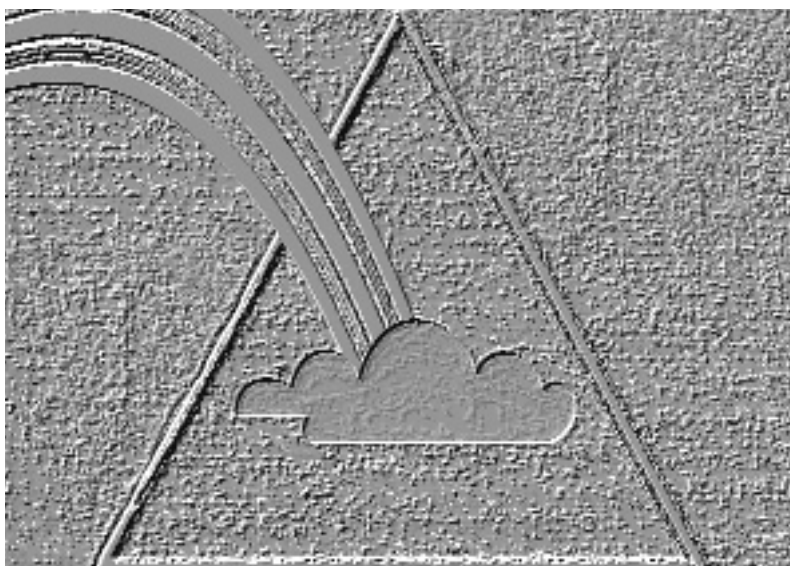


'Pink' and different: sexuality and addiction

ARE YOU COMFORTABLE WORKING WITH GAY/LESBIAN/BISEXUAL/TRANSGENDER OR QUESTIONING CLIENTS? REST EASY – JOSEPH AMICO GIVES PRACTICAL GUIDELINES



A new client entered my office and explained that he had first been to another therapist, who reminded him of a stereotypical librarian. “How can I tell this matronly librarian about my experiences of meeting another man in another city and of all my conflicts around telling my family and people at work?” he asked himself. “Can she handle the information and questions I have about myself?” His friends encouraged him to call the referral network back and explain that he needed a gay or gay-sensitive therapist.

Another client said that he had seen three therapists before landing in my office. One therapist told him that her religion did not believe that homosexuality was acceptable. A second had no clue after three sessions that the client was gay. The third stated that he did not see any reason to treat a gay client differently than other clients.

I am often asked by non-gay therapists “Can a straight therapist work with a gay client?”. My response often is “Can a non-recovering therapist help an addict?”. The answers are obvious. If a clinician is knowledgeable about the issues and sensitive to the client's needs, the answer to both questions is “yes”. If the clinician is uncomfortable with the issues or believes the scope is out their expertise, they should refer the client to someone else.

Another response to the question is “You are working with GLBTQ clients right now, whether you realise it or not”. If 10% of the population is GLBT, then chances are that 10% of your caseload is GLBT. They might or might not reveal that to you, depending on how safe they feel. Clients have told me that they did not share their sexual orientation with previous therapists for fear the therapist would reject them.

Many non-gay therapists will say “I treat them like I do any other client. Isn't that right?”. Yes and no. An addict is an addict is an addict... If the primary issue is working on an addict's defence mechanisms, we use the same principles. If a client's shame about being gay is the primary reason they get drunk or high, there are other issues to address.

I am working with a lesbian who is 37 years old, has had six rhinoplasty surgeries, has an enmeshed relationship with her mother, and is unable to maintain a close intimate relationship outside her family of origin. We have explored self-esteem issues and love addiction issues, including the fear of

Author's note:

To get the most from this article, it is important to understand my use of the letters GLBTQ. Gay refers to men who are attracted to other men. Lesbian refers to women attracted to other women. Bisexual refers to either gender who are attracted equally to both genders. Transgender refers to people born with one set of genitals but who believe themselves to be of the opposite gender. Questioning refers to people who are questioning their own sexual orientation.

“IF YOU COULD CHANGE YOUR SEXUAL ORIENTATION, WOULD YOU? SURPRISINGLY, SOME CLIENTS WISH THEY COULD. THAT REVEALS SELF-ACCEPTANCE AND SELF-LOVE ISSUES”

intimacy. But the underlying issue we continue to circle back to and around is the fact that she has never told her mother that she is lesbian. Her mother has said of a gay nephew “That would endear a son even more to me”. So why can't she tell her mother? It is her own core belief that being lesbian is “gross, not right”. Until she can change her core belief about herself as a lesbian she will not be able to come out to her mother, her “best friend”, or be able to have a satisfying long-term relationship.

When I do my initial biopsychosocial at intake, I add a section of questions for GLBTQ-identified clients. If I do not ask these questions in the first interview, I will miss key understandings in working with the client.

HERE ARE THE QUESTIONS:

1. How old were you when you had your first thoughts about being gay (or lesbian, bisexual, transgender)?
2. How old were you when you first acted on the thoughts?
3. Describe your first sexual experiences; might or might not be the same as (2)
4. When was your first sexual experience with an adult?
5. Who are you “out” to? Ask about friends, family, work
6. How do you feel about being gay?
7. If you could change your sexual orientation, would you?

The answer to these questions will help clinicians to understand how comfortable the client is with his or her own sexual orientation. Many clients will answer the question about being gay with words like “fine”, “it is who I am, I can't change it”, “it's ok now” or “love it”.

But when I ask the question about being able to change, many clients become tearful or, surprisingly, say that they wish they could change. That is revealing in terms of knowing that we will have to help the clients to deal with self-acceptance and self-love issues.

One of the problems with a client admitting to him or herself that s/he is GLBT is the grief of letting go of the heterosexual dream: being married, with the proverbial two children and white picket fence. These all become topics for future sessions, to learn how to cope with letting go of the dream and accepting themselves for who they truly are.

Questions about sexual behaviour are especially important. Some therapists tell me that they are uncomfortable asking sexual questions. Why? Aren't we sexual beings? If we do not know a client's sexual history, we miss an important segment of their whole being, which again contributes to their understanding of self and self-worth.

It is estimated that as many as 77% of gay men have experienced sexual abuse. Many will not report their experiences as abuse. When doing the family history, I ask a client if there was any history of physical,

sexual or emotional abuse. They will often deny any sexual abuse. Then, when I ask the question about their first sexual experience with an adult, they often relay stories of being a teenager and meeting an “older” man in a library bathroom, a park, their pastor, a boy scout leader, teacher, etc. When asked why they did not see this as abuse, I get responses like “I liked it and went back for more” or “I was looking for it”. Most of us, as clinicians, would agree that a 40-year-old man having sex with a teenager is abuse. Because these clients were so hungry for affirmation of their sexuality, they believed that what happened to them was positive and not negative, and so could not be abuse.

At this point in therapy, it is not important for us to convince the client that what happened to them was abuse – that will only put a block in the therapeutic relationship at that point. But it is significant information for us, as clinicians, to use in understanding how this person began to develop sexual, and thus intimate, relationships with persons of the same sex.

Here are five fundamentals to keep in mind as you work with GLBTQ clients.

First, examine your own beliefs and feelings about sexual orientation. If you are uncomfortable with your feelings about GLBTQ individuals, you must refer such people to someone else. A GLBTQ client will pick up on your feelings quickly and the therapeutic alliance will be destroyed. If you do not accept diverse sexual orientations as appropriate, you again need to refer the client to someone else. Despite how “professional” you believe yourself to be, your beliefs and feelings will enter the therapeutic process and can be damaging, especially to the questioning client.

