Transgender youth and addictions

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Addictions in the transgender population

The transgender population suffer from many public health problems including mental and physical health, addictions and substance use, suicides, verbal, physical and emotional abuse, eating disorders, discrimination, stigma and lack of social-economic equality including justice. The biggest oppression experienced by transgender people around the world is cisgenderism.

Addictions as a search term is broad, which allows for the most range in finding journal articles regarding transgender people. Most of the existing research is from the US, and all National Institute of Health funded research (1989-2011) on transgender issues (excluding HIV/AIDS) **accounts for only 0.1%** (n = 113) studies concern**ing** LGBT health, of the 113 studies **only 6.8% studied transgender populations** (Coulter, Kenst, Bowen, & Scout, 2014). Canada has most of the studies stemming from the Trans Pulse study based in Ontario.

Cisgenderism - the pathologizing (treating people's genders and bodies as disordered) and misgendering (disregarding people's own understanding and classifications of their genders and bodies). Cisgenderism often functions at systemic and structural levels that perpetuate and manufacture cisgenderism.

Transgender - refers to all individuals whose gender identity and/or gender expression does not match the societal norms connected to the sex that they were assigned at birth. Some individuals live outside the gender binary {non-binary, genderqueer, agender, genderfluid}

(Ansara, 2015; Carmel, & Erickson-Schroth, 2016; Kattari, Walls, Speer, & Kattari, 2016)

Addictions treatment facilities

Historically, the models of addictions treatment were developed for adult, cisgender (i.e., identifying with the binary male/female gender assigned at birth), heterosexual men, without regard for non-normative sexuality and gender

Addictions facilities are often not equipped to meet the unique needs of transgender individuals, and many transgender clients desire treatment programs that are sensitive to their specific experiences and deal with the realities they face in everyday society

Despite pronounced rates of alcohol and other drug (AOD) use, transgender individuals often forgo treatment in a predominantly cisgender, heterosexual setting, which contributes to negative treatment outcomes

When an Addictions counselor perceives their client's sexual orientation or nontraditional gender identity as the primary therapeutic concern (Broken arm syndrome), rather than the AOD abuse, the Addictions counselor fails to address important experiences and emotions surrounding the client's gender identity. Stigma and structural barriers include treatment provider attitudes.

3 major concerns of Addictions treatment facilities for transgender clients:
(a) being the recipients of verbal and physical abuse by other clients and staff
(b) being required to solely wear clothes judged appropriate for their sex assigned at birth
(c) being required to shower and sleep in areas judged to be appropriate for their sex assigned at birth

(Knutson, Koch, Arthur, Mitchell, Martyr, 2016; Lyons, Shannon, Pierre, Small, Krüsi, & Kerr, 2015; Oberheim, DePue, & Hagedorn, 2017)

Institutional erasure of transgender youth

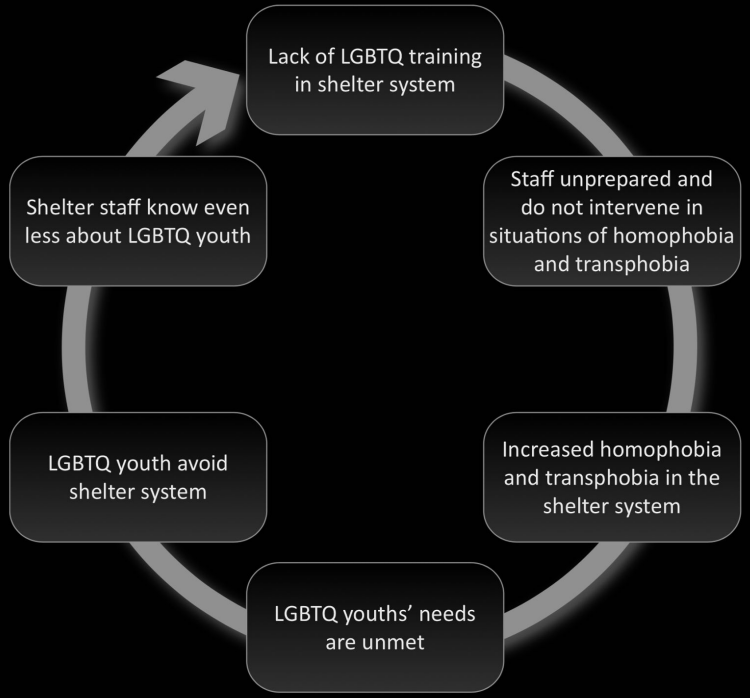

Figure 1. Cyclical nature of the relations.

