

CHAPTER 4

**TRANS PEOPLE AND
SUBSTANCE ABUSE**

CHAPTER SUMMARY

Research into transgender substance use is in its infancy, but studies have found that substance use is highly problematic for trans people. This chapter explores the reasons for this conclusion and the many issues that must be addressed in treatment, from the client's perspective and the provider's perspective.

OVERVIEW

The definition of transgender has become increasingly encompassing and inclusive, and society is slowly recognizing the existence of a diverse group of individuals who depart from traditional gender norms and identification. While studies of substance use by transgender individuals did not get under way in earnest until the late 1990s, they find strikingly high rates. Research also finds that many transgender individuals experience cumulative and catastrophic levels of minority stress, which can help to explain a high prevalence of co-occurring disorders.

Treatment providers often have little information and/or negative attitudes about transgender individuals; treatment facilities are often unprepared to work with members of this group. Successful treatment must factor in the unfortunately common experiences of discrimination, violence, stigma, poverty, co-occurring disorders, HIV, and other health concerns.

KEY TERMS

Transgender; gender-fluid; cisgender; gender identity disorder; gender dysphoria; social transitioning; medical transitioning; transgender substance use; HIV and the transgender demographic; co-occurring disorders and the transgender demographic; minority stress; poverty; treatment milieu recommendations; provider biases

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Fundamentals of LGBT Substance Use Disorders: Multiple Identities, Multiple Challenges

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CASE STUDY

A twenty-four-year-old African American pre-operative transsexual presents for intake at your residential drug-treatment program. She is dressed in female attire and tells you that she has been living full-time as a female for more than five years. She has had a legal name change and has identification that states she is a female. She tells you she is revealing that she is transgender because she “doesn’t want there to be any trouble.” She also tells you that she has been in treatment before and says she had a very bad experience; for example, the staff refused to address her as a female and other clients sexually and verbally harassed her. She says she has a long history of abusing heroin and alcohol and that she is ready to change her life and wants to enter your residential treatment program.¹

Transgender people have been common throughout history, but they did not become a subject of clinical research until the mid-nineteenth century. Then, the early research was minimal and based on convenience samples, typically made up of men engaged in cross-dressing. In 1952, when the American Christine Jorgensen traveled to Denmark for a sex-change operation, the event was a major story in the world press. While the surgical alteration of genitals had been performed since ancient times and several world cultures have long acknowledged and supported a nonbinary conceptualization of gender, Jorgensen's operation introduced the general public to the idea that gender is mutable. Over the next decade hundreds of men and women came forward seeking sexual reassignment therapy, and in 1966 endocrinologist Harry Benjamin published his text *The Transsexual Phenomenon*, which described the population he had been working with.² Three years later the first textbook describing the medical protocol for sex reassignment was published by Johns Hopkins University.³

After 1980, variations of a transgender diagnosis were included in the DSM (e.g., transsexualism, gender identity disorder); in short, to have a transgender identity was considered a mental illness. These diagnoses were a source of contention; many transgender people, advocates, and professionals objected to the pathologizing of transgender identity merely because it was not the norm. *DSM-V*, published in 2013, made efforts to overcome decades of controversy by creating a new diagnosis, *gender dysphoria*, which no longer conflates gender status and mental illness.⁴ The *DSM* now recognizes that many transgender individuals live satisfying and fulfilling lives and have no need for a diagnosis indicating mental illness. The diagnosis of gender dysphoria focuses on distress or discomfort, in contrast to earlier criteria that focused on the incongruity between someone's birth gender and the gender with which he or she identified. In short, the authors of the *DSM* placed the genesis of distress and discomfort on societal values of gender normativity.

While the changes in the *DSM* were being made, mainstream society was belatedly recognizing the myriad forms of gender expression that had furtively existed along its periphery. This increased recognition may be thanks in large part to a growing number of depictions in the media. In 2012 Vice President Joe Biden credited a single television series, *Will and Grace*, with educating the American public and increasing comfort with LGB individuals.⁵ The same may hold true for transgender characters, which began to proliferate on television in 2014 and 2015. Sev-

eral shows focusing on positive trans characters and experiences were aired during prime time, and trans performers also became a visible presence. Possibly the culminating event was a televised April 24, 2015, interview with Caitlyn Jenner (formerly Bruce Jenner) that had an audience of nearly 17 million viewers. According to Jen Richards, a transgender advocate, "Not since Christine Jorgensen stepped off an airplane in 1952, if ever, have so many people been interested in someone who does not identify as the gender the world had assumed them to be."⁶

Still, there are many in the transgender community who caution that individuals highlighted in the media are not representative of the population. In a scathing 2015 article in the LGBT periodical *The Advocate*, Jen Richards wrote that the narrative most palpable to the general public is that of "an apparent straight white man, often in a masculine career, married with children, who reveals herself as trans at a later age." Richards then goes on to describe the experiences of other populations of transgender individuals: "Another completely different set of experiences is shared by those who did not benefit from occupying such a privileged space. Black, Latina, and Asian Pacific Islander trans women, along with some white artists and performers who came from the gay male communities, found one another on city streets, in nightclubs, and underground balls. . . . Total exclusion from mainstream society, reliance on sex work and underground economies, and the necessity of sharing resources put greater emphasis on groups than on individuals."⁷ The experiences of trans men are likewise missing from society's current spotlight on transgender individuals.

