

The Importance of Specialized Treatment Programs for Lesbian and Gay Patients

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SUMMARY. This article describes a dual diagnosis treatment program for the lesbian, gay, bisexual, and transgendered community in Washington, DC called the Lambda Center. By using a case example, the article describes how a specialized treatment program can more effectively treat and return a gay or lesbian patient to full functioning, by addressing specific issues which would be overlooked in a mainstream program. These unique issues include coming out, internalized homophobia, socialization, dating and intimacy for sexual minorities, use of certain recreational drugs, and the role of spirituality. The article also gives examples of failures and difficulties faced by lesbian and gay patients in straight programs. The author calls for further studies to prove the superior efficacy of specialized programs for lesbians and gay men and urges patients and providers demand that third party payers and HMOs authorize gay affirmative treatment programs because they are better for patients and probably more cost effective. [Article copies available for a fee from *The Haworth Document Delivery Service*: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>>]

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Specialized addiction treatment programs provide a safe place for lesbian and gay persons to talk about all aspects of their lives without fear of criticism or judgement (Skinner and Otis 1992). This is a great relief for many

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gay people in addiction treatment who have tended to segregate their lives, being in the closet at work or with their families, and only being out of the closet when they are at home or with friends. This can be a liberating experience for persons who are still struggling with acceptance of their identity and have few supports to openly discuss their feelings. It is also important that gay men and women find supportive and affirming groups outside of formal addiction treatment settings, such as lesbian and gay 12 step meetings or openly supportive meetings where it is safe to discuss their gay and lesbian issues without fear.

Specialized addiction treatment programs have experience dealing with the specific ways that substances are used in the gay and lesbian community, and which substances are somewhat unique to this community, which may not be understood in many mainstream programs. Specialized programs for gay men and lesbians can help people find alternative ways to socialize and be intimate without drugs or alcohol. They can also focus on safer sex education and responsible behavior, because HIV is so prevalent in the community and inextricably tied to substance use as risk factors. These programs also understand the coming out process, and how the conflicts in coming out often lead to substance abuse. This allows them to help the patient recognize internalized homophobia and find greater balance and self-acceptance. These programs also understand the role of spirituality for gays and lesbians in recovery, sometimes counteracting past damage caused by organized religion and offering an opportunity to open a spiritual path as part of the recovery process.

Because of oppression in society, lesbian and gay people are more prone to turn to substances for a variety of reasons. It is the goal of specialized treatment programs to understand these risks, and to be able to help patients not only become sober, but also to move on to greater self-acceptance and maturity. This involves overcoming self-preoccupation and fear caused by internalized homophobia, and shifting the focus to outside goals such as professional and career achievements, family and community, as well as increased political and church involvement.

In the last several years, more and more specialized programs offering mental health treatment for lesbian and gay people have emerged, especially those with substance abuse problems. It was recognized that relapse and failure seemed more common for many in the sexual minority community, because they were unable to express themselves openly and integrate the principles of recovery into their lives following treatment in mainstream programs. In many cases, lesbians and gay men were reluctant to enter into treatment because of fear of homophobia and prejudice. This paper will use a case example to demonstrate the effectiveness of a specialized treatment called the Lambda Center, and point out the unique interventions and knowl-

edge which make these programs possibly more effective in reaching the gay or lesbian patient.

Michael was a 35-year-old professional gay white man who had recently begun to show signs of social withdrawal, irritability and erratic behavior. Lateness at work, missed appointments, and errors marred his usually excellent work performance. When friends tried to talk with him about these personality changes, he would become defensive and withdrawn. Finally, a group of close personal and professional friends gathered together to confront Michael about their concerns and encourage him to seek help. He finally admitted that his recreational cocaine and crystal methamphetamine use had begun spreading from the weekends into the weekdays, and was beginning to threaten his career. He accepted his friends' advice and agreed to seek treatment.

Michael had excellent insurance, and could go anywhere for treatment, but he chose a gay affirmative treatment program recommended by his friends. This was crucial to his recovery for several reasons. Many insurance companies would only authorize outpatient treatment for stimulant abuse, feeling that these drugs do not cause serious medical withdrawal, as is seen with alcohol or sedative detoxification, and therefore patients with addiction to stimulants could be safely treated in an outpatient program. These are common drugs of abuse in the gay community, and it is clear that they are intensely addictive. Because of this, the user often must be hospitalized for at least a few days, to break the cycle of use, and also allow the substance to begin clearing from their body. Specialized programs such as the Lambda Center are familiar with drugs endemic to the gay community. The Lambda Center has developed special relationships with third party payers that allow it to successfully obtain reimbursement for this more intensive treatment.

During these few days of treatment, dysphoria, restlessness, anxiety, and drug cravings emerged. It became clear that Michael was not only suffering from methamphetamine withdrawal, but also from Major Depressive Disorder, which is often hard to diagnose in the early stages of substance withdrawal. Michael had been in a seven-year relationship during which he occasionally used drugs and alcohol socially but never excessively. His lover had become involved with someone else and left about a year prior to admission. After the breakup, he coped with his depression by increasing his hours of work and isolating himself from many of his friends. This allowed him to move up rapidly in his firm due to his dedication and hard work. In order to relieve stress when he was not working and to cope with his loneliness, he had begun to go out every weekend and party excessively with drugs, dancing, and sex. He regularly traveled to "circuit parties" at various cities around the country. These consisted of long weekends of dancing and sex, fueled by recreational drugs such as ecstasy, Ketamine, cocaine, and crystal methamphetamine. His

life consisted of work, going to the gym so he could look good at the parties, and intense dancing and drugs every weekend. There was little room for rest and relaxation, an intolerance for intense affect and an impaired ability for emotional intimacy.

Over time, his excessive weekend recreation began to make him more tired and less effective at work, so he started using a little cocaine and amphetamine to increase his energy and performance. This was only a temporary solution, and gradually the drug use increased. He began showing up late and becoming delinquent in meeting deadlines. This led his friends to confront this need for addiction treatment. As he withdrew from the drugs, his sadness, grief and depression over the loss of his relationship became more apparent. He was started on antidepressant medication for treatment of depressive symptoms and to help decrease drug cravings. In many mainstream programs, this depression may have been attributed only to withdrawal and never medicated, because the patient would not have been as open to discussing the losses in his life or their emotional significance.

HISTORY OF SPECIALIZED TREATMENT PROGRAMS FOR THE LGBT COMMUNITY

Specific treatment programs for gays and lesbians did not exist until 1986 with the formation of the PRIDE Institute (Ratner 1988). Although precise demographics about the lesbian and gay community are difficult to clearly delineate due to the fact that many persons are unwilling to self-identify, most studies do support the idea that there is an increased incidence of substance abuse in the lesbian and gay community (Erwin 1993). Estimates of incidence of addiction in this population range between 28-35%, compared with 10-12% in the heterosexual community (Cabaj 1996). One derogatory explanation is that homosexuality and alcoholism arose through a common pathological psychosexual developmental arrest; fortunately, this theory has been put to rest (Nardi 1982). As studies have inquired into the origins of homosexuality, it has been hypothesized that a gene for alcoholism, which clearly has a strong genetic component, may be in close proximity to a gene for homosexuality, so that a person who is homosexual may also be at higher risk to be alcoholic (Cabaj 1996).

More psychological explanations for the increased incidence of addiction in the gay and lesbian community describe addiction as a learned behavior, possibly superimposed upon a genetic predisposition (Ghindia and Kola 1996). For years, the only place to meet other lesbian or gay people safely (or at all) was in bars. This phenomenon still exists for many people today, especially in small towns where there are no gay neighborhoods or other social venues (Kelly 1994). If one spends enough time in an environment that encourages drinking and drug use, some individuals will develop a substance

abuse problem, especially those with a genetic predisposition. For others with social anxieties or discomfort about having sex, drugs and alcohol may be experienced as necessary in order to relax enough to approach strangers, to socialize, or to perform sexually.

Another important factor in understanding addiction in the gay and lesbian community is both internalized and societal homophobia (Fleisher and Fillman 1995). Societal homophobia is also called heterosexism (Amico 1997). Homophobia is characterized by self-blame, a negative self-concept, and self directed anger. It is associated at times with self-destructive behaviors such as substance abuse, the development of a sense of victimization, feelings of inadequacy, hopelessness, and despair (Niesen and Sandall 1990). This inner self-hatred due to one's sexual feelings can interfere with psychological development, with drugs and/or alcohol providing escape from these negative feelings (Niesen, 1993). The phenomenon of increased substance abuse is often seen in oppressed communities, especially racial minorities and other socioeconomically oppressed groups.

STRUCTURE OF SPECIALIZED PROGRAMS

The program at the Lambda Center is a unique partnership between the Psychiatric Institute of Washington (DC) and the Whitman Walker Clinic, one of the nation's largest gay and lesbian health clinics. The Whitman Walker Clinic has become the District of Columbia's largest HIV service provider. The Lambda Center provides inpatient and partial hospitalization for the lesbian, gay, bisexual, and transgender community with psychiatric and/or substance abuse problems. The unit is on a locked ward with 8-10 beds, which also houses the partial hospitalization program for outpatients daily (Monday-Friday) from 10:00 AM to 3:30 PM. The program currently includes a psychoeducational group (Niesen 1997) which focuses on such topics as anger management, stress reduction, depression, medication, grief, safer sex, and HIV. A social worker, pastoral counselor, or nurse clinician leads this group. There is an expressive therapy group, led by an art therapist, in which patients work in a variety of expressive media: art, writing, storytelling, music therapy and sociodrama-type role playing. These therapeutic modalities seek to access emotions not always available through verbal or language based therapy. There is a break for lunch, then traditional process group psychotherapy, which works with current or past issues in a group format. Each day there is an addictions group, led by a Certified Addictions Counselor. These groups deal with such topics as: relapse triggers, relapse prevention, 12 step Meeting participation, relaxation/meditation techniques, the importance of social support for recovery, spirituality, and other issues related to recovery. The psychiatrist sees patients for psychiatric evaluation and treatment. Case management services are offered which provide assis-

tance with social services, housing, and communication with families and work. Individual, family, and couples therapy may be done when indicated and time allows, but often this is coordinated with outside therapists. There is usually a morning and evening checkout time to support abstinence in the community and to provide planning for the evening and next day's activities. Individuals in treatment are strongly encouraged to attend 12 step or recovery meetings in the evenings and on weekends. Outpatients are encouraged to explore both gay and "straight" meetings in the community to develop a compatible recovery support system.

The staff is multidisciplinary with a psychiatrist as medical director and a program director who is an ordained minister and pastoral counselor. Also on staff are nurses, psychiatric technicians, an art therapist, social worker, and addiction counselor. Some members of the staff are straight and some gay; all staff are asked to be open about their sexual orientation and relationship status with patients. This is because honesty and openness are felt to be important for optimal health and recovery, and should be modeled by the staff whenever possible.

The non-gay staff is gay-affirmative, and all staff participate in regular in-service education about lesbian and gay issues, such as dating, safer sex and intimacy, gay male couples and lesbian couples, treatment of HIV disease, grief and loss, discrimination in the community, political advocacy, gay families and parenting, and other issues that emerge in the course of treatment. There are also plans to offer evening and weekend components of the treatment program in order to provide greater continuity and safety for inpatients and outpatients. These treatment times are important also for potential patients who work during the day, but need an Intensive Outpatient Program.

As demonstrated in the case example, patients may begin their treatment as inpatients for detoxification, safety and establishment of abstinence. They then move to the partial hospitalization program, living at home and coming to the Center for groups each day. If their living environment is unsafe due to strong relapse potential, they are encouraged to go into recovery housing, either through Whitman Walker Clinic or in the community. This increases the chances of successful recovery. Those who cannot access safe housing or who relapse repeatedly despite maximal treatment efforts are often referred to more restrictive long-term treatment programs in the community where patients are closely monitored and supervised for several months until their recovery is more stable.

Offering a continuum of treatment intensity ranging from inpatient to partial hospitalization also gives a much greater opportunity for monitoring of early abstinence and psychotropic medication effectiveness. Once patients' mood and recovery are more stable, their treatment session frequency is decreased, allowing them to return to work or other community activities.

Alternatively, the patient is referred to the intensive outpatient program, and may be seen on 2-5 days/week. This frequency is often helpful for further stabilization, and helps the patient remain focused on his or her recovery goals. In addition to options for housing for addictions and for HIV, our affiliation with Whitman Walker Clinic also gives access to a two day/week intensive evening addiction program that lasts for several months. Once the patient is functioning adequately, and in stable recovery, they may be referred for further treatment in their community, often including individual therapy and 12 step meetings. As in the case with Michael, the community program lasted several months, allowing him to have support as he came out at work and to his family.

