and gender variation or make assumptions about their gender based on appearance?
- Do you routinely ask all clients about their sexual orientation or identity? What language do you use?

Three ways to define sexuality:

1. Sexual orientation implies that sexuality is fixed early in life and stays stable throughout life. People who believe that sexuality is inborn or genetic use this term. For the majority of people, their sense of sexual orientation is stable over time.

2. Sexual preference means that sexuality is a matter of choice. This term is used by people who believe LGBT people can and should change their sexuality to heterosexual. A small number of people do experience changes in their core sexual identities, but LGBT people are no more likely to experience these changes than are heterosexual people. These changes rarely stem from a conscious effort to change one's sexual orientation, such as therapy, but come from life experiences that are not predictable.

■ Sexual identity is the way that people think about their own sexual behaviors, attitudes, knowledge, fantasies, etc. This term refers to clients' own self-concept and understanding of themselves. Sexual identity is the most neutral term, as it makes no assumptions about how sexuality comes about, and only describes how an individual experiences their sexuality at any given time.

The term homosexual first appeared in the medical literature in 1869 and has been used throughout the years to indicate a psychiatric disorder. In 1973, homosexuality was removed from the Diagnostic and Statistical Manual (DSM) after considerable research found that sexuality itself did not cause any mental health problems—it was the effects of stigma in society that created problems. Most LGBT people today do not use the word "homosexual" to refer to themselves, but instead, use the terms of the community's choosing: LGB or T.

Gender identity disorder, the term used to classify transgender people, is still in the DSM, although many experts are urging to remove it. Some people in the transgender community still use the term transsexual to refer to themselves, others do not. Transsexual is only one of many identities contained in the umbrella term of transgender.

Sexuality has at least three components:

1. Sexual identity is the label that people use to describe themselves. The most common are lesbian, gay, bisexual, and heterosexual, but there are age, ethnic group, and regional differences in the specific terms that are used. Some people refuse to label their sexuality at all and just call themselves "sexual beings" or "fluid." Some African Americans use the term "same-gender loving," some American Indians use the term "two-spirit," and some youth use terms like "queer" or "gender queer."

2. Sexual behavior refers to what people actually do. Some people have lots of same-sex experiences, but never label themselves as lesbian, gay, or bisexual. Some LGBT people are celibate. There is no way to predict a person's sexual behavior by their sexual identity.

3. Finally, there is attraction, fantasy, and desire. These are the things that people think about, but may not act upon. Some people would act on same-sex attractions if the stigma in society were not so great. For others, fantasy is a fun pastime, but they have no interest in acting on the desires (Laumann, et al., 1994).

Terms that describe gender include:

■ Sex: this is the term that indicates the biological or physical characteristics that we assign as male or female, such as genitalia, internal reproductive organs, hormones, and chromosomes. We generally assign sex to an infant at birth.

■ Gender identity includes the labels that people use to describe their gender, such as thinking of themselves as male or female, or where they fit on societal stereotypes for how men and women are supposed to look and behave (masculinity and femininity).

■ Gender expression refers to how one presents to the world in terms of appearance and behavior. We all have some conscious control over our gender expression because we determine how we wear our hair, what clothes we will wear, whether we will accessorize, and how we walk, talk, and interact with others. Women have much more freedom to express their gender than do men (Hansmann, et al., 2008).

We propose that intake forms include sexuality and gender identity questions. We gather data on other social identities so that we can determine if we are meeting the needs of subpopulations of the population, such as women, ethnic minorities, and people with disabilities. We need to collect information about sexual and gender identities as well, or we cannot determine if we are adequately serving LGBT individuals and communities.

Second, we collect data that helps plan the treatment. Some treatment issues for LGBT people are related to sexual identities, behaviors, or fantasies. For many, substance abuse might be related to their personal experiences with stigma or to the coming out process or transition (from one gender to the other). If we do not take into account these issues, the treatment is not likely to be successful.

Finally, many substance abuse treatment agencies provide education on HIV prevention. Sexual behavior is one critical part of HIV education. Knowing a person's

sexual risk behaviors is vital to counseling them about risk reduction. The intake forms are the simplest way to be inclusive of LGBT people as well as people who have same-sex behaviors but do not identify as LGBT.

What to Ask on Intake Forms

There is no one best way to ask questions about gender and sexuality. We provide several examples of how questions can be framed so that you can choose questions that best fit your own settings and the populations you serve.

Assessing Sexuality

In 2005, the National Center for Health Statistics, along with LGBT researchers, cognitively tested an item about sexual orientation and found this question to work the best (Scout, 2008)

Do you consider yourself to be:

- ☐ **Heterosexual or straight**
- ☐ **Gay or lesbian**
- ☐ **Bisexual**

Here are three other examples of ways of asking about a person's sexual identity. The first two use the terms LGB. The second one allows people a category of "mostly heterosexual." Recent studies of youth and young adults are finding that quite a few are still exploring their sexuality and this option gives them a place to disclose. The third question does not use the terms LGB, but focuses instead on sexual attraction.

1. Do you identify as: heterosexual or straight, gay, lesbian, bisexual, questioning or unsure, or another identification?

2. Do you identify as only heterosexual, mostly heterosexual, bisexual, mostly gay or lesbian, only gay or lesbian?

3. Are you exclusively attracted to the other sex, mostly attracted to the other sex, equally attracted to men and women, mostly attracted to the same sex, exclusively attracted to the same sex?

4. Do you have any concerns or questions about your sexuality?

Assessing Gender

To really know how many transgender people an agency serves, there must be at least two questions. One asks about sex assignment at birth and one about gender identity now. The first two questions do this.

1. Were you born male, female, intersex, or another sex?

2. Do you currently identify as male, female, or another identification

3. Are you currently questioning any aspect of your gender?

If the population you serve includes a significant number of transgender individuals, you might want to name those terms in the questions, as the next example does. It is validating to see your identity reflected on official forms. A study in 2007 of the National LGBT Tobacco Control network tested the following question with youth and found it to be successful.

Sex/Gender

- ☐ **Female**
- ☐ **Male**
- ☐ **Transgender male to female**
- ☐ **Transgender female to male**
- ☐ **Transgender do not identify as exclusively male or female**
- ☐ **Not sure**

Finally, it may be useful to have an item that asks clients if they are questioning their gender—that might allow people who are very early in the process of considering a transgender identity to get some resources before they consider unhealthy options, such as injecting oils or purchasing hormones on the street.

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