DEFINITIONS

The understanding of transgender has become increasingly encompassing and inclusive. A 2011 Institute of Medicine report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, defined transgender as "an umbrella term that encompasses a diverse group of individuals who depart from traditional gender norms."⁸

A wide diversity of individuals falls within the transgender spectrum. Some people have lived a trans identity since adolescence (and maybe even childhood), while others, including senior citizens, come out for the first time much later in life. Some transgender individuals who seek treatment prioritize blending in or passing as a member of the other

sex; for others, this is not a concern. Some are highly conflicted regarding their identity, and others are quite comfortable and satisfied with it. Some will make a physical transition via surgery and hormones while others purposefully eschew feminizing or masculinizing their bodies through medical treatment or even attempt to live their new gender on a part-time basis. Finally, some clients want to integrate their transgender feelings into the gender role they were assigned at birth. The Center of Excellence for Transgender Health reminds us of the diversity subsumed under the transgender label, noting that these individuals “come in all shapes, sizes, ages, races, sexual orientations, socioeconomic levels, and educational backgrounds” and that they do not necessarily identify with the terms “transgender” or “transsexual.”⁹ One should not assume that all gender-variant people have the same attitudes, behaviors, beliefs, experience, or understanding of their experience.

Finally, the term *cisgender* is now commonly used to describe a person whose gender identity and expression are aligned with the gender assigned at birth, which is the majority of the population.¹⁰

DEMOGRAPHICS OF THE TRANS POPULATION

The majority of local, state, and federal agencies do not accurately count transgender people. Indeed, it is still rare for data-collection forms to offer an option for trans people, and when they do, the forms typically list three gender categories: male, female, and transgender. The single designation “transgender” does not allow us to distinguish the aforementioned variety within this population. Even on forms that do offer an option of a transgender identity, many trans people inaccurately indicate their identity due to fear of repercussions.¹¹ In the 2011 National Transgender Discrimination Survey, for example, 71 percent of respondents said they hid their gender or gender transition to avoid discrimination.¹² Finally, some do not identify as transgender but instead identify as the new gender they have been living. For example, a person assigned female at birth who has lived as male for many years may not consider himself “transgender”; rather, he sees himself as male.

Earlier estimates of transgender population size were based on studies of individuals diagnosed with gender identity disorder and/or people receiving services at gender clinics; however, these specific groups are obviously not inclusive of all trans people. The American Psychological Association estimated that trans women represent 1 of every 30,000

people and trans men, 1 of every 100,000 people.¹³ A well-received 2011 study combined data from several U.S. population surveys to produce estimates of the size of the trans community. The study acknowledged that “population-based data sources that estimate the percentage of adults who are transgender are very rare” and concluded that transgender individuals in the United States make up 0.3 percent of U.S. adults.¹⁴

Studies of young people tend to find higher rates as well as more expansive views of gender. For example, a 2012 study of LGBT youth, *Strengths and Silences*, found that of 2,387 study participants, 7.8 percent stated they were transgender and 6.6 percent described themselves as other than female or male.¹⁵ Similarly, the 2013 National School Climate Survey determined that of 7,466 participants, 9.5 percent reported they were “transgender” and another 10.6 percent identified as “gender-queer.”¹⁶ A 2014 study by the Human Rights Campaign (HRC) examined the experiences of trans youth and used the phrase “gender expansive youth.” Of the more than 10,000 LGBT youths between the ages of thirteen and seventeen who completed the survey, 925 did not check the male or female box and instead checked “transgender” or wrote in a different response. One-third chose transgender and two-thirds chose other to identify their gender. Descriptors used included gender-fluid, nonbinary female, questioning, genderless, nongender, both genders, gender queer, androgynous, and bigender.¹⁷ The abundance of terms was noted by Facebook, which in 2014 added more than fifty customized gender options for users who do not identify simply as male or female.¹⁸

In summary: The transgender experience is underrepresented in data and research. Counting the transgender population remains a challenge because national surveys do not ask subjects whether they are transgender, and when surveys do ask, responses may be unreliable because some people are afraid to answer; in addition, there is disagreement on the definition of “transgender.”

ETIOLOGY

Many researchers continue to explore the etiology of being transgender, particularly because it was classified as a mental illness until the change in the 2013 edition of the *DSM*. Theories have been abundant. Earlier psychological theories pointed to parenting styles or trauma as the cause of gender nonconformity. Biological theories speculate that

hormone fluctuations or imbalances, or the use of certain medications by the mother during pregnancy may lead to the birth of a transgender child.¹⁹ Cultural studies examine transgender manifestations across cultures and note that different interpretations of “masculine” and “feminine” exist. One study has suggested that male-to-female transsexuality is 1.5 to 3 times more prevalent than the female-to-male, although there is no clear reason why this should be the case.²⁰

Most current researchers believe that there is no single reason why a person is transgender and that a variety of factors are in play. Current research recognizes the confluence of biology, sociology, psychology, gender studies, and queer theory. For example, the Children’s National Medical Center in Washington, D.C., which runs an outreach program for children with gender-variant behaviors and their families, counsels against the notion that there is a “cause” of gender nonconformity and instead presents the concept of gender identity as “something that begins with a genetic propensity, hard-wired in the brain before or soon after birth, and is then influenced by the gender roles that are learned and specific to each time and place.”²¹

THE PROCESS OF TRANSITIONING

Transitioning can be divided into two approaches: social transitioning and medical transitioning. *Social transitioning* entails a progression of nonmedical changes that allow a person to express their gender identity, including name changes and wearing preferred clothing. Social transitioning also includes learning how to navigate the environment—family, school, community, religious faith, and so on. For many trans individuals, these steps suffice to affirm their identity.

