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## Transgressing gender norms in addiction treatment: Transgender rights to access within gender-segregated facilities

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### ABSTRACT

Despite having disproportionately high rates of substance use disorder and co-occurring health and mental health issues compared to the general population, transgender individuals experience significant barriers to accessing and engaging in addiction treatment programs. Inpatient addiction treatment centers were originally designed to treat substance-dependent heterosexual cisgender populations and, as such, feature gender-segregated housing, bathrooms, and treatment sessions. The heteronormative structural and programmatic barriers, combined with exposures to stigmatic and prejudicial attitudes, may dissuade transgender populations from benefiting from the addiction treatment they so direly need. The purpose of this article is to examine the current policy debate surrounding the rights of transgender individuals in public accommodations in the context of inpatient addiction treatment centers.

### KEYWORDS

addiction treatment; policy;  
substance use disorder;  
transgender

Heteronormative perspectives remain deeply rooted in the present-day features of inpatient addiction treatment centers such as with gender-segregated residential housing, bathrooms, and group sessions (Herman, 2013). Gender-segregated structural and programmatic components are among a multitude of barriers that transgender individuals face when engaging in inpatient addiction treatment. Additional issues this population may face include the inability to continue hormone replacement therapy, the right to use their chosen name rather than birth name, exposures to stigma and discrimination, and cultural incompetence among staff and administrators (Eliason & Hughes, 2004; Herman, 2013; Holman & Goldberg, 2006; Sperber, Landers, & Lawrence, 2005). There is evidence that approximately 50% of substance-abusing and dependent transgender individuals are discouraged from seeking addiction treatment due to expectations of stigma (Cochran & Cauce, 2006; Lombardi & Van Servellen, 2000; Lurie, 2005; Sperber et al., 2005). This statistic is particularly alarming considering the high rates of substance use disorder (Operario, Nemoto, Iwamoto, & Moore, 2011;

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Operario & Nemoto, 2005; Ramirez-Valles, Garcia, Campbell, Diaz, & Heckathorn, 2008) and co-occurring mental health concerns within the transgender population (Budge, Adelson, & Howard, 2013; Clements-Nolle, Marx, Guzman, & Katz, 2001; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005; Mustanski, Garofalo, & Emerson, 2010; Nemoto, Bodeker, & Iwamoto, 2011).

Recently, there has been increased policy attention to the rights of transgender individuals in public accommodations, particularly surrounding North Carolina's House Bill 2, which seeks to deny transgender individuals the right to use bathrooms that correspond with their identified gender (Mallory & Sears, 2016). At the center of this and similar debates is the collision of traditional gender binary views with emergent perspectives that actively challenge conventional gender norms (Herman, 2013; Mizock & Hopwood, 2016). The results of such policy discussions could have significant ramifications for the policies and infrastructures of public and private institutions nationwide (Herman, 2013; Mallory & Sears, 2016).

The purpose of this article is to examine the current policy debate surrounding the rights of transgender individuals in public accommodations in the context of inpatient addiction treatment centers. To achieve this end, this article will (a) review key demographics, terminology, and characteristics related to the transgender population; (b) present minority stress theory as a framework for examining how discrimination within public accommodations can lead to substance use disorder and comorbid issues among transgender individuals; (c) examine the context of the policy debate around transgender-friendly bathrooms; and (d) examine the state of research regarding the effect of gender segregation on transgender populations in inpatient addiction treatment.

## Overview of transgender population

### Demographics

Recent estimates indicate that approximately 0.6% of adults in the United States (1.4 million individuals) identify as transgender (Flores, Herman, Gates, & Brown, 2016). Age is associated with the likelihood of identifying as transgender, with 0.7% of individuals age 18–24, 0.6% of individuals age 25–64, and 0.5% of adults age 65 and older identifying as transgender (Flores et al., 2016). The term *transgender* describes individuals whose gender identity is not congruent with their birth sex (Bockting, 1999; Mayer et al., 2008). Gender identity can be defined as an individual's perception of their gender, which can include female, male, both female and male, or neither female nor male (American Psychological Association Task Force on Gender Identity and Gender Variance, 2008). Gender expression involves how an individual

presents their gender (e.g., mannerisms, clothing), which may or may not be congruent with expectations based on the binary gender system (American Psychological Association Task Force on Gender Identity and Gender Variance, 2008). The gender binary system classifies behaviors related to gender and sexuality according to the assumed alignment between birth sex, gender, and sexuality (Nuttbrock, 2012).

### ***Gender identity and sexual orientation***

Scholarly attention pertaining to the intersections between gender nonconformity and sexual orientation has been increasing, particularly research examining the diversity of sexual identities among transgender populations (Meier & Labuski, 2013; Mizock & Hopwood, 2016; Nagoshi, Nagoshi, Terrell, & Brzuzzy, 2014; Reisner, Perkovich, & Mimiaga, 2010). This research demonstrates evidence of the fluidity of sexuality throughout the gender affirmation process (Diamond, Pardo, & Butterworth, 2011; Meier, Pardo, Labuski, & Babcock, 2013; Mizock & Hopwood, 2016; Nagoshi et al., 2014). Despite common errors with the conflation of gender identity and sexual orientation, being transgender does not directly correspond with being homosexual (Mizock & Fleming, 2011; Mizock & Hopwood, 2016).

Transgenderism challenges heteronormative institutions and gender binary beliefs (Mizock & Hopwood, 2016), and thus, it can be met with transphobia (Grant et al., 2011) along with homophobia based on a conflation of gender identity and sexual orientation (Mizock & Lewis, 2008). Experiences with transphobia and homophobia, along with the intersecting oppressive force of racism, are linked to health and mental health disparities among LGBT populations (Dilley, Simmons, Boysun, Pizancani, & Stark, 2010; Fredriksen-Goldsen et al., 2014; Grant, 2010; Institute of Medicine, 2011; Lee, 2000; Lenning & Buist, 2013; Nuttbrock, Rosenblum, & Blumenstein, 2002; U.S. Department of Health and Human Services (USDHHS), 2012).

### ***Addiction and co-occurring issues***

Transgender populations experience mental health issues at a higher rate than cisgender populations (Bockting, Miner, Swinburn-Romine, Hamilton, & Coleman, 2013; Fredriksen-Goldsen et al., 2014). Transgender individuals have high rates of depression (Budge et al., 2013; Clements-Nolle et al., 2001; Nemoto et al., 2011; Nuttbrock et al., 2010), anxiety (Budge et al., 2013; Hepp et al., 2005; Mustanski et al., 2010), substance use disorder (Operario & Nemoto, 2005; Ramirez-Valles et al., 2008), HIV and AIDS (Clements-Nolle et al., 2001; Edwards, Fisher, & Reynolds, 2007; Garofolo, Deleon, Osmer, Doll, & Harper, 2006; Herbst et al., 2008; Nuttbrock et al., 2009; Operario, Nemoto, Iwamoto, & Moore, 2011; Schulden et al., 2008),

and suicidal behaviors (Conron, Mimiaga, & Landers, 2010; Lee, 2000; Liu & Mustanski, 2012). Grant (2010) reports that 41% of transgender individuals reported attempting suicide compared to 2% of the U.S. general population. Lee (2000) attributes this increased risk of suicide to the repercussions of a lifetime of exposure to stigma and limited supportive resources.

### ***Gender identity development***

Transgender individuals often face challenges associated with navigating the complex process of gender identity development and affirmation, whereby they attempt to resolve an inner conflict regarding a perceived misalignment of their “psychological gender” and their “biological sex” (Diamond & Butterworth, 2008). Transgender individuals may or may not choose to identify as exclusively either male or female (Valentine, 2007, p. 33) or to transition into male or female sexual identities via sexual reassignment surgery and/or hormone replacement (Horvath, Iantaffi, Swinbrune-Romine, & Bockting, 2014). Regardless of their choice to live in or out of the gender binary, transgender individuals face significant minority stressors that place them at increased risk of health and mental health issues (Bockting et al., 2013; Fredriksen-Goldsen et al., 2014; Horvath et al., 2014). Such minority stressors are composed of internal stressors related to gender identity development and external forces of stigma and discrimination (Cashore & Tuason, 2009; Devor, 2004; Levitt & Hiestand, 2005; Levitt & Ippolito, 2014a, 2014b).

## **Theoretical framework**

### ***Minority stress theory***

Illan Meyer’s minority stress theory is an explanatory framework for understanding how chronic societally based stressors can lead to health risks among minority populations (Meyer, 2003). Studies indicate that chronic exposures to prejudice, discrimination, and maltreatment render sexual minorities at high risk for negative health outcomes (Herman, 2013; Kertzner, Meyer, Frost, & Stirratt, 2009; Meyer, 2003). Specific stressors that transgender individuals face include barriers to obtaining gender-affirmative state- and federal-issued identification, accessing transgender-affirmative health care, accessing gender-segregated public accommodations, and gaining full federal protections from discrimination (Badgett, Lau, Sears, & Ho, 2007; Cahill, South, & Spade, 2000; Johnson, 2013).

Despite research that indicates high levels of discrimination and violence toward transgender populations (Diaz, Ayala, Bein, Henne, & Marin, 2001; Factor & Rothblum, 2008; Gordon & Meyer, 2007; Grant et al., 2011; Mizock & Lewis, 2008; Stotzer, 2009), there has been limited research that applies minority stress theory to the experiences of transgender individuals (Garofalo,

Emerson, & Mustanski, 2010; Herman, 2013; Kelleher, 2009). Minority stress theory provides a framework for understanding substance use among transgender populations as a maladaptive behavioral response for coping with stressors related to their gender identity (D'Augelli, Grossman, & Starks, 2006; Friedman, Koeske, Silvestre, Korr, & Sites, 2006; McCabe, Bostwick, Hughes, West, & Boyd, 2010; Meyer, 2003). Specifically, there is a need to apply minority stress theory to further contextualize transgender experiences within gender-segregated public accommodations such as inpatient addiction treatment centers (Garofalo et al., 2010; Herman, 2013; Kelleher, 2009). This includes gathering data on the prevalence, frequency, and types of stressors experienced by transgender populations in inpatient addiction treatment and measuring related effects on client treatment retention and completion.

### **Transgressing gender norms**

The rapid evolution of gender as a social construct has been challenging essentialist ideas that place gender identity, gender roles, gender expression, and sexual orientation within the gender binary (Mizock & Hopwood, 2016; Nagoshi et al., 2014). Gender norms are social expectations around an individual's roles and behaviors based on a gender binary understanding of sex and gender (Mizock & Hopwood, 2016; Nagoshi, Brzuzy, & Terrell, 2012; Nagoshi et al., 2014; Norton & Herek, 2013). Transgenderism transgresses the gender binary by presenting variations in gender identity and behavior (Mizock & Hopwood, 2016; Nagoshi et al., 2014; Stryker, 2008; Williams, Weinberg, & Rosenberger, 2013).

Challenging conventional gender norms can trigger public fear based on perceived threats to heteronormative patriarchal systems of privilege, which can lead to the transphobic mistreatment of transgender and gender nonconforming individuals (Mizock & Hopwood, 2016). Transphobia involves stigma, prejudice, and violence toward transgender individuals (Grant et al., 2011; Mizock & Hopwood, 2016; Mizock & Lewis, 2008). The transgressing of traditional gender norms by transgender populations is central to the present debate regarding transgender individuals' rights within public accommodations. Furthermore, this debate must consider how transphobic and homophobic exposures within gender-segregated public accommodations affect the mental and behavioral health of transgender individuals.

### **Transgender access to gender-segregated bathrooms**

#### **Background**

There is a long history of segregation of bathroom facilities in the United States. In 1887, Massachusetts became the first state to require gender-segregated bathrooms as a reaction to women entering the workplace. In

1896, the Supreme Court ruling in *Plessy v. Ferguson* concluded that racial segregation is legal in all public spaces, including bathrooms. The segregation of bathrooms by race continued until the Civil Rights Act (1964), which banned segregation in public facilities based on race and national origin. The Americans with Disabilities Act (1990) provided disabled individuals with more accessible public restroom options.

There are a multitude of facilities and spaces throughout the United States that are gender segregated with the intention of providing a sense of safety and privacy to male and female patrons alike (Herman, 2013). Gender binarism is central to gender segregation in that individuals are expected to use a bathroom that aligns with the sex they were assigned at birth, to the exclusion of transgender and gender nonconforming populations. Recently, transgender activists and allies have been advocating for the right of transgender individuals to access bathrooms that correspond with their gender identity. Despite some recent legislative advances in promoting equal access to public accommodations regardless of gender identity, bathrooms continue to marginalize transgender and gender nonconforming individuals. There is currently no federal or state legislation that grants and protects the rights of transgender individuals to use bathrooms that align with their gender identity. Without this protection, transgender individuals continue to face the risk of harassment, discrimination, and violence within public bathrooms.

### ***Effect of gender-segregated facilities on transgender populations***

There is evidence of bias against transgender individuals in residential social service centers relating to gender-segregated facilities (Herman, 2013; Minter & Daley, 2003; Mottet & Ohle, 2003; Stotzer, Silverschanz, & Wilson, 2013). Herman (2013) conducted a Washington, DC-based survey using convenience sampling to explore the experiences of transgender and gender nonconforming individuals in bathrooms. The study found that 70% of respondents reported being denied access to or being harassed when trying to use bathrooms that aligned with their gender identity (Herman, 2013). The Transgender Law Center (TLC) partnered with the National Center for Lesbian Rights (NCLR) to conduct a San Francisco-based survey of transgender individuals around their experiences with gender-segregated restrooms (Minter & Daley, 2003). The results found that 63% of respondents reported experiencing harassment within and/or denied access to bathrooms (Minter & Daley, 2003). Cavanagh (2010) published *Queering Bathrooms: Gender, Sexuality, and the Hygienic Imagination*, which brought attention to findings from 100 interviews with LGBTI individuals who reported widespread experiences with prejudice and discrimination within bathrooms.

The cumulative effect of initial research efforts serves as a starting point for gathering evidence around the effects of gender segregation on transgender

populations. These studies present limitations in generalizability due to sampling methods and geographical constraints. Further examination is also needed to determine the additional effect of racism on discriminatory experiences within gender-segregated public accommodations.

### **Gender-segregated addiction treatment centers**

There remains a high rate of substance use disorder within the transgender population (Operario et al., 2011; Operario & Nemoto, 2005; Ramirez-Valles et al., 2008), yet they have numerous problems engaging in addiction treatment (Cochran & Cauce, 2006; Lombardi & Van Servellen, 2000; Lurie, 2005; Sperber et al., 2005). It is estimated that approximately 50% of transgender individuals avoided addiction treatment because of anticipated exposures to stigma (Cochran & Cauce, 2006; Sperber et al., 2005).

Inpatient addiction treatment programs have been designed to treat cisgender populations, leaving addiction facilities underprepared to serve transgender populations (Mayer et al., 2008). As a result, transgender individuals face unique barriers when seeking and engaging in addiction treatment, including gender-segregated treatment, institutional biases, and stigmatized beliefs among health care professionals (Cochran & Cauce, 2006; Eliason & Hughes, 2004; Herman, 2013; Holman & Goldberg, 2006; Lombardi & Van Servellen, 2000; Lurie, 2005; Lyons et al., 2015; Senreich, 2011; Sperber et al., 2005; Stotzer et al., 2013).

Unfortunately, research indicates a lack of cultural competence among addiction treatment staff leading to potentially ineffective if not harmful outcomes for transgender clients (Lyons et al., 2015; Nuttbrock, 2012; Rachlin, Green, & Lombardi, 2008). Rachlin et al. (2008) indicate that less than 5% of counselors and administrators in addiction treatment programs are formally trained to provide culturally competent care to transgender populations. In a qualitative study using in-depth semistructured interviews with 34 transgender individuals in Vancouver, Canada, Lyons et al. (2015) found that “enacted and felt stigma” experienced by transgender individuals can result in negative treatment experiences. Lyons et al. (2015) identified that participants who reported stigmatized experiences were more likely to leave treatment prematurely compared to participants who felt supported within the treatment process.

In his seminal work on stigma, Goffman (1963) characterized a stigmatized individual as being perceived by those within dominant social groups as having “an undesirable difference.” Link and Phelan (2001) furthered this claim and conceptualized stigma as manifesting in individual, interpersonal, and structural forms. Specific to stigma-based barriers to engaging in and benefiting from addiction treatment, transgender populations must contend with interpersonal stigma among treatment providers and client populations



as well as structural stigma through transphobic institutional policies (Lyons et al., 2015; Senreich, 2011). Interpersonal and structural stigmatic exposures can, in turn, deepen internalized stigma, reinforcing a lifetime of experience with societal transphobia (Bradford et al., 2013; Cruz, 2014), potentially triggering an exacerbation of substance use issues—the very problem for which transgender individuals sought treatment.

### ***Recommendations for inpatient addiction treatment service providers***

Central to the gender-segregated components of inpatient addiction treatment are the persisting stigmatizing attitudes and beliefs of a cisnormative society manifesting within an institutional setting. This includes transphobic stigma and discrimination delivered through structural and interpersonal means. To provide for greater inclusivity of the transgender population within inpatient addiction treatment, there is a need to address both structural and interpersonal forms of transphobic stigma. First, this includes dismantling institutional policies around gender segregation that alienate and discriminate against transgender populations. This includes policies that conflate sex and gender, designating transgender individuals to facilities and program components on the basis of their birth sex as opposed to identified gender. In addition, structural transphobia within inpatient addiction treatment centers can exist in the form of a lack of protections for transgender populations. Thus, explicit policies should be instituted or enhanced to provide full protections for transgender clients against discrimination or violence, including related to their right to use facilities and participate in treatment components that align with their gender identity and their right to gender expression. Finally, inpatient addiction treatment centers should seek to reduce stigma toward transgender populations among staff through supervision and training on effective clinical work with transgender populations. There remains a need for stronger institutional commitments to ensuring the provision of culturally competent services to transgender populations in addiction treatment, including creating accountability for staff to confront their stigmatizing beliefs and to build the necessary skills, sensitivities, and knowledge for effective work with this high-risk population (Burdge, 2007; Eliason & Hughes, 2004; Lurie, 2005).

### **Conclusion**

The growing public discourse around the rights of transgender individuals in public accommodations indicates an immediate need for public and private institutions to examine their policies around gender-segregated facilities. For inpatient addiction treatment centers, this includes a need to examine how gender-segregated structural and programmatic components marginalize

transgender clients and affect their treatment outcomes. Current research indicates that addiction treatment centers do not adequately support the needs of transgender populations due to heteronormative institutional practices, gender-segregated structural barriers, and cultural incompetence among staff and administrators (Cochran & Cauce, 2006; Eliason & Hughes, 2004; Herman, 2013; Holman & Goldberg, 2006; Lombardi & Van Servellen, 2000; Lurie, 2005; Lyons et al., 2015; Senreich, 2011; Sperber et al., 2005; Stotzer et al., 2013).

There are opportunities for research around the gender-segregated structural and programmatic barriers faced by transgender individuals in addiction treatment. This includes examining the effect of gender segregation in public accommodations on the mental health, behavioral health, and substance use behaviors of transgender individuals. Quantitative research is particularly needed to understand the prevalence, frequency, and types of distal stressors experienced by transgender populations in inpatient addiction treatment and the ramifications to client treatment retention and completion. There is also a need for research exploring the relationship between structural transphobic stigma, interpersonal transphobic stigma, and internalized transphobic stigma among transgender clients in addiction treatment. Research should also explore the extent to which transgender-specific programs are more, equally, or less effective than efforts to integrate transgender individuals into general addiction treatment populations. In addition, research should consider the intersectionality of gender identity with race, sex, and class as correlates with the experience of minority stress within gender-segregated settings. Finally, there should be ongoing scholarly discourse around and critique of the gender binary system for its marginalizing effects on transgender and gender non-conforming individuals (Burdge, 2007).

For three decades, addiction treatment centers have significantly evolved in their approach toward inclusivity, initially promoting ethnic diversity (Philleo & Brisbare, 1997), later expanding toward women (Stevens & Wexler, 1998), and most recently toward sexual minority populations (Van Den Bergh & Crisp, 2004). However, to advertise inclusivity with the absence of policies that protect the safety, growth, and integrity of all clients is to provide a false promise to referring professionals and current and prospective clients alike. It is vital that the scholarly community produce research around the effects of gender segregation to inform the development of policy and practices that can improve the addiction treatment experiences of transgender populations.

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