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Institutional erasure is the conceptual and institutional relations that render transgender individuals invisible and non-existent.

LGBT training is often voluntary and therefore continues unsafe situations for LGBT youth (homophobia, transphobia, cisgenderism).

This often forces LGBT youth to hide their identities in order to receive help which leads to further adverse health and invisibility. The lack of support for LGBT youth adds to incidence rates of LGBT homelessness and substance use, risky sexual behaviour, victimization, and crime. All of these factors come together in adverse mental health.

(Abramovich, 2016)

The fuel to the fire, minority stress

Transgender individuals may have a high need for substance abuse treatment, but specific needs or profiles of transgender individuals in treatment are largely unknown or limited in study sample sizes.

Meyer's minority stress theory
originally developed to explain increased mental health and substance use risk among lesbian, gay, and bisexual individuals, which posits that members of minority groups may experience additional stress as a result of stigma associated with their minority group membership.

The prevalence of substance use among a diverse population of transgender youth, and risk factors that may mediate the relationship between gender identity and substance use is critical information for targeted prevention and intervention efforts.

Transgender mental health variables :
depressive symptoms, suicidality, alcohol or substance use, psychological distress, anxiety, quality of life, posttraumatic stress symptoms, HIV sexual risk, mental health or substance use services, disability status (physical and mental)

Transgender minority stress variables :
discrimination, violence, rejection, identity concealment, internalized stigma (transphobia)

(Valentine & Shipherd, 2018)

(Day, Fish, Perez-Brumer, Hatzenbuehler, & Russell, 2017; Flentje, Heck, & Sorensen, 2014)

The driving forces for addictions

LGBT youth who reveal their sexual orientation and/or gender identity to their friends and family often risk negative responses

Responses can range from acceptance and support, to tolerance or avoidance, to rejection and abuse.

Negative responses often have a devastating effect on the individual, particularly for youth who often do not have well-developed coping strategies, resources to be on their own, or other forms of social support.

Unique risk factors for substance abuse for LGBT individuals, such as **family rejection and lack of social support, stigma and minority stress, abuse and harassment**, may call for unique theoretical perspectives to guide the development and delivery of substance abuse treatment interventions for them

Higher levels of **family rejection** during one's adolescence is **significantly associated with poorer health** outcomes for young LGBT adults aged 21–25 years compared with non-LGBT adults aged 21–25 years.

Young LGBT are:

- **8.4 times more likely** to have **attempted suicide**
- **5.9 times** more likely to report high levels of **depression**
- **3.4 times** more likely to engage in **unprotected sex**
- **3.4 times** more likely to have used **illegal drugs**

(Scheim, Bauer, & Shokoohi, 2017; Stevens, 2012)

Drug use in transgender youth

Middle and high school students from a California substance use study **clearly show higher rates of use** despite being only 0.8% of the study population (n= 4778)

In a sample of youth (n= 155) recruited in New York and Los Angeles who had a history of prescription drug misuse, the authors showed that LGBT youth initiated misuse of opioid and tranquilizer medications at an earlier age than comparable heterosexual youth.

The misuse of prescription drugs has been linked to negative outcomes including dependence, overdose, and adverse drug interactions

(Benotsch, Zimmerman, Cathers, McNulty, Pierce, Heck, . . . Snipes, 2013)

Table 2. **Substance Use Among Transgender and Nontransgender Youth (N = 634,770)**

Variable	Overall (%)	Transgender (%)	Nontransgender (%)	Adjusted Odds Ratios
Lifetime substance use				
Cigarettes*	59,384 (9.4)	21.5	9.3	1.61 (1.45-1.79)
Tobacco*	23,554 (3.7)	11.8	3.7	1.72 (1.50-1.97)
Alcohol*	191,524 (30.3)	42.0	30.2	1.18 (1.09-1.28)
Marijuana*	131,586 (20.8)	33.1	20.7	1.32 (1.21-1.45)
Inhalants*	33,925 (5.4)	14.8	5.3	1.78 (1.58-2.00)
Cocaine/Methamphetamine*	14,525 (3.4)	13.1	3.3	2.53 (2.18-2.95)
Ecstacy*	21,434 (5.0)	14.5	4.9	1.89 (1.64-2.18)
Prescription painkillers*	53,507 (12.4)	23.2	12.3	1.47 (1.32-1.64)
Diet pills*	23,213 (5.4)	13.3	5.3	1.64 (1.43-1.88)
Ritalin or Adderrall*	18,811 (4.4)	12.9	4.3	1.93 (1.68-2.22)
Cold medicine*	167,382 (39.0)	40.0	39.0	.85 (.78-.93)
Other drug*	34,325 (8.0)	18.6	7.9	1.64 (1.46-1.86)
Past 30-day substance use				
Cigarettes*	24,625 (3.9)	14.0	3.8	2.14 (1.89-2.44)
Tobacco*	9947 (1.6)	8.9	1.5	2.48 (2.11-2.93)
Alcohol (1 drink)*	102,614 (16.3)	27.0	16.2	1.27 (1.15-1.39)
Alcohol (5 or more drinks)*	53,230 (8.4)	18.9	8.4	1.49 (1.33-1.66)
Marijuana*	69,021 (10.9)	22.6	10.8	1.54 (1.39-1.70)
Inhalants*	12,032 (1.9)	10.7	1.8	2.80 (2.41-3.26)
Prescription pain medication*	16,129 (3.8)	14.6	3.7	2.19 (1.90-2.53)
Other drugs*	16,003 (2.5)	11.9	2.5	2.44 (2.12-2.81)
2 or more drugs*	25,255 (5.9)	16.6	5.8	1.74 (1.51-1.99)
Substance use in school				
Cigarettes*	7598 (1.2)	9.6	1.1	3.37 (2.84-3.99)
Tobacco*	6763 (1.1)	8.5	1.0	3.08 (2.58-3.69)
Alcohol*	22,436 (3.6)	13.8	3.5	2.14 (1.87-2.44)
Marijuana*	11,072 (1.8)	10.9	1.7	2.88 (2.47-3.36)
Other illegal drugs	377,013 (60.0)	61.0	60.0	1.04 (.97-1.13)

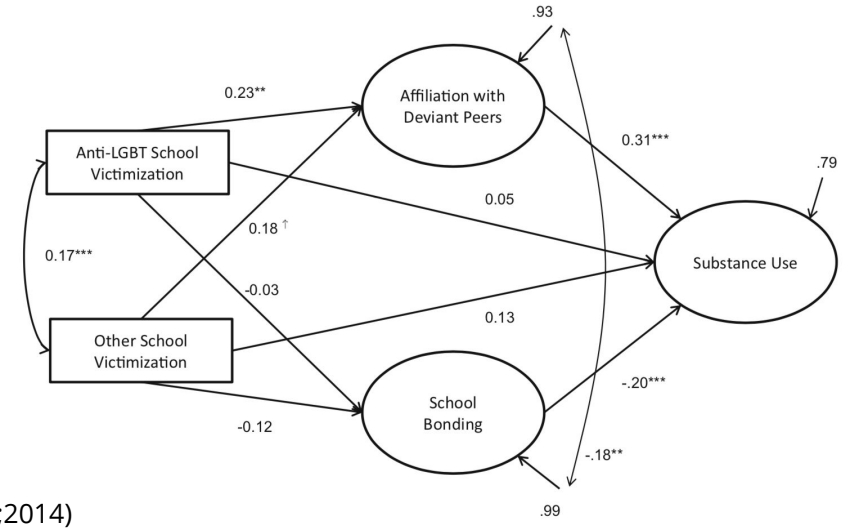
*p < .01.

(De Pedro, Gilreath, Jackson, & Esqueda, 2017)

School victimization and substance use in LGBT youth

LGBT adolescents do report less “school belonging” (a construct similar to “attachment” (having positive affect toward school and teachers)) relative to heterosexual students, resulting from school-based victimization. Commitment is an investment in doing well at school.

Fig. 1 SEM illustrating associations among victimization, school bonding, affiliation with deviant peers, and substance use. Note: Estimates illustrated are the standardized path coefficients from the SEM. $^{\dagger}p=0.06$; $*p<.05$; $**p<.01$; $***p<.001$



Sample n= 504,
7.1% transgender

Huebner, Thoma, & Neilands, (2015;2014)

31% Threatened or injured with weapon

69.4% been in physical fight

18.3% Binge drink (5+ drinks) in past year

48% had lies or rumors spread about them

Canadian transgender drug use in adults

Trans populations experience disparities in drug use related to social stigma and exclusion. Disparities in drug use may also be related to gender dysphoria, or psychological distress caused by lack of alignment between one's sex characteristics and gender identity.

Social stigma and exclusion have been associated with substance use among trans persons and may partially account for the higher levels of use observed.

Table 1
Past-year drug use among transgender Ontarians, by gender identity (n = 406).

	All Trans People		Transmasculine[a]		Transfeminine[a]	
	%	95% CI	%	95% CI	%	95% CI
Crack cocaine	2.4	(0.0, 4.9)	0.7*	(0.0, 1.5)	4.5*	(0.0, 9.7)
Powder cocaine	7.3	(3.3, 11.4)	9.4	(3.3, 15.5)	5.0	(0.0, 10.2)
Crystal methamphetamine	0.4	(0.0, 0.7)	0.4	(0.0, 0.9)	0.4	(0.0, 0.9)
Other amphetamine	1.6	(0.5, 2.7)	1.4	(0.0, 3.1)	1.9	(0.5, 3.4)
Ketamine	2.6	(1.1, 4.2)	2.9	(0.6, 5.3)	2.3	(0.3, 4.3)
Gamma Hydroxybutyrate (GHB)	0.6	(0.0, 1.4)	0.8	(0.0, 2.1)	0.4	(0.0, 1.0)
Heroin	0.6	(0.0, 1.4)	0.8	(0.0, 2.2)	0.4	(0.0, 1.2)
Non-medical use of prescription narcotics	6.2	(2.9, 9.6)	7.5	(2.6, 12.5)	4.7	(0.0, 9.6)
At least one of above		12.3	(7.7, 17.0)	13.2	(6.7, 19.7)	11.4 (4.3, 18.5)
More than one class of drug[b]	4.1	(1.7, 6.5)	5.2	(1.1, 9.4)	2.8	(0.8, 4.8)

[a] Transmasculine = assigned female at birth and identifies as male or masculine; transfeminine = assigned male at birth and identifies as female or feminine.
[b] Classes were defined as: cocaine (powder or crack), amphetamines, "club drugs" (Ketamine and GHB), and opiates (heroin, prescription narcotics).
* $p < 0.05$ for difference between transmasculine and transfeminine persons.

(Scheim, Bauer, & Shokoohi, 2017)

Drug use *within* transgender identities

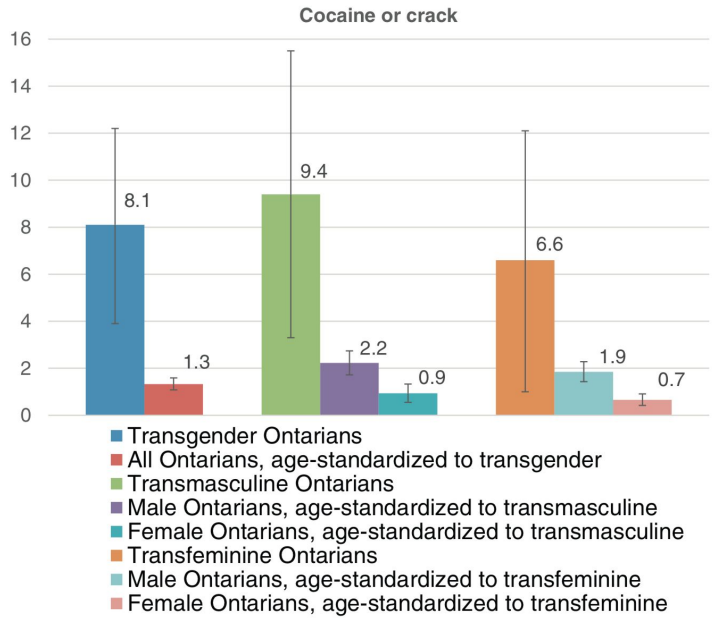


Fig. 1. Past-year cocaine or crack use among transgender Ontarians and the age-standardized Ontario population, 2009–2010.Note: Error bars indicate 95% confidence intervals.

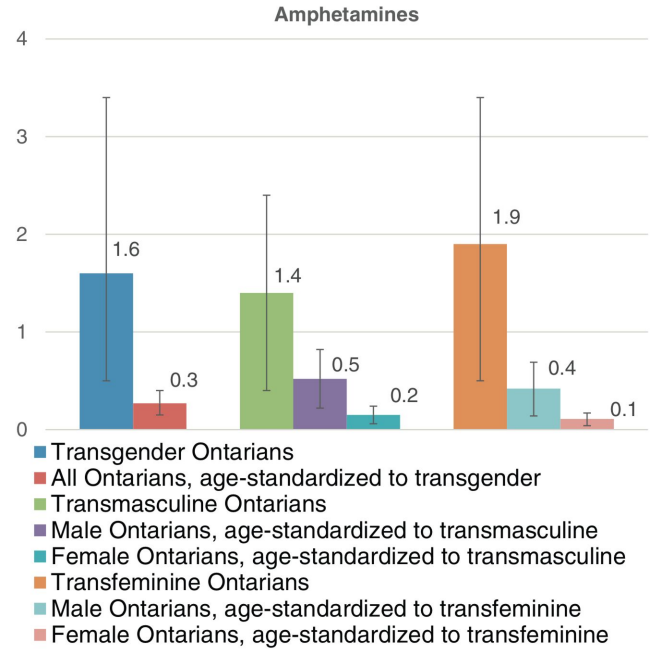


Fig. 2. Past-year amphetamine use among transgender Ontarians and the age-standardized Ontario population, 2009–2010.Note: Error bars indicate 95% confidence intervals.

24.7% of trans people in study have strong parental support for gender

17.6% are underhoused/ homeless

20.3% have experienced transphobic assault

12.8% have experienced transphobia

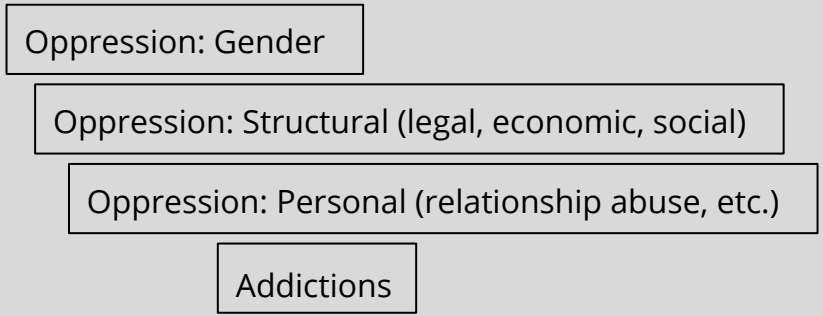
(Scheim, Bauer, & Shokoohi, 2017)

Theoretical explanations

Feminist theory

Considers the legal, economic, and social context of women's lives and the multiple oppressions

Does not specifically address the heightened and unique issues of sexism and oppression experienced by LBT women as does queer and transgender theory



Queer theory

Takes the position that gender roles, gender identity, and sexual orientations are social constructs and are open to questioning, subversion and self-construction.

Queer theory challenges heteronormative assumptions about sexuality

It is criticized for retaining the gender binary (M vs F) construction.

Queer theory excludes non-binary transgender individuals who live outside the gender binary.

(Stevens, 2012)

Relevance to Public Health

A biopsychosocial model of illness is often applied to understand addictions, including consideration of the relationship of demographic, gender-related, mental health, and socio-structural risk factors to substance use and addictions treatment

Substance use may be a means of coping with discrimination, as a national study found that 35% of transgender people who experienced school-related verbal harassment, physical assault, sexual assault, or expulsion reported using substances to cope with mistreatment. Transgender adults may **use alcohol and drugs to cope with stress from stigma** and discrimination throughout the life course

Transgender youth have higher odds of lifetime **alcohol use** than cisgender youth.

Suicidal ideation while drinking was also much more common among transgender-identified people than cisgender people.

Sexual assaults are more common among transgender people than cisgender, which is notable because cisgender females in the general population disproportionately experience sexual assault victimization.

Transgender female youth (age 16–24) are at high risk for **polysubstance abuse and HIV infection** with comorbid concerns such as **PTSD**, gender-related **discrimination, psychological distress, and parental drug and alcohol problems**

(Coulter, Blosnich, Bukowski, Herrick, Siconolfi & Stall, 2015; Keuroghlian, Reisner, White, & Weiss, 2015; Polak, Haug, Drachenberg, & Svikis, 2015)

The role of Addictions Professionals

Not all LGBT allies are equal in understanding heterosexism in treatment practice. Counselors as social agents are never neutral to the influences of sociopolitical **heteronormativity** which is a dominant force in society.

Heteronormative relationships and sexualities conform to the patriarchal ideal of sexual relationships based on heterosexual pairings, are nominally monogamous, and intended for procreation.

Heteronormative and **cisgender biases** often operate in collusion to create further oppressive beliefs and expectations.

Cisgender bias

based on beliefs and attitudes that emphasize rigid and deterministic gender binaries (i.e., man/woman), an emphasis on birth-assigned sex characteristics as determinants of gender identity, and patriarchal gender role conformity

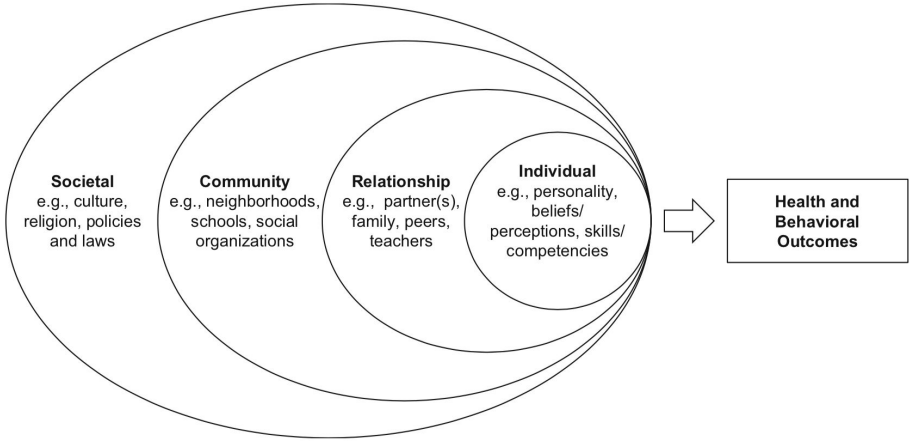
Transgender people are misunderstood and poorly treated in many (perhaps most) mainstream substance abuse treatment programs.

A key ingredient of these programs is counteracting internalized negative attitudes associated with being a sexual or gender minority.

(Moe, Finnerty, Sparkman, & Yates, 2015; Nuttbrock, Bockting, Rosenblum, Hwahng, Mason, Macri, & Becker, 2014)

Positive protective factors

Bronfenbrenner's Socioecological model for understanding the protective factors of reducing adverse health of transgender people



Community

- Trusted adults = supportive educators and staff, transgender role models, and helpful service providers, are protective.
- Peer support and networks has some evidence for being protective.
- School policies = School policies against bullying and LGBT inclusive curricula demonstrate some evidence of being protective

individual protective factors

- Beliefs/perceptions = self-esteem, body esteem, religiosity, positive sense of self, and self-efficacy.
- Skills/Competencies = ability to use internet or social media for information or support, problem solving skills, and self-advocacy skills

Relationship protective factors

- Parents & family = Family cohesion (i.e., strong familial ties) is associated with higher self-esteem, higher sexual self-efficacy

Societal

Transgender health and social services and organizational resources with support are protective factors.

(Johns, Beltran, Armstrong, Jayne, & Barrios, 2018; De Pedro, Gilreath, Jackson, & Esqueda, 2017)

Conclusion

Treatment programs alone cannot address economic, gender and socio-structural oppression that burdens many transgender persons but they do help reduce health burdens.

A cost-effective way to reduce drinking disparities may be to explicitly incorporate transgender and gender nonconformity issues into existing drinking and violence intervention prevention programs.

To improve the health and treatment outcomes of transgender populations, including those who use drugs, it is imperative to design and evaluate interventions and policies that include anti-stigma education.

Recommendations:

- Ensure emergency shelter beds are inclusive to LGBT+ youth
- Have LGBT+ health clinic
- Have LGBT+ inclusive intake forms
- Ensure staff are trained on LGBT+ issues and identities with mandatory and regular training sessions
- Ensure staff respect names and gender pronouns
- Have gender inclusive washrooms
- Have reference materials regarding access to transgender health services (hormones, legal name change forms and process, counselling, etc)

Addictions professionals:

- Understand the unique needs of transgender clients seeking treatment
- Have an inclusive and nonjudgmental attitude
- Examine personal beliefs about gender and transitioning

(Abramovich, 2016; Oberheim, DePue, & Hagedorn, 2017)

(Coulter, Blosnich, Bukowski, Herrick, Siconolfi & Stall, 2015; Lyons, Shannon, Pierre, Small, Krüsi, & Kerr, 2015)

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