Vol. XXIII, No. 1, Winter, 2010 NALGAP: The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals & Their Allies

NALGAP reporter

Serving the Lesbian, Gay, Bisexual, and Transgender Communities since 1979

"In the state of nature… all people are born equal, but they cannot continue in this equality. Society makes them lose it, and they recover it only by the protection of the law."

—Charles de Montesquieu (1689–1755)

NALGAP reporter

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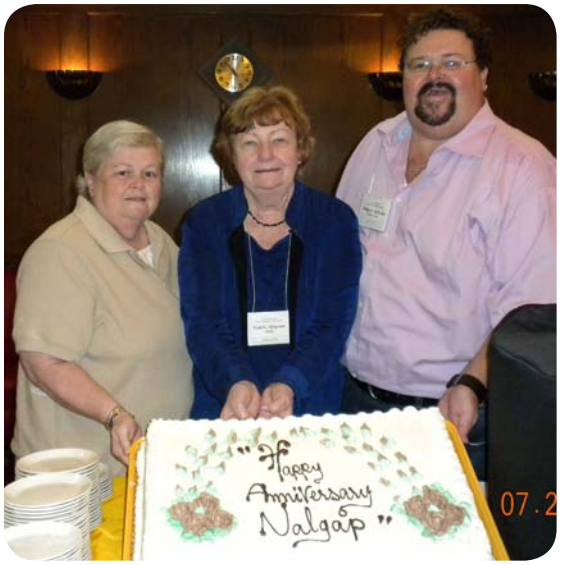
1979–2009: NALGAP'S 30th ANNIVERSARY

NALGAP celebrated its thirty-year anniversary with three memorable events.

1) The first celebration occurred at Rutgers (NJ) Summer School of Alcohol and Drug Studies (SSADS). This was very fitting because that's where NALGAP began 30 years ago. In July, 1979, 15 lesbians and gay men and one transgender person got together and decided to start NALGAP (then NAGAP) because there was nothing anywhere in the country that addressed the needs of LGBT people struggling to recover from alcoholism and other drugs. LGBT substance abusers were just "out there," with no support and no help in combating the homophobia that threatened their attempts to get sober. NALGAP was formed to be a voice of national conscience, a trainer of substance abuse counselors, and an advocate for the voiceless LGBT substance abuser.

In July, 2009, two NALGAP Board members, Joni Whelan and Phil McCabe, and Gail Milgram, Ed.D, Director of Education and Training at the Rutgers Center of Alcohol Studies and Director of the SSADS, celebrated NALGAP's 30 years with assembled Summer School students and faculty. Joni and Phil thanked Gail Milgram for the long-standing and invaluable support given to NALGAP by her and the Rutgers SSADS. It is the ongoing support of our Allies that has enabled NALGAP to continue its work.



Joni Whelan, Gail Milgram, Ed.D., Phil McCabe

2) The next event occurred at the NAADAC/ AUSAP/NALGAP Conference–Sowing the Seeds of Recovery—in Salt Lake City, August 18-22, a conference that attracted some 900 participants. In addition to a Plenary speaker and two workshops, NALGAP held a membership meeting with a cake to celebrate the anniversary. NALGAP also recognized the invaluable support offered to NALGAP and the cause of LGBT substance abusers by NAADAC which has partnered with NALGAP over the years.

(article continued on page 2)