Second, if you are comfortable with diverse sexual orientations in your caseload, make your clients more comfortable and let them know that it is “ok” to be GLBTQ in your office. HERE ARE SOME SUGGESTIONS:

- place GLBTQ literature or artwork in the waiting area; I share an office with two non-gay therapists who have no objection to my placement of GLBTQ newspapers and magazines on our coffee tables; the wall artwork depicts favourite holiday spots frequented by GLBTQ individuals, letting inquiring eyes know that “GLBTQ is spoken and accepted here”; other universal GLBTQ symbols that could send a welcoming message are pink triangles or rainbows
- on your intake forms, ensure that same-sex relationships can be easily reported; if you only have choices for “single, married, divorced, or widowed”, same-sex people will know that this is not a GLBTQ-sensitive office; add categories like “significant other”, “partner” or “committed relationship”.

“GLBTQ CLIENTS DID NOT CHOOSE TO BE A SEXUAL MINORITY: NO ONE WILLINGLY CHOOSES TO BE SOMEONE WHO IS ABUSED, OPPRESSED, SHUNNED OR SCORNED”



Third, study the developmental stages of coming out. There are several guides available. One of the best resources for addiction professionals is *Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities* by Dana Finnegan and Emily McNally, published only last year (Haworth Press).

Other resources for further reading and referrals are listed at the end of this article.

Next, acquaint yourself with the term “heterosexism” and shame due to heterosexism. Some people refer to this concept as homophobia and internalised homophobia. I prefer the term heterosexism to homophobia, as it is more consistent with the rest of our language about prejudice, such as racism, classism, ageism and sexism. Nothing drives addiction like shame, and GLBTQ clients have a great deal of shame.

They are born into heterosexual families who expect them to grow up heterosexual. When they realise that they are not fitting the heterosexist norm, they feel ashamed. That is “shame due to heterosexism”. It is nothing the client caused to happen. My definition of shame is being blamed for something over which you have no control. GLBTQ clients did not choose to be a sexual minority: no one willingly chooses to be someone who is abused, oppressed, shunned or scorned.

When GLBTQ people discover that they do not fit what others expect them to be, this causes a great deal of shame. Many turn to addictive behaviours – such as alcohol, drugs, compulsive sex, gambling, spending or eating – to cope with the shame. Helping clients to understand this concept of shame and where it comes from is an important part of the therapeutic process.

Finally, know the GLBTQ resources in your community. Particularly for recovering GLBT people, be prepared to assist in finding non-drinking resources. Many gay people say that “The only place to meet other GLBT persons is at a bar”. Have information about gay- and lesbian-specific recovery meetings available or know how to find those resources when needed. Find out if there are hotlines or GLBTQ community centres in your area. Know the GLBT-identified therapists and use them for referrals or supervision of your own cases.

One of my popular treatment plan assignments is for the client to pick up a local GLBT newspaper and go through the community Events Calendar or list of community groups. They are to then make a list of the events and groups they would be willing to try and come in and discuss those in the next session. Remember that isolation is another contributor to relapse.

SUGGESTED RESOURCES FOR THE PROFESSIONAL:

Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities by Dana Finnegan PhD and Emily McNally PhD, Haworth Press, 2002. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (2001)* by the Center for Substance Abuse Treatment/Substance Abuse & Mental Health Services Administration, DHHS; free from info@health.org or as PDF files from www.health.org/govpubs/bkd392/index.pdf. National Association of Lesbian and Gay Addiction Professionals: www.nalgap.org

SUGGESTED RESOURCES FOR THE CLIENT:

Accepting Ourselves & Others: A Journey into Recovery from Addictive and Compulsive Behaviors for Gays, Lesbians & Bisexuals by Sheppard Kominars, Kathryn Kominars, Hazelden, 1996. *The Gay and Lesbian Self-Esteem Book: A Guide to Loving Ourselves* by Kimeron Hardin, New Harbinger Publications, 1999. *Positively Gay: New Approaches to Gay and Lesbian Life* by Betty Berzon (ed), Barney Frank, 2001.



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