Whitman Walker Clinic and Lambda Center also have access to a community-wide network of mental health providers who are willing to see patients for individual, couples, family, or group therapy. These gay affirmative practitioners are in private practice settings, and offer a broad spectrum of treatment expertise. Some offer a sliding scale fee. The Lambda Center offers monthly educational programs for providers in the community on various mental health topics including substance abuse, transgender issues, employment discrimination, domestic violence, gay and lesbian youth, trauma survivors, couples and family therapy, psychopharmacology and other issues pertinent to the community.

TREATMENT OPTIONS

Individuals are often limited in their choice of addiction treatment settings by their HMO or insurance company. Such restrictions may also limit the effectiveness of treatment if the program does not address the patient's specific needs (Garnets et al. 1997). One patient at the Lambda Center sought addiction treatment at several programs in his small town in Alabama. He had found them interesting and helpful, but he found himself listening to others and never really sharing his own life story: coming out after being married with children, and his difficulties in meeting and socializing without using alcohol. In a gay affirmative program, he was able to open up and talk about his life, and for the first time felt like he had really begun to recover. Another patient, who had been diagnosed with AIDS and was forced to retire soon after his initial HIV test, developed cocaine addiction to cope with his depression, illness, and drastic change in lifestyle. He entered the same treatment program on two occasions; he was very open about his sexuality and health status and even had his family involved in treatment. However, the patient continued to relapse and went from powder to crack cocaine, because the full weight of his depression in the face of AIDS was not recognized and treated in this mainstream treatment program. When he entered a specialized pro-

gram, he was able to grieve the loss of his lover, his job, and his past professional achievements. He was able to work through family issues and become closer to his supportive family. He also began to explore his spirituality and worked toward finding a new level of satisfaction in life without drugs or a highly-paid career.

Some treatment programs, and some 12-step meetings have actually encouraged people not to talk about their homosexuality (Lewis and Jordan 1989) or their HIV disease. There was concern that it might cause too much disturbance to the other people in the group, or that it was not relevant to their addiction treatment (Green and Faltz 1991). Other programs may claim to be sensitive to gay and lesbian issues, but may not really understand the coming out process and the special issues faced by lesbian and gay people. Some openly gay people go to treatment programs and have no trouble being fully out of the closet and even may present as free of internalized homophobia. They may say to their therapists, "You don't understand what it's like in the gay community; everyone drinks," or "everyone gets high" or "you have to do this to fit in." The therapists and the treatment program need to identify and confront this common presentation of denial and avoidance of therapeutic interventions.

One clinician, a well-known specialist in addictions treatment, became very upset when it was suggested that two of his patients who were referred for a mainstream chemical dependency program for cocaine addiction, might be better served in a gay and lesbian dual diagnosis program. Both of the patients were openly gay men with HIV Disease who had much more in common with the other patients in the lesbian and gay program. This clinician insisted that "addiction is addiction" and that he had treated many lesbian and gay people as well as HIV positive persons in his addiction program and they had done well. There continues to be a common misperception by many clinicians and psychiatrists that all addiction treatment is equal, so that any standard treatment program should be equally effective, without looking at complicating co-morbid factors (Ubell and Sumberg 1992).

To gain access to gay and lesbian affirmative treatment, it is necessary for patients and clinicians to speak up to the insurance companies. Patients are encouraged to ask their HMOs and insurance companies for access to specialized programs and gay affirmative therapists. Many patients who have been in other treatment settings realize the importance of being able to integrate all aspects of their life in their treatment. The law of supply and demand will eventually encourage insurance companies to recognize the importance of gay and lesbian treatment for both inpatient and outpatient therapy, and so they will hopefully include gay specific programs and gay-identified therapists in their panels.

COMING OUT AND HOMOPHOBIA

Michael seemed to be fairly open and “out.” He had had a long-term committed relationship, and most of his socialization was within the gay community. However, he had never integrated his personal, emotional life with his family of origin, nor had he really “come out” at work except to a few close, trusted friends. This compartmentalization of his life set up a state of tension and secrecy. He could not really talk about his personal life or relationship at work, and lived in some fear of what would happen if he were found out. He also avoided many interactions with his family except for periodic dutiful holiday visits home, which he enjoyed. He was warmly received by his family and friends, but never included his lover in his visits. When at home, he did not reveal much about his personal life in the city. These secrets led to a constant underlying state of anxiety, which eventually resulted in depression and turning to substances for relief.

As Michael’s mood lifted in treatment and he felt better about himself, he began to realize the cost of keeping his life so segregated. He began to explore the idea of “coming out” more, both at work and with his family. Over time, he began to self-identify as gay at work where he was accepted and supported. His visibility and his efforts led his company to offer domestic partner benefits for gay and lesbian employees. He was also allowed to do pro bono work for his firm in the lesbian and gay community. With this success, he also came out to his family, first to a trusted sister, then to other siblings and then to his parents. With the help of his therapist and the work he had done in the groups, he was prepared for the emotional reactions of his family. He was able to provide them information and materials to help them understand homosexuality, and to answer their questions about his health and counter some of their religious arguments. He also told them about PFLAG (Parents, Friends and Families of Lesbians and Gays), and they became involved with their local chapter for further understanding. His visits home became easier, and his communication with them was much more open and fulfilling.

The process of coming out and coming to self-acceptance is a unique journey for lesbian and gay people. Society tends to negate and condemn persons with different sexual orientation, and these negative feelings become integrated into the psyches of lesbian and gay people. Recognizing and coming to terms with these sexual/emotional feelings creates a cognitive dissonance, and usually leads to some pain and distress. Some gay men and lesbians are able to confront and accept these feelings and move to acceptance without professional help; others become extremely depressed, even suicidal, or turn to drugs and alcohol for relief.

Coming out is a non-linear, often lifetime process of coming to full acceptance of one’s sexuality. Some gay men such as Michael, feel they are “out,”

and seem to live a fairly open life, but still avoid certain painful or sensitive areas. That is why many lesbian and gay people move to gay ghettos, where they can experience affirmation from other gay people, and avoid censure by family or close friends during the coming out process.

Adolescents struggling with their sexuality are at increased risk of suicide, or they turn to drugs and alcohol to escape (Schneider and Farberow 1989). Many lesbian and gay people become overly dependent on drugs and alcohol to ease their anxiety in the coming out process, to aid in socializing and early sexual experimentation (Kus 1988). They sometimes become dependent on alcohol or drugs to function sexually and socially. For others, like Michael, they may turn to drugs or alcohol to fit in with their social circle, or when they encounter losses and disappointments later in life. A mainstream program may not have been as able to help Michael recognize that his coming out process had been halted, similar to an early developmental arrest due to some life trauma. For him to continue to grow and develop, it was essential to be able to help him continue his coming out process and so achieve a greater degree of self-realization and self-acceptance.

SOCIAL ISSUES IN RECOVERY

For years, the main social and gathering place for lesbians and gay men have been bars—even when they were not safe and subject to police harassment. In many small towns and communities, bars continue to be the main social outlet for the lesbian and gay community. Since the development of alcohol dependence is thought to have a strong genetic component, and many gay and lesbian people still tend to associate in bars, a certain percentage of these people will develop substance abuse problems. Many lesbians and gay men have marked anxiety about their sexual interest and behavior, and alcohol becomes a way to lessen that anxiety and help people perform sexually; for some this leads to abuse or dependence. Others have a great deal of social anxiety and fear, having never learned how to “date.” Once again, alcohol or drugs become a social lubricant, lowering anxiety and inhibitions. For some, this becomes the only means of socializing comfortably (McKirnan and Peterson 1989).

Another major issue in the gay male community is the marked emphasis on sexuality and physicality. One can see pictures of perfect bodies advertising bars, phone lines, bathhouses, classified ads, etc. This gives the impression that the majority of gay men are predominantly interested in the sexual aspects of being gay and the key to self-acceptance and contentment is to be highly physically attractive. Most gay men and lesbians are capable of having wonderful relationships and sex without dwelling excessively on physical beauty, which tends to evaporate with time. The focus on physicality is exemplified by the circuit party—a series of weekend gatherings in various

cities throughout the year, which draw thousands of mostly affluent gay men who dance and have sex all weekend under the influence of a variety of alcohol and drugs. These began as a way to raise money for AIDS organizations, but developed into a tribal ritual. They are justified as a legitimate fund-raising venue, and as a well-earned outlet and reward for a community which has survived a plague. But this environment provides a new avenue for drugs into the community. These parties are settings which support the heavy use of drugs of abuse that are somewhat unique to the gay community: ecstasy, Ketamine, GHB, crystal methamphetamine and "poppers," as well as the ubiquitous alcohol, marijuana and cocaine. The emphasis on perfect bodies and the use of steroids first for wasting, decreased libido, and depression in HIV disease, and then for cosmetic reasons can generate increased sexual acting out, frequently with lowered regard for safety due to the influence of drugs. Because of the attractiveness and visibility of this segment of the gay male community, many others are undoubtedly being influenced to use "party" drugs and practice unsafe behavior, leading to further HIV transmission as well as substance abuse. This certainly drew in Michael, who began using to escape his work tensions and loneliness, to find relief and sexual gratification, but who became dependent on the drugs due to his depression and his underlying predisposition.

Another important risk factor for substance abuse among gays and lesbians is the shame and guilt around sexual behavior. Many people grow up with inhibitions about sex due to religious backgrounds or social upbringing. This is compounded further for lesbians and gay men who lack affirmations for their sexuality. Alcohol or drugs become a way to desensitize a person to the anxiety surrounding sexuality. For a percentage of people, this becomes the only way to be sexually active, and thus sets up the pattern of substance abuse or addiction.

SPIRITUALITY AND HOMOSEXUALITY

AA is still considered one of the most successful methods for overcoming alcoholism; other 12 step groups use similar approaches to address other addictions. AA began as a religious approach to recovery (Kominars 1987). Most 12-step programs are essentially spiritual paths. For many people in the lesbian and gay community, organized religion tends to be a difficult area, because mainstream religions have tended to reject and condemn homosexuality. For many gay and lesbian people, this rejection creates an insurmountable problem, so they are reluctant to pursue 12 step programs that appear religious in nature. It is essential that treatment programs recognize that some lesbian and gay people come from very religious or spiritual backgrounds, but after coming out, found that their church rejected them. Due to this cognitive dissonance between their church and their sexuality, these gay

people choose to walk away from organized religion, and often harbor bitterness. This is reinforced by the fact that fundamentalist religions continue to be the strongest spokespersons against gay people.

Many lesbian and gay people are very spiritual, despite the damage done to them by the church. There are many gay clergy, and many churches are openly embracing lesbian and gay people in their congregations and their leadership, especially in choir and music. But many people with substance abuse problems are estranged from their religion and oppose any discussion of spirituality. They often resist attending 12 step meetings because there is talk about "God," and some meetings are experienced as judgmental and condemning of gays and lesbians. Specialized treatment programs are aware of these conflicts, but also know the importance of spiritual repair in recovery. To address this, the program needs to help patients expand their concept of God, religion, faith, and spirituality. It is valuable in recovery to support the process of being open to exploring various religions, and entering one's own journey to find a power or force greater than one's self. This is the basis of spirituality; some people can find these answers in organized religion, but others need to find their own spiritual path.

CONCLUSION

Specialized treatment programs for lesbians and gay men are a relatively recent phenomenon. Although there are not enough controlled studies to demonstrate effectiveness, it is clear to many who work in these programs that they seem to be more powerful in helping patients achieve recovery and healing. Specialized treatment programs provide a safe space for sexual minority persons with substance abuse and emotional problems to talk about their lives freely. The issues discussed may have little or nothing to do with their sexual orientation, but the groups provide a sense of acceptance and support. The issues discussed may have little or nothing to do with their sexual orientation, but the groups provide a sense of acceptance and support, which may be a new experience for these patients. This nurturing environment allows patients to share secrets and pain they have often kept hidden. In being able to look at these issues, many persons can face painful issues and reach some resolution and healing so that they become stronger and more likely to stay sober when faced with new problems.

The strength of the specialized programs seems to be in providing a safe space for gay men and lesbians to confront problems in a community of support. A gay-affirming and supportive treatment program can help people resolve past issues such as incest and abuse, as well as foster the coming out process and self-acceptance. These programs offer the opportunity to address socialization skills, dating and intimacy issues, as well as HIV, grief and loss.

Specialized programs are sensitive to the damage experienced by many gays and lesbians within organized religion, and aid patients in finding their spiritual center.

Because of the special issues that the lesbian and gay community faces, it is important to fight for specialized programs and affirmative treatments. Hospitals, insurance carriers and third party payers should be requested to provide access to these programs. Further research needs to be done to prove their effectiveness, so that payers will realize they should be funded.

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