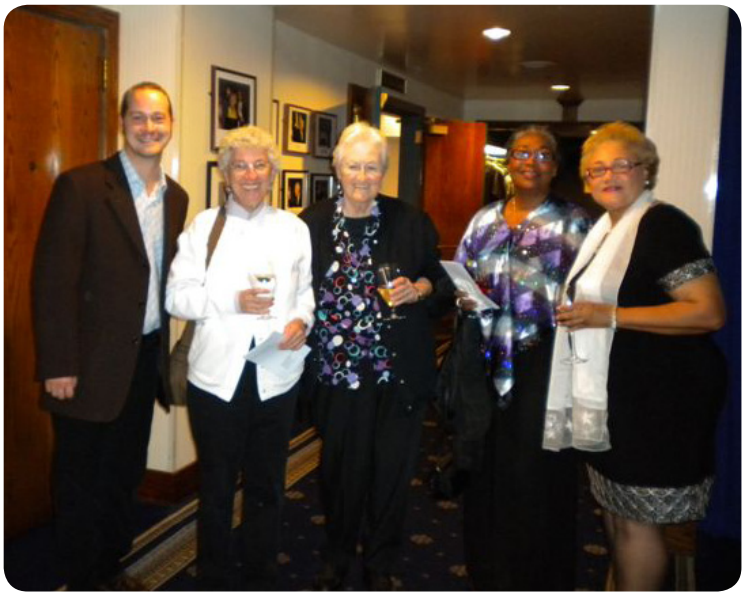
3) The third event occurred at NALGAP's conference within the Gay and Lesbian Medical Association (GLMA) conference in Washington, DC, from Sept. 30 – Oct. 4. NALGAP's co-founders, Emily McNally and Dana Finnegan, addressed the crowd at GLMA's reception and talked about the early years of NALGAP and the ongoing need for younger people's involvement. The watchword of this gathering turned out to be: "Pick up the torch — and run like hell!"

The next day, NALGAP's Plenary—Addressing Substance Abuse in the LGBT Community: Reflections on the Past, Present, and Future—drew a good crowd. The Co-Founders spoke about NALGAP's history and its place in the growth of the substance abuse treatment field. Barbara Warren, PsyD, talked about the current need for a strong voice to advocate for LGBT substance abusers. And NALGAP President Joe Amico spoke about where NALGAP is headed in the future.

L to R: Joe Amico, Barbara Warren, Dana Finnegan, Emily McNally at NALGAP's Plenary

At the GLMA Gala Dinner, Joe Amico, presented Bryan Cochran, PhD with a NALGAP award recognizing his seminal research in LGBT substance abuse. Joe then presented Jes Montgomery, MD, with a NALGAP President's award for his contributions to bettering treatment for LGBT substance abusers.

All three of these celebratory events underscore the importance of NALGAP's role as a national and international voice of conscience and the need for alliances with both the LGBT and the straight communities. Rutgers SSADS and NAADAC have been, and continue to be, powerful straight allies and GLMA has become a valuable LGBT partner in the struggle to ensure non-discriminatory treatment for all LGBT substance abusers.



Bryan Cochran, with NALGAP Board Members Emily McNally, Dana Finnegan, Cheryl Reese, Pamela Alexander

Jes Montgomery [speaking], Joe Amico

It is important to note, however, that everything points to the on-going need for strong and effective advocacy for non-discriminatory treatment for LGBT substance abusers. In a climate of outright hatred and homophobia fueled by the "Gay Marriage" controversy, LGBT people who are struggling with substance abuse and trying to recover from it are especially vulnerable and need help and support. NALGAP is there to provide that help and support. ■

NALGAP Board Member Cheryl Reese, LPC, Resigns from Coalition Board

Although I have resigned, I will continue to represent NALGAP at the Fall meetings of the Coalition.

The National Coalition for Lesbian, Gay, Bisexual and Transgender Health is committed to improving the health and well-being of lesbian, gay, bisexual and transgender individuals and communities through public education, coalition building and advocacy that focus on research, policy, education and training. Our members are dedicated to the concept that our ability to effect change will be determined by our bringing together the rich diversity of the LGBT community at a national level — across gender/gender identity, race/ethnicity, disability, education, income, age and geography.

Cheryl Reese. LPC, reports: "Since being on the NALGAP Board, I have served on the Board of the National Coalition For Lesbian, Gay, Bisexual And Transgender Health, attending every Spring and Fall meeting for the past several years. I have lobbied on the Hill for LGBT health, and strongly voiced my opinions about LGBT Health and aging as well as diversity. As of this fall (2009), I am resigning from the Coalition Board. Although I have resigned, I will continue to represent NALGAP at the Fall meetings of the Coalition." ■

HHS to Create a National Resource Center for Lesbian, Gay, Bisexual and Transgender Elders

The Administration on Aging will award a single Resource Center grant at approximately $250,000 per year, pending availability of funds. Eligible entities will include public-private nonprofit organizations with experience working on LGBT issues on a national level.

In late October (2009), HHS Secretary Kathleen Sebelius announced plans to establish the nation's first national resource center to assist communities across the country in their efforts to provide services and supports for older lesbian, gay, bisexual and transgender (LGBT) individuals.

Experts estimate that as many as 1.5 to 4 million LGBT individuals are age 60 and older. Agencies that provide services to older individuals may be unfamiliar or uncomfortable with the needs of this group of individuals. The new Resource Center for LGBT Elders will provide information, assistance and resources for both LGBT organizations and mainstream aging services providers at the state and community level to assist them in the development and provision of culturally sensitive supports and services. The LGBT Center will also be available to educate the LGBT community about the importance of planning ahead for future long-term care needs.

The LGBT Resource Center will help community-based organizations understand the unique needs and concerns of older LGBT individuals and assist them in implementing programs for local service providers, including providing help to LGBT caregivers who are providing care for an older partner with health or other challenges.

The Administration on Aging will award a single Resource Center grant at approximately $250,000 per year, pending availability of funds. Eligible entities will include public-private nonprofit organizations with experience working on LGBT issues on a national level. The funding announcement for the Resource Center will be made available on the following website very soon: http://www.aoa.gov/AoARoot/Grants/Funding/index.aspx ■

BIVERSITY: A Primer for Treating Bisexual Clients

By: Margaret C. Charmoli, Ph.D., Licensed Psychologist, Former NALGAP Board Member

Working with any client who may be different from us or from what we know and understand can pose challenges to providing effective treatment. Working with bisexual clients is no exception. This article will highlight some considerations to aid you in better understanding and helping your bisexual clients.

Concerns Facing Bisexual Clients. Many concerns facing bisexual clients are similar to clients who are gay, lesbian and/or transgender. These issues include coming out, identity formation, self-acceptance of sexual orientation and/or gender identity, family support, resources and co-disorders. The remainder of this article will focus primarily on how the experience of bisexual clients differs from the aforementioned groups.

Myths. Like other minority groups, bisexual people get stereotyped and misunderstood by the dominant culture. These myths may pose problems for bisexual clients, other clients, and the treatment staff in creating a safe environment for healing. A particularly disturbing myth is that bisexuality doesn't exist at all. Many people, including counselors, continue to believe that bisexuality is not a valid sexual orientation or, worse yet, that it is pathological.

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Other common myths are that bisexual people are confused about their orientation and that they are fence-sitters who are afraid of being gay or lesbian. Those who believe that bisexual people are simply afraid to be gay or lesbian might be surprised at one of the findings that psychologist Ron Fox learned through his doctoral dissertation research: 30% of self-identified bisexual people had previously identified as gay or lesbian.

Many people also wrongly assume that bisexual people are equally attracted to both genders, that they need to be in a relationship with more than one gender at the same time, and that they are unable to commit to relationships.

If other clients or therapists subscribe to those myths, it will be harder for bisexual clients to focus on their treatment issues. One way, then, to be more effective in counseling bisexual clients is to examine our own bi-ases (pun intended) and address them when they surface in ourselves or our treatment settings. Some ways to do that will be discussed later in this article.

The Bisexual Eye/I. The "bisexual eye/I" is a term I use to reference common challenges and perspectives shared by most people who identify as bisexual. Understanding these issues can facilitate your work with these clients.

The bisexual community is largely invisible even in sizeable cities. The community also tends to be less cohesive than the gay, lesbian and transgender communities, perhaps because of the diversity within the community in regard to primary affiliations. Bisexuals who are in primary relationships with someone of the opposite gender easily blend in with heterosexual society. Those in primary relationships with someone of the same gender often seek support from the gay and lesbian community. Despite those appearances and affiliations, neither of those communities feels completely like "home" for bi people: nor can they fully mirror or validate what is needed for healthy identity formation or recovery.

Another factor contributing to a relatively small and invisible community is that bisexual behavior is much more prevalent than people who identify as bisexual. Kinsey's research (1948/1953) found that 30-40% of men and 15-35% of women were bisexual based on behavior. Yet the Janus Report (1993) noted that only five percent of men and three percent of women identify as bisexual. One can only speculate about why that is so.

Bisexual men and women frequently feel rejected by both the straight and the gay/lesbian communities and feel unwelcome anywhere. This has led some bi activists to proclaim that "we are twice rejected" and that "we don't get half-bashed." It is helpful to remember that nowhere is it the norm to be bisexual.

The invisibility of the bi community coupled with a paucity of resources can make it extremely difficult to get the kind of support that is needed for recovery from addictions or co-disorders. This leaves bisexual people more prone to taking in only the negative myths shared by the larger culture thereby creating an insidious breeding ground for self-loathing and the development of bi phobia. It's nearly impossible to hear and nurture the healthy piccolo inside when a large brass band is blaring on the outside. That can create confusion and isolation for people who are at vulnerable points in exploring their identities or in their recovery process.

Instead of saying that bisexual people are dishonest (another variant of not admitting that they are really lesbian/gay), say that they may be more honest than people whose behavior doesn't match their identity.

Challenges posed by all of the above factors create conditions and environments that are neither good for chemical nor mental health. Recent studies at the University of Minnesota, for example, indicated that bisexual women were more prone to depression than heterosexual women or lesbians. That can bode unfavorably for both physical and chemical well-being.

Benefits and Joys of Being Bi. The prominence of positive psychology in the past decade has encouraged counselors to become more aware of reinforcing the resilience of our clients. Following are some gifts and advantages of being bisexual.

As the old song goes "I've looked at love from both sides now." The ability to experience romantic attachments to different genders can make it easier to appreciate and have empathy for the qualities that both men and women bring to relationships. A by-product (or perhaps a "bi-product") of that empathy is that opposite gender put-downs are rarely heard in the bi community (at least in this author's experience).

Living with a "both/and" identity as opposed to an "either/or" one ("monosexuality") can foster a more flexible and tolerant approach to life's vicissitudes. The ability to be fluid and adaptable can be useful for adjusting to an ever-changing world. Finally, it can equip people to better tolerate ambiguity and the gray zones of life.

Counseling Bisexual Clients. Developing an understanding of the aforementioned considerations will go a long way toward being more effective with bisexual clients.

Another important thing that counselors can do to create a safe and welcoming environment for bisexual clients is to *validate, validate, validate* that bisexuality exists and that it is a legitimate sexual orientation. Clients can and should be supported for exploring their bisexual feelings or proclaiming their bisexual identities.

Practice positive psychology and consider modeling what I regard as Charmoli's Bi-ased Reframes. Instead of saying that bisexual people are confused, say that bisexuals are flexible and tolerant. Instead of saying that bisexual people lack courage (aka they are *really* gay/lesbian), say that it takes exceptional courage to transcend the norms of the culture.

Instead of saying that bisexual people are dishonest (another variant of not admitting that they are really lesbian/gay), say that they may be more honest than people whose behavior doesn't match their identity.

Finally instead of saying that bisexual people are fence-sitters, say that they are bridge-builders who hold that invisible space that both unites and divides the straight and gay/lesbian worlds.

Summary. Remaining open to the gifts of biversity can make life more interesting in general and can make us better counselors. Developing an appreciation for the challenges and gifts that go along with being bisexual will increase the likelihood that your bisexual clients will have a more welcoming and successful treatment experience. ■

President's Corner: Fall 2009

Collaboration, cooperation, integration. Those are the words that come to mind after celebrating our 30th Anniversary with a number of diverse organizations this year.

It was truly awesome to stand amidst both our addiction professional peers at NAADAC and our LGBT peers at the GLMA conference this year. The NAADAC conference in Salt Lake City was the largest gathering of addiction professionals I can remember. In addition to partnering with NAADAC, the conference was co-sponsored by the Utah Association of Alcohol and Drug Abuse Counselors, the State of Utah Alcohol and Drug Abuse Services, and a branch of the US Air Force! I don't' think I've ever had such a diverse group of attendees at my "Gay 101" workshop as I had in Utah! I'm not accustomed to seeing men and women in uniform coming to hear about treating LGBT folk but *Hallelujah*!

NALGAP has often provided substance abuse workshops for GLMA (the Gay and Lesbian Medical Association) but this was our first time with a full-fledged NALGAP Track including a Plenary. I was astounded by the number of GLMA folks taking advantage of our presentations. It was truly a joy to be part of GLMA's Annual GALA on Saturday night, held at the National Press Club where we honored Jes Montgomery, an MD and therefore one of their peers, with our President's Award and Bryan Cochran with NALGAP's first Research Award. One of the emphases of NALGAP with CSAT/SAMHSA has been that we don't have the data we need on our population. Bryan has done some seminal work in that area, and others became known to NALGAP during this conference. One of the goals for our Board is to investigate grants to assist Bryan and other researchers to keep on collecting the kind of data that will continue to support our mission.

Another highlight was celebrating our 30th Anniversary at GLMA at the reception for the National Coalition on LGBT Health. NALGAP is a founding member of the coalition so it seemed appropriate to be recognized at their reception and to introduce to the larger audience, our co-founders Dana Finnegan and Emily McNally who were attending the Conference. Dana and Emily impressed the crowd with reminisces of what it was like 30 years ago when NALGAP began.

At the GLMA conference, NALGAP Board members learned that Lambda Legal and GLMA have been consulting with the Joint Commission (JCAHO) on a new standard for cultural diversity that will include LGBT. What great news! It suggests, then, that every hospital and agency accredited by JCAHO will have to meet new standards for treating LGBT folks both as staff and as patients! Hurray!

We also learned that HRC and GLMA have produced a great document on cultural diversity standards. At NAADAC, I serve on the Clinical Issues Committee and learned that there's a good possibility that the body that is responsible for doing certifications will take up the issue of creating a standard or certification for LGBT specific training and education.

What all this impressed upon me is the fact that our little organization need no longer work in a vacuum. Whether it's with our addiction professional allies or our LGBT sister organizations, we can form coalitions and collaborate with one another to help accomplish the goals we all have to make health care a safer, saner, environment for all LGBT clients. May the collaboration, cooperation and integration continue!

Sincerely,

Joe Amico, President *joecd1@aol.com*

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Addiction Psyciatric Help:
The Doctor is Out...

Although they are different diseases, there are many other parallels between addiction and BPD. They are both chronic diseases with a tendency toward relapse, usually brought on by denial. They are both about loss of control.

Dear Dr. Penny:

I have a friend I have known for six years. I met Marty in A.A., and we are both very involved in our home GL group, and other local groups. In addition to her alcoholism, she has bipolar disorder. She has a psychiatrist who prescribes many medications, but I'm not sure if she takes them regularly. Ever since I have known her, she has suffered with bouts of depression and times when she becomes irritable, racy and impossible to deal with. She has been in several relationships during her six years in recovery, but they have broken up after a few months, and when that happens she usually goes out drinking for a few days. Recently she lost her job due to her angry outbursts with co-workers and absenteeism. Since this happened she has started drinking again and is talking about suicide. Her friends, including me, have been trying to help, but we don't know what to do. Can you give us some advice?

— Concerned in Columbia

Dear Concerned:

One of the core principles of 12 Step and other recovery programs is the process of one person helping another and members providing mutual support based on a common understanding and purpose. This can become very complicated when a friend in the fellowship is also struggling with another chronic disease, especially when the illness manifests itself through puzzling and alarming behaviors. When a sober friend is talking or acting like she might be at risk of returning to using, other members feel comfortable reaching out, expressing concern, etc. But what if the friend's talk and behavior is not directly related to addiction, and also is frightening and sometimes downright irrational?

A first step in helping a recovering friend with bipolar disorder is to discuss with her (preferably when she is not in crisis) if and how she would like you to help— "How can I help you to keep your illness in stable remission?" Or "I'd like to be supportive with your bipolar disorder. What can I do?" Related questions might include, "What would be most useful to you when you are feeling down, despondent or hopeless?" or "Do you think it would help you if I pointed out when you get racy, irritable or unrealistic?"

Friends and family members often feel overwhelmed, confused and powerless in the face of some of the symptoms common in bipolar disorder (BPD). A few basic facts about the disease may help.

- BPD is a brain disorder which runs in families and in which imbalances in brain chemicals lead to severe mood swings, bouts of major depression and periods of increased psychic energy with speeded up thoughts, speech and actions. The imbalances probably involve the brain's chemical messengers or neurotransmitters, including serotonin, norepinephrine and dopamine. Fortunately, medications can go a long way toward stabilizing the mood and controlling these symptoms, although it usually takes a combination of different drugs.
- Unfortunately, denial plays just as big a role in BPD as it does in addiction. The person with BPD who is doing well may think, "Maybe I don't really need to take this medication. I wasn't really that bad, anyway." Does this sound familiar? Think: "Maybe I'm not a real alcoholic. I can have just one glass of wine, right?" A friend or family member may be able to help the person "think it all the way through," remembering what happened the last time she stopped her medication.
- Once the person has become severely depressed or manic, it may be too late to try to help with support and discussion. When someone

is not rational, it is not possible to reason with her! Once the person's thinking has become irrational, trying to "talk sense" into her is unlikely to work, and may only make things worse. Think how impossible it is to reason with someone who is intoxicated ("talking to a bottle"). At this point, outside medical help is needed to stabilize the person's brain. If the person is uncooperative, combative or actively self-destructive, it is best to call 911 and allow the police to subdue the sick person for her own protection.

Although they are different diseases, there are many other parallels between addiction and BPD. They are both chronic diseases with a tendency toward relapse, usually brought on by denial. They are both about loss of control. In alcoholism and other drug addiction, the affected individual has lost control over the use of substances. In BPD, the person has lost control over the chemical stability of his or her brain systems that manage mood, thinking, impulse control, judgment. In both disorders, people continue to engage in unhealthy behaviors in spite of negative consequences (in addiction, using; in BPD, not taking meds, not seeing therapists and psychiatrists, etc.) They both have distorted thinking, primarily denial, even when not in crisis.

What is driving this distorted thinking? In both cases, there is the human tendency to forget pain and minimize past difficulties. Probably more important is the desire to feel pleasure and other positive, rewarding emotions. In addiction, depending on the individual's choice of drug, this can include euphoria, excitement, relaxation, freedom from fear and worry, loss of inhibitions, relief of physical pain, etc. In BPD, the person desires to feel energized, excited, euphoric, productive, competent, attractive, not despondent or not empty. In both cases, the answer to the question, "Why would someone do that again (drink, take drugs, stop medications, etc.) when every time she did it before it resulted in disaster?" is "Because they want to feel good or feel better." And besides, in many cases, disaster doesn't happen every single time, and this reinforces the denial. Isn't this how we define insanity: doing the same thing over and over again, and expecting different results?

Other approaches that can help the person with both BPD and addiction are actually the same tools we learn in 12 Step programs that work so well to maintain sobriety. These include:

- Daily maintenance: Having addiction or BPD means having to take action every day to stay in recovery, including
- Asking for help
- Following directions
- Checking out plans and ideas with others (sponsor, friends, therapist, psychiatrist) before acting
- Developing spiritual connections and relying on a Higher Power (which can be God, the sponsor and group, one's psychiatrist, etc.)
- Taking personal inventory and taking responsibility for one's own actions
- Honesty, Openmindedness and Willingness
- Meetings: Depending on where you live, your friend might want to check out the availability of meetings for persons recovering from both addiction and BPD. These include Dual Recovery Anonymous (draonline.org), Double Trouble and others. In DRA, the only requirements for membership are a desire to stay sober and a desire to manage our emotional or psychiatric illness in a healthy and constructive manner. When recovering alcoholics/addicts with BPD attend these meetings and see others accepting and living with their BPD, a strong sense of relief, of belonging, and a new commitment to recovery is often the result. If you live in a smaller community where such meetings are not available, there are resources and meetings online that can really make a difference.

Other approaches that can help the person with both BPD and addiction are actually the same tools we learn in 12 Step programs that work so well to maintain sobriety.

—Penny Ziegler, M.D.
Addiction Psychiatrist