Medical transitioning typically consists of a linear process in three stages, though many people do not follow a linear model. First, a trans person initiates hormone therapy. Second, they attempt to live as the other gender in their day-to-day life. Third, sex-reassignment therapy (also known as gender affirmation therapy) is undergone. Research indicates that those who go through these three steps are overwhelmingly satisfied with the outcomes and have few regrets.²² However, owing to the increasing recognition of the diversity of identities subsumed under the trans umbrella, each of these steps has become a separate option, and a trans-identified individual may take some or none of them:

Individuals may explore and find a comfortable gender role and expression accompanied by hormones but no surgery, surgery but no hormones, neither, or both. Individuals may or may not change gender roles from male to female or female to male completely and permanently, may adopt both roles part-time, or may grow up with a gender-variant or transgender identity without ever conforming to one role only to have to consider transitioning to another. In other words, greater acceptance and visibility of gender variance have contributed to an environment in which there is greater room to explore and define one's gender within or outside of a binary conceptualization of gender as either man or woman, masculine or feminine, including the adoption of such identity labels as gender variant or gender queer.²³

SUBSTANCE USE

Studies of substance use by transgender individuals did not begin in earnest until the late 1990s, almost two decades after researchers began to study lesbian and gay male drug and alcohol use. The federal government's first treatment guide on LGBT substance use, released in 2001, found few studies on transgender populations on which to base conclusions.²⁴ Similarly, an often-cited 2002 review of LGBT substance use found there was such limited work on transgender substance use that the topic ultimately comprised only two paragraphs in the final review (in contrast to the many pages allotted to substance use among gay men, lesbians, and bisexual men and women).²⁵ Nonetheless, early studies reached several conclusions:

- Most studies examined male-to-female (MTF) substance use.
- There was a high prevalence of substance use, particularly methamphetamine use, among trans people.
- Trans women obtained and used illegal hormones.
- Trans women had high rates of HIV infection, and substance use played a role in the transmission of the virus. Often cited is a 1998 study by the San Francisco Department of Public Health AIDS Office, which found that 35 percent of MTF individuals and 1.6 percent of female-to-male (FTM) individuals tested positive for HIV.²⁶

- Based on research on gay men and lesbians, it was hypothesized that transgender individuals experience minority stress. The first major study of violence and discrimination against transgender people was not done until 2002.²⁷

Current Research on Substance Use

Early studies stressed the need for more research, and the years that followed saw growing clinical interest in the transgender population. A 2008 systematic review of research on HIV risk behaviors, including substance use, found twenty-nine studies focusing on MTF individuals. The mean rates for MTF substance use across studies were as follows: for alcohol use, 43.7 percent; cannabis, 20.2 percent; and illicit drug use, 26.7 percent. The date of last use reported by participants in these studies ranged from one month to one year. The authors of the review concluded that 11.2 to 16.3 percent of transgender individuals meet criteria for a substance use disorder, and acknowledged the paucity of studies on FTM individuals (only five studies of this group could be located).²⁸ As a contrast, SAMHSA's most recent survey on drug use and health determined that 8.2 percent of the U.S. population age twelve and older was classified with substance dependence or abuse in the past year, based on criteria specified in the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders*.²⁹ Following are the results of several other relevant studies:

- The 2001 Los Angeles Transgender Health Study found that the most frequently used substances were alcohol (77 percent), marijuana (39 percent), "crystal" methamphetamine (28 percent), powder cocaine (25 percent), crack cocaine (15 percent), amyl nitrate or "poppers" (10 percent), and ecstasy (7 percent).³⁰
- A 2005 study of trans people of color found that almost half of the sample engaged in substance use, and of those, only half had sought treatment.³¹
- The Virginia Transgender Health Initiative Study, conducted between 2005 and 2006, found that among its 387 participants there were "strikingly high" rates of tobacco use, and that almost a quarter of those surveyed reported a past or current alcohol problem.³²
- Clements-Nolle, Marx, and Katz interviewed 392 MTF and 123 FTM individuals and found a substance abuse treatment rate of 28 percent.³³

- The 2011 National Transgender Discrimination Survey found that more than one-fourth of respondents misused drugs or alcohol.³⁴
- Reback and Fletcher determined that alcohol use was the most frequently reported substance used by MTFs (by more than 50 percent of participants), followed by cannabis (25.6 percent) and methamphetamine (21.5 percent).³⁵
- A 2013 study examined nonmedical use of prescription drugs by transgender adults; it found that 26.5 percent of participants reported nonmedical use of a prescription drug in their lifetime; the most commonly reported medications used nonmedically were prescription analgesics (reported by 23.9 percent of participants), anxiolytics (17.4 percent), stimulants (13.5 percent), and sedatives (8.4 percent). Nonmedical use of hormones was also frequently reported (30.3 percent). Participants reporting nonmedical use of prescription drugs were also more likely to report the use of illicit drugs.³⁶
- A 2014 study examined substance use patterns by rural transgender individuals and found that 6 percent of trans women and 7 percent of trans men reported engaging in heavy alcohol use on a regular basis. Ten percent of both groups engaged in binge drinking. Eight percent of trans women and 7 percent of trans men engaged in illicit substance use (not including cannabis). Cannabis use was the most commonly reported substance for both trans women (15 percent) and trans men (29 percent).³⁷
- Injection of nonmedical-grade products (often illicit silicone) by transgender individuals in order to change their appearance continues to be a concern, and the areas most targeted include the buttocks, hips, breasts, face, and calves.³⁸ Sixteen percent of trans women in a San Francisco-based study reported engaging in this practice.³⁹ In a sample of fifty-one trans youth in Chicago in 2006, 29 percent reported engaging in this activity.⁴⁰ Often these procedures occur in nonsterile and nonprofessional environments but at a price far less expensive than formal plastic surgery. Tragically, such injections can lead to serious health complications, permanent disfigurement, and sometimes death. A 2010 qualitative analysis found factors such as poor self-image, misperceptions about silicone, discomfort in public settings, and low access to health insurance to be related to the use of illicit fillers.⁴¹

Substance use by trans youth is highlighted in the literature. The 2014 HRC report on gender-expansive youth found that almost half of the youths surveyed agreed “strongly” or “somewhat” that they had experimented with alcohol and drugs, which is double the rate of their straight, gender-conforming peers.⁴² A 2014 study examined HIV risk factors of MTF youth ages sixteen through twenty-five from communi-

ties of color. It found high rates of substance use; 71 percent reported cannabis use and 65 percent reported alcohol use during the previous year.⁴³ A 2015 study, the Teen Health and Technology Study, compared transgender and gender-nonconforming adolescents ages thirteen to eighteen with their cisgender peers. Gender-minority youth had increased odds of alcohol use, marijuana use, and non-marijuana illicit drug use in the previous twelve months; they had also experienced disproportionately high rates of bullying and harassment in the twelve months before the survey. The study determined that victimization was associated with increased odds for all substance use indicators.⁴⁴ Another 2015 study examined substance use by trans female youth ages sixteen through twenty-four; 69 percent reported recent drug use. Gender-based discrimination and trauma were found to influence use.⁴⁵

HIV, Substance Use, and Transgender Populations

HIV infection continues to be a major concern in the transgender population. The Centers for Disease Control and Prevention estimate the prevalence of HIV infection in the United States to be between 0.3 and 0.4 percent, but the odds of being HIV-positive are estimated to be 34.2 times higher for trans women compared with other adults in the United States.⁴⁶ The aforementioned 2008 review of studies examining transgender risk factors for HIV determined that approximately 28 percent of transgender respondents were infected with HIV and 21 percent were infected with other sexually transmitted infections, with the highest infection rates being among transgender women of color.⁴⁷ Another study showed that nearly 52 percent of transgender persons living in Los Angeles reported HIV infection, with highest rates among black participants.⁴⁸

Earlier research focused on the risk of HIV transmission via sharing of syringes containing illegal street hormones.⁴⁹ More recent research, however, focuses on sexual activity while under the influence of one or more substances. Nemoto and colleagues (2004) surveyed participants who reported having a primary partner. Of those participants, 55 percent reported engaging in sex with them while under the influence of drugs during the previous thirty days; the rate was highest among African Americans (63 percent) and Latinas (60 percent). Close to half (45 percent) of the participants who had casual partners reported having sex with them while under the influence of drugs during the previous thirty days; the rate was highest among African Americans (71 percent), fol-

lowed by Latinas (53 percent) and Asian/Pacific Islanders (43 percent). Roughly half (52 percent) of the participants who reporting having had sex with commercial partners reported having sex with them while under the influence of drugs in the preceding thirty days, with no significant ethnic group differences.⁵⁰

Researchers have examined the characteristics of intimate relationships that expose transgender individuals to such a high risk of HIV infection. In a 2004 study, focus groups consisting of African American, Latina, and Pacific Islander MTF transgender individuals were asked about HIV risk behaviors in the context of substance use. Participants acknowledged that substance use was common in the community as a means of coping with past or current life stress and anxiety. Substance use was also common within the context of sex work, and some of the study participants stated that drug use and sex work were “rites of passage” for young MTFs. Owing to the difficulty of finding employment in the regular job market and their resulting desperate financial needs, sex work had become a source of income for many in the study. (The National Transgender Discrimination Survey, or NTDS, found that transgender respondents experienced unemployment at twice the rate of the general population at the time of the survey, with rates for trans people of color up to four times the national unemployment rate.⁵¹) Additionally, respondents reported substance use and having unprotected sex with primary romantic partners as a means of expressing love and trust.⁵² In their 2007 study, Melendez and Pinto found MTFs were also willing to engage in unsafe sexual behaviors within romantic relationships to provide a sense of security; study participants reported difficulty finding a male partner who would accept them and, when romantically involved, gave in to male partners’ requests for high-risk activities.⁵³ Finally, some researchers have suggested that anal sex is more common because taking hormones makes it difficult to maintain an erection and assuming a receptive role is viewed as more feminine.⁵⁴

Studies repeatedly decry the lack of research on trans men in spite of evidence that they, too, are at a high risk for HIV. In their 2008 systematic review of available studies, Herbst and colleagues could locate only five studies involving trans men, and HIV prevalence rates in those few studies ranged from zero to 3 percent.⁵⁵ A 2001 study in San Francisco found that 50 percent of trans men identified as gay or bisexual men, and more than 60 percent reported previous unprotected vaginal sex with a cisgender male, and 27 percent reported unprotected anal

sex with a cisgender male partner. In contrast to the HIV prevalence of 35 percent for trans women in the sample, the rate for trans men was 2 percent.⁵⁶ Similarly, a 2005 study of transgender individuals found that almost 60 percent identified as gay and 81 percent reported engaging in high-risk sexual activity in the three months prior to the study.⁵⁷ A 2011 series of interviews with trans men found that some were involved in sex work, primarily to test if they passed well enough to attract gay men as clients and to pay for surgery for transitioning. Drug and alcohol use was cited by participants.⁵⁸ A small 2011 study of the sexual health needs of trans men found that 62.5 percent of participants had engaged in substance use during sex at least one time during the previous twelve months; the most common substances were alcohol and cannabis. Additionally, 37.5 percent had engaged in alcohol use during their most recent encounter with a cisgender male.⁵⁹

THE IMPACT OF MINORITY STRESS

The Institute of Medicine concluded that transgender individuals encounter health disparities owing to societal stigmatization.⁶⁰ Similarly, the American Psychological Association concluded that “stigma is a significant factor that negatively impacts transgender people’s mental health.”⁶¹ Indicative of this stigmatization is the amount of violence experienced by trans individuals. A 2014 report by the National Coalition of Anti-Violence Programs (NCAVP), a collaborative effort among organizations tracking, preventing, and responding to violence against LGBT people, determined that trans individuals were more likely to experience threats, harassment, and intimidation than LGB people. They were also more likely to experience sexual violence. The report concluded, “Trans women face an alarming vulnerability to hate violence.”⁶²

Trans individuals, particularly trans women, report engaging in substance use as a means of coping with stigma, discrimination, and the daily hardships of their gender presentation.⁶³ Such experiences and the resulting substance use often begin at an early age. The 2011 National Transgender Discrimination Survey found that those who expressed a transgender identity or gender nonconformity while in grades K–12 reported “alarming” rates of harassment, physical assault, and sexual violence; harassment was so severe that it led almost one-sixth (15 percent) to leave a school while a student in a K–12 setting or in higher education.⁶⁴ The 2013 School Climate Survey reported that

55.2 percent of the 7,898 participants between the ages of thirteen and twenty-one and attending K–12 school in the United States had been verbally harassed during the preceding year because of their gender expression. Additionally, 22.7 percent had been physically harassed as a result of their gender expression. For the first time, in 2013, the School Climate Survey asked a question about hearing remarks or comments about trans people. The survey reported that 55.5 percent of participants had heard negative remarks made by their teachers and other school staff.⁶⁵

The aforementioned 2014 Human Rights Campaign study depicts the experiences often encountered by trans youth. The study sought to explore their experiences in their home, school, and community. All of the participants were between the ages of 13 and 17. Forty percent reported being excluded by peers and approximately the same percentage of students reported receiving verbal abuse in school.⁶⁶ Unfortunately, the home front parallels the school experience for many trans youth. The survey also found that only 43 percent of trans youths reported having an adult family member they could turn to, noting that parents of gender-nonconforming children are often distraught and conflicted.

Transgender youth who do not engage in gender-nonconforming behavior in childhood and adolescence may protect themselves from stigma and minority stress during their formative years but then encounter them along with myriad other issues as they transition in their later years. Sadly, life continues to hold obstacles for many transgender individuals as they mature into adulthood, as the National Transgender Discrimination Survey study poignantly indicated.⁶⁷

- 90 percent of respondents said they had directly experienced harassment or mistreatment at work or felt forced to take protective actions that had a negative impact on their career or their well-being, such as hiding who they were, in order to avoid workplace repercussions. Survey respondents experienced unemployment at twice the rate of the general population at the time of the survey, with rates for trans people of color up to four times the national unemployment rate.
- 19 percent had been refused an apartment or house; 11 percent had been evicted.
- 53 percent had been harassed or disrespected in public.
- 29 percent reported police disrespect or harassment.

The authors of the NTDS study were careful to point out that these experiences are cumulative for many trans individuals and that as many as 23 percent of study participants had experienced “catastrophic” levels of discrimination.

Those who transition later in their life likely do not have a community support system in place and are often isolated.⁶⁸ *Still Out, Still Aging: The MetLife Study of Lesbian, Gay, Bisexual, and Transgender Baby Boomers*, a national survey of LGBT people age forty-five to sixty-four, reported vast differences among the groups regarding the extent to which respondents described themselves as “out.” Only 39 percent of transgender people were completely or mostly out (compared with 74 percent of gay men and 76 percent of lesbians).⁶⁹ Those who come out later in life often must work through developmental events commonly experienced earlier in life, including dating, sexual experimentation, and exploration of their masculinity or femininity. Also, many who come out later in life are heterosexually married and have a family whose members face their own process of coming to terms with their loved one’s transgender identity.⁷⁰ The American Psychological Association Task Force on Gender Identity and Gender Variance’s review concluded that little research has been published on the family issues of adult transgender people; research in this area remains a critical need.⁷¹ The NTDS survey found 55 percent of trans respondents reporting that their family was not as strong as it was prior to their coming out. In regard to romantic relationships, 55 percent continued in the same relationship postdisclosure (though those who transitioned saw higher rates of relationship termination); trans women were more likely to experience the end of a relationship than trans men. Relationships with children remained the same for the majority of respondents.⁷²

CO-OCCURRING DISORDERS

Compared with the general U.S. population, transgender and gender-nonconforming individuals report significantly higher levels of anxiety and depression.⁷³ Within the literature, rates of depression for transgender individuals range from 48 percent to 62 percent, and anxiety and overall distress rates for transgender individuals range from 26 percent to 38 percent.⁷⁴ Depression and anxiety seem to be associated with gender-related stigma.⁷⁵ Testa and colleagues evaluated use of the Gender Minority Stress and Resilience (GMSR) measure assessing nine

constructs: gender-related discrimination, gender-related rejection, gender-related victimization, nonaffirmation of gender identity, internalized transphobia, negative expectations for future events, nondisclosure, community connectedness, and pride. Higher scores on the first seven scales correlated with anxiety and depressive symptoms.⁷⁶

A related finding is that transgender individuals have a high rate of attempted suicide. For example, in the NTDS, 41 percent of respondents reported attempted suicide, and those experiencing the most stressors presented with the highest rates.⁷⁷ (In the United States, recent suicide attempt rates in adults were found to be between 1.9 and 8.7 percent, whereas globally they were between 0.4 and 5.1 percent.⁷⁸) For a 2005 study researchers interviewed 182 trans adults ranging in age from seventeen through sixty-eight; more than 30 percent reported that they had attempted suicide, and 60 percent reported that their trans status was a factor in the attempt.⁷⁹ A 2010 study examined trans women and found that of participants between the ages of nineteen and thirty-nine, 53 percent had experienced suicidal ideation and 31.2 percent had made an attempt to take their own life.⁸⁰ Clements-Nolle and colleagues, in interviews with trans men and trans women, determined a suicide attempt rate of 32 percent and found that suicide attempts were associated with recent unemployment, forced sex or rape, verbal and physical victimization related to gender, and low self-esteem.⁸¹

TREATMENT CONSIDERATIONS

A study of trans women in Washington, D.C., found that only 53 percent of those who acknowledged having an alcohol or drug use problem sought treatment.⁸² In her examination of the substance abuse treatment experiences of transgender individuals, Lombardi concludes that this reluctance to engage in treatment was based on past experiences with discriminatory practices in medical care settings and expectations that the same will occur while in treatment for substance use.⁸³

Unfortunately, these expectations too often prove true. For example, the Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, and Transgender Substance Abuse Task Force found that those in substance abuse treatment programs were subjected to verbal and physical abuse by other clients and staff; were required to wear clothing judged to be appropriate for

their biological gender; and were required to sleep in areas appropriate for their biological gender.⁸⁴ Lombardi's 2007 study—completed more than a decade after the San Francisco report—determined that these practices still continued. Additionally, the trans men and trans women in her study reported that staff members in some cases were even forbidden to talk about trans issues. Lombardi's respondents also reported that self-help groups were unwelcoming and even hostile, citing verbal abuse by members, being forced to keep silent about their transgender status, or being pressured into sex by a group member. Overall, the majority in her study reported that programs did not address transgender issues.⁸⁵

In interviews conducted with transgender individuals in 2011, Senreich found that the majority expressed negativity about their treatment experiences, particularly because of unsafe treatment milieus, unwelcoming staff, and disrespectful treatment by other clients.⁸⁶ A 2015 study received responses along similar themes, and participants also described incidents of discrimination, rejection, lack of support, and denial of services. Some study participants reported feeling as if their presence was a disturbance to others in treatment.⁸⁷

Environmental Issues

What can be done to ensure that a treatment milieu is supportive of transgender clients? In addition to creating an affirmative treatment environment incorporating trauma-informed care (as described in Chapter 3), transgender-specific recommendations have evolved. The Center of Excellence for Transgender Health offers a quick self-assessment for treatment providers to help them evaluate how prepared they are to work with trans populations. The assessment consists of six questions, each to be answered with “always,” “sometimes,” or “never.”⁸⁸

1. I understand my transgender patients' specific needs.
2. My waiting room environment is transgender-affirming.
3. I am aware of which of my patients are transgender people.
4. I have literature available for the unique needs of transgender people.
5. I have experience with transgender patients.
6. My staff is sensitive to transgender needs.

The Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, and Transgender Task Force formulated several guidelines for cultural sensitivity and program design:

- Allow transgender individuals to define their own gender, rather than imposing an identity on them.
- Be prepared to separate gender identity and sexual orientation—they are two distinct aspects of each person's life; also acknowledge the variation that exists among transgender individuals.
- Add transgender/gender identity to antidiscrimination policies.
- Protect transgender individuals by not forcing them to disclose their transgender status.
- Do not impose arbitrary dress codes where they are not necessary. Where there is a reasonable requirement for a dress code, then reasonable accommodations should be made so that transgender individuals' dignity and privacy are preserved along with the concerns of others.
- Do not restrict transgender individuals' access to public restroom facilities that are appropriate to their gender identity.⁸⁹

SAMHSA's *Provider's Guide* offers a series of similar recommendations designed to improve clients' treatment experiences:

- Use pronouns based on the client's self-identity. Ask every client on meeting them what name and pronoun they use.
- Allow transgender clients to use bathrooms and showers based on their gender self-identity.
- Post a nondiscrimination policy that explicitly includes sexual orientation and gender identity, and be prepared to back it up (i.e., staff should be prepared to address this topic with the general community when people balk, complain, mock, etc.).
- Do not assume that transgender women and men are gay.
- Do not make transgender individuals living as females use male facilities or transgender individuals living as males use female facilities. This accommodation might necessitate the use of private rooms.
- Facility staff should reflect the diverse treatment population; hire transgender staff (including therapists and counselors).⁹⁰

Counselor Attitudes and Knowledge

A 2002 study of substance abuse counselors' attitudes regarding LGBT clients found that they reported the most negativity toward transgender clients and had the least knowledge about them.⁹¹ The NTDS survey, for example, found that half of the transgender individuals surveyed had to teach providers about transgender needs.⁹² Thus, SAMHSA promulgated guidelines for clinicians mandating that professionals should self-monitor for their own biases regarding transgender individuals as well as recognize that society's treatment of them places them at risk for discrimination, violence, and mental-health problems. Treatment providers must also educate themselves about this population.⁹³ This concern was more recently reiterated by the American Psychological Association's Task Force on Gender Identity and Gender Variance, which delineated three levels of information that all treatment providers should provide for their clients and staff.⁹⁴ First, all treatment facilities should provide basic information, consisting of definitions of terms, guidelines for culturally sensitive language, answers to frequently asked questions, and suggested sources of additional information. This information, which should be disseminated to all staff (including nonclinical staff) and clients in a treatment setting, prepares the groundwork for a safe and respectful treatment environment.

The next level of information (intermediate-level information) is aimed at professionals who may work with transgender clients. It should include information about clinical presentations, prevalence, etiology, life-span development, assessment and treatment, comorbidity, and aspects of cultural competency.

Finally, advanced or specialized information should be provided, including in-depth consideration of the topics listed under the intermediate level. This information is most relevant to clinicians working intensively with transgender clients and to students with particular interests in transgender issues.

Hendricks and Testa discuss cross-cultural competence with transgender clients and conclude that the primary skill is to assess for factors described in the minority stress model (see Chapter 2), such as prior discrimination or victimization, expectations of future victimization or rejection, and internalized transphobia. All of these factors may lead trans clients to be less open during treatment or to disengage

in the treatment process. Hendricks and Testa likewise strongly urge a trauma-informed approach.⁹⁵

Treatment Topics

Herbst and colleagues determined that practitioners working with transgender individuals who engage in behaviors at high risk for HIV (including substance use) need to incorporate a comprehensive approach to treatment at the individual, interpersonal, and societal levels.⁹⁶

- **Individual-level needs.** In addition to substance use concerns, transgender individuals often present with other needs. One concern is gender dysphoria—the stress and discomfort associated with gender-nonconforming feelings.⁹⁷ Other issues that might surface in behavioral-health work with trans populations include sexual-orientation issues and social ostracism.⁹⁸ Mental-health needs may also need to be addressed.
- **Interpersonal-level needs.** Transgender individuals will often need assistance in their efforts to recover from physical and sexual abuse, violence at home, family relationships, romantic relationships, and discomfort in public settings. Moody and colleagues highlighted the importance of helping trans individuals augment their social support system.⁹⁹
- **Societal-level needs.** Providers need to be knowledgeable about the myriad societal obstacles trans individuals can encounter daily, including in employment, social services, and medical services settings.

The Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, and Transgender Task Force formulated several common topics that are likely to come up during treatment:

- Self-esteem issues related to how transgender individuals look and feel about themselves
- Dealing with the transgender person's family issues and level of self-acceptance
- Changing gender on the job, and finding and changing jobs
- Experiencing discrimination and/or violence
- Issues related to transgender participation in sex work¹⁰⁰

Of course it will be very difficult to even broach these issues if one fails to address or acknowledge the day-to-day obstacles encountered

by the trans population. In the words of Judy Morrissey, a Philadelphia-based therapist, "How can you get to these other issues when you don't know what it was like for the person even getting to the office? Did they have car fare? Where they heckled on the bus? Did they receive unwanted comments walking down the street? Clinicians should prepare for this."¹⁰¹

Finally, behavioral-health clinicians should not work on modifying or changing gender identity. In its most recent standards of care document, the World Professional Association for Transgender Health (WPATH), the preeminent professional organization focused on gender identity and expression, stated, "Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth . . . is no longer considered ethical."¹⁰² In some states, it is illegal.

Treatment of Trans Youth and Their Families

Compared with their gay, lesbian, and bisexual peers, trans youth have the fewest interpersonal resources available to them and report being the unhappiest, and an increasing amount of clinical work has focused on interventions for the entire family.¹⁰³ Not only can this work lead to healthier family functioning, but it also can lead to better developmental outcomes for the child involved. For example, a 2010 study published in the *Journal of Sex & Marital Therapy* compared outcomes for children whose parents supported and affirmed their child's gender expression with outcomes for children whose parents considered it a disorder. The children whose parents affirmed their child's gender identity had substantially fewer behavioral problems.¹⁰⁴

The APA Task Force on Gender Identity and Gender Variance describes several stages of family adjustment for gender variance.¹⁰⁵ After initial shock and denial have passed, family members pass through a period of anger directed at both the gender-variant person and at themselves for a perceived failure in parenting. Family members then begin grieving the loss of their expectations for the trans member. In the best outcomes, family members next enter a period of discovery in which they take tentative steps to accept and welcome the gender-variant person. The final stage is one of pride in which family members become advocates for trans people. (The APA acknowledges that many of the models its task force reviewed were based on the bereavement model

created by Elisabeth Kübler-Ross.) Of course, it cannot be assumed that all families will reach a level of pride or even acceptance. In the NTDS, for example, 40 percent of the survey respondents reported that their families chose not to speak to them after their coming out.¹⁰⁶

Interventions for families include the following:

- Helping parents recognize the diversity of gender expression
- Helping parents to recognize and prevent stigmatizing behaviors in which they might be engaging
- Promoting a child's self-worth and resilience
- Strengthening the parent-child bond
- Creating opportunities for peer support for families
- Helping parents develop advocacy skills to assist their children in navigating a society that does not accept or appreciate gender variance
- Leaving transition options open¹⁰⁷

Some children have a consistent desire to transition to a different gender; for others, this is not even a consideration. If given support and room for exploration, many young people position themselves comfortably along the male-female continuum and feel quite comfortable in their birth gender.¹⁰⁷

Finally, parents of trans children have the same concerns about their children's welfare that all parents share: concerns for their safety, education, employment, relationships. A trans identity will likely compound these concerns, so parental worries are often justified.

CONCLUSIONS

Professionals in the behavioral-health field may work with an increasing number of gender-nonconforming clients, including gender-nonconforming children and teens, their worried parents, adults who have been living as another gender for most of their lives, and others who are taking their first tentative steps in that direction. Tragically, many transgender individuals experience overwhelming and possibly catastrophic levels of stress, and substance use is a means, albeit temporary, of succor.

For those who do seek behavioral-health care, the treatment provider's responsibility is not to deal with the client's gender identity per

se but to address the minority stress that accompanies it, which many start to feel at an early age in cultures hostile to any deviation from a strict male/female dichotomy. The combination of an affirmative and trauma-informed treatment milieu that incorporates transgender-specific contextual supports, the treatment provider's knowledge, and a program's ability to address each client's needs at the individual, interpersonal, and societal levels offers the best approach to working with transgender and gender-nonconforming individuals seeking help for substance use.

- Transgender people have been common throughout history, but they not become a subject of clinical research until the mid-nineteenth century.
- Since 1980, various diagnoses with respect to transgender people have been included in the *DSM*. One current diagnosis is *gender dysphoria*, which does not conflate gender status and mental illness.
- There is tremendous diversity within the transgender spectrum.
- There is a dearth of information regarding trans populations. Counting the transgender population remains a challenge because national surveys do not ask respondents if they are transgender, responses are not reliable because some people are afraid to answer truthfully, and there is disagreement as to the definition of "transgender."
- Studies of substance use by transgender individuals did not get under way in earnest until the late 1990s, almost two decades after researchers began to study drug and alcohol abuse by lesbians and gay men.
- Alcohol, cannabis, illicit drugs, and nonmedical use of prescription drugs can be problematic for the trans population, including trans youth.
- HIV rates are significantly higher in the trans populations, and sexual activity while under the influence of alcohol or other addictive substances is a prevalent risk factor.
- Minority stress affects the physical and mental health of transgender individuals. Society's treatment of them places them at risk for discrimination, violence, and mental-health problems.
- Trans individuals, particularly trans women, report engaging in substance use as a means of coping with stigma, discrimination, and the daily hardships of their gender presentation.
- Transgender and gender-nonconforming individuals report significantly higher levels of anxiety, depression, suicidal ideation, and suicide attempts.

- The reluctance of some transgender people to engage in treatment can be based on past experiences with discriminatory practices in medical-care settings and expectations that the same will occur in treatment for substance use.
- Treatment providers often have little information and/or negative attitudes about transgender individuals. Treatment facilities are often unprepared to work with this group of people.
- Family interventions are being developed to work with families of trans youth.

DISCUSSION QUESTIONS

1. Owing to the difficulty of counting trans populations in surveys and polls, how would you improve methodology so as to obtain a more accurate count?
2. The Institute of Medicine defines “transgender” as an umbrella term covering a diverse group of individuals who depart from traditional gender norms. Describe some of the diversity found within this population.
3. Describe how the concept of minority stress applies to trans individuals. How does minority stress affect substance use patterns in this population?
4. List some of the indignities that may have an impact on trans individuals, perhaps even on a daily basis.
5. How would you counsel the concerned parents of a child engaging in nonnormative gender behavior?
6. List some of the environmental changes that must occur in treatment facilities so that they are safe, supportive, and welcoming to the trans population.
7. As a clinician, you find that several patients in your treatment facility have been disrespectful to trans clients, including mocking and shunning them. How would you manage this predicament?

NOTES TO CHAPTER 4

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