Promoting Inclusion: Best Practices for Substance-Dependent LGBTQ Clients

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Introduction

In spring 2012, MRC intern Liam Bugelhol constructed a survey that was designed to gather data from former clients of Portland-area drug and alcohol treatment programs who identified as being LGBTQ. From the data, six recurrent themes were found regarding their experiences:

1. The need to provide alternatives to hetero-normative language and pronouns in treatment settings.
2. The prevalence of hetero-normative rules and invisibility of LGBTQ clients in treatment communities.
3. The importance of fostering openness in disclosing orientation and safety.
4. A stronger need for LGBTQ education/training for staff and clients.
5. How LGBTQ counselors, supports, and community can enhance treatment experiences.
6. Building on strengths, impact of environment in fostering strengths

Purpose

In addition to providing general information regarding LGBTQ individuals in recovery, this presentation will address each of the above stated themes, presenting the data from survey respondents and some of the academic literature surrounding the topic.

About the General Population

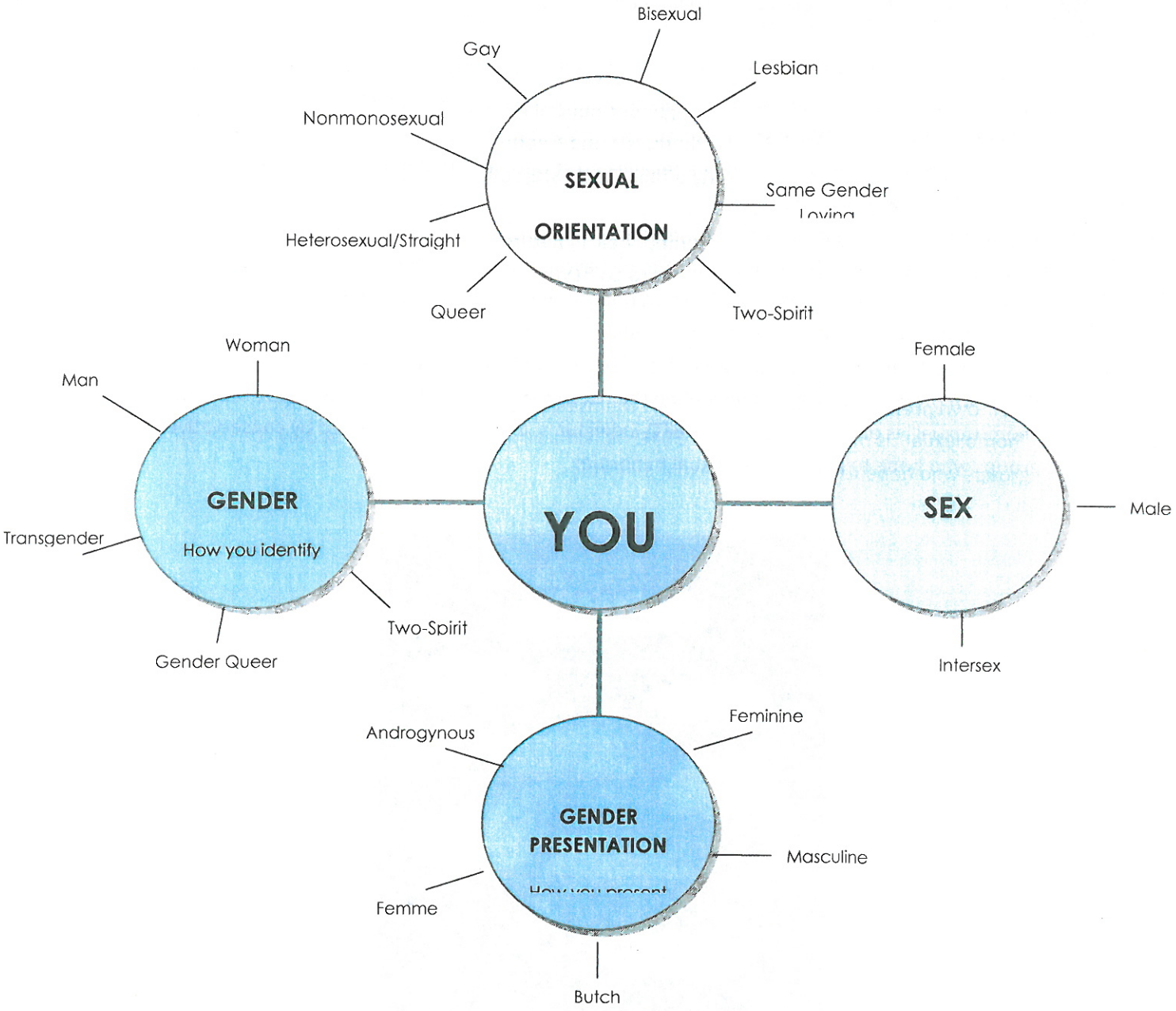
- According to most data, one in ten persons in the United states experience some form of substance dependence or abuse, but within the LGBTQ population, that ratio is closer to one in three (Senreich 2009, Kominars 1996).
- Two reasons are commonly cited to help explain why there are higher rates of substance abuse and dependence within the LGBTQ community: 1. That LGBTQ persons use as a means to medicate feelings of isolation, anger, confusion, and grief that are brought on by larger society's intolerance of sexual minorities, and 2. That many of the social outlets offered to LGBTQ individuals have a high prevalence of substance use (bars, parties, raves, etc.)

- In one study, it was found that LGBTQ individuals had significantly lower treatment retention rate than their heterosexual counterparts, and also felt significantly lower levels of connection with their treatment communities (Senriech 2009).

To understand the complex issues facing LGBTQ individuals in treatment, a few definitions are important to know:

Cultural Competence: The ability to interact effectively with persons from various demographics and backgrounds.	**Cultural Humility:** Preferable over "cultural competence". A lifelong commitment to self-exploration and evaluation of one's understanding of other cultures and backgrounds. Does not assume that one can achieve a complete and comprehensive understanding of a culture outside their own.
LGBTQIA: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual. This acronym is not all-inclusive. Additional classifications can be found, such as Two-Spirited (primarily used in American Indian communities), ally, bi-gendered, cis-gendered, pan-sexual, Curious, and many others.	**Homophobia:** The irrational fear of gayness or same-sex loving; (Brown and Zimmer 1986) define this operationally as the fear and hatred of same-sex intimacy, love, sexuality, and relationships, and those individuals and institutions that participate in, affirm, and support same-sex relating. Homophobia also manifests itself as hatred, revulsion, disgust, and culturally sanctioned prejudice and violence (Kominars 1996).
Heterosexism: The assumption that heterosexuality is superior to homosexuality. In many instances, homophobia is an intentional attitude of hatred toward LGBTQ individuals, while heterosexism can be more unintentional or passive.	**Ally:** Someone who actively confronts heterosexism and participates in causes that support the wellbeing and advancement of LGBTQ persons.
Transition: As described by UC Davis's LGBTQ resource center: An individualized process by which transsexual and transgender people 'switch' from one gender presentation to another. There are three general aspects to transitioning: social (i.e. name, pronouns, interactions, etc.), medical (i.e. hormones, surgery, etc.), and legal (i.e. gender marker and name change, etc.). A trans* individual may transition in any combination, or none, of these aspects.	**Internalized homophobia:** The internalization of harmful societal myths, prejudices, and hatred toward LGBTQ persons by someone who is themselves homosexual or non-heterosexual.

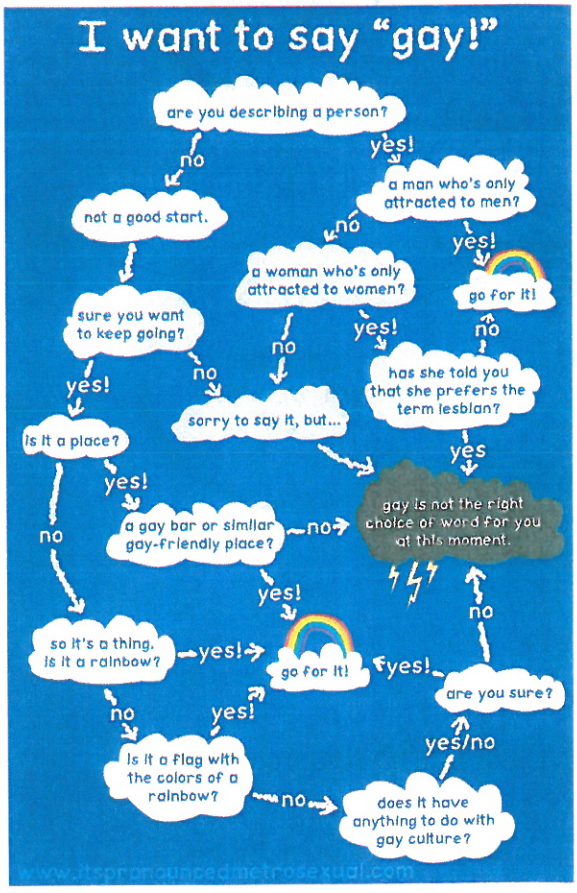
http://www.nohomophobes.com



Above image courtesy UC-Davis LGBTQ resource center

Hetero-normative language and pronouns

- In order to provide a setting in which an LGBTQ individual will feel comfortable in disclosing their orientation, it is essential to use gender-neutral language and avoid assumptions regarding a client's background. While some therapists and treatment staff may pride themselves in having a "gaydar", this is in actuality a reliance on stereotypes that may lead to harmful consequences (Kominars 1996).
- When clients use language that is homophobic in nature, it is essential to interrupt this language immediately, though it is also important to go beyond the statement that the language is "inappropriate". This may be an important opportunity for the client to receive education on why this language is harmful to the community as a whole.
- It is vital that treatment staff allow clients to self-identify, as LGBTQ individuals will likely have their own preference on how they define themselves (SAMSHA 2009). For example, the term "homosexual" is offensive to some LGBTQ individuals, as it has been coopted by conservative groups who hope to pathologize sexual minorities.



"No Homo" - Masculinity, Homophobia, and Hip-Hop Culture:
http://www.youtube.com/watch?v=84wHXT2KgWY

From our Portland survey:

1. *I was in a youth program. Staff got to choose what pronouns they used for me based on their own comfort. All the other clients were on board and respected me though. It created a weird dynamic.*
2. *Counselors could be more aware of pronouns in group settings.*
3. *.....Also the general invisibility that most gay people feel due to language. Pronouns, or counselors in group speaking to us regarding husbands and boyfriends. In the twelve months I was there, there were only two instances (out of sixteen groups a week) that a counselor included "girlfriends" when talking about spouses/SO's.*

Hetero-normative rules and invisibility

- While appropriate verbal communication is essential to providing a safe environment for LGBTQ individuals, it is equally important to remain attentive to non-verbal signs of affirmation (SAMSHA 2009). How might a LGBTQ individual know that she or he has entered a safe place based on the décor of the front lobby of your agency? Your office?
- Some treatment staff prioritize conventional alcohol and drug treatment over assisting a client to process feelings regarding their sexual orientation, though the research indicates that assisting individuals to live comfortably as a sexual minority is essential work in order to maintain sobriety (Kominars 1996).
- Alcohol and drug treatment is often centered on the development of a clean and sober network of support. This is no exception for LGBTQ individuals, though there are important considerations that must be made in working with this population. LGBTQ persons may feel more comfortable in connecting with a member of the opposite sex, allowing them to avoid instances of sexual attraction. The literature also indicates that LGBTQ individuals may benefit more from developing relationships with persons who have a high level of psychological health, than connecting with a heterosexual person in traditional recovery (Cabaj et al 2009).
- Limitations exist within many of the traditional treatment modalities: Moral Model (may reinforce feelings of shame/guilt, bases morals on heterosexual assumptions), Medical Model (many LGBTQ individuals wish to avoid adding additional titles and labels), Spiritual Model (many LGBTQ persons have negative associations with religion/spirituality), Social Learning Model (does not account for hereditary factors of addiction, and may result in self-shame for behaviors that LGBTQ persons have needed to adopt in order to survive).
- Many treatment modalities rely on human lifecycle principles to guide treatment that may have heterosexist implications.

Make Homosexuals Marry Gay Ad
http://www.youtube.com/watch?v=9REAB1bBrHc

From our Portland Survey:

1. *I felt accepted a lot of the times, once we got to a place where we realized that we benefit from finding our similarities and not our differences. I began to relate and bond with people who I'd never consider partying with, that's for sure. One difficulty for me was the rules that separated the men and the women. All justifications for these rules came from a hetero-normative place. This didn't make sense for me, to not be allowed alone with a man, but I could be with a woman, which was intended to prevent sexual activity. All that did for me was make it easier to engage in sexual activity.*
2. *Being open about my sexual orientation with individuals or coming out to my mom was difficult in treatment because they promote honesty and letting go of shame all the while making you feel ashamed for who you are.*
3. *The hetero-normative rules regarding gender just made no sense for me. It wasn't a barrier so much as it was just some annoying reminder that I was "different". Not being allowed to sit down with a man in his room to talk about sobriety because he had a penis and I had a vagina, but I was totally allowed to share a room with, get naked, or whatever with another woman, was a glaring message that I wasn't taken into consideration when people made these rules.*
4. *I felt like I could not be open about it. There was enough confusion about my gender, let alone my sexual orientation.*

Openness in Disclosing Orientation and Safety

- Many treatment staff may not be familiar with the coming out process, though they may play an important role in assisting clients to work through the stages, which will in turn provide the client with a much better chance of remaining sober.
- It is also important to remember that coming out is not always a linear process. LGBTQ individuals must make choices about disclosure throughout their lives.

Stages of Coming Out

Stage I: Identity Confusion *Occurs when a person begins to realize that he or she may relate to and/or identify with being gay or lesbian; a process of personalizing the identity.* ***Tasks:*** *Exploration and increasing awareness* ***Feelings:*** *Anxiety, confusion* ***Defenses:*** *Denial* ***Recovery:*** *Having a confidential support person*

Stage II: Identity Comparison *Occurs when a person accepts the possibility that he or she might be gay or lesbian.* ***Tasks:*** *Exploration of implications, encountering others like oneself* ***Feelings:*** *Anxiety, excitement* ***Defenses:*** *Bargaining and rationalizing* ***Recovery:*** *Meeting gays and lesbians in recovery*

Stage III: Identity Tolerance *Occurs when a person comes to accept the probability that he or she is gay or lesbian.* ***Tasks:*** *Recognizing one's social and emotional needs as a gay man or lesbian* ***Feelings:*** *Anger, excitement* ***Defenses:*** *Reactivity* ***Recovery:*** *How to be gay or lesbian and stay sober*

Stage IV: Identity Acceptance *Occurs when a person fully accepts rather than tolerates being gay or lesbian.* ***Tasks:*** *Development of community and acculturation* ***Feelings:*** *Rage, sadness* ***Defenses:*** *Hostility toward straight culture* ***Recovery:*** *Lesbian and gay recovering community building*

Stage V: Identity Pride *Occurs when a person immerses himself or herself in the lesbian and gay community and culture to live out his or her identity.* ***Tasks:*** *Fully experiencing being gay or lesbian, confronting internalized homophobia* ***Feelings:*** *Excitement, focused anger* ***Defenses:*** *Arrogant pride and rejection of straight culture as the norm* ***Recovery:*** *Sexuality, identity, and recovery*

Stage VI: Identity Synthesis *Occurs when a person develops a fully internalized and integrated lesbian or gay identity and experiences himself or herself as whole when interacting with others in every environment.* ***Tasks:*** *Coming out as fully as possible; having an intimate gay or lesbian relationship; self-actualization as a gay man or lesbian* ***Feelings:*** *Excitement, happiness* ***Defenses:*** *Minimal* ***Recovery:*** *Maintenance (end stage)* Adapted from Cass, 1979.

- While coming out may play an essential role in enhancing a client's recovery, it is vital that treatment staff consider the client's safety within her/his current environment. Coaching a client to come out before the client is ready, or asking them to embrace their identity in an environment that is not supportive may not be appropriate, productive, or safe in all contexts.

MACKLEMORE & RYAN LEWIS - SAME LOVE feat. MARY LAMBERT (OFFICIAL VIDEO): http://www.youtube.com/watch?v=hIVBg7_08n0

From our Portland Survey:

1. *Some clients questioned my religious preference. No one really had a problem with my sexual orientation.*
2. *The clients were open- minded. They saw and understood that I identified differently than they did.*

From a Survey Conducted in New York City:

1. *"Coming out", as encouraged by counselors made my time difficult to say the least. Several instances of harassment occurred. Counselors finessed this abuse by asking me to accept these incidents as outside/real world situations that I must confront and deal with, and I needed to "work on these issues". Necessary? I think not. Painful / hurtful / upsetting? Yes.*

LGBTQ Education/Training for Staff and Clients

- Self-awareness on the part of treatment staff is an important component to working with LGBTQ clients. While staff may support LGBTQ causes, identify as an ally, or even have LGBTQ friends, they may experience a surprising reaction when they witness a same-sex display of affection, or when a client discloses her/his sexual activities. Therefore, it is important that staff prepare themselves for these reactions by not only by attending trainings or seminars related to LGBTQ issues, but make also conscious efforts to expose themselves to LGBTQ cultural (Kominars 1996).
- It is also that treatment staff are aware of strengths and areas for growth in creating an affirming environment.

Anti-LGBT Treatment	Traditional Treatment	LGBT-Naive Treatment	LGBT-Tolerant Treatment	LGBT-Sensitive Treatment	LGBT-Affirming Treatment
No LGBT sensitivity	No LGBT sensitivity	No LGBT sensitivity	Minimal LGBT sensitivity	Moderate level of LGBT sensitivity	Highest level of LGBT sensitivity
Antagonistic toward LGBT individuals	No realization that there are LGBT clients	Realization that there are LGBT clients	Recognition that there are LGBT clients	Several clients and/or staff are open with their LGBT identity	Program primarily targets LGBT population
Treatment focuses exclusively on heterosexuals and excludes LGBT clients	No acknowl-edgment or discussion of LGBT issues; it is assumed everyone is heterosexual	As an agency, has not yet begun to address the special issues of the LGBT population	Some staff may verbalize that it is okay to be an LGBT individual; however, such discussions are limited to individual sessions	Several workshops and/or groups focus on LGBT issues; they may have LGBT groups or a "track" for LGBT issues; groups are generally mixed	All workshops specifically for LGBT clients; workshops and groups affirm the LGBT individual, have LGBT-specific materials, etc.; groups and workshops are not mixed with heterosexuals
No specific LGBT treatment components	No specific LGBT treatment components	No specific LGBT treatment components	No specific LGBT treatment components	Some specific LGBT treatment components	All treatment components are LGBT specific

Adapted from Neisen, 1997

- Heterosexist and homophobic attitudes can also prevent heterosexual clients from treatment success, as many gender stereotypes support behaviors that perpetuate maladaptive behaviors. For example, hyper-masculinity (an exaggeration of masculine stereotypes that includes violence toward women) can be countered by an understanding that men are capable of a broad range of emotions and behaviors that does not threaten their sexuality.

Miss Representation Extended Trailer:
http://www.youtube.com/watch?v=S5pM1fW6hNs

From our Portland Survey:

1. *There was no education for the clients about LGBT issues because they were wrong and needed to be changed.*
2. *There was an incident where another (female) client grabbed my breast. That client left before staff had a chance to do anything about it. A week later another client did it as a "joke", in reference to the initial incident and the staff response/reaction was to have that client, myself, and a counselor meet in the office where the counselor asked me (in front of the other clients) what I thought they should do. Did I want them to discharge her? And they did not follow up with me individually in any way, regarding how I felt about the incidents. I had a roommate that wanted to move out of my room because I was gay. A couple of clients said extremely graphic things that they wanted from me. When the breast grabbing incidences happened I had several people ask me "you didn't do anything to make her think that would be okay?" My roommate (the homophobic one) said she didn't believe I didn't encourage that. Mostly I felt as though my peers treatment me like they had never met a gay person before.*
3. *For the first few months I was hesitant to mention anything about my sexual orientation. I was very afraid of making anyone uncomfortable. I was approached sexually by a lot of clients when I did not yet have the tools to set boundaries with them, which was very uncomfortable and in one instance led to a physical relationship that I felt very pressured into. Fortunately the counselors sensed something, but had no proof of anything, so they just restricted us from being alone together, even in a communal room such as the dining room.*
4. *People need to be trained on how to work with LGBT, especially transgendered individuals. An open and accepting stance should be taken where we are embraced, not merely an attitude of tolerance. MORE SAFETY assurances* [are needed].
5. *Educate staff. Have forms that ask about gender identity versus the "male/female" options. Create a culture among clients that they have to be respectful of their peers. Educated clients in treatment about LGBTQ issues, as they do for other minority issues (race/class/sexism).*

Sample Transition Letter

To whom it may concern, 5/2/13

I am sending over a referral for (name), D.O.B. **/**/**** , to receive medical assistance.

(Name) is a male bodied (age) year old whose gender expression and gender identity are female.

She uses a female name and prefers female pronouns. She desires to have her body match her gender identity for congruence. (Name) has been seen at the VOA Men's Residential Center to address substance dependence since **/**/****. Random urinalysis testing, (Name's) self-report, and staff observation indicate that she has maintained alcohol and drug abstinence since her treatment entry.

(Name) has augmented her treatment plan to receive counseling and support related to her gender identity. (Name) will be able to continue receiving counseling and support with our agency until her needs and goals are met.

(Name) does not have insurance coverage.

(Name) meets the criteria for Gender Identity Disorder according to the DSM-IV-TR. From counseling assessment, (Name) does not appear to have any significant co-morbid conditions that would prevent her from transitioning. (Name's) partner is supportive and she is hopeful that she may be able to transition medically.

Contact information for (name) is as follows:
Phone Number: (503) 555-5555
Email Address: name@hotmail.com
Address: 2318 NE MLK Blvd. Portland, OR 97217

I am faxing over the client file that includes intake information and assessments.

Please let me know if there is anything else that you need.

Sincerely,

Victor Boomer-Jenks, LCSW, CADC-1
Volunteers of America, Men's Residential Center
2318 NE MLK jr. Blvd.
Portland, Oregon 97212
Ph: 503-802-0309
Fax: 503-335-8636
Email: vboomer-jenks@voaor.org

LGBTQ Counselors, Supports, and Community

- LGBTQ clients may or may not prefer to work with LGBTQ counselors. For some sexual minorities, being able to connect with a counselor who has first-hand experience with issues related to sexual identity can be an important step in working through the phases of coming out. For other clients, this may not be an important concern. In either case, sexual identity should never be considered outside the realm of what is relevant in treatment planning (SAMSHA 2009). Referral of LGBTQ clients to LGBTQ providers and community support should always be considered when working with this population, though clients may have varied responses to these resources.
- If clients are not able to use group settings to discuss their sexuality, they may not be able to identify and process important relapse prevention information. This may account for why some studies indicate that gay men in particular have higher recidivism rates upon treatment completion than their heterosexual counterparts (Senriceich 2009).

- The Portland area has a variety of LGBQ community resources that will be helpful for treatment staff to be familiar with:

Q center: 4115 N Mississippi Ave, Portland Oregon 97217, 503-234-7837	**Sexual and Gender Minority Youth Resource Center (SMYRC):** 4115 N Mississippi Ave, Portland Oregon 97217, (503) 872-9664	**Extended Family AA meeting:** held every day at 5:30pm at 2400 NE Broadway, Portland Oregon, 97232.
Lunch Bunch (AA)2400 NE Broadway, MCC Church 1pm Sunday / 12pm Monday-Saturday	**Principles not Personalities** (CMA), Quest Center, 1pm Sunday	**Rose City Men's** (AA), NW 19 & Irving, Sunday 730pm
Nova Men's (AA), SE Division & Tamarack (Rectory Basement), 730pm Tuesday	**Diversity Group** (NA), 4810 NE Sandy, Community Room, 7pm Saturday	

- Connecting with an affirming spiritual community may be an important place of healing for LGBTQ individuals:

Metropolitan Community Church: 2400 NE Broadway, Portland Oregon 97232, 503-281-8868.	**Congregation Beth-Israel:** 1972 NW Flanders Street, Portland, Oregon 97209, 503-222-1069.
Ainsworth United Church of Christ: 2941 NE Ainsworth, Portland Oregon 97212, 503-284-8767.	

From our Portland Survey:

1. *For the most part, I felt very respected by my counselor. I always know that I was lucky, in a sense, to share the common bond of identifying as queer, with him. As far as the small amount of time that I didn't fell understood, I believe today that that was a mere result of my ego, false sense of uniqueness, and just still being in a position where I was sick and suffering, not having a sober community I could relate to.*
2. *Being a gay woman, I feel a very close bond with other women, that makes it easy for me to open up and trust women.*
3. [Being connected with] *a strong beautiful bisexual woman who was not ashamed of who she was.*

Building on Strengths, Impact of Environment in Fostering Strengths

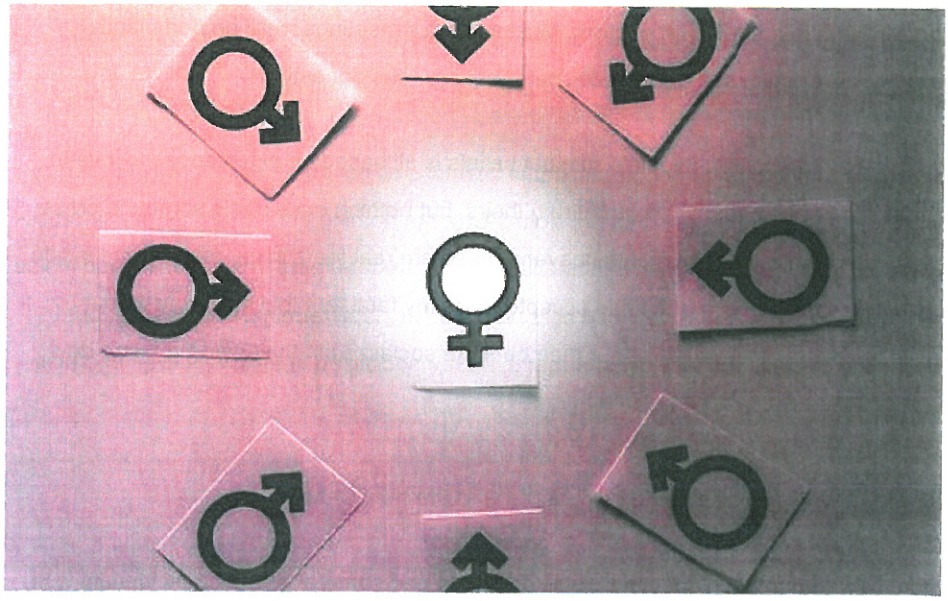
- LGBTQ individuals have many strengths that can translate into protective factors for recovery. While in one sense, identifying as being LGBTQ can be isolating, it can also lend itself to finding unexpected connections with others over economic, racial, and gender lines.
- Today, LGBTQ individuals have a broad range of choices outside of when searching for affirming communities to connect with, many of which embrace principles of recovery.

From our Portland Survey:

1. *I was lucky enough to have a queer counselor with lots of great resources for getting further help and support within the queer community. But I also found this incredible sense of unity within the sober community in general, a place where a lot of my identity wasn't what was important, but instead just sharing the commonality of being a human, struggling with addiction.*

Being a Lesbian in AA

How do you manage terminal uniqueness when you are in fact unique? A minority AA member from Portland reports.



AA is a man's program. It was designed to help alcoholic men fix their lives to go on to become better providers, fathers, husbands and sons. The main guiding voice, left to your own interpretation, is *Him*. *He* suggests the framework in which your quest for sanity and sobriety should look like.

It is up to the individual to decide for themselves what their program will look like. I spent a lot of time eradicating the visual of the Christian God's face when I came across the words *He*, *Him* and *God*. I didn't realize I knew "His" face by heart until I ran across those words in the Big Book. Every time, that bearded iconic image would appear in my head. Now I see it as a symbol for something I've created to be my own. I don't have any image at all: I get to choose my Higher Power and I have chosen for it to be fluid. Not etched out in my memory or pinpointed, but ever changing and only wanting what's best for me.

The fear of judgment, hate speech and infringing on people's spiritual beliefs is all based on experience.

I've adhered to a male-dominated AA since I first came in over seven years ago. I am a minority within a minority within a minority: In recovery, woman, lesbian. Out of a sense of survival, I have sought out meetings based on where

I feel most comfortable in lieu, sometimes, of where the most nurturing form of recovery might be. Nobody ever told me it was ok to question where the suggestions were coming from; they just told me to follow suit as the AA forefathers did, and to see it as a blessing.

In terms of life after recovery—fellowshipping, and the friendships I'm supposed to build to carry me through—I've never really identified with most people in recovery. I have tried all kinds of tricks and program-related suggestions to work this out. Young people in recovery are dominated by straight people, and I found overall I typically had nothing in common with younger members beyond our shared alcoholism. Most women's meetings were predominantly straight and I felt like a token lesbian, never quite safe enough to share with rigorous honesty.

The fear of judgment, hate speech, and infringing on people's spiritual beliefs is all based on experience. I'd love to leave everyone up to their own maturity to decipher my program from theirs, but nothing quite beats someone cross-talking about how being heterosexual is going to get them into heaven. These are real fears in my real life and inside of AA, two things I have learned to keep mostly separate. I had accepted it as my fatal terminal uniqueness, but I think it's more than that. I think it is the overall tone in which our members are socialized in their own lives and how they take that into our safer space of AA.

AA is supposed to level the playing field. We're all suffering alcoholics who are here to help.

A few years ago I showed up to a new-to-me GLBT meeting. I was hoping to find some women I could identify with, my own age, who were lesbian. When I got there I noticed there were only a bunch of men, mostly older, and I immediately thought I had misread the schedule. I was the only female in a group of 20 or so men. I felt embarrassed and wanted to run out the door as fast and discreetly as possible. I whispered to the man next to me, "Is this a men's meeting?" He leaned over, and said, "Nope, you're welcome to stay."

I stayed for the meeting and returned a couple of times before I decided to make it my home group. My decision to stay was based on the insecure and helpless feeling I got when I entered the room and found only men. I wanted to be there in case any women showed up. There are a few more women now, though it's hard to say whether or not I had anything to do with their arrival or staying.

Balancing principles before personalities can be challenging when your mental safety depends on whoever is in the room. Its not like we get to do a background check, and we all know we're sick people. I have some really sweet gay friends in that group, but for the most part I feel trapped and forced to accept it.

There aren't many other GLBT meetings in Portland to go to. I don't really feel like the men in recovery see me as a human—a woman, with a life I am trying to save—but more just a body that fills the seat. They sometimes refer to me

as "The Token," which is funny—right? Until it isn't. Until I don't have a voice of my own and my home group can't stop talking about penis size or ass at fellowship—a time I reserve for developing a deeper connection for my fellows.

I feel isolated. I feel watched, judged and out of place.

I have learned to accept what I have and make it work, but what is it about women my age (I'm 35) in recovery? Do they exist? Where are they? For over 20 years women haven't equally filled the seats in my home group. When I asked what the old-timers thought the reason was (a topic they never consider until I bring it up) they said it maybe had "something to do with gay vs. lesbian history." My home group is one of the only GLBT groups that isn't segregated by gender, so I find it odd that it is still an issue. They have gently suggested that if I don't like it here, there are plenty of other meetings I can check out and to "call your sponsor." Both of which are entitled and passive aggressive ways of dealing with the problem.

I question the principles before personalities sometimes in reflection of my own experiences. Is it a matter of acceptance? Is it something I am doing wrong? Does it really matter? I can say it's a little of everything. It does matter. As a woman I am socialized to be passive, to acquiesce so as not to seem aggressive. But as a lesbian I have learned that safety is first in matter of heart and health—and to fight for it.

AA is weird territory, where you shouldn't ask questions because your life depends on following the suggestions of your forefathers (and foremothers). Even though we go to AA to feel whole again, what it has really taught me is to keep myself split into loose compartments so I don't overtly compromise my lifeline and usefulness by intersecting the fragilities and inequalities with real life experiences in an AA meeting. Plus, I haven't really implemented my sobriety in a useful way into my real life yet because the uniqueness of my sobriety is a threat to some of my drinking friends.

Before you naysayers tell me to "call your sponsor," my bet is that you're mostly men—straight, or non-minority.

When is the last time you thought, "Wow, I wish I had more straight people to identify with in recovery"? Being a minority is real everywhere you go. Sexism, institutionalized racism and misogyny exist in AA too. At what point am I allowed to talk about it there?

Michaela Miller is a pseudonym for a writer based in Portland, Oregon.