NEEDS ASSESSMENT FOR GENDER-SENSITIVE TRAINING IN SUBSTANCE USE DISORDER TREATMENT FOR GENDER-NONCONFORMING PEOPLE

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Abstract

Research suggests that queer people face both general discrimination and inadequate support in substance use disorder (SUD) treatment. One recommendation made by scholarship to address this is to improve the treatment capabilities of practitioners, thus improving practitioner readiness and reducing access barriers for a potentially at-risk population. The purpose of this study is to explore SUD treatment practitioners' experiences of treating queer clients and identify their training needs. Semi-structured interviews were conducted with seven registered mental healthcare practitioners operating in Cape Town, South Africa. Data was analysed via thematic analysis, using a social constructionist approach to gender and practitioner knowledge. The findings reflect a strong interest in gender-sensitive training to better prepare practitioners for treating queer clients. Participants provided feedback on areas in need of improvement and made recommendations on how training should be conducted. Findings indicate that queer clients may enter treatment with a high burden of trauma due to discrimination, and that healthcare structures abiding by a binary approach to gender may not be able to address queer people's diverse needs. Recommendations for future research are made, with particular emphasis on including queer people in surveillance data. Target areas for training programmes are described, with emphasis on terminological understanding and accessibility of training.

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Acronyms

AFAB	Assigned Female at Birth
AMAB	Assigned Male at Birth
COVID-19	Coronavirus Disease 2019
CPD	Continuing Professional Development
GAH	Gender Affirming Healthcare
HPCSA	Health Professions Council of South Africa
HRT	Hormone Replacement Therapy
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
SAMRC	South African Medical Research Council
MSM	Men who have Sex with Men
NBGQ	Non-Binary and Genderqueer
NPO	Non-Profit Organisation
PTSD	Post-Traumatic Stress Disorder
RUESC	Rhodes University Ethical Standards Committee
SACENDU	South African Community Epidemiology Network on Drug Use
SACSSP	South African Council for Social Service Professions
SUD	Substance Use Disorder(s)

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CHAPTER 1: INTRODUCTION

1.0. Introduction

This study aims to ascertain whether gender-sensitive training is required for mental healthcare practitioners in pursuit of South Africa's gender-mainstreaming goals (Miller & Razavi, 1995). This body of work exists as part of a larger project headed by Prof. Liezille Jacobs, in which a nation-wide needs assessment for gender-sensitive training in South African substance use disorder (SUD) treatment settings is being conducted. Pilot work (Jacobs, 2019, 2021) suggests a need for gender-sensitive training for SUD treatment practitioners, with practitioners voicing a desire for enhanced training. This chapter will address the study's objectives and the main research question, which seeks to define terms and outline the thesis.

South Africa contends with a sizable substance use problem and its treatment centres for SUD face serious challenges related to funding and accessibility (Myers et al., 2009; Peltzer et al., 2010; Pretorius et al., 2009; Ramlagan et al., 2010). In addition to barriers in accessing treatment such as historical disadvantages (Myers et al., 2009; Myers et al., 2014), finances (Burnhams et al., 2012; Myers et al., 2010) and lower access to treatment in rural areas (Myers et al., 2011), there are also gender-based barriers in the accessibility of SUD treatment in South Africa (Pretorius et al., 2009).

With rare exceptions (Dada et al., 2018), non-binary gender identities go unmentioned in surveillance data, despite evidence suggesting that they experience increased problematic substance use (Glynn & van den Berg, 2017; Keuroghlian, et al., 2015; Kidd et al., 2018). There is likely a paucity of access to substance use healthcare for queer populations, with minimal literature related to the treatment of queer people in South Africa. The limited literature available goes to lengths to describe this lack of data (Jobson et al., 2012; Nduna, 2012). Although the scale of problematic substance use among queer people in South Africa is unknown, evidence suggests that they suffer from this just as any other population does. Evidence for coping-related substance use among queer people already exists (Felner et al., 2020; Goldbach et al., 2014) around the world and there is no data to suggest that the situation is any different in South Africa. Rather than queer people in South Africa being disproportionately healthy, it seems more likely that a problem exists and it is not being adequately studied or addressed.

One under-researched concern is whether queer people are being adequately supported in SUD treatment settings in line with national gender-mainstreaming goals (Barrett, 2018; Miller & Razavi, 1995). This includes whether they encounter discrimination or treatment barriers before, during and after the treatment process. The very limited amount of data pertaining to queer people and their interactions with SUD treatment suggests a dire situation overall (Glynn & van den Berg, 2017; Flentje et al., 2015; Wanta & Unger, 2017), where they are minimally represented in literature, face systemic discrimination in healthcare and contend with unique healthcare challenges. The situation in South Africa is just as dire, with less literature available than the rest of the world and what is available lamenting the lack of research in this area (Jobson et al., 2012; Nduna, 2012).

Pilot research conducted by Jacobs (2019) found that practitioners in SUD treatment centres may be under-trained when addressing the needs of queer clients. Jacobs' work (N = 16) used a thematic analysis derived from focus group data to determine some of the gender-sensitive training needs of SUD treatment practitioners in the Eastern Cape, South Africa. Challenges faced by practitioners included personal prejudice, lack of knowledge and conflict with other clients; all resulting in a feeling of being unready to deliver the same standard of treatment to queer clients as others. While some of these difficulties stem from limited resources and a lack of training, the presence of discrimination is another indicator of insufficient adherence to a constitution that enshrines the right to fair treatment to people regardless of gender and sex (Potgieter & Reygan, 2012).

The conclusion raised by practitioners in Jacobs' (2019) study reflected a desire for training so that they could better serve queer clients. The call for improving queer healthcare experiences by reducing discrimination, conducting research, and developing context-specific treatments is mirrored in literature both local (Jacobs, 2019; Nduna & Nkoana, 2012) and abroad (Cochran et al., 2007; Glynn & van den Berg, 2017; Lombardi & van Servellen, 2000).

This study draws its participants from Cape Town, South Africa, with a series of one-on-one, semi-structured interviews being conducted. The data was analysed via thematic analysis and compared to Jacobs' (2019) study. The findings revealed practitioner experiences of working with genderqueer people, facility organisational structures and training needs. The interpretation of these findings is viewed through a social constructionist approach to gender.

1.1. Terminology Used

This section is a glossary outlining the terminology used throughout this thesis. A particularly large section is devoted to the terms ‘queer’ and ‘substance use disorder(s)’, as they are central to this study.

Assigned Female at Birth (AFAB): A person who was assigned the female category at birth by outside parties, commonly parents and/or medical professionals.

Assigned Male at Birth (AMAB): A person who was assigned the male category at birth by outside parties, commonly parents and/or medical professionals.

Cisgender: A person whose internal sense of gender identity matches the sex or gender identity that they were assigned at birth (Aultman, 2014).

Gender Binary: A conceptualisation of gender that presumes that there are only two genders: masculine and feminine (Hyde et al., 2019). This study refers to ‘gender binarism’ at times, where the ‘ism’ suffix changes the term to a non-countable noun, but still refers to a gender binary or its characteristics.

Heteronormativity: A presumption of heterosexuality as the norm, generally enforced and propagated at the expense of those who are not heterosexual, through discrimination and denial of recognition (Röndahl, 2011).

Homosexual: A person who forms sexual relationships with members of the same gender. Synonymous with the colloquial term ‘gay’. Gendered variants of the term ‘homosexual’ include ‘gay’ for men and ‘lesbian’ for women.

Transgender: A person whose internal sense of gender identity does not match the sex or gender they were assigned at birth. Some transgender people address this by undergoing a gender transition through medical treatment and social transition (Heath & Wynne, 2019).

Substance Use Disorder(s): This study uses a broad definition of SUD, primarily informed by the DSM-V (American Psychiatric Association, 2013). The DSM-V differentiates between substance use disorders and substance-induced disorders. The former disorder is characterised by clusters of mental and physiological symptoms indicating continued use of substances, despite negative outcomes. The latter disorder is characterised by reversible

disorders directly caused by substances which are generally acute and temporary in nature. To account for the extraordinarily diverse manifestations of SUD, the DSM outlines 11 diagnostic criteria, grading the severity of the disorder based on the number of diagnostic criteria met.

With very few exceptions, the DSM-V applies the rule that the phenomenon in question must be "clinically significant," or be "associated with significant distress or disability in social, occupational, or other important activities." (American Psychiatric Association, 2013, p. 20) before being considered a disorder. A client must both experience substantial distress and meet a number of specific diagnostic criteria before being characterised as having a SUD. For the purpose of this study, registered mental healthcare professionals are assumed to have a working knowledge of SUD as a requirement for registration as health professionals and for their continued employment.

Queer: A person whose gender and/or sexual identification is any other than simultaneously cisgender and heterosexual. Examples include people who are transgender and heterosexual, cisgender and homosexual, genderfluid and asexual or transgender and undecided.

A challenge is raised when selecting the main term to use for clients in the context of this study. Broadly speaking, the experiences related by practitioners in Jacobs' (2019) work encompass gender non-binary identities as well as sexual identities other than heterosexuality. Sexual and gender identity mix and interact in complex ways and as such are sometimes conflated (Lombardi & van Servellen, 2000; Nduna, 2012; Valdes, 1996). As a result, the terms chosen to categorise people may vary even before considering the evolution of terminology over time.

The term 'transgender' is at-times used as a blanket term to describe anybody who exhibits identities and behaviours which do not conform to the gender binary (Ryan & Futterman, 1997; Norton & Herek, 2012). This definition is useful in addressing the wide range of identities; however, it is rightly criticised for homogenising them into one concept that is propped up next to a binary, thus simply creating a new binary consisting of 'standard' genders and the transgender-genders (Buck, 2016).

Another common definition places transgender people in an in-between position on the binary, where they traverse the gender binary with a multitude of behaviours and expressions that do not conform to the binary, including seeking gender-affirming surgery and therapy (Davidson, 2007). This locates transgender people in between two poles of a binary, where

the previous definition locates people outside and in between the poles of a binary. Valentine (2003) argues that the broad application of the term "transgender" to an entire bloc of people without forethought can constitute a silencing act that denies people self-identification. For people whose understanding of gender and sexuality are inexpressible in English, or who differ from the academic norm, this action both imposes an ideology upon them and is also inaccurate in defining their experiences.

This is further complicated by people wittingly or unwittingly conflating sexual orientation with gender identity (Valdes, 1996). Labels chosen by people do not always match academic definitions and people may combine sexuality and gender identity in new ways. In one historical South African example, some men would take men as lovers and the passive or subservient partner would take a feminine role in the relationship (Donham, 1998). Donham argues this changed following the end of apartheid and a new 'identity based on sexuality' formed, making both partners the same – gay men, rather than the previous system of man and wife. This is not the only expression of gender-nonconformity in this time, however, Donham's ethnographic example describes some of the complexities involved in terminology and classification of people.

This study has settled on the term 'queer' and uses definitions from Otis (2015). Otis offers three approaches to defining queerness: queerness being independence from the gender binary; queerness as an amalgamation of masculine and feminine traits; or queerness as fluidity in gender expression. The latter two approaches are more applicable to this study. I argue that genderqueer people rarely exist entirely independently of the gender binary as their socialisation and formative experiences expose them to a binarised understanding of gender, even if they wish to live away from it. Directly or indirectly, there are no documented instances of individuals in South Africa who reached adulthood with zero exposure to masculine and feminine conventions, and socialisation. Jacobs' interviews (2019) show that healthcare practitioners conflate sexuality and gender expression on occasion without a full understanding of the differences.

The term 'queer' is chosen for its contextual flexibility: Not all social settings are governed by a gender binary, however, social settings are generally governed by norms, mores and roles that can be transgressed or changed. Furthermore, the term 'queer' is chosen with the understanding that it homogenises an array of experiences, thus stripping those

experiences of some merit and uniqueness. This may exclude people for whom sexual identity forms a crucial component of gender identity.

This study therefore understands being ‘queer’ as a self-identification that meets any or all of the following criteria:

1. The person’s chosen identification transgresses the gender binary.
2. The person’s gender identity exists fluidly between masculine and feminine.
3. The person is not heterosexual.

Clients or Patients?

With regards to the use of the terminology ‘clients’ or ‘patients’ when referring to service users of SUD treatment, I align myself with Rogers’ humanistic approach (Rogers, 1959; Shevell, 2009) and use the term ‘clients’ in my work. However, the convention in South African SUD treatment centres is to use the term ‘patient’ in line with biomedically-aligned institutions. When quoting directly from interviews, the term used by the participant will be used as it is their representation of a word.

1.2. Gaps in the Literature

Available literature on South African queer people’s access to SUD treatment shows severe gaps. At this study’s commencement, the only work specifically dealing with queer or transgender people in South African SUD treatment that could be located was the pilot publication used in my study (Jacobs, 2019). The state of research into queer people and their access to healthcare services is elaborated upon in greater detail in the literature review. The situation in South Africa is largely mirrored abroad with the literature being replete with calls to action (Glynn & van den Berg, 2017; Wanta & Unger, 2017; Winter et al., 2016) and missing data in almost every sub-specialisation of healthcare for queer people. The gap in the literature regarding queer people in South African SUD treatment bears less resemblance to a gap and is more akin to a canyon.

1.3. Rationale

This study aims to contribute qualitative data about treatment experiences of SUD treatment practitioners and training needs when seeing queer clients. Existing work (Flentje et al., 2015; Glynn & van den Berg, 2017) suggests that queer people face both general healthcare discrimination and inadequate support in SUD treatment (Jacobs, 2019; Jobson et al., 2012). Therefore, improving the conditions in treatment for practitioners may reduce access barriers (Cochran et al., 2007) to treatment for a population that may be at higher risk of SUD (Keuroghlian et al., 2015).

Forming a part of a larger group of studies across South Africa which aim to evaluate a need on a national scale, this study contributes to research about the challenges faced by healthcare practitioners and their clients in South Africa. By joining this study to a larger whole, it allows the researchers involved to build a comprehensive overview of the state of practitioner's gender-sensitivity in SUD treatment and allows for comparison of results from different provinces. A comprehensive needs assessment of gender sensitive training in South African SUD practice could be used as a basis for enhanced practitioner training or generating awareness about challenges faced by queer people seeking SUD treatment. This has the potential to filter down to queer clients entering treatment and ideally improve their experience of the treatment process.

1.4. Objectives

This study's main objectives are to:

1. Use a qualitative methodology to ascertain whether there is a need for gender-sensitive training for practitioners of SUD treatment in the metropolitan area of Cape Town, South Africa.

2. Conduct one-on-one interviews with HPCSA-registered mental healthcare professionals who treat clients to learn their experiences in treating queer clientele and the potential challenges that they face.

1.5. Research Question

What are the gender-awareness training needs of mental health professionals when treating queer clients with SUD?

1.6. Outline of the Thesis

Chapter 1: Introduction

The introduction describes the study's background, presenting problems and objectives while contextualising the research and outlining key terminology which is used in the remainder of the thesis. Toward the end, an outline of the thesis' structure is provided as a guide.

Chapter 2: Literature Review

The literature review contains existing literature on queer substance use healthcare from within South Africa and abroad. An attempt is made to describe the current state of SUD treatment for queer people, collect information about queer healthcare experiences and identify areas of missing research (Webster & Watson, 2002). Studies are contrasted and compared to each other to identify points of agreement and contention. Calls and recommendations by existing authors are integrated and where warranted, links to South Africa are established and analysed. Chiefly, queer identities are found to be under-represented in research and there is considerable consensus that they face healthcare deficiencies due to a lack of knowledge, and discrimination.

Chapter 3: Theoretical Framework

This chapter discusses the chosen theoretical framework which supports the study and

aims to illustrate its relevance to the work. Where necessary, the theory used is critiqued or interpreted for use in this study's context. This study is principally developed from a social constructionist perspective of gender: that understandings and values around gender are developed from collected human interaction and are therefore ever-changing and not immutable. This does not ignore the quantitative and observable worldview, but challenges the values and assumptions applied by people to what they observe.

Chapter 4: Methodology

An outline is provided on the macro and micro-level procedures undertaken to achieve this study. The study's qualitative paradigm is discussed, and the recruitment process of participants is rationalised in full. All procedures followed in sampling and data collection are described and rationalised, including data analysis and presentation. Space is given to the logistical constraints imposed by conducting research in the COVID-19 pandemic, as well as a discussion of steps taken to ensure research rigour.

Chapter 5: Interpretation of the Findings

This chapter collects all findings from the study and presents them alongside my interpretation of the data to address the research question. Notes and context are used to guide the reader and contextualise the research. Findings are discussed and connected to the greater body of literature. The two components of the interpretation step are a thematic analysis to identify patterned phenomena in the data, and a comparison of results with a similar study. Key findings from the interpretation process include ways in which the SUD treatment space is gendered and discussion on different forms of queer discrimination in the treatment space. Research participants discussed gaps in their knowledge, which are discussed as part of the interpretations and tied to existing literature.

Chapter 6: Implications of the Findings and Critical Review of the Research

Reflections on the research process, reviews of possible authorial bias and methodological limitations are made in this chapter. Its main components are an extended reflective piece relating to my personal experience of conducting the research alongside an excerpt of the data. This is aimed at presenting a living example of some of the challenges experienced by visibly queer people in a SUD treatment space from the data and my life. After reflecting, recommendations for future research and practitioner training are provided and supported by the study's findings and existing literature. Lastly, methodological limitations of the study are addressed, and some concluding remarks are made.

CHAPTER 2: LITERATURE REVIEW

2.0. Introduction

This chapter presents existing peer-reviewed research on healthcare for queer people and practitioner development in treating queer clients. The state of research, both in South Africa and abroad, is discussed with common themes addressed. Evidence for the scarcity of research and the need for practitioner training and sensitisation are presented, with conclusions about existing research being reached.

The South African Community Epidemiology Network on Drug Use (SACENDU), an agency monitoring the epidemiology of SUD trends in South Africa, has found that on average over 70% of people entering treatment are male (Dada et al., 2018). This is illustrative of a gender disparity in treatment access that seems to favour male-identified people. South African SUD treatment centres face considerable challenges in funding and accessibility (Jacobs et al., 2012; Myers et al., 2009; Peltzer et al., 2010; Ramlagan, et al., 2010), however, the situation for queer people entering treatment may be worse (Jacobs, 2019). Simultaneously, not all South African SUD treatment facilities face internal challenges. Some of South Africa's facilities offer high-quality care, more so in private facilities requiring health insurance or wealth for accessibility (Myers et al., 2008; Pasche & Myers, 2012).

Queer people are an under-researched demographic in South African SUD literature. Only two instances of transgender or queer people appearing in SUD treatment literature were found. A 2018 South African Community Epidemiology Network on Drug Use (SACENDU) report listed transgender people as a separate demographic for the first time in demographic data on people who were tested for HIV and used drugs (Dada et al., 2018). Later, Jacobs' (2019) work appears to be the first published work on the topic of queer people in SUD treatment and specifically targets practitioners, rather than substance users.

Multiple factors can impede SUD treatment access for queer people. There are barriers which exist regardless of gender and sexual identity, such as historical disadvantages (Myers et al., 2009), understaffing (Jacobs, 2019), finances (Burnhams et al., 2012; Myers et al., 2010) and rurality (Myers et al., 2011). Existing research is well-aware that SUD treatment is not a linear process achievable through direct application of a solution, but derives its success

or failure from social, financial and interpersonal conditions attached to the people involved. Factors affecting treatment access, retention and relapse can readily include complexities and interpersonal factors which cannot be accounted for within the limited scope of an intervention.

Discrimination is a barrier to healthcare access for queer people. Queer clients entering healthcare face stigma from healthcare practitioners (Lombardi & van Servellen, 2000), insufficient training (Jacobs, 2019) and broader experiences of transphobia and victimisation specific to their queerness (Flentje, et al., 2015; Lombardi, 2007; Müller, 2016). These can amount to substantial barriers in accessing and remaining in healthcare which others do not encounter. This situation is not isolated to the area of substance use. General healthcare for queer clients is marred by negative user experiences and failures to understand queerness, if not direct discrimination (Heng et al., 2018; Lykens et al., 2018; Scandurra et al., 2019; Zeeman et al., 2018). Likewise, queer people attempting to obtain SUD treatment face stigma, a lack of programmes tailored to their specific needs and an ignorance of their experiences that can worsen their treatment experiences (Cochran et al., 2007; Lombardi & van Servellen, 2000; Scandurra et al., 2019).

2.1. Substance Use in Queer Populations

The experiences of queer people are of interest as studies show that they may be more prone to substance use than other populations (Flentje et al., 2015; Glynn & van den Berg, 2017; Keuroghlian et al., 2015; Newcomb et al., 2019), and may be in greater need of treatment. South African data on the prevalence of substance use in queer populations is extraordinarily scarce. The situation for more inclusive treatment is, however, not hopeless. SACENDU's 2018 Full Report marked the first time they included transgender people as a demographic (Dada et al., 2018), and it identified two trans women and one trans man in demographic data on people who were tested for HIV and used drugs. However, a definition for what constituted as a trans man or a trans woman was not provided in the report. Inclusion in the data is one step toward recognition of the complexities that drive substance use and recovery of queer people.

In South Africa, Polders et al. (2008) hypothesised that substance use among sexual minorities could be a coping mechanism for increased minority stress and exposure to

violence, however, their study (N = 385) correlates with depression. A later qualitative interview study by (McAdams-Mahmoud et al., 2014) found that nearly half of their respondents (N = 22) used alcohol to cope with the stresses of their identity as men who have sex with men (MSM). This is corroborated by Struthers et al., (2013) who found that 48% of their participants (N = 25) reported 'significant' alcohol and substance use problems. Substance use prevalence was only one of several mental health disorders investigated by the researchers, and as with the previous study, the participant group consisted of MSM. South African literature which investigates substance use among queer people outside of MSM or male populations is even scarcer, although it does exist. Stevens (2012) reported from a survey of 90 participants of whom a large portion (N = 41) identified as transgender, that substance use was common. 24 of the 90 participants mentioned substance use during interviews, although the severity of this use was not described. Detailed information on substance use was beyond the scope of that study, as its topic was sexual health, however, the author emphasised that: "Alcohol and substance abuse does take place on a large scale with this being linked to unprotected sex." (Stevens, 2012, p. 23).

The pattern emerging from South African literature on queer substance use prevalence is that there is little-to-no overall surveillance data by demographic. Rather, substance use, and its associated distress are noted repeatedly in research on other topics ranging from minority stress to sexual health access. Despite SUD generally being discussed as a secondary topic in South African studies, the studies are all in agreement that substance use in their samples is very high and frequently presented in a harmful manner.

More data is available internationally. McCabe et al. (2013) found via a national survey in the USA (N = 34 653) that sexual minorities had a greater chance of meeting DSM-IV criteria for SUD. Examples from their work include the finding that over 60% of lesbian and bisexual women met criteria for lifetime SUD, compared to 24% of heterosexual women, although the comparison between heterosexual and homosexual men did not show as clear a disparity. They also note that SUD may originate or manifest with different patterns in sexual minorities and advise that treatment-seeking may be hampered by widespread healthcare discrimination against queer people. In another case, Mereish & Bradford's (2014) survey study used regression analysis (N = 2 556) and identified significantly higher probabilities of lifetime SUD among sexual minority men and women alike. Their study accounted for the intersection of race into the analysis and found higher SUD prevalence among sexual minority women of colour as compared to their white counterparts. The authors concluded

that intersectional analysis accounts for diverse demographic factors including race and sexual orientation, and can improve the collection of surveillance data and recommend the inclusion of more specific demographic data to improve healthcare research.

The latter conclusion is especially relevant to this work, as by the time of SACENDU's 2020 report (Dada et al., 2021), the acknowledgement of transgender clients in the data had extended to include a note that they were included under female clients. Although inclusive of transgender women in data, this does not provide usable data on transgender clients' patterns and prevalence of substance use, as the report does for other demographics. This is a living example of the need to expand demographic data collection to include queer identities with the aim of improving the quality of surveillance data (Jacobs, 2021). Otherwise, collected figures encounter the pitfall of relegating queer identities and their complex experiences of SUD to the category of 'missing data'. Flentje et al. (2015) presented a systematic review (N = 200) on the reporting of queer identities in substance use research and reached the conclusion that standard practice in data collection was to omit queer identities. This generates data that cannot comprehend the prevalence and patterns of substance use among queer populations, leaving a large gap in demographic data. The process of improving healthcare for queer people is made more difficult when the extent of the presenting problem is not understood.

The shortage of data on queer identities in SUD treatment in South Africa and abroad (Cochran et al., 2007; Flentje et al., 2015) makes it challenging to know the extent of the problem at hand. Many difficulties experienced by queer clients in embarking on SUD treatment are not for a lack of trying. Some authors (Flentje et al., 2015; McCabe et al., 2013) have noted that sexual minorities may be more likely to enter SUD treatment, although these works examined sexual minorities rather than gender minorities. Keuroghlian et al (2015) conducted some of the first research on SUD treatment utilisation amongst gender minorities and found high treatment utilisation in a small sample, albeit in the USA. They suggest that this need for treatment may have arisen from disproportionate experiences of intimate partner violence, Post-Traumatic Stress Disorder (PTSD), unstable housing, discrimination and sex work participation that have impacted their substance use patterns.

As it stands, there is insufficient work to provide a clear picture of problematic substance use rates amongst queer people abroad, however, there is enough theorising to warrant substantial concern (Cochran et al., 2007; Flentje et al., 2015). There is no evidence

to suggest that the situation in South Africa is better than elsewhere, and research on problematic substance use prevalence among queer populations in South Africa is effectively non-existent (Jobson et al., 2012; Nduna, 2012). Research into queer experiences of SUD is also intimately linked to HIV research, as the two conditions can become risk factors for each other (Browne & Wechsberg, 2010; Earnshaw et al., 2018).

2.2. Queerness and HIV/AIDS in Substance Use Treatment

A discussion of healthcare among queer people and especially transgender people is incomplete without discussing the pool of violence, exclusion, and discrimination which they find themselves immersed in. The relationship between substance use and HIV/AIDS in South Africa should also be discussed (Browne & Wechsberg, 2010; Shisana et al., 2014). The first known mention of transgender people in SUD treatment statistics reported in South Africa was in relation to several transgender-identifying people testing for HIV/AIDS in conjunction with SUD treatment (Dada et al., 2018). This illustrates how little data there is on the area and is evidential of the close relationship between HIV and SUD treatment in South Africa.

Much of the literature describing the broad picture of transgender healthcare stresses HIV care as a cornerstone of healthcare for queer people (Operario & Nemoto; 2010; Winter et al., 2016; Wylie et al., 2016). A large proportion of the research on the healthcare of queer people is derived from the United States of America (USA) and reflects their trends and attitudes toward HIV/AIDS. The most well-known HIV/AIDS epidemic in the USA has been characterised by some as a phenomenon largely affecting MSM from the 1980's onward (Catania et al., 2001; Morris & Little, 2011). The 21st Century understanding of HIV is more complex than this and is ever-changing (Beyrer & Karim, 2013; Fenton, 2007). In South Africa, HIV/AIDS is a broader health issue which crosses demographic boundaries and is a focus of national health (Connolly et al., 2004; Kenyon et al., 2013). Though notable in its very existence, literature on queer SUD and HIV/AIDS risk is primarily concerned with HIV/AIDS and its associated risk factors, providing little information on mental health practitioners treating queer people.

2.3. A Need for Gender-Sensitive Treatment and Training

Negative healthcare experiences for queer people are well-described in the literature (Cicero et al., 2019; Lykens et al., 2018; Scandurra et al., 2019), indicating that healthcare practitioners form a part of queer people's negative healthcare experiences. Cicero et al. (2019) undertook a mixed literature review ($N = 23$) which found evidence of numerous barriers to safe and knowledgeable care, including exclusionary intake documentation, a lack of knowledgeable healthcare practitioners, or open prejudice. Scandurra et al' (2019) review on the healthcare of queer people ($N = 11$) found a mixture of better and worse health status among the queer people analysed. Their study suggests that data on queer people in healthcare research was scarce and maintained that it was important to continue developing welcoming healthcare environments for queer users of healthcare. Measures suggested included improving the recognition of queer people in forms and practice, as well as the suggestion that, "… healthcare providers could benefit from specialized training aimed at improving the knowledge on NBGQ identities, as well as the related specific health need." (Scandurra et al., 2019, p. 9) An interview study using thematic analysis with 10 participants reported that healthcare providers struggled to see beyond a two-gender model, and that there was a lack of knowledge on gender-nonconforming people even among transgender-specific services (Cicero et al., 2019).

Evidence for mixed to poor healthcare experiences by queer clients is corroborated by the literature making numerous calls for additional training in different healthcare fields (Heng et al., 2018; Lykens et al., 2018; Matsuno & Budge, 2017; Scandurra et al., 2019). The combined weight of this call for additional training should not be ignored, given the importance of healthcare practitioners in healthcare. Throughout the literature, calls for additional training and sensitisation to the unique challenges and life experiences of queer people are routinely suggested. While they are by no means the only way to address negative healthcare experiences, they are a prominent point of failure in the negative perception many queer people have of the healthcare system (Hudak & Bates, 2018; Veltman & Chaimowitz, 2014). This study joins the growing procession of research aimed at addressing the negative healthcare experiences of queer people by means of improved training and understanding of practitioners.

In South Africa, Jacobs (2019) found that the support for people who do not conform to conventional gender and sexual identities is lacking in SUD treatment settings in parts of the country. Her focus groups with mental healthcare practitioners found that practitioners experienced uncertainty on how to treat clients who did not fit heteronormative, binary categories of sexuality and gender. Participants voiced concerns over bullying of queer clients by other inpatients, or personal difficulties in interacting with queer clients. Particularly worrying outcomes of this for queer people included cases of practitioners describing themselves as behaving "unethically" (Jacobs, 2019, p. 189). A desire for gender-sensitive training for non-binary clients was voiced to address this problem. There appears to be willingness to engage with the topic to improve client well-being (Jacobs, 2019, 2021).

A further complication is the absence of data on queer people in SUD treatment in South Africa. Most examples, recommendations and research specific to queer people used in this study have been drawn from international sources out of necessity. Despite recommendations (Dos Santos et al., 2010; Groenewald & Bhana, 2016) that precedents and measures to be used in South Africa should be developed locally, such work is almost non-existent. Taken alongside the understanding that clients of different genders require different, or at least targeted interventions (Brady & Randall, 1999; Glynn & van den Berg, 2017; Greenfield et al., 2010; Jacobs, 2014), the lack of gender sensitive training (Jacobs, 2019) and tailor-made programmes (Cochran et al., 2007; Glynn & van den Berg, 2017; Nemoto et al., 2005) should be a cause for alarm and warrant changing.

The literature displays a number of themes and similarities, all of which are cause for concern. Queer people are the targets of discrimination in healthcare and face rejection from general healthcare and substance use treatment facilities (Jacobs, 2019; Sperber et al., 2005). They are under-represented both in literature, and in SUD treatment facilities (Glynn & van den Berg, 2017; Matsuno & Budge, 2017; Nemoto et al., 2005). Lastly, an unmet need for improved SUD treatment has been expressed for decades (Cochran et al., 2007; Lombardi & van Servellen, 2000) and continues to this day (Jacobs, 2019). Though improving, the healthcare situation for queer people has yet to reach the standard of satisfaction set by people in the dominant gender and sexual categories: cisgender and heterosexual.

2.4. Trends in Queer Healthcare Literature

Existing research on queer healthcare experiences show some recurring phenomena and on occasion provide suggestions for addressing them.

Effective SUD treatment should be targeted toward clients' specific needs, experiences, and social contexts (Cochran et al., 2007; Wylie et al., 2016), rather than be a one-size-fits-all approach (Koch & Rubin, 1997; Leshner, 1999). This recommendation is repeated when the clients are queer or transgender (Cochran et al., 2007; Jacobs, 2019; Lombardi & van Servellen, 2000), suggesting that at the very least, an understanding of the experiences of queer people could be beneficial to treating them.

Queer people are critically under-represented in substance use literature in South Africa. Though the situation is better abroad, they remain under-represented in SUD treatment settings (Flentje et al., 2015; Nemoto et al., 2005) and literature in general, (Glynn & van den Berg, 2017; Wanta & Unger, 2017) while facing a range of healthcare access challenges (Sperber et al., 2005; Winters et al., 2016). As an example of this, Glynn and van den Berg's (2017) work describes itself as, "…the first known systematic review investigating interventions for problematic substance use for transgender individuals," (p. 47) and could only locate two articles that met its inclusion criteria, with a further seven articles involving interventions, but reporting no outcomes. The primary suggestion for addressing this problem is increased funding and labour devoted to the topic of queer people in substance use.

Queer people may be at higher risk of problematic substance use as a by-product of exposure to discrimination and violence (Glynn & van den Berg, 2017; Keuroghlian et al., 2015). However, the literature also describes multiple barriers preventing entry to, or completion of treatment. These barriers include discrimination, inexperienced healthcare practitioners and experiences of violence. Specific examples include enforced two-gender dress codes, bullying from clients and practitioners, discriminatory rejection, and a lack of understanding of their experiences (Burgess et al., 2007; Jacobs, 2019; Lombardi & van Servellen, 2000; Stroumsa, 2014). A combination of heightened risk of problematic substance use, fraught access to healthcare, and poor substance use treatment outcomes may compound the damage done by SUD in excess of that experienced by others.

The healthcare experiences of queer people are generally not described positively, with a prevailing belief that healthcare for an openly queer person is filled with barriers, misunderstanding and discrimination (Cicero et al., 2019; Lykens et al., 2018; Müller, 2016; Scandurra et al., 2019). The precise deficiencies experienced vary depending on locale and identity. To name a few, transgender clients may not be met with an understanding of what it means to be transgender, or an unwillingness to learn about them. This is particularly problematic for those transgender clients attempting to medically transition – a process that requires medical supervision to be conducted safely. Genderqueer clients may encounter intake documentation that does not recognise their gender identity or find that they receive an array of invasive and unnecessary questioning. This particular criticism of healthcare is generally traced back to practitioner training, resulting in practitioners whose established views on gender have not been met with new evidence and scientific consensus (Müller, 2015).

The misunderstandings and discrimination will plague queer people to the extent where they will seek out queer-friendly healthcare (Hudak & Bates, 2018). The term 'queer-friendly healthcare' implies that healthcare is 'unfriendly' to queer people by default. In this case, 'unfriendly' is a euphemism meaning 'untrustworthy and discriminatory'. Scholars (Glynn & van den Berg, 2017; Lombardi & van Servellen, 2000), practitioners (Jacobs, 2019) and clients (Sperber et al., 2005) have expressed a desire for additional training of SUD treatment practitioners specifically. This exists alongside a broadly expressed need for improved healthcare for queer people as seen in the literature (Müller, 2015; Winter et al., 2016; Wylie et al., 2016).

Recommendations for improved treatment of queer people are seen throughout the literature. These include respecting chosen pronouns and names, using inclusive language, and the reconsideration of gendered dress codes and restrooms (Baldwin et al., 2018; Lombardi & van Servellen, 2000). One intervention aimed at trans women (Oggins & Eichenbaum, 2002) made recommendations that may be transferable, such as recommending sensitivity training for clients and practitioners, respecting clients as individuals, and developing peer support. As with other demographics, specific interventions and Lesbian, Gay, Bisexual, Transgender, Queer Plus (LGBTQ+) friendly treatment programmes can address many of these concerns. Such interventions should be tailored effectively to their target audience with a comprehensive understanding of the clients, rather than be a rehash of existing programmes (Cochran et al., 2007).

The recommendation for sensitivity training, in both biomedical and substance use healthcare, is echoed by many authors (Cochran et al., 2007; Glynn & van den Berg, 2017; Heng et al., 2018; Jacobs, 2019; McCann & Sharek, 2016; Mizock & Lundquist, 2016). Put simply:

> *First, NBGQ identities should be recognized by healthcare service systems and providers as existing and healthy identities. To this end, healthcare providers could benefit from specialized training aimed at improving the knowledge on NBGQ identities, as well as the related specific health needs (Lykens et al., 2018), thus becoming gender-literate.* (Scandurra et al., 2019, p.9)

Lastly, the call for improved access to healthcare for queer people strongly stresses that it be multi-pronged and comprehensive (Lo & Horton, 2016). The violence, discrimination and psychological ills faced by queer people do not arise in isolation and should be addressed systematically in healthcare and in society (Edmiston et al., 2016; Keuroghlian et al., 2015; Operario & Nemoto, 2010; Reisner et al., 2016; Wylie et al., 2016). Addressing this concern in South Africa is a colossal task, but recent steps such as opening its first "transgender healthcare facility" aimed at offering de-stigmatised, comprehensive healthcare to its clientele (eNCA, 2019) may be helpful as this is a step towards inclusive queer healthcare. Successfully implementing recommendations to improve training and professionalism among healthcare practitioners would address the myriad of negative healthcare experiences which queer people face (Müller, 2014, 2015).

2.5. Responses to the Call for Improved Healthcare for Queer People

The largest practical resource for addressing the needs and complexities of queer lives is the field of Gender Affirming Healthcare (GAH). A burgeoning field which encompasses the interconnected mental and physiological aspects of healthcare for queer people, GAH is not well-defined. Some authors consider GAH to solely be the medical component of addressing gender dysphoria (Puckett et al., 2018): essentially being the biomedical procedures used to alter a person's gendered physiology to their satisfaction. Though this definition is straightforward and is an area of persistent need, predominantly among transgender people, it leaves little room for mental healthcare or anyone other than transgender people. Others characterise GAH as healthcare that is:

> "*… affirming of a person's unique sense of gender and provides support to identify and facilitate gender healthcare goals. These goals may include supporting exploration of gender expression, support around social transition, hormone and/or surgical interventions.*" (Oliphant et al., 2018, p. 4)

Such a broad definition leaves much to the imagination, however, it does consider the multidimensionality of healthcare being such that it should see to social, physiological, and mental needs alike, while being able to manage each client's differences in a productive manner.

Due to the nature and focus on mental health care and its consideration of social and environmental factors surrounding a person that may affect the delivery of healthcare, this study aligns itself with understandings of GAH closer to that within the work of Oliphant et al. (2018). Although medical transition can be valuable in addressing one dimension of some queer people's experiences (Costa & Colizzi, 2016; Dhejne, et al., 2016), it is by no means a universal need for all queer people, and medical transitioning is not the only way to affirm a person's sense of gender. This study is primarily concerned with the type of GAH that is practical and addresses aspects in healthcare which make it discriminatory or marginalising for queer people.

GAH is a body of research consisting of manuals of practice which aims to address the trends and issues raised previously in an actionable manner. Work in this field (Chang et al., 2018; Heath & Wynne, 2019; Oliphant et al., 2018) is written with reflection on their context and that of the client. Of the three aforementioned manuals, all feature segments describe diverse gender identities, the value of appropriate name and pronoun usage, the social experience of queerness, as well as medical transition. Even manuals aimed at transgender people address the psychosocial aspects of gender, alongside important biomedical topics such as medical transition.

Perhaps the most important component of GAH is its emphasis on 'affirming' a person's gender identity, so long as it is not detrimental to their well-being. Affirmation in this context is complex, but the underlying principle therein is to respect and work with the client's decisions and needs wherever possible. Chang et al. (2018, p. 19) describe it as to, "respect client self-determination." Oliphant et al., (2018) agree:

> "*Autonomy in the context of transgender healthcare involves transgender people being able to able to make informed choices for themselves regarding gender*

> *affirming care and being free from experiencing harmful pathologisation and other barriers to accessing this care."* (Oliphant et al., 2018, p. 6)

There is an emphasis on transgender populations in GAH, possibly owing to many transgender people's need to medically transition. However, the basic tenet of respecting a client's self-determination would still apply to any other person: queer or cisgender.

Respecting self-determination in practice takes on many forms. A number of them essentially doing the opposite of the complaints and shortcomings highlighted in the literature: addressing clients by chosen names and pronouns (Chang et al., 2018; Heath & Wynne, 2019) rather than making presumptions, taking note of queer people in research data (Fiani & Han, 2018; Matsuno & Budge, 2017) and reconsidering unnecessarily gendered regulations around personal address, presentation and restrooms (Lombardi & van Servellen, 2000). Suggestions such as these are aimed at deconstructing the status quo that imposes the assumption that all people are cisgender and heterosexual. In practice, introducing measures to improve treatment for queer people does not automatically result in a loss of treatment quality for cisgender and heterosexual people. The removal of unnecessarily gendered dress codes, increased consideration for people's chosen mode of living, or building awareness of the socio-political factors that affect people's health can benefit everyone.

GAH proposes feasible solutions to problems which queer people have endured for decades. It is by no means this study's ambition to mass-manufacture queer healthcare centres or replace existing programmes, however, GAH can provide useful guidelines to improve the experiences of queer people and practitioners alike. Small steps such as making the existence of queer people known, understanding the differences between identities and critiquing gendered practices can pave the way forward for a basic degree of comfort for queer clients without over-burdening practitioners. In making its own recommendations, this study will later draw on GAH as a body of research.

2.6. Conclusion

The research reviewed in this chapter is in agreement that comprehensive and effective healthcare for queer people is an unmet necessity. On an international scale, the only clearly established consensus is that queer people's healthcare needs are disproportionately

dissatisfied, and that they may experience higher rates of substance use overall. Worse still, there is a severe dearth of research on the topic in South Africa in all areas of research regarding queer people and their healthcare. The extent to which this high rate of substance use is harmful, or not, is also not fully established, but must be considered with care.

If effective SUD treatment is tailored to the context of its clients and queer people lack access to such care, or worse, are excluded from even one-size-fits-all care, then their situation is of serious concern. Ideally, queer people would have accessed an array of treatment programmes specially tailored to their needs in the presence of healthcare practitioners who are sensitive to the lived experiences of their clients. In the absence of deploying specialised programmes that take a long time to develop and test, gender-sensitivity training may address practitioners' training needs in the interim.

The under-representation of queer people in research, coupled with the disturbing possibility that they may be at greater risk of SUD acts as a call for further action. If queer people encounter difficulties in treatment that result from their status, then gender-sensitive training could alleviate some of those issues and make treatment centres a more welcoming environment. Having effective access to basic, one-size treatment aimed at cisgender populations is arguably better than outright rejection, discrimination, or ignorance, which is what queer people face at present (Jacobs, 2019, 2021; Snelgrove et al., 2012; Sperber et al., 2005).

CHAPTER 3: THEORETICAL FRAMEWORK

3.0. Introduction

This chapter outlines the study's theoretical underpinnings. The social constructionist approach is used to grasp, contextualise, and interpret the findings. The chosen framework is described alongside some of its origins and characteristics. The framework's limitations are discussed, with particular attention given to the challenge of generating actionable outcomes from research informed by social constructionism.

3.1. Relevance to This Study

A social constructionist approach was appropriate for this study given that the knowledge of gender that mental healthcare practitioners possess is itself constructed. While it is not impossible that some of their knowledge is innate, or developed independently of outside influence, much of what practitioners know stems from knowledge created by societies. Facets such as language have the potential to impact their perceptions through gendered or genderless words. Their understanding of male/female on identification and intake documents, or expectations of gendered behaviours expressed by people are largely learned from existing knowledge. In exploring their socially constructed knowledge of gender in relation to treatment experiences, it may be possible to identify gaps in their knowledge.

The literature reviewed for this study highlights areas for improvement such as under-representation of queer people in data, a lack of knowledge of queer clients and discriminatory practices, both overt and covert. While no two practitioners share identical experiences and views of their training, practitioners are trained through systems of knowledge that may marginalise queerness. Social constructionism holds value in interpreting these constructed systems of knowledge and, in doing so, contribute to the development of newer systems of knowledge that value, or at least acknowledge, people's differences.

A social constructionist approach is useful in addressing the sensitive and fluid experience of gender I expected to encounter in my interviews. The comparative openness of

social constructionism and its ability to value different forms of knowledge derived from individual experience lends itself well to a topic as diverse as gender and sexualities. I would be doing a disservice to my participants, and more importantly, their clients, if I approached their lived experiences with the assumption that their existence fit neatly into well-defined categories. Worse still would be entering with the assumption that my system of knowledge is a definitive truth that is universally applicable to their lived experiences.

Beyond a desire to accurately describe the diverse experiences my participants have social constructionism is especially relevant to interrogating experiences of discrimination and exclusion. Gendered discrimination appears to be thriving in South African SUD treatment with the first criterion for someone to suffer discrimination being that they are identified as sufficiently different to warrant non-standard treatment (Jacobs, 2019). That is to say, a pre-existing knowledge of what a gender-nonconforming individual [*appears as*] must exist before someone can act on it in any manner.

3.2. Social Constructionism

Social constructionism traces its roots to a number of philosophical traditions, including the phenomenological traditions of Alfred Schutz, Thomas Luckmann, Peter Berger and Edmund Husserl, and the sociological traditions of Émile Durkheim and Max Weber (Andrews, 2012; Embree, 2009; Weinberg, 2009). It is occasionally described as a theory of knowledge that human understanding of the world is largely social in origin (Hibberd, 2006; Marecek et al., 2004). In its essence, the theory argues that human knowledge originates from interactions between people. This notion is embodied by Hibberd's (2006) discussion of Hacking and Hacking's (1999) inevitability and flexibility: theories and knowledge are not inevitable and are not produced by the subject they are about. This knowledge was instead produced by thinking beings working cohesively from their own frames of reference and experience. Therefore, knowledge is neither inevitable, nor static. If the assumption that knowledge was created is upheld, then it is also true that knowledge can be re-framed and manipulated (Butler, 2016).

In undertaking this study, the phenomenological tradition is particularly relevant as the experiences reported by individual participants often reflect personal worldviews and experiences. Edmund Husserl is frequently credited as the originator of phenomenology, with

most branches of phenomenology stemming from his original writings (Husserl, 2019; Moran, 2005). Husserl's argument was that the methodology applied in laboratories was insufficient for addressing human experiences and that the pursuit of objectivity ran counter to documenting human experience, which is subjective. Core to his argument was the existence of a [*lifeworld*] - the sum of sensory information received by people that exists before being processed into experiences and memories. Husserl supposed that the lifeworld was pre-reflective and could be broken down into components dubbed essences, which could be identified and examined (Brooks, 2015).

Martin Heidegger's contribution followed Husserl's work and expanded on the importance of language, history, and multiple factors beyond what is immediately present (McConnell-Henry et al., 2009) in the lifeworld. Bearing that in mind, Husserl's vision of investigating the human experience as a series of essential components was impossible, as the observer always observed from their own context. This amounted to a critique of objectivity in qualitative research and calling attention to the importance of history and pre-existing knowledge in any research endeavor. Heidegger termed these presuppositions a person held while experiencing the present a [*fore-structure*] (Johnson, 2000). Fore-structure accounts for the observer's past (knowledge and history) and their surroundings (setting) to form the context of their observation in the present lifeworld.

A range of thinkers made contributions to Husserl's original assertion that laboratory settings were insufficient for examining human experiences. Jürgen Habermas contributed extensive work on the importance of shared communication in the day-to-day activities of accomplishing goals, adding language to the proverbial pot (Fairtlough, 1991). Michel Foucault added a body of work on power and social imbalance (McLaren, 2012) to highlight the importance of what, and who, is colloquially above and beneath the observer. As McLaren points out Foucault intentionally did not make generalisations on the limits and uses of power, and his work emphasised laying a groundwork for analysing power dynamics which McLaren (2012, p. 36) calls, "an 'analytics of power', rather than a theory of power." Foucault's contribution and emphasis on power relations is indispensable to feminist studies, and remains so to this day (McNay, 2013).

Lastly, Maurice Merleau-Ponty's critique of dualism, being the separation of mind and body, is often characterised as being infeasible. On this, Brooks (2015, p. 643) writes that, "we cannot, when considering human experience, meaningfully detach mind from body, nor

subject from object." This contribution is especially meaningful to the field of psychology, where a longstanding gulf between the biochemistry of the brain and a person's subjective experiences of suffering and other emotions has yet to be negotiated (Ellis, 2006).

Social constructionism complicates and enhances the process of the human scientific approach by not only asserting that reality is created by people living it, but that research processes must account for people's pre-existing knowledge, language, and assumptions (Marecek et al., 2004). Without taking a firm stance on where in the world of social constructionism this study stands, there is no doubt that my primary concern deals with people's experiences, mainly those of the practitioner. The practitioner's experiences of training, learning and practice directly inform the treatment of their clients, ultimately impacting the client. This study supports itself on social constructionism as a theory of knowledge in order to understand how practitioners treat queer clients when their clients do not always mould into pre-existing categories.

For an academic framework there is little consensus on the exact characteristics of social constructionism beyond its formal requirements being that it assumes that the object at hand is constructed through social means, such as discussion/discourse, learning or shared experiences. Some facets of social constructionism do appear consistently in explanations of what it is.

Social constructionism is largely opposed to long-standard positivist approaches to academia (Gergen, 2001; Young & Collin, 2004). It critiques the notion that science exists on an objective plane uncorrupted by bias and raises the opposite argument being that any human endeavour is influenced by people's subjective experiences. The logical extension of the assumption that knowledge is made would be that knowledge can also be willingly reshaped. The social constructionist approach views any constructed subject as being open to change. Hacking and Hacking (1999) describe this as knowledge not being inevitable, while Butler (2016) describes this as the ability to re-frame knowledge to suit an agenda.

Social constructionist approaches are often concerned with power dynamics (Gergen, 2001; Marecek et al., 2004). Having arisen as a criticism of a dominant, positivist structure, the constructionist approach is interested in outlining the meta-level forces at play in the creation of knowledge. Less quantifiable forces such as internalised biases, unconscious behaviours and power are common topics of discussion. Marecek et al. (2004, p. 196) write that, "Some accounts of reality become dominant discourses, assuming the status of truth or

common sense; others remain muted or unavailable." Social constructionism is therefore deeply concerned with the 'who gets to speak and who is heard' aspect of knowledge creation, and fields such as discourse analysis and critical health psychology rise to explore these questions.

3.3. Social Constructionist Approaches to Gender

A full account on the social constructionist perspective and its relationship with gender is beyond the scope of this chapter, however, Marecek et al. (2004) summarise it. They describe social constructionism as challenging established beliefs about sex and gender by applying its tenets. Their notion is that gender is developed through education, coercion and being, rather than being entirely innate. They continue to describe social constructionism as that which challenges the notion that gender has the same meaning across all societies. This grows from the constructionist assumption that different groups construct knowledge differently and would develop different values and understandings about the same observable phenomena. Social constructionism also disavows the assertion that gender is immutable and only exists as an uncompromising masculine or feminine. Examples from research are used to support this, such as different views of gender in some Native American societies (Sheppard & Mayo, 2013), sexual violence in men's prisons (Gear, 2007; Trammell, 2011) and the reconstruction of homosexuality as foreign, 'un-African' and unwelcome in Southern Africa (Muparamoto, 2021).

An extension of the social constructionist approach to gender's ever-changing nature is the importance of performativity. If we assume that gender is built on a system of knowledge and experience that is variable, then it makes sense that people exert some control over their gender. Judith Butler (2004) summarises this as follows:

> *Gender is not exactly what one "is" nor is it precisely what one "has." Gender is the apparatus by which the production and normalization of masculine and feminine take place along with the interstitial forms of hormonal, chromosomal, psychic, and performative that gender assumes*. (Butler, 2004, p. 42)

In West and Zimmerman's (1987) terms, gender is something that is 'done' and not just solely *is*. The characterisation of gender as performative is two-fold: A criticism of a

long-held viewpoint that gender is inherent and unchanging, and an effort to highlight the agency people have in their gender expression. Cases such as the aforementioned transgender people undergoing transition and remaining at their place of work, (Schilt & Westbrook, 2009) or a non-passing trans woman attempting to join a women's substance use group, are illustrative of the importance of choices involved in one's gender presentation, as well as the possible effects of these choices. The performative aspect of gender for visibly queer people can involve a complex cost-benefit analysis. Be it in the workplace or elsewhere, (Levitt & Ippolito, 2014) active decisions are made to decide what gender a person could perform on a given day. A social constructionist approach to gender, which describes it as fluid, addresses questions that cannot be answered if gender is assumed to be universally fixed. Such questions are how different societies have developed different numbers of gender categories, why some languages gender their articles and inanimate objects, and how transgender people can exist at all.

3.4. Limitations

The social constructionist approach is not without its flaws. Its origins as a critique of 'objectivity' and the positivist establishment can lead people to think that it is only useful for critical analysis. There is a standing opinion that social constructionism provides a great deal of criticism and call to action without the pragmatic backbone to support itself (Gergen, 2001). Marecek et al. (2004) state that constructionist projects tend not to produce generalisable results however, they can still align themselves to practice by conducting hands-on research that supports real-world applications and positive change.

Further limitations of social constructionist approaches are the dilution of every aspect of human experience into a series of social constructs. Together with its rejection of objective truth, there is a concern that social constructionism reaches an "*absurd outcome of 'anything goes*'" (Hibberd, 2006, p. 29). To avoid this pitfall, some (Marecek et al., 2004, p. 194) argue that social constructionism should not characterise all measurable phenomena as constructs, but to consider that human-made "assumptions and linguistic constructs that enable people to talk and think about the phenomena are products of social negotiation and are therefore not universal."

One such example being the Human Immunodeficiency Virus (HIV) which is not a social construct, with its existence lying entirely in physical processes beyond human control. However, the USA's initial characterisation of its HIV/AIDS epidemic as 'Gay Related Immune Deficiency Syndrome' often attributed to immoral sexual behaviour, (Forstein, 2013) was a social construct. This was no 'mere' social construct without consequence as it directed public discourse and legislature (Platt & Platt, 2013) while cultivating misinformation and discrimination (Treichler, 1987) within many populations. The linguistic characterisations of HIV/AIDS described by Treichler (1987, p. 358) include social constructions of HIV/AIDS with consequences well-beyond the observable effects of the disease: "Nature's way of cleaning house", "God's test of our strengths", "The price paid for anal intercourse" and "A gay plague, probably emanating from San Francisco". In the same manner, the observable characteristics of gender such as chemical reactions, hormonal interactions and the firing of synapses that govern consciousness all exist independently of human intervention. However, the values and assumptions assigned to these observable characteristics are generated through socially mediated processes.

When socially constructed values gather in sufficiently large numbers to form a body of action, they have the potential to shift people's opinions and actions. The consequences of social constructs applied to daily life may include ostracism, discrimination, and empowerment. In SUD treatment the minds of practitioners hold socially constructed understandings of gender developed through their socialisation and training. While these constructions are not inherently moral or amoral, they can affect the treatment of queer clients by their very existence.

3.5. Conclusion

This study employs a social constructionist approach by placing importance on the socially constructed values and knowledge which practitioners have accumulated during training and through their work. This is relevant as practitioners do not exist in isolation, but are people formed and taught by others. Understandings of gender in treatment practices which are taken for granted have the ability inform their knowledge or alter how they approach treatment. Allusions to constructed characterisations of queer people are already seen in the pilot work of Jacobs (2019), which this study is based on. Jacobs (2019) notes

signs of queer stigmatisation and the risk of bullying and rejection due to queer people's identities. These events do not occur in a vacuum, but rather occur in social contexts.

The rejection of a gender-nonconforming client from treatment due to an inability to handle them, or an experience of queerphobic bullying are all social events and a solely individualistic or statistical approach could not adequately address them. Although the approach's limitations include excessive criticism without providing useful answers, this study seeks to address this by raising practical examples of GAH that could be deployed in line with participant suggestions and literature.

CHAPTER 4: METHODOLOGY

4.0. Introduction

This chapter discusses the research methodology and provides a description of data collection procedures, participant information and data analysis methods. The impact of the COVID-19 (coronavirus disease 2019) pandemic on data collection proceedings is discussed, as are considerations on research rigour.

4.1. Research Paradigm

The qualitative research paradigm generally addresses unquantifiable research problems via methods which are theoretically inductive, and interpretivist in their understanding of the social world (Bryman, 2016). In comparison to quantitative approaches, there is much less emphasis on hypothesis testing and mathematical analysis, although these need not be absent from the qualitative research process. Qualitative research often adopts a constructivist ontological position which privileges the importance of social interactions, rather than completely separating natural phenomena from the social world (Bryman, 2016).

This paradigm was suitable for addressing the research question due to the need for in-depth data that was highly variable between participants. Extensive personal accounts, anecdotes and opinions cannot be feasibly analysed mathematically without the loss of nuance. As the study's goal is to identify a range of potential training needs from a smaller sample, and elaborate on them, a qualitative approach that privileges participant expression and the depth of data is more ideal.

4.2. Inclusion Criteria and Recruitment Strategy

Inclusion criteria for this study consists of registered mental healthcare practitioners working in SUD treatment who have also treated queer clients during their careers. Mental healthcare practitioners are defined as counsellors, psychologists, and social workers

registered with professional boards who see to the day-to-day treatment of people with SUD. These mental health practitioners universally undergo tertiary education and register with the Health Professions Council of South Africa (HPCSA), or the South African Council for Social Service Professions (SACSSP). They treat clients in a range of settings including private practice and SUD treatment facilities.

Participants were initially contacted directly via an online database of SUD treatment stakeholders and practitioners involved with the South African Community Epidemiology Network on Drug Use (SACENDU). This database is overseen by a gatekeeper, Dr. Nadine Harker Burnhams of the South African Medical Research Council (SAMRC) and her permission was obtained to use the database to contact potential participants. The rationale for contacting participants directly via work e-mail addresses was not only for the purpose of professionalism, but to reduce social pressures that may encourage or discourage participation (such as supervisors instructing them to participate).

The onset of the COVID-19 pandemic and the implementation of strict national lockdowns resulted in great difficulty in contacting people at their workplaces. I liaised with my supervisor and ethical review board to expand participant recruitment to include using publicly available contact details of SUD treatment facilities and practitioners via a Google search and contacting them via listed business e-mail addresses. When contacting potential participants in this manner, care was taken to respect gatekeeper permissions where possible. If contacting a facility, the first contact was always made to the facility director or a person of similar responsibility in order to request permission to interview at their facility.

When contacting individual practitioners, only e-mail addresses listed in business profiles or websites were used to make contact. Approximately 140 e-mails were sent out to facilities and practitioners, yielding seven participants. The vast majority of facilities did not respond, although those that did worked proactively to link me to participants. The absence of reasons for people's non-responses meant that I could not discern whether the disappointing response rate resulted from the difficulty of life in the COVID-19 pandemic, or if this was an ordinary part of the research process.

The recruitment strategy located seven participants willing to take part in a one to two hour-long semi-structured interview using their choice of the Zoom platform or e-mail interview. Participant's backgrounds included new practitioners and career veterans, and in accordance with selection criteria were always registered mental healthcare practitioners

working in South Africa's Cape Town Metropolitan Area. Employment sectors were split fairly evenly, with four participants interviewed from Non-Profit Organisations (NPOs) and three from private sector employment, including private practice and private hospitals. There was some overlap between NPO employed practitioners and the private sector in cases where they split their time between an NPO and private practice. State-operated facilities could not be accessed as research access to these facilities required special permission from the provincial government of the Western Cape, South Africa. These permissions were applied for, however, government closures during the COVID-19 pandemic delayed the reply, rendering it unfeasible to interview from such facilities during the data collection period.

4.3. Participant Profiles

Participant background and work information was used to build profiles of each participant to better understand responses across the interviews. Of the interviews conducted, 6 were audio interviews and 1 was an e-mail interview. Participant 4 took part in the sole e-mail interview. Simplified versions of these profiles are tabulated below for ease of reference when navigating the results. Some data has been intentionally obscured to protect participant privacy.

Table 1
Participant Profiles

Participant	Age	Gender	Qualification	Work Setting	Treatment Configuration
1	30s	F	Social Worker	NGO; Private Practice	Individual and Group
2	30s	F	Psychologist	Private Hospital	Individual and Group
3	50s	F	Social Worker	NGO	Individual and Group
4	40s	F	Social Worker	NGO	Individual and Group
5	50s	F	Psychologist	NGO; Private Practice	Group
6	30s	F	Psychologist	Private Hospital; Private Practice	Individual and Group
7	40s	M	Registered Counsellor	Private Practice	Individual

The participants' treatment settings were a mix of inpatient and outpatient, varying in each facility. Five participants reported working in fully outpatient or primarily outpatient settings while two participants worked in private hospitals with an inpatient focus. A precise accounting of treatment settings during data collection was complicated by the COVID-19 pandemic. Facilities were required to change their methods of treatment to maximise safety and comply with national COVID-19 restrictions. The exact measures taken varied from facility to facility. Some shut down temporarily and attempted to re-open with physically distanced treatment, while others such as private hospitals switched to a day-visit system. Further investigation into the changes brought about by the COVID-19 pandemic on the landscape of SUD treatment was outside the scope of this study.

With regards to treatment configurations, the majority of participants facilitated group therapy, with individual therapy as a secondary component at facilities, or a primary component in private practice work. Few participants worked primarily with individuals, or solely with groups. Group-based SUD treatment was popular, but was not the only approach to treatment (Coco et al., 2019). The majority of participants described their treatment programmes as combining group and individual treatment so that clients received the social support found in groups alongside the privacy and attention of individual therapy. Although the focus of this body of work is on practitioners, clients make up an all-important part of the treatment process and it bears mentioning that differences in funding and client socio-economic status can drastically alter their access to healthcare. Private hospitals tend to be considerably better resourced than state or NGO facilities, as evidenced by Participant 6's description of her hospital network's facilities as 'beautiful'. This is in direct contrast to participants from NGOs remarking on their funding shortfalls during interviews. The remarkable gulf between facilities that are so well-supported as to be aesthetically pleasing in the same metropole as facilities that struggle to make ends meet is a manifestation of the inequalities in the South African healthcare system (Gordon et al., 2020). Consequently, the demographics and experiences of clients at different facilities may be vastly different.

4.4. COVID-19 and Methodological Changes

The study's initial methodology called for in-person focus group discussions in Cape Town which would have replicated Jacobs' (2019) methodology. Focus group interviews

were chosen to generate rich data from interactions between participants through joint construction of meanings (Bryman, 2016; Gaskell, 2000; Pope et al., 2000). The sudden onset of the COVID-19 pandemic came with associated travel restrictions in South Africa which resulted in the rapid, unplanned disassembly of this plan. As a supportive measure for postgraduate candidates during COVID-19, Rhodes University issued a communique encouraging social sciences students to switch to electronic methods of data collection (Appendix A). The communique stated that ethical re-approval was not necessary if the data collection method was altered without changing the study's underlying principles. Thus, the study's data collection modality was changed to complete the study in a reasonable timeframe.

Digital focus groups were considered. It was decided that they were logistically unfeasible given the circumstances. Under normal circumstances arranging for participants to meet digitally at a specified time can fall afoul of internet connectivity issues and lack of experience with digital applications. If the strength of focus groups is that they rely on a strong group dynamic to produce valuable interactions, then introducing internet connectivity and technical issues while removing the ability to interact in person would have impeded the usefulness of focus groups. The disruptions brought about by the COVID-19 pandemic, whereby some participants became un-contactable, ceased work operations, or became overloaded made arranging multiple focus groups a daunting task. The COVID-19 pandemic is described as, uncertain, unprecedented, and unpredictable (Brown & Walensky, 2020; Durodié, 2020; Sperling, 2020) meaning that securing multiple participants for online focus groups in the timeframe was unattainable.

Semi-structured, one-on-one interviews were chosen as the primary data collection modality and semi-structured e-mail interviews were retained as a secondary option in cases where the former option was impractical or undesirable for participants. One-on-one interviews allowed for the logistical ease of organising myself and a single participant at a time.

The shift from a group setting to a private setting raised questions around the type of data that would be produced. Initially the plan was to replicate Jacobs' (2019) study in a different province with the intention of strengthening the study's transferability by producing findings from a different locale while making use of the same method. There is a possibility that some of the transferability and strength from replication is lost in the methodological

change. The expectation was that the disclosure from deeper, one-on-one interviews would make up for the loss of immediate transferability, which is not to say that these methodological changes resulted directly in a loss of quality. On the contrary, focus groups may discourage disclosure where the disclosure would result in discomfort or rejection from the group (Hollander, 2004). To that end, Hollander (2004) describes the desire for focus group participants to strategically manage their speech or remain silent within the group. When the topic of interview may result in discomfort by highlighting inadequacies in a system or organisation, such silence and shaping could be detrimental to the data collected. Even participants in an individual setting will strategically manage their speech, however, they need only contend with the interviewer, rather the people around them, who may be co-workers and associates. Conversely, the privacy offered by one-on-one interviews can enhance participant disclosure, but the co-operative creation of opinions offered by focus groups is lost.

It has been pointed out that the main loss incurred between a face-to-face interview and a telephonic, or similar long distance-interview, is that social cues and facial expressions are lost (Opdenakker, 2006; Sturges & Hanrahan 2004). Social cues are not central to addressing this study's research question and the loss thereof was deemed acceptable in order to complete the research at all. There is evidence that suggests that the enhanced distance provided by distance- interviews can enhance intimate disclosure, as the interviewee is situated somewhere of their choosing with enhanced privacy (Bowker & Tuffin, 2004; Jenner & Myers, 2018; Meho, 2006). There is no one-size solution to data collection methods in qualitative studies (Daniel & Valencia, 1991; Hofisi et al., 2014) and selecting one is as much a process of locating a best-fit solution as it is confronting resource limitations and unexpected circumstances. The shift in data collection modality in this study no doubt caused some opportunities to be lost and new insights to be gained. Whatever information that could have been lost cannot be identified and, characteristically of qualitative research, is impossible to replicate. The opportunity cost of using one-on-one distance- interviews versus the planned focus groups is unquantifiable, however, the present data collection method was deemed able to address the research question.

4.5. Data Collection Procedure

Data was collected through the use of semi-structured Zoom platform and e-mail interviews. Semi-structured interviews are characterised by the flexibility with which participants can answer questions (Hofisi et al., 2014). Conducted successfully, they bridge structured and unstructured interviews, retaining some of the depth found in long form, in-depth interviews without the rigidity of a structured interview (Queirós et al., 2017). Interviews are especially useful when people's opinions and worldviews are desired (Longhurst, 2003). Semi-structured interviews have merit in addressing this study's research question, as the crux of the study involves learning about the participant's experiences in the sensitive area of treating queer clients and learning about their opinions on gender-sensitive training.

Due to the greater normalisation of electronic communication during the COVID-19 pandemic, accompanied with concerns around the requirement for participants to have adequate hardware and software for audio interviews, e-mail interviews were an option for participation. E-mail interviews are an asynchronous data collection method whereby the interviewer and interviewee engage in an ongoing e-mail conversation in which questions and answers are exchanged (Meho, 2006). Studies on this method have indicated that it is useful in settings when distance or costs are a barrier (Meho, 2006; Opdenakker, 2006). Both distance and cost were barriers in the context of conducting research during the COVID pandemic. Less frequently mentioned in research is that e-mail interviewing increases convenience after the interview, as transcription is built into the method resulting in a digital paper trail. As the majority of correspondence to organise interviews was done via e-mail, offering e-mail interviews as a secondary option was a rational next step.

At the commencement of the interview process, participants were provided with essential information on the research (Appendix B), as well as given consent forms for participation and audio recording (Appendices C-E). When the interview commenced, participants were assured of their right to withdraw, and were politely asked to contact me should they decide to withdraw. Online audio interviews may suffer from technical errors and a participant vanishing in the midst of a sensitive discussion could just as easily be a connectivity issue as a sudden desire to withdraw. Clarifying whether the disconnection was a

result of an intentional withdrawal or an accidental occurrence would inform me about the interview's outcome, and what I should do with the data.

During the first interview a disconnection occurred and a standard procedure followed for subsequent interviews to establish a plan of how to reconnect and how many attempts to reconnect should be made before rescheduling. Over the course of data collection, interviews were rescheduled for reasons which included participant's desire for a better internet connection to a participant's client suffering a medical emergency which required immediate attendance. In all cases, continuous, respectful contact with participants was maintained to ensure clear communication with the possibility of rescheduling. While some of the points described above constitute basic practice in online interviewing, these data collection procedures were improvised during the uncertain, unprecedented COVID-19 pandemic alongside existing literature on conducting effective distance interviews (Connor & Madge, 2017).

The interview questions were concerned with how practitioners perceived gender-nonconforming people and their experiences of treating them. Gender-sensitivity was explored to determine interest and opinions. Broadly speaking, an initial set of questions established the participant's educational background, work experience and and work environment. This was followed by branching sets of questions into areas including treatment and planning processes, how they did or did not accommodate gender-nonconforming people, the presence of gender-sensitive language in treatment materials and research, and lastly practitioner training and development needs. Participants were generally encouraged to give their opinions without fear of judgment and encouraged to give long-form answers and opinions. Many interesting insights in the results originated from anecdotes, formative experiences, and other divergences from the interview questions themselves.

Breaks were offered at points in the interview process and, with all of the challenges associated with conducting a distance- interview, it was important to leverage some of the benefits. Participants were generally located in a comfortable place of their choosing and allowed to enjoy their amenities. Participants were asked whether they wished to be given any reports or publications that resulted from their contributions.

4.6. Interview Structure

Participants took part in semi-structured interviews, with main questions drawn from a prepared list (Appendix F). Each interview commenced with a reassurance of the terms of informed consent, in particular the right to skip questions or withdraw from the interview at any time, for any reason. Participants were given time to ask any questions they had regarding myself or the study as a whole. When participants deviated from questions, while still providing topical information, they were encouraged to continue. The initial questions consisted of background information related to their education, area of registration and work experience. Content-related questions revolved around a range of topics relevant to gender-sensitivity. These included the gender compositions of clients and treatment teams, the existence or non-existence of gender-sensitive language in treatment materials, promotional materials or literature encountered. Special interest was given to a practitioner's direct experiences of treating queer clients and how those clients were perceived by practitioners and other clients in the treatment space.

Practitioners were also asked directly about whether additional training in gender sensitivity was necessary and to suggest areas of improvement if they could think of any. I considered this line of questioning important. Asking directly and receiving unambiguous answers ensured that my participants had a direct stake in addressing the research topic and had an opportunity to provide valuable data directly. This was done in pursuit of creating a collaborative research process between the participant and I, with the aim of benefitting the client, the practitioner and myself.

4.7. Data Analysis

Data analysis for this study consists of a thematic analysis. While a thematic analysis alone would have been adequate to address the research question, findings from this study were compared to Jacobs' (2019) work which is referenced throughout. Comparison can benefit research in a number of ways, (Esser & Vliegenthart 2017) such as enhancing the understanding of the data by comparing it to other information, contributing to a transferable pool of knowledge, and reducing the likelihood of researchers over-generalising from their data without adequate support. A critical review was undertaken to bring to light the

researcher's worldviews and opinions regarding queerness being a sensitive and complex topic. The critical review includes my interpretation of a particularly rich excerpt from the data in relation to the literature, constituting being fully immersed in the topic. That segment treats the data in a more personal light than the thematic analysis or comparison, both of which remain largely detached from the human element.

Thematic analysis was chosen for data analysis, as it is useful in synthesising a set of overarching themes from qualitative data and unifying diverse data into a cohesive report. In the pursuit of reliability, thematic analysis was used to maintain similarity with regards to Jacobs (2019) publication. Braun and Clarke's (2006) procedure was used as a guideline as it was both structured for psychological research and used in Jacobs (2019). The thematic analysis was a software-assisted process, using NVivo to support the coding process alongside more conventional inductive methods. Software-assisted coding enables considerably better organisation and modification of codes in real-time, as well as easily being able to reference codes to their sources swiftly (Hilal & Alabri, 2013; Woods et al., 2016).

Due to the importance of Braun and Clarke's (2006) approach and thematic analysis applied to this study, their approach is summarised below with notes on how I addressed a given phase or deviated from it. Deviation is a natural component of research where modifying an existing guideline can yield more applicable analysis outputs. The authors themselves have noted that they have no desire to be treated as gospel, and originally published their article of stellar popularity as an accessible guideline (Braun et al., 2019). Where no significant notes are made, it can be assumed that I followed the step as outlined by the authors with little change.

Phase 1: Familiarisation

Familiarisation is the process of immersing oneself in the data by reading or transcribing the data. Familiarisation establishes starting impressions and understandings of the data and allows the researcher to begin understanding the dataset and determining future directions of the research.

My familiarisation with the data occurred during and after transcription. I transcribed the data personally, according to Braun and Clarke's recommendation of immersing oneself in the data, and began to develop initial insights (Braun & Clarke, 2013). Transcripts were read several times, and notes were made. One useful measure I employed was linking

questions asked in interviews to the original interview questions written down for reference and streamlined comparison of answers between transcripts. Side questions were re-written and marked so that each transcript was a navigable document divided into discrete sections by question.

Phase 2: Generate Initial Codes

Initial coding is used to organise the data in preparation for deeper work. Initial codes allow researchers to further understand the data and also begin seeing connections and commonalities between different participants or samples. Initial codes can be tentative and subject to modification, or form the basis for the main investigation at a later stage.

Due to the less interpretive nature of this study I opted for a semantic approach which took statements made at face value and coded them inductively from the transcribed text (Terry et al., 2017). The study's research question is concerned with collecting information, and an interpretive approach that would address latent meanings was not necessary. The data was digitally coded using the aforementioned NVivo, which allowed for the frequency and locations of codes to be easily tracked. A digital interface simplified the categorisation and organisation of codes. Codes and sub-codes could be modified or moved at will, and their source text was instantly viewable with its context. This organisation allowed for smoother analysis in later steps.

Phase 3: Searching for Themes

After initial familiarisation and basic coding, there is sufficient information to begin forming themes. Themes are connected clusters of data or meaningful ideas identified by the researcher and serve to connect individual codes and data points to the wider researcher question.

The search for themes was aided by NVivo, as the software allowed for intuitive categorisation of codes in a digital environment. Codes were already sorted by prevalence within the data and could be readily arranged into broader categories. The first active step in searching for themes was to create categories of codes which could be further examined or modified. Once created and organised patterns and differences between categories and codes were identified. Identifying themes was an active process anchored by adherence to the study's focus area: practitioner training, and treatment experiences with queer clients. Themes that were identified were formed with summaries and relevant excerpts from the data

as a means to develop an over-arching narrative for each theme which was relevant to, or otherwise substantiated by existing literature.

Phase 4: Reviewing Potential Themes

After an initial set of themes are developed, themes are examined and refined for fitness to the research goal. Themes are checked for quality and where necessary, they can be modified, divided or omitted entirely to best serve the research question. During this process, codes can continue to be modified or combined to better suit the interpretive goals of the researcher.

Once developed, themes were reviewed in relation to the research question, various other themes as well as existing literature. Emphasis was placed on identifying similarities and differences between participants' responses to the same question to develop a unified but nuanced account of a given theme. Some themes were merged into or split from others.

Phase 5: Naming and Defining Themes

Once themes are fairly well-established, they should be clearly named and defined in preparation for writing the research report. Themes should be named and defined in a manner that is cohesive, understandable and distinct from each other. Themes should have a clear scope with appropriate limitations, but also fit into the wider structure of the narrative report that will be prepared. Definitions should be clear and care should be taken to avoid having themes overlap in purpose.

Themes were named in a manner that was clear and organised, and listed in an order that reflected a research narrative from the large, to the small, as well as their connectedness to each other. The opening theme of 'Gender Binarism in SUD Treatment' is concerned with a macro-scale problem identified in the literature (Jacobs, 2019; Müller, 2017) that affects many parts of the treatment process. This is followed by 'Queer Discrimination and Substance Use', which was developed from frequent descriptions of trauma related to discrimination relayed by participants. It illustrates living examples of the risk factors clients may face, as identified by mental healthcare practitioners and addresses some of the unique experiences of queerness that may fuel problematic substance use.

The following themes were all related to training and by extension, the research question. Firstly, 'Interest in Gender-Sensitive Training' discusses the generally high interest participants expressed in training and described their specific reasons and knowledge gaps. 'Queer Literacy' was a sufficiently identified area of improvement that it warranted its own

theme, which expands on queer literacy and the importance of language use in treatment structures – something that can improve or worsen the treatment experience of queer clients. Lastly, 'Considerations for Training' described additional considerations and concerns reported by participants that could not be counted as part of other training-related themes, but were still important and warranted attention as part of a nuanced report about the data.

Phase 6: Producing the Report

The research report is most likely underway by this stage, but completion of the data analysis contributes the major novel findings and interpretations of the project. Braun and Clarke (2006) characterise producing a report as writing a cohesive narrative with a research question at its heart. The purpose of this narrative is to form a convincing and compelling argument that addresses the research question and effectively articulates the evidence, interpretation and limitations inherent to the project.

The themes from Phase 5 were anchored into the over-arching narrative and written up as a report. A portion of the report was dedicated to comparing results to those from Jacobs' (2019) work to draw from an existing pool of knowledge directly pertinent to South Africa.

Critical reviews of the research were undertaken using a reflective process, which produced an interpretative piece from one participant's experiences with a transgender client. This provided a detailed example of the challenges faced by a particular queer person, which was anchored to research into queer people's lived experiences in the literature. Although a comparison to a similar study is not explicitly part of the thematic analysis, it adds additional depth to findings in the thematic analysis.

4.8. Credibility and Rigour

This study adheres to a range of criteria for measuring research quality in the pursuit of producing a high-quality output. Contrary to a quantitative approach which places emphasis on hypothesis testing of numerical data to demonstrate the relationship between theory and outcome (Bryman, 2016), this study uses a wholly qualitative approach. While criterion for preserving the quality of research is paramount, its theoretical framework renders it impossible to use criteria designed for hypothetico-deductive research. By extension, I take the position that a study so different from hypothetico-deductive models should be evaluated

with different criteria for rigour. In practice, this is the model outlined by Guba and Lincoln (1994), describing trustworthiness and authenticity as main criteria for the evaluation of qualitative research, with sub-categories that parallel some criteria used to evaluate quantitative research (Treharne & Riggs, 2014).

Trustworthiness describes the broad quality of a qualitative study, and is sub-divided into criteria that parallel quantitative research criteria (Bryman, 2016). The most important of these is summarised by Bryman (2016) as credibility, which parallels internal validity; transferability, which parallels external validity; dependability, which parallels reliability and confirmability, which parallels objectivity. This study's credibility is primarily supported by adherence to ethical mandates and effective supervision.

Transferability is demonstrated in the comparison of this study's results with a similar study by Jacobs (2019), which aims to identify similarities and differences across locations. The choice of Cape Town, South Africa, as the research site to expand Jacobs' (2019, 2021) work to another metropolitan area was aimed at creating greater transferability. This could be achieved by performing a similar study to assess whether congruent results could be found in South Africa's Cape Town metropolitan area as in other provinces of the country (Jacobs, 2019, 2021). Comparison of results between the two studies can then be used to identify commonalities and differences while strengthening a core of research on gender-sensitive training for SUD treatment practitioners in South Africa.

Dependability is enacted via the creation and maintenance of accurate interview transcriptions which are supplied in this thesis to assist in the evaluation of this study. Adherence to methodological literature, such as Braun and Clarke's (2006) guidelines, and clear motivations for research decisions, supporting the requirement for dependability. Adherence does not equate to compliance and divergence from Braun and Clarke's guidelines were made where justifiable to improve the quality of the research. A reflexive, critical review of my internal processes and views are undertaken to improve dependability. Confirmability is concerned with the researcher's adherence to credibility in their conduct (Bryman, 2016) and it is recommended that this be the task of external evaluators, owing to the acknowledged impossibility of objectivity in this research and evaluation framework. The provision of complete data, researcher explanations for decision-making and comparisons to existing literature is aimed at streamlining this process for the evaluator.

Guba and Lincoln's (1994) approach is criticised for, among other things, placing too great a responsibility of evaluating research on external auditors or evaluators (Morse et al., 2002). In particular, they assert the need for researchers to take responsibility for rigour during the process, by means of verification strategies that can be carried out as part of the research undertaking. Verification strategies (Morse et al., 2002) include methodological coherence, which is the degree to which the chosen method fits the research question and goals; the use of appropriate sample sizes; the concurrent collection and analysis of data and theory development, which stresses the importance of shifting between micro and macro-level understandings of the data and theory to ensure applicability between the realms. Of the verification strategies listed care was taken to select a research methodology that is fitting to the research question, while remaining comparable to existing research and providing additional depth which a qualitative methodology can supply. An appropriate sample size was chosen to address the research question, albeit shaped by the vagaries of an unprecedented healthcare crisis, and software-assisted data analysis allowed data to be analysed swiftly after collection. It is hoped that the adherence to standards of research conduct, alongside measures to ensure rigour will prove sufficient to address these concerns.

4.9. Ethical Considerations

Risk considerations for ethical research practice were considered before and throughout the study. This study obtained ethical clearance from the Rhodes University Ethical Standards Committee (RUESC; reference no. 2019-0451-909, Appendix H). The RUESC is a body which oversees research ethics independently of individual departments and all applications are panel-reviewed prior to approval. Particular ethical considerations for this study center on protecting the dignity of participants, and by extension their workplaces and clients. This study's topic can be viewed as being in opposition to mental healthcare practitioners by its argument that they require additional training. Furthermore, the process of disclosing treatment experiences places participants at risk of embarrassment. In the event of a data breach, information discussed with me may become publicly available. This may result in harmful outcomes. The sensitive nature of the information being conveyed must be protected as participants divulged experiences of confidential therapeutic processes. In all cases, respecting client-practitioner disclosure is of paramount importance.

Concerns regarding confidentiality and information protection were addressed through a conscious effort to protect participant data and scrutinise written reports for information that could compromise an individual's identity or data. The former was addressed through digital data protection. Research data containing interviews, drafts and reports were only stored on password or biometric protected devices with up-to-date anti-malware software using licensed operating systems. Data was exclusively transferred between password and biometric protected devices via further password protected means such as e-mail or encrypted cloud storage. This is in contrast to moving data from device to device via USB device, where data may not be password-protected or can be otherwise lost. Confidentiality was addressed by publishing the minimum required amount of participant data and omitting any information that could identify participants or their workplaces. This resulted in the data in Table 1 which only describes essential information in relation to context without providing other information. During interviews, participants themselves took steps to maintain the confidentiality of their clients by only referring to them as clients, rather than by name. Participants omitted any information not immediately relevant to a question. For example, participants may have referred to someone as "a gay client," when the client being gay was relevant to the question. Ethical procedures were observed such as ensuring safe storage of research data and the protection of that data for a minimum period of five years after the study's completion in case of an investigation. This study is bound to its supervisor and the RUESC, all of whom are empowered to act independently of me to address ethical concerns.

4.10. Conclusion

This study uses a social constructionist and phenomenological framework to interpret the experiences of SUD treatment practitioners working in the Western Cape, South Africa, in order to address training needs that they may have pertaining to their queer clients. Data collected from one-on-one, unstructured interviews was run through a digitally assisted thematic analysis, and comparisons were made in relation to existing data in order to identify similarities and differences. A reflexive account, alongside existing literature, strengthens the analysis by providing a micro-level perspective of the real challenges queer clients face and addressing the researcher's positionality and views of the research process.

CHAPTER 5: INTERPRETATION OF THE FINDINGS

5.0. Introduction

Based on the lack of surveillance data on genderqueer individuals accessing substance use disorder (SUD) treatment, this study sets out to establish whether there is a need for gender-sensitive training for SUD treatment practitioners in Cape Town, South Africa. This body of work explores practitioner knowledge and training needs in the area of gender-sensitivity. This chapter presents the findings obtained during the course of semi-structured interviews on this topic.

Findings from the interviews with seven registered mental healthcare professionals are presented herewith. Meaningful themes are developed from these findings in which the data begins as a collection of independent topics, where commonalities are identified, described, and interpreted. Where a collection of answers appears to feed into a unified theme, with a category of meaningful patterns relevant to the research, – I present the theme with discussion. Furthermore, the themes developed from my findings are compared to Jacobs' (2019) work with the aim of identifying key similarities, differences, and new information. The comparison to Jacobs' study is pertinent, considering both the lack of research in this area in South Africa, and that this study was intended to be a replication of her study, in a different location with the aim of contributing additional data to a growing body of research.

5.1. Presentation of Findings

This chapter presents the findings and interprets such findings through the social constructionist lens of the study with the aim of addressing the research question. The focus is not on creating an overarching explanation, but to instead discuss recurring, meaningful themes identified by myself which highlight relevant parts of SUD treatment to queer clients. The participants' answers display importance as they describe the topic from their lived experience (Ricoeur, 1984), while providing valuable perspective from a key human component of the treatment process. No participant is considered more valuable than another, and I draw meaningful information from each participant's contribution. The chapter makes

extensive use of direct quotations in order to examine participant's words and viewpoints. Where relevant, I contextualise excerpts and link them to the argument being made in a given section. Participant privacy is maintained by referring to each participant by a numeric designation. A more detailed profile of each participant is available in Table 1, Chapter 4: Methodology.

5.2. Outline of the Main Findings

Table 2 presents the themes in a summary table for easy identification.

Table 2

Themes developed from the thematic analysis

No.	Theme	Explanatory Notes
1	Gender Binarism in SUD Treatment	The application of a binary understanding of gender in SUD treatment.
2	Queer Discrimination and Substance Use	Types of queer discrimination identified during the study and their effects on treatment processes.
3	Interest in Gender-Sensitive Training	Direct interest from participants in gender-sensitive training as well as areas of improvement noted by participants.
3.1	Queer Literacy	Improving mental healthcare workers understanding of queer literacy.
4	Considerations for Training	Considerations of how training should be undertaken to improve understanding of queer people's needs in SUD treatment.

5.3. Theme 1: Gender Binarism in SUD Treatment

Participants were asked about treatment processes. Answers provided give insight into aspects of group SUD treatment that are affected by gender. The default or standard group is a non-specific SUD treatment group, wherein clients work together with a facilitator toward a common goal of recovery. Entry into this group is generally only limited by logistical occurrences such as venue size and limitations on group numbers and all participants who work at facilities with group treatment describe having a standard group of this nature. Depending on client needs and facility procedures, this group can be a constant throughout a client's entire recovery process, with individual therapy and specialised groups

supplementing it. The client might be moved to specialised groups during their treatment. Participants report that forming groups with a special focus requires additional resources and depends on client availability. This restricted the feasibility of specialised groups, and the non-specific, standard groups becomes the default when alternatives are unavailable.

> *We do have literature and manuals that are specifically designed for women. And we're not doing it at the moment, but we have had specific groups treatment groups only for women. At the moment, we're doing mixed co-ed groups. We have a specific manual for females, and we have specific literature for females in recovery - for women in recovery... we find that when it comes to women, we will then hold a women's-only group if we have enough numbers. At the moment in our treatment programme, we only have two women so then we'll do a co-ed group.* (Participant 1)

Participant 1's organisation is willing and able to hold groups for women pursuant to demand, but the demand is not always present. In the absence of a feasible group, women are folded into standard co-ed groups despite the risk of exposing them to the conditions that women's groups and treatment materials were designed to address.

> *It's mainly group based, but there's also individual sessions with the person, and there is significant family involvement also. So, I'm mentioning that because the Matrix is a set, manualised program. It's aimed at males and females and whoever else comes to the program.* (Participant 3)

Participant 3's organisation differed by having a programme designed to address all genders, though this likely means cisgender men and women. The programme's broader scope involving group, individual and family therapy may set limits on how much content can fit into the programme before it becomes unwieldy. In this case, the programme's content is the main focus and it is not gender-specific.

> *Well, we do one-on-one sessions, but then we do a lot of group work. So, our program is very much centred around that. We do group lectures, we do group therapy, talks, group processes, and then we also do one-on-ones with your individual psychologists.* (Participant 6)

Group sessions are the focus of Participant 6's programme, once again highlighting the high prevalence of group therapy in SUD treatment. Their programme is based in a private

hospital and includes individual therapy with psychologists alongside a wide array of structured group work.

Unlike an individual therapeutic alliance between a therapist and client, groups rely on the facilitator/therapist and a group of clients to form mutual support systems for recovery. As a result, procedures are established to maintain group cohesion. These include keeping one facilitator for a group for the duration of a programme, reducing, but not barring, transfer between groups and maintaining an atmosphere of open-mindedness and mutual respect. The latter point is of special note, as it may have space for GAH practices. Participant 3's setting strongly emphasises acceptance and open-mindedness in its group as a core tenet, raising this as a possible strength that could counter-act discrimination.

> *There have been times where there's been discomfort in the group, but we have a very strict agreement. Before a client enters the treatment group, when we go through the contract and the confidentiality agreement, there is a big section in our contract that talks about acceptance, realising that people are going to go in a group with people from different cultures, different races, different sexualities, all that kind of stuff.* (Participant 1)

> *In Matrix* [their programme]*, it's very much that everybody is welcome, and everybody is accepted. There's very high regard for being non-judgemental. And that is the kind of behaviour and thinking that we try to build and emanate in the group for patients for other clients. Not to say it didn't happen, but none* [overt discrimination] *that I can recall or that was reported to me.* (Participant 3)

Beyond the standard group, facilities run specialised groups on a needs-and-availability basis. Facilities recognise the relationship between SUD and gender-based violence or process addictions and would form separate treatment groups to address these topics. Specialised groups are formed pending the availability of clients sharing the topical issue and the availability of a practitioner to coordinate it. Specialised groups mentioned included women-only groups and addiction groups such as sex, love, gambling and eating. By far the most common specialised group is the women's group, which is formed as a safe space for women to discuss issues specific to women that affected mental health and recovery. The formation of women's groups is reportedly hampered by low representation of women in SUD treatment overall, as described by Participants 1 (above) 3 and 5 (below).

> *But the problem is, for example, because of the very low numbers of women who actually come for help, it's mainly male. Like ninety nine percent of people who actually walk into our doors is male. Maybe not ninety-nine, but, you know, it's a very high percentage. Although we've been keen to actually also do the Matrix women's sessions, we've never had enough women to actually constitute a group to actually run sessions*. (Participant 3)

> *…there are not enough participants to even create a feasible group of three or four. We might have a person here and there, and if there were enough, we would try to create a group space specifically for that group. As an NGO with very limited government funding and constant financial challenges, we can't have endless options, programmes and social workers.* (Participant 5)

The specialised groups are formed in response to a need related to the substance such as a process addiction. Process addictions are a range of pathological behaviours in which people become dependent upon specific pleasurable behaviours (Sussman et al., 2011). Exercise, love, sex, and shopping are examples of process addictions. Some participants reported process addictions as a factor to consider when treating the main issue of SUD in a client. In the case of women in treatment, topics cited as contributing to substance use include gender-based violence, sex work, love, sex addiction and eating disorders. These listed experiences are certainly not solely experienced by women, but women appear to experience them disproportionately – to the point where materials and training exist to address women's issues specifically. The examples below describe gender-based violence and process addictions, respectively.

> *Women are generally a minority group in this field. It's generally more men in treatment, and seeking treatment. We have far fewer women than men and that could put them in a vulnerable place. For example, in group therapy when sharing personal things about abortion or prostitution and they're in a group with men who they could perceive as similar to the people who have abused them. For that reason, we feel it is important to try and create a safer space for women. In practicality, we run a separate women's group and we ask people what gender they would prefer for their counsellor.* (Participant 5)

> *…eating disorder groups tend to be more female-focussed. Much of the sexual practice among gay men involves drugs, especially methamphetamine. It seems that*

> *certain drugs facilitate sexual contact more than other drugs. For example, crack cocaine and similar stimulants may increase the feeling of being energised as opposed to depressant drugs like benzodiazepines.* (Participant 7)

The role of a women's group is described as protective by Participant 2. In their case, the formation of a women's group is aimed at allowing them to feel less threatened by men when discussing certain topics.

> *At times when we feel the need, if there are people battling with a sex addiction, we might have a group, if we feel the need to… it's happened in the past where we feel we need a separate group for those battling the sex addiction. 'Cause there's a lot of shame around that. Then we will have a separate group, and we did split that according to gender, if I remember. It's been a while since we've done that, but we did split it. So the female sex addicts and the male sex addicts had their own space to speak about it, but beyond that, no, we don't really separate.* (Participant 2)

In Participant 1's case, women's issues are covered in a separate women's manual and they are ready to form a group pending availability. Specialised groups like this can be beneficial, as creating a safe space among clients can encourage healthy disclosure and give privacy to sensitive topics (Greenfield et al., 2013; Grella, 2008). Participant 5's description of ensuring the women's groups are facilitated by women makes sense considering the context of working with a group of clients who may have been victimised by men.

When queried about the reason for a sex addiction group being segregated by gender, Participant 2 said that, "The reason was comfort. I think the female patients wanted their own group. If memory serves. So the female sex addicts didn't want to be in the group with the male sex addicts." Even though Participant 2 indicated that they, "don't really separate" their groups by gender, the women in the sex addiction group requested it. The sentiment for protecting the comfort of women is echoed by Participant 5's earlier statement that women being both a minority in treatment, and often having been abused by men, necessitated additional protective measures. This presents a scenario where even if a facility does not normally gender-segregate treatment groups, they may encounter situations where a group of client's express discomfort at the presence of another. The construction of men as a potential threat to women's spaces and privacy in the minds of clients could make a case for this request, even when the men have not necessarily violated anyone yet. In these cases, client well-being is prioritised, and reasonable or feasible requests can be accommodated. This also

applies to situations where clients request a practitioner of a certain gender for comfortability reasons, as recounted by Participant 5:

> *"…we run a separate women's group and we ask people what gender they would prefer for their counsellor. And we make sure if a woman wants a woman counsellor - that is always accommodated*."

Entry into the women's group as a client is simple: one need only be a woman to be eligible. However, my reflexive interpretation of Participant 5 attempting to integrate a trans woman into a women's group will later lead to argument being that entry into a women's group is more complex than that.

The predominant two-gender model of treatment is reflected in manuals and research literature accessed by practitioners. Participants pointed to literature which is directed at genderqueer identities beyond the common man/woman dyad. They reported occasionally seeing gender-neutral language where it may be relevant.

> *I think it's very much the 'he/she' narrative that plays out, but I don't think that's always true. I think that's probably mostly true, but I have found some literature - whether it's textbooks, or your academic articles, and your various sources of literature - that are pronoun sensitive. And more inclusive in terms of the gender. But I would say it is more the 'he/she' narrative.* (Participant 2)

> *Again, I think the problem is that much of the research and much of the focus of programming is usually aimed at males. So even understanding substance use disorder for women is quite lacking. The research focusses on the male body. So, the people who partake in the research would be male. There's very little focus—and now there is starting, I think, more of the recognition of the need to look at researching the impact, you know, how SUDs show themselves in women, in terms of the aetiology, in terms of the progression of the disease particular to the female physiology.* (Participant 3)

> *But also related to what women experience with a substance use disorder and how that impacts on their lives and interacts with other factors in their lives. So, there is that component very much so, so one can already think that if women also are neglected, how much more people in the LGBTI community?* (Participant 3)

Participant 3's description of their encounters with literature that has been repeated by researchers for years (Glynn & van den Berg, 2017; Matsuno & Budge, 2017). The conclusion they reached is that women being under-represented in research must leave queer people in an even worse position and is reflective of the numerous issues outlined in my literature review, which describes the inadequacy of research on queer people in SUD treatment.

The dominance of research focusing on men and women may lead to an impression that men and women are the only clients in SUD treatment. This impression is strengthened by normalised behaviours and customs that reinforce a strict gender binary. The construction of gender as a binary, with two possible options, permeates all levels of society and for SUD treatment it includes the education that practitioners are exposed to, the norms that they live with and the literature they absorb. Eventually, a binary construction gender extends to the facility's preparations of advertising, treatment plans and other in-house materials. When asked if the language used in the preparation of the facility's materials made us of any particular gender categories, Participant 4 reported that there was none, "…besides the predominant genders of male / female." Their answer is frank and reflects the sentiment expressed by many researchers who are concerned about the gender binary and its impact on healthcare.

Some participants note that programmes and manuals themselves tend to use gender-neutral text. Those who go into depth about the materials in use at their facility note that the primary forms of reference to clients were genderless and direct, or gendered but encompassing the two main genders. Likewise, promotional materials aimed at the clientele may use direct language such as *you* to make the material more personal and targeted.

> *So a lot of our literature is, I think, gender-neutral, because we use manuals and stuff. Instead of saying 'he' or 'she' we say 'the recovering person'. Or a lot of the literature's written from the perspective of, 'I will conduct myself', 'I will help you to think,' or 'patients stopping their use.' So it's quite gender-neutral.* (Participant 1)

> *We would say 'for everybody, males and females' because if one looks at programs, people would ask 'is it for males or women and men?' Because inpatient programs would usually focus on men or women, you know? Have that separation. It would then be that we would say, 'males and females.' You know, anybody is welcome to come.*

> *And then I think also just to add in to be more specific also to the geographical area - because our services are registered for a specific area.* (Participant 3)

> *No, we keep everything vague. So it's more about what we do, more about our services, and its more termed of, 'should you feel like you would like to get treatment' It's more personalised but not anything termed of male/female, nothing like that… Or we'll say, 'if you are feeling this, this, this, and this, or, 'if you are experiencing this, this, this, and this.' But it's not anything to do with anything male/female or gender or sexuality or anything like that. Because it's about the addiction, not about the person themselves, if that makes sense? Because the addiction is the problem, 'you' are not the problem. So, we kind of separated them.* (Participant 6)

While technically open to all, Participant 3's description of their programme being open to anyone who is male, or female, addresses one of this study's central topics: What happens to people who are not male or female-identified when they enter treatment? People who do not identify with either pole of the binary, or who identify entirely outside the binary, are at odds with the assertion that treatment is for everyone who is male or female. Rather, what Participant 3 says may actually be true for a queer-exclusionary healthcare system (Hudak & Bates, 2018), one where SUD treatment is open to everyone, as long as they are a cisgender man or woman. This statement is not intended by the participant to be discriminatory, but is made from their constructed system of knowledge which identifies men and women as 'everyone'.

In Participant 1 and 6's case, the use of genderless language may have benefits, however, it is of less use when targeting people for whom gender, or sexual identity adds anxiety to when they enter treatment. Sometimes, a purposeful decision is made to centre identity in movements such as Black Lives Matter (Liebermann, 2020), or Gay Pride in order to centre people who are not part of the status quo. This is illustrated by queer people's conscious decision to search for queer-friendly healthcare (Hudak & Bates, 2018). Their search stems from an awareness that despite claiming to be for everyone, standard healthcare is often fraught with discrimination to queer people and serves a status quo: men and women. Healthcare that is specifically marked as queer-friendly advertises a reduced risk of discrimination and greater recognition of queer issues. This presents a possibility for more queer-friendly advertising by tailoring messages to be inclusive of queer people to convey a message that queerness is accepted in a facility. The notion of advertising treatments tailored

specifically to women or people with process addictions is not foreign but as Participant 6 points out, there is a line between piquing a client's interest and implying that their disorder is inherent to their personhood.

The contrast in how different facilities target their promotional materials and form of address speaks to each facility's constructions of gender. Some address it by focusing on the client independent of their identity, thus reaching a wider range of people by stressing the substance use, rather than their identities. This occurs even when these facilities may have resources and expertise to run specialised treatment groups for certain demographics and process addictions. However, a binary understanding of gender as a norm is still present and ingrained as a default.

Gendered issues in SUD treatment are not as clear cut as an over-emphasis on one gender or the other. However, the fact that SUD treatment is somehow gendered is undeniable. Some people receive targeted treatment and research to improve their healthcare conditions and others do not. Some treatment groups are accessible to certain genders only. Practitioners themselves are gendered and this can factor into treatment decisions made by clients or facilities. In particular, the presence of dedicated women's treatment groups and facilities suggest that there are aspects of SUD related to gender that are significant enough to warrant special investment. There is a documented history of SUD treatment focusing on men at the expense of other genders, or otherwise upholding men as the default body in medical research and relegating everyone else to other categories (Dada et al., 2018).

Of complexity is the existing intersection between gender-based violence and gendered experiences of SUD. Women's experiences of SUD can be linked to other gender-based violence, or manifest in ways different to men (Jacobs et al., 2012; Pretorius, 2010) and the formation of groups and facilities for women is a step to addressing that. The need for women to have dedicated spaces to work through trauma as part of their recovery process is highly pertinent and is not an intentional effort to harm genderqueer people. However, the formation of women's groups and facilities to counteract the often male, over-represented standard groups and facilities, also reinforces a binary construction of gender.

For mental health practitioners, this binary conceptualisation of gender appears to be a standard component of facility procedure and the knowledge that they have been exposed to. A number of participants relate their understanding of some genders being over-represented or under-represented in treatment. This understanding appears to stem from a dominant

narrative in their lived experiences as well as research that, men are generally over-represented in treatment. The former is illustrated by accounts such as Participant 4 who indicates that they do not see categories besides the predominant male and female in treatment materials and research; or Participant 2 finding that some texts are inclusive of more than two genders, but mostly finding a "he/she," approach to gender. The component of participants' lived experience can reinforce the gender binary. As they reported, participants were predominantly trained through academic narratives and figures that only reported on men and women. Only Participant 2 reported receiving education on non-binary genders (which is elaborated on later) during their coursework, and this was provided by a guest speaker at the lecturer's behest rather than as part of the curriculum. Once they enter the workplace, this existing knowledge of gender is further reinforced by standard workplace practices such as providing treatment to two genders in their gender-specific groups or classifying practitioners in accordance with the gender binary so that they may receive certain genders for safety and comfort reasons.

'Facts' about life which are taken for granted such as the standardisation of treatment into two genders or none at all, or the extensive focus on men and women in statistics with no other groups represented, constitute the environment in which practitioners live and work. This extended critique of the binarised state of substance use treatment is not a wholesale rejection of the corpus of work on gender in substance use. The figures on men being over-represented in treatment, the ways in which women experience gender-based violence alongside substance use, and the need for effective safe spaces to promote comfort are all important. What I am challenging is the adequacy and fit of the existing conceptualisation of gender for treating a person who does not conform to the gender binary.

My discussion focusses on gender and not sexualities, and the way people's understanding of gender and sexuality are constructed side-by-side means that people who are not heterosexual still experience worse treatment. Some of Jacobs' (2019) participants reported gay men requesting women as their practitioners out of fear of judgement from a practitioner who is a man. Men/women gendered treatment groups and manuals targeted at women were developed out of necessity to address areas of improvement in treatment. It is now asked: Where do people who exist outside of, in-between, or do not look like the two main genders go for treatment? In a case such as Jacobs' participant reporting that gay men requested women mental health practitioners, even clients who identify within the gender binary face challenges related to the conceptualisation of gender. Where does that person go

for treatment? In the aforementioned example from Jacobs' (2019) study, the construction of gay men as not being men, but feminine is shown to still permeate South African society (Henderson, 2015; Luyt, 2012) and may lead to discrimination on the basis of gay men's perceived femininity. At the very least, it contributes to the client's anxiety on seeking healthcare for fear of discrimination. As a result, gay men are aware of this and may seek to protect themselves by avoiding those they perceive as discriminatory.

5.4. Theme 2: Queer Discrimination and Substance Use

Multiple participants describe discrimination suffered by queer people as risk for difficulties, whether it be a driving force for substance use, or impedance to recovery. The marginalisation of queer people being a contributor to substance use is well documented (Felner et al., 2020; Parent et al., 2019), and these participants provided insight into their work in South Africa's Cape Town metropolitan area. This theme combines findings related to discrimination as a driver of substance use and the difficulties faced by queer people in recovery due to continued discrimination. The reason for this is that the amount of data was insufficient to create two separate themes on this topic. Further to this, the scope of this study is not large enough to address the topic of queer discrimination as a risk factor in satisfactory detail. The first set of findings in this topic are related to trauma resulting from discrimination as a potential catalyst for substance use.

Participant 1 describes the effects of discrimination, and the lasting impact of discrimination as follows:

> *My experience working with them is I feel that you need to be a little bit more empathetic and understanding. A lot of the clients come with a huge amount of trauma regarding their queerness or lesbian or gay status - whatever they identify with. It's usually a big part of the treatment plan, whether it's trying to help them work through accepting who they are, or trying to help mend family relationships, because you know the family relationships a lot of the time are broken because the person has come out. On top of the fact that they're having a problem with drugs and alcohol and by coming out, they've had to deal with huge amounts of abuse from other people or within their families. So yes, they're quite complicated cases. Lots of shame - I hate to say this, but sometimes more shame and guilt than someone who*

> *doesn't have to go through the experience of having to come out, you know?* (Participant 1)

Their approach to address a weakened support system involves working on self-acceptance with the client or trying to mend family relationships to re-establish the familial support system. The well-known queer experience of rejection from a family or community as a source of trauma (Abreu et al., 2019; Hall, 2017) was reflected by other participants too.

> *I know that parents have been a big thing. Parental rejection, parental abandonment, parents not understanding the patient and their gender identity or their sexual orientation, and feeling rejected on that front. Which is quite a big thing, because if that's not accepted, them "I'm not accepted." If that is rejected, then, "I'm rejected."* (Participant 2)

Later in a discussion of pronoun usage, they continue by saying:

> *Remember I told you about those family meetings we had? And then we have when the parent will refer to the patient by the wrong pronoun, you know? When I've been part of the previous discussion of "Mom, this is my pronoun", ten minutes earlier, you know? So there's just, like, no consideration for that, I suppose. So the parents are a big thing, and it's not only in gender identity now. It's not only in that, it's across the board. A lot of patients we see have a lot of pain from their parental relationships. I mean the patient needs to be discharged right back into that family system. And that's often what they say is: "Here I'm protected, but I need to go back into the world at some point.* (Participant 2)

Not recognising a person's chosen pronouns disrespects their self-determination (Dietert & Dentice, 2009) by overruling their decisions about their own selves and is one of many forms of discrimination experienced by queer people. Participant 2 is aware of this due to how it may impede treatment processes that rely on strengthening familial bonds. Their description of clients describing the treatment setting as protective, however, having to face the anxiety of being discharged back into a discriminatory world, contains two interesting implications. Firstly, it implies that Participant 2's treatment facility is contained, protective and therefore less discriminatory than the client's norm. This is contrary to existing literature on queer healthcare experiences in South Africa (Müller, 2017). Participant 2's employment at a private hospital in Cape Town may bear relevance to the protective environment reported

by their queer client, as wealthier suburbs or private healthcare facilities in South Africa have been associated with comfort and safety by queer people (Ngidi et al., 2020).

The second implication is the link that Participant 2 makes between queerphobic discrimination and problematic substance use. They note that queerphobic discrimination is actively impeding a treatment process in a way that would otherwise not exist if the participant conformed to their assigned gender. This discrimination complicates treatment and potentially lowers its likelihood of success by reducing the support a client has. Furthermore, the client's own commentary about being discharged from a containing space back into a discriminatory family system seems to imply that the discrimination they encounter outside could impact their ability to maintain sobriety as they are being discharged into a hostile environment.

Participant 3 identifies a very similar problem of damaged support structures, and briefly describes their method of addressing it. They also note the prevalence of negative value judgements from families and their deleterious effect on recovery. Their recommendation was to identify alternate support structures and work with those instead.

> *I also think of family-related matters, because the issues of disorganisation in the family, judgement and acceptance in the family and support structures are also important. That is going to determine a person's ability to deal with the substance use - whether they have a healthy, positive support system that they can lean on. If that support system isn't there, then it's working with the person in identifying and developing a support system.* (Participant 3)

Trauma resultant from familial rejection is a driver of substance use among queer people (Felner et al., 2020; Parent et al., 2019). The observations made by practitioners in this study are no different. Another point raised by the participants is that the stigma of being queer can compound with the stigma of being a substance user, making management of both more difficult.

> *Lots of shame - I hate to say this, but sometimes more shame and guilt than someone who doesn't have to go through the experience of having to come out, you know? To open up to their families like, 'oh hey, I'm actually gay, and guess what I have a heroin problem." So it's almost like a double-whammy in some ways*. (Participant 1)

An internalised feeling of shame can develop as a result of relentless discrimination experienced by queer people (Ngidi et al., 2020; Pollard et al., 2017). Participant 2 identifies this alongside their knowledge of shame experienced by problematic substance users, whether as a driver of substance use (Rahim & Patton, 2015) or within treatment itself (Wiechelt, 2007).

> *I don't know about specific links to substance use, but I know in terms of the object that you internalise, and your attachment, and all of that. And connecting to this parent - that is impacted. But I'm not sure what the link is with the substances. And you know, what I'm thinking about now, which often comes to mind is they feel like their parents are trying to fix them. Not just the alcoholism. You know that, "I am broken." And that hurts deeply.* (Participant 2)

In addition to identifying challenges in treating substance-using queer clients, Participant 2 speaks openly about the impact on a client of feeling as though they are damaged due to their queerness and having been sent to a facility to treat their queerness as well as their substance use.

Although family was not the sole source of queerphobic discrimination reported in interviews, the prevalence of family-related discrimination was likely due to the need for practitioners to work closely with family. Accounts such as Participant 2 noting a parent's unwillingness to use chosen pronouns arise in programmes where family therapy is part of the treatment programme. The intention of these programmes to reinforce the support structures surrounding a client is perfectly reasonable, but the presence of an actively discriminatory family could erode the client's trust in their family and weaken their support system, despite efforts by those involved. Participant 3's approach in identifying and developing separate support systems is an effort to bypass the family entirely if they are unwilling to offer support to the client.

Participants occasionally note other mental health challenges experienced by queer people, but responses are limited to what they saw in their line of work being shame and trauma. Participants are aware of non-familial discrimination such as that imposed by society, from religion, and other travails of queerness such as living in the closet. Their responses are limited to their direct experiences of these wider problems: Clients presenting with considerable shame, pain, and damaged families alongside their presenting problem of

substance use. This does not constitute a lack of acknowledgement of wider forms of discrimination, but rather an emphasis on what practitioners witnessed in their work.

Participant 2's account of a queer client describing the treatment space as containing and secure in contrast to their family environment, as well as the participant's position in a private hospital, speaks to the geographies of queer discrimination described by Ngidi et al. (2020). Ngidi et al. (2020) write on spaces in which queer discrimination manifests in parts of South Africa, and how it can be linked to the constructions of queerness in those spaces. Participants in their paper who were queer people residing in South Africa and Namibia reported varying degrees of threat depending on where they were. Areas that were wealthier, or suburban were experienced as safer, or more accepting of queerness, while home environments in poorer areas were sites of constant harassment and threat of direct violence. The authors link this to the construction of queerness in different spaces – whether queerness is constructed as deviant and damaging or as just another form of personhood can dictate the social attitudes of families, communities, and public institutions.

Participant 2's client' account suggests that the facility they are situated in is considerably safer than the client's home environment, leading to the impression of safety as well as a fear of what is to come when they are discharged. Likewise, the authors (Ngidi et al., 2020) point out that dislodging discrimination is not only up to awareness or campaigning from a single stakeholder but requires fundamental changes in how queerness is perceived and constructed in communities. If queerness is perceived as a threat or negative deviance, then it may be treated as such, and the consequences can be violent. In a space such as Participant 2's private hospital where practitioners expressed concern about the client's recognition in the face of a hostile family, clients experienced containment and security which are beneficial to their treatment.

When the effect of being stigmatised simultaneously for substance use and queerness are taken into account alongside reflections of clients being released back into damaging homes and communities, a picture emerges on the complex interaction between discriminatory trauma and substance use. There is a real possibility that trauma drove these clients to substance use in the first place and those who were out of the closet and rejected for it would have to endure the recovery process with a drastically weakened support structure. From participant accounts there are experiences of shame and stigma attached to being queer,

weakened support structures during recovery, followed by discharge out of the protective space of recovery into the world where discrimination remains as pertinent as ever before.

5.5. Theme 3: Interest in Gender-Sensitive Training

When asked directly whether they thought gender-sensitive training in treating queer clients was necessary, all participants answered with an affirmative. Two participants gave answers in the vein of, 'Yes, but…' and provided additional clarification on their apprehensions but were otherwise not closed off to the idea. The areas of improvement identified by various participants were quite broad on account of their interviews being open-ended. As a result, participants tended to identify priority areas related to their expertise, however, the topic of queer literacy occurred repeatedly and is described as a sub-theme further down.

> *Certainly, I think there is a need for that* [gender-sensitive training]. *For at least the awareness, the sensitivity, the start of the conversations around that. And then I think making those specific concerns more visible, more mainstream in a sense.* (Participant 3)

Participant 3 speaks to the importance of awareness around queer issues, discrimination and mainstreaming these. This approach echoes Ngidi et al (2020) in their assertion that reducing discrimination is a societal effort, not solely an organisational one. Participant 1 felt similarly about this sentiment, saying that:

> *There's so many different things happening in the world at the moment, but if there is one thing that is definitely coming across for people of colour or the LGBT community, is that everyone just needs to shush and just listen. We all need to just sit down and listen to people who are marginalised, who are struggling to be heard. I think that's where it's starts. Because we've been talking about it, and also because of the context we live in in South Africa where the majority of our population is people of colour, where never mind people who are LGBTQ where they struggle because they're marginalised, what about people of colour who are trans or people of colour who are part of the LGBTQ community. That's even more challenging. That's another risk factor on top of everything.* (Participant 1)

I open this set of findings by mentioning advocacy and awareness due to the number of participants reporting having positive experiences with gender-sensitive training in regard to queerness in the past. These experiences have shaped their knowledge and interactions with queer clients, often through a single speaker or short course. Participant 2 had a guest speaker during their master's year who spoke on being transgender:

> *…we had some people come speak to us about it, people who were trans spoke to us about their experiences, their difficulties, what they prefer. Sorry, it was one person, not people. Yes, it was one person. So we had that and we had lectures. So that kind of thing was great, but I definitely do think there's space for more. That was really awesome… It was someone known to one of our lecturers, and they had said that they would like to come speak with us, so the lecturer said that would be awesome. So I think it was part of the person's journey, was to share this. So it wasn't a patient, it was just someone that one of the lecturers knew, and they wanted to come chat to us, and so they did.* (Participant 2)

The participant's description of this interaction as 'awesome' is surprising, considering how infrequently formal education is described in that manner. On the other hand, it is noteworthy that among all of my participants, Participant 2 was the only one who received any education in gender-sensitivity during tertiary education. This education on the topic was impromptu and not a component of the formal curriculum. The impromptu nature of this education is shared by Participant 5, whose experience of 'scratching around' speaks to both the scarcity of this training as well as a very real desire for it.

> *There's very little actually, we sort of scratch around for stuff. It was somebody from some organisation who was very approachable who contacted us to find out about referring. And I just took the opportunity to grab him to come and present something on the area to our team. I had to take the opportunity for myself and it was extremely helpful, but it wasn't laid down on any level in our training in our community or organisations. There's a need, a huge need, even if it's all final year university social workers getting a module that equips them for understanding. It's just that it's not readily available from the organisations that might be able to offer it. This guy I contacted. He wasn't even offering – I mean he was happy to do it and fantastic but that wasn't something his organisation was doing routinely.* (Participant 5)

Participants took the opportunity to ask me for information on gender-related issues. Early in Participant 6's interview, they described the process of keeping pace with ever-changing queer language as being difficult, saying that:

> *It's hard for me to kind of keep track with what's what sometimes, and it's hard just to be respectful. Like, LGBQ-what? LGBTQ+… the 'I'. I don't even know what the 'I' means now, and obviously I'll have to go and find out, you know? And like it's bad.* (Participant 6)

By the end of the interview, they used the opportunity to ask questions about queer terminology, "What does LGBTQ+I stand for? So I know the first four, but the rest—you have lost me by the 'I' and the plus." After my effort to answer the question, they indicated their desire to report this new information to their team and said, "Ja, that's why I was going 'what?' And now I can tell my staff that. So I can go and tell them what those things mean too, and these things will be more sense of what's what."

Care and interest taken in this was incredibly encouraging for me to see as a researcher and once again, its impromptu and informal nature, immediately after a research interview, is indicative of the unfulfilled desire mentioned by Participant 5. Taken in the context of participants scrounging for knowledge from wherever they can, it speaks to the need for training as the relevance of queer or LGBTQ issues grows. Jacobs (2019) advocates for the need for training to alleviate what is essentially discriminatory practice from medical practitioners. I too have encountered a pressing need for training and seen shades of exclusionary practices, however equally, the participants spoke frankly about their desire and efforts to locate information to better serve their clients.

Their interest in training was essentially concerned with the well-being of their clients and improving their knowledge. From a social constructionist perspective, I interpreted this as practitioners realising the limitations of their existing knowledge and actively attempting to improve it through adjustment and reconstruction. This can involve identifying one's knowledge gaps as Participant 1 does when they say, "That's [queer literacy] one of the things I struggle with personally - well not struggle with - but I'm just not conscious of it and I haven't put effort in, which is bad from my side." Otherwise, it may involve seeking out new resources by any means available, such as in Participant 5's "scratch around," search or Participant 6 asking questions of a researcher. The call for training did not begin and end in a classroom setting. Participant 6's experiences led them to allude to t a call for education to

the societal level, saying that: *Your sexuality shouldn't be seen as what is right or what's not right. It should be about a person. And I think it needs to be normalised, and it needs to be seen as not a thing that needs to be fixed, because there's nothing wrong there. And I think there needs to be more discussions around this. It needs to be taken from schools, to varsities, to treatments, to therapies, to CBDs, to talks, to everything. I think more people need to be talking about it, to make it normal, to make it okay. And I do feel that part of a psychologist's countertransference needs to take this into consideration because I think that's not been happening.* (Participant 6)

Aside from making a call to bring greater awareness to the existence of queer people and the challenges that they face, Participant 6 reflects on their own practices as a therapist in relation to queer clients. The concern for countertransference and personal issues impacting on the therapeutic alliance is raised by Participant 3 in a different manner. Participant 3 takes aim at the importance of supervision. Supervision is a prized component of mental healthcare practitioners' training and reinforcing it through the use of a reflection to address pre-existing queerphobia is highly pertinent.

> *In training, it's also important to look at one's own issues around gender identity and acceptance of the fluidity, the variety. So practitioner's personal issues, personal concerns, personal judgements during training is going to be important, too. Especially as it comes up in supervision. So the aspect of professional supervision is very important too*. (Participant 3)

Specific areas of improvement cited by participants include enhancing their understanding of language related to queerness, addressing standard SUD treatment paradigms which treat gender as a fixed binary, and managing client trauma when it is related to their queerness. These areas highlighted by participants provide first-hand recommendations of the challenges of providing gender-sensitive healthcare to clients and point to avenues of training that may address them. Authors such as Scandurra et al. (2019) have called for training healthcare practitioners in gender literacy enabling them to improve their knowledge of queer clients. The need to reduce discrimination and improve the understanding of queerphobic violence and its impact on trauma identified by Glynn & van den Berg (2017) is mentioned by participants and occasionally identified as an area requiring improvement.

I devoted this theme solely to the broad range of training interests and areas expressed by participants due to the unexpectedly large number of areas identified for improvement. Topics mentioned in this theme alone include the need to listen to marginalised voices, giving proportional research attention to women and non-binary genders, the impromptu yet impactful nature of informal training and facilitating practitioner reflection in their treatment spaces. Each of these topics is worthy of investigation that could contribute to the web of training needs and practice for enhancing gender-queer SUD treatment. The one common theme uniting these areas of improvement is an underlying desire for training, even if the style of training varies from person to person.

5.6. Sub-theme 3.1: Queer Literacy

One area of interest which is reported by participants frequently to warrant a sub-theme is queer literacy. Different participants report different areas of improvement when asked around the topic and generally make suggestions relevant to their context. Five participants specifically mention learning queer terminology or the language of queerness as something which is potentially beneficial. The desire for learning in this area was undergird with an anxiety about addressing clients in an appropriate, politically correct, or relatable manner that would be most appropriate. Participants are aware that addressing a person appropriately strengthens the therapeutic relationship, with practices that strengthen the therapeutic relationship having the potential to improve treatment outcomes.

Participant 5 outlines it simply with specific reference to the outside speaker who assisted their organisation:

> *There should be help for social workers to understand the different identities that people in that group experience. And how to speak in a politically correct, inoffensive way about those people and to those people. This could the main thing. I think your average social worker doesn't know the different identities are in that group. They have a vague idea, but they don't really understand. That's what was extremely valuable about the talk we had that the person helped to unpack. The different identities that people have and what those things actually mean. And how to refer to them, what pronouns to use. They introduced us to new words that we didn't know. There's a great lack of knowledge*. (Participant 5)

Another participant's concern in this area was its potential impact on the therapeutic alliance:

> *When we started this talk, I mean I need to even now find out what is exactly the meaning of LGBTQI+. Things such as that, as what are the different subsets, you know? How does that person feel, and how can I be respectful of that person? And especially if I'm going to be seeing this patient, my transferences need to be considered, but how can I do that if I don't know what I am dealing with? What that person is experiencing? I need to try to understand to the best that I can so that I can make sense of their life and their experiences and help them with that. But if I don't even know, how can I do that?* (Participant 6)

This concern is well-warranted, as a practitioner's mishandling of something as essential as a name, pronoun or other form of address can be detrimental to the healthcare experience of their client (Bell & Purkey, 2019; Hudson, 2018). Perhaps reassuringly, Participant 6 took the opportunity to ask me about queer literacy after the interview and received an answer on what the 'LGBTQI' acronym means. Other participants also wished to clarify their understanding of queer terminology. Participant 1 and 2's responses are chiefly concerned with learning the basics of what different forms of queerness entails:

> *That's one of the things I struggle with personally - well not struggle with - but I'm just not conscious of it and I haven't put effort in, which is bad from my side. It's one of the things that I think we have to work on - I actually wrote it down on my piece of paper. The biggest space is our issue around language. What term do you use? What is the correct language? I don't think it's something we have necessarily focussed on.* (Participant 1)

> *Professionals need training to learn the correct language to use. I think we need training to understand the different, you know, how people identify, what makes them different. I think even though we have people who are trained in psychology or social work or counselling or whatever it is. Maybe because I was trained long ago, but I don't think any of our training touches on any of these issues at all.* (Participant 1)

> *I think just in terms of the different categories, you know? Just to outline that, because I know that people don't always know 'cisgender'. They don't always know those kind of things. Which is ignorant, but I do think training in that would be great for the sensitivity to it. Not teaching them to be sensitive, but teaching them what the categories entail. Their different personal identities and so on*. (Participant 2)

Use of an individual's name, pronoun and related forms of address are a frequent recommendation in caring for queer people (Baldwin et al., 2018; Knutson et al., 2019; Lombardi & van Servellen, 2000). Consequently, the lack of such practice is a frequently identified negative experience held by queer clients in healthcare services (Bell & Purkey, 2019; Brooker & Loshak, 2020; Wylie & Wylie, 2016). Use of language that is true to the client's sense of being improves the therapeutic process by accurately aligning forms of address to an individual's self-perception with it being better the earlier on it may occur. A failure to do so may cause an early break in the therapeutic alliance by planting a perception in the client's mind that they are not being recognised.

> *I'm also thinking of dealing with one's own knowledge of the various terms. So information on that in training would be important. To know the various terms. I don't know in other areas in the country, but in the Western Cape people speak a gay language. People have different knowledge about that, because certain terms have become a part of mainstream, the way people talk.* (Participant 3)

On the topic of language, Participant 3 notes that the prevalence of queerness in the Western Cape, South Africa, appears to contribute to a wider understanding of queer literacy. There is a possibility that a wider acceptance of queerness can contribute to greater pre-existing knowledge in a given locality. Cape Town has been described as the gay capital of Africa since at least 2003 (Visser, 2003) and remains a noted travel destination for queer tourists (Hattingh & Spencer, 2018). This implies a degree of acceptance for queerness, although the emphasis on Cape Town's queer-friendly tourism is not without critique for its impetus to attract tourist revenue while still marginalising poorer queer people of colour (Comer, 2018).

The common interest from practitioners in queer literacy presents favourable circumstances. Successfully imparting understandings of queer identities and experiences could improve treatment for queer clients, and address worries and knowledge gaps for practitioners. Something as 'simple' as a pronoun or name usage is a frequent recommendation in the literature and a point of contention for clients (Baldwin et al., 2018; Brooker & Loshak, 2020; Knutson et al., 2019). Not only do responses from this theme identify a present desire from practitioners to learn more but suggests a practical direction for interventions that address the needs of practitioners and clients alike. The development of

courses and materials that integrate queer literacy is both common in GAH practice, and is an attainable goal.

5.7. Theme 4: Considerations for Training

I would be remiss in giving all perspectives a fair account if I only wrote on the need for training and its positive aspects without discussing concerns and limitations highlighted by participants. Participants note that they were strained by their current workload, training needs and available resources, with those working in Non-Profit Organisations (NPOs) citing funding as a constant limitation on their operations. Those working in private settings do not specifically report funding as an immediate concern, but describe hefty workloads, training, and Continuing Professional Development[1] (CPD) as barriers. In addition to under-resourcing and ordinary stress, unexpected calamities can strain practitioners further. Data collection for this study took place during 2020, at the height of the COVID-19 restrictions in South Africa and participants reported that COVID-19 and its related effects had negatively impacted their organisation or well-being. When discussing how their facility operates, Participant 6 spoke on the difference between their operations during the COVID-19 pandemic and prior to it:

> *But what we've started to do recently, is we're doing outpatient work now. So we're trying to get that off. So basically we can see people onsite for a session and then they can leave. But they would be mainly focussed on one-on-ones or a family session. So we're trying to help and see what we can do. Look, we are quite full now, but I think it's still a service is needed because not all people, like you said, can come in for a 24-day time. Off from work, or leave, et cetera. Or because of the financial component, so what we can then do is do more one-on-one sessions at the hospital or on Zoom, if somebody wants a one-on-one. Some help, basically.* (Participant 6)

In an illustration of the challenging nature of Participant 6's work, their interview was initially postponed due to a medical emergency at their facility. The participant was required to attend to this medical emergency directly. Of this, they said:

[1] CPD is the ongoing skills maintenance and development programme for registered healthcare professionals in South Africa. It is governed by the Health Professions Council of South Africa (HPCSA).

> *You saw how hard it was just to sit down and have this conversation, so I mean just to read for fun, you know, it's hard. Because you are booked. Each hour of your day is booked for something, so it's very hard to do reading.* (Participant 6)

Participant 2, who was working on a PhD while employed at their facility was direct about the additional reading they did, and Participant 5 cited resource constraints on their NGO as a main limiting factor in devoting more resources to queer clients:

> *To be honest, I read the CPD* [Continuing Professional Development] *points I have to do. And then I read for my PhD. I think I could do more reading, but sadly not. I mean if I have a topic that I need to explore for a patient, then I'll go read up on it. Sometimes, if I need to look something up for a patient, or if I want to plan something for a patient session, or plan a new group, then I read up.* (Participant 2)

> *That* [additional treatment considerations for queer clients] *would be wonderful, but there are not enough participants to even create a feasible group of three or four. We might have a person here and there, and if there were enough, we would try to create a group space specifically for that group. As an NGO with very limited government funding and constant financial challenges, we can't have endless options, programmes and social workers.* (Participant 5)

Practitioner workload and extraneous circumstances are not the only factors that could limit the effective deployment of training that participants reported an interest in. One area reported by participants could be summed up as a concern around the palatability of training. I characterise 'palatability' as presenting training content in a manner which is accessible and comfortable so that the learner does not reject it. When asked about what they would like to see in training, some participants reflected on the sensitivity of the topic of gender identity, and their past interactions with it in academic settings.

> *Furthermore, and I'm being really honest with you here is, the further problem is organisations that refer people from that group tend to be very... I'm just going to say my experience – dogmatic and militant. And are not happy with the decisions that we make that are practical decisions to make our programme work with limited resources.* (Participant 5)

Later, the same Participant reflected on their anxiety and expanded, saying that:

> *You know what it is? It's that… and it's something even this interview I might be feeling to some extent. You've got to be so political correct. Do not say the wrong thing. As I said before, we've experienced it with groups that work in that field are militant and sometimes you just step on a button. "You can't say that and you can't assume that," I don't think it serves the actual people in that group that those that support them are militant and dogmatic. I think there should be more understanding that for most people that this is unfamiliar and quite new. Your average person or counsellor doesn't really know what are the right questions and wrong things to say… one is so careful and scared of making a mistake, and appearing to be politically incorrect.* (Participant 5)

Participant 5's negative encounters with prescriptive or dogmatic approaches to addressing queerphobia appears to have diminished their willingness to engage with the topic. In their own words, it may have had a cooling effect on the answers they gave during our interview out of a fear of causing offence or saying something 'wrong' and eliciting a hostile response. Participant 5 was not closed off to gender-sensitive training in entirely, as they reported having a guest speaker come in and educate people on queer literacy and treated the experience as valuable. However, their point was that training is unproductive if a person is fearful of engaging with it at all.

Participant 7 raised concerns that the landscape of psychology has become over-politicised, saying that:

> *Psychology has also been politicised too much, such as via the 'social justice movement'. Social justice is a political ideology and I feels that it's really dangerous to bring politics into psychology. The goal of psychology should be to help, not politicise. So when it comes to social justice, people seem okay with political opinions being projected onto clients. This is similar to religious-based counselling modalities which project an ideology onto the client alongside treatment. A mental health worker should not project any ideology, religious or political onto clients.* (Participant 7)

> *I wouldn't have a problem with presenting new points of view, but I do have problems with someone with someone who has a specific idea that they think is right. I want people who are experts to do the teaching and for gender, it would not be great to teach it as dogma because that would be highly problematic. It should be about teaching varying points of view and new ideas - then it's better... Ideally, training*

> *should not be prescriptive, but training that presents new data, new information, new research. Especially so if there are counter-arguments and a presentation of many different theories.* (Participant 7)

Without ever meeting each other to my knowledge, Participants 7 and 5 came to a similar interest about the need for training to be approachable and open to the recipient's worldviews. They both note that prescriptive training that seeks solely to enforce a worldview without elaboration or complex engagement is more difficult to absorb. Participant 4 reached the same conclusion:

> *Training should be conducted in a manner that allows for processing and discussion of individuals' different attitudes – my experience has been that queer individuals may be confrontational in their approach, defensive to the point of being militant…this is not my experience with individual clients as such - in fact, those clients have been generally quite respectful – it has been my experience more so with specific NGO staff that may be working with queer individuals.* (Participant 4)

These responses touch on the important topic of how potential training programmes could be implemented and received by mental health practitioners. Even concerns and anxieties presented by participants can be highly valuable in providing feasible recommendations toward making the training process productive and allaying practitioners' fears.

The palatability of training content is a serious consideration for any programme that may be considered. Some participants have had negative experiences with more prescriptivist approaches. The existence of anxieties or resistance toward new ideas around gender should not be discounted, to say nothing of the existence of outright prejudice (Jacobs, 2019). Practical concerns should always take precedent in any potential implementation of gender-sensitive training, and a programme would be null and void if the practitioner is fundamentally opposed to it.

5.8. Summary of the Thematic Analysis

The thematic analysis yields four themes, which are listed in Table 2. They are individually summarised below.

Theme 1 identified practices and structures which abide by a binary view of gender as a view that prescribes the existence of two genders that are effectively unchangeable. Aspects of gender binary are identified in small and large-scale structures within SUD treatment. This exists in research that continues to classify gender within two categories and addresses the needs of the binary genders: men and women without inclusion of other gender identities. Intake forms, manuals and programme materials often adopt a binary view of gender, reinforcing it further (Jacobs, 2021). There is a divide in manuals and programmes between default programmes and women's programmes. The default programme intends to be suitable to all clients, with women's programmes being developed to address the specific SUD experiences of women such as childcare, high rates of sex work and gender-based violence. Although the default programmes should be sufficient for all clients, the need for a separate women's programme implies that the default programmes do not adequately account for the contextual needs and experiences of every gender group.

This leaves genderqueer people in the precarious position of relying on a default programme that is already known to have gaps. In treatment, the effect of the gender binary is sometimes observed when groups were segregated by gender, often by the clients' request. More often than not, it appears that women request segregation from men in women-only safe spaces for additional comfort. Chapter 6 elaborates on the ways in which this enforces the gender binary and leaves transgender or other genderqueer people in the discomforting position of lacking a suitable safe place when they may want separation.

Theme 2 discusses some of the ways in which discrimination against queer people could complicate treatment processes. Participants report that queer clients tend to bear a greater burden of shame and trauma on arrival. This was in excess of the shame and trauma that clients in SUD treatment may already carry. Much of this trauma stems from enduring discrimination due to their gender identity or sexuality in family and community settings, which hampers treatment programmes that rely on building familial and communal support structures. Some clients are effectively burdened with the stress of having a SUD as well as being queer, both of which may be stigmatised. Parents of clients in treatment are an area of contention, as they exist in a position of power over younger clients. What would normally be a supportive force in a client's life could become detrimental in the face of unsupportive of queerphobic parents if clients are discharged back into a hostile family environment.

Theme 3 describes the unanimous support of gender-sensitive training for SUD treatment practitioners from the participants interviewed. Of those interviewed, as mentioned, only one participant received training related to queer genders during their studies and this occurred in an informal capacity. Participants who received additional training in this area reported it as valuable for better understanding their clients and learning how to approach their clients' identities in a more respectful manner. They reported that training in the area was scarce, despite the interest in it. Participants described several areas of improvement that would benefit their knowledge or the conditions of queer people at large, including de-stigmatisation of queer identities, efforts to address discrimination in treatment facilities and society at large. They reflected on the gaps in their knowledge and how this could impact treatment, be it in poorer management of countertransference or simply a lacking in understanding of their client's being.

A sub-theme for Theme 3 dedicates itself to the most commonly identified area of improvement cited by participants being the knowledge of queer identities, literacy, and language. Participants consistently indicate that there is a lack of understanding over the meanings and differences between identities and the appropriate use of language to queer clients that would considered as being respectful or affirming. Queer literacy is both a commonly cited issue in the literacy surrounding queer healthcare experiences, and an area that could feasibly be addressed through skills development. Addressing queer clients in a manner which affirms or validates their existence is a common recommendation in literature (Brooker & Loshak, 2020; Knutson et al., 2019; Oliphant et al., 2018). It can improve a queer client's healthcare experience by showing that an effort to recognise them exists, and that there is a basic awareness of queerness in the setting – two factors that also promote less discriminatory environments for queer people.

Theme 4 outlines considerations for any gender-sensitive training efforts that should be addressed. Practicalities such as the full capacity of tertiary education curriculums, practitioner schedules and the lack of facility resources should all be seriously considered. A further consideration is the need for training to be approached in a manner that is palatable and non-prescriptive. Three participants adhere to the idea that training should be conducted in a manner that accounts for different viewpoints and presents up-to-date information without imposing it as absolute. Dissatisfaction was voiced toward approaches characterised as prescriptivist and more open approaches were favoured. Striking a balance between

education and the effective presentation of a sensitive topic is key to the success of any training endeavour.

5.9. Comparison to Jacobs (2019)

Findings from this study suggest a state of SUD treatment in South Africa broadly consistent with that of Jacobs' (2019) findings. SUD treatment remains gendered, although not without explanation. The case of dedicating resources and treatment procedures to populations in need, such as women and those with process addictions, should be considered. However, knowledge regarding queer people's particular challenges pertaining to substance use is considerably thin, owing to a lack of materials and literature, and the ever-changing socio-political understanding of queerness. Mental health practitioners interviewed for this study note blind spots in their knowledge around queer people and express a desire for additional training to fill these gaps.

This section compares themes and results to the similar study by Jacobs (2019). Her findings indicate that practitioners are at best inadequately trained to address queer-specific experiences related to problematic substance use, and at worst, are actively discriminatory. Emphasis is placed on the conformity of SUD treatment centres to the gender binary and how that could be detrimental to queer clients in a multitude of areas from intake to retention. Considerable interest or need for gender-sensitive training is reported by participants, with the author concurring. In general, a need for gender-sensitive training is identified as a matter of consideration, however, the study revealed aspects of the greater ignorance and discrimination against queer people that pervades healthcare at a systemic level. This is an undesirable finding that is congruent with existing research.

The comparison of findings between this study and Jacobs' (2019) is provided below, with an emphasis on comparing and contrasting specific themes.

5.10. 'Gender binarism in substance use treatment'

The standardised adherence to a binary understanding of gender is reflected in both studies as the first major theme. The deficiencies of a healthcare system developed solely for

cisgender people in treating genderqueer or sexually variant people are central to the motivations of this research. This study, and the literature that preceded it, would not have been necessary if healthcare parity had already existed and it is unsurprising that gender binarism was reported in SUD treatment. Examples of participant-reported harm related to gender binarism in SUD treatment includes a comparatively large number of resources devoted to treating men and, to a lesser extent, women, and few to non-existent mention of genderqueer people in literature. Jacobs' (2019) participants report that societal stigma against gender non-binary people is an extant problem, a feeling that concurs with my participant's accounts.

The frequency with which my participants discussed the need for separate programmes or single-gender treatment groups for women for comfort and safety belies two important considerations. Firstly, it conveys an understanding that different gender identities may have distinct treatment needs and this knowledge already exists in the development of treatment materials. At present, women's needs are being identified and addressed in contextually relevant programmes and spaces. Secondly, it implies that even the two-gender binary which is deployed as standard in healthcare consists of gender imbalances. At no point did my participants describe the existence of a 'men's manual/programme' in contrast to a 'women's manual/programme'. Rather, all treatment programmes described to me were presented as 'the manual/programme' and where available, a separate 'women's manual/programme' was mentioned. The implication of these statements is that the original programmes were developed to be gender-neutral, but were insufficient for treating women, necessitating the development of new materials for women. However, the lower desire for a men's programme implies that the standard programmes are adequate for treating men, at least enough to not warrant the development of new and separate materials. All-told this is indicative of programmes being reasonably effective at treating men and inadequate for treating women without the development of new materials and formation of separate groups.

The possibility of increased stigma and lack of effective treatment materials may contribute to the disparity between men entering treatment compared to queer people and women. Men account for more admissions in the Western Cape area as reported in statistics (Dada et al., 2018), with this being corroborated in interviews by participants. Jacobs' (2019) participants described men accounting for more admissions and consequently, promotional materials were targeted more toward men.

From my work, men are described as accounting for more vastly more admissions:

> *Women really can't - they don't access treatment as often as men access treatment for many reasons. For one, we don't have childcare facilities, there's a lot of shame, there's a lot of trauma when it comes to females. So that's what I've personally seen with regards to the female/male gender gap, I guess.* (Participant 1)

> *Like ninety nine percent of people who actually walk into our doors is male. Maybe not ninety-nine, but, you know, it's a very high percentage.* (Participant 3)

Efforts such as exclusive treatment groups and facilities directly targeted at women, as well as the development of manuals and resources to address issues experienced by women, such as sex work and abortion, are an attempt to address this. The combination of safe spaces for women and additional training for practitioners on what is colloquially termed 'women's issues' are intended to mitigate the challenge, but these measures are only available to women who register for treatment. Although they may be marketed to cisgender women and may better serve them, they cannot guarantee that their target audience can overcome other barriers to treatment. On the other hand, no targeted discrimination or gender-based violence aimed at men was reported by my participant group. This does not deny the existence of gender-based violence aimed at men but is suggestive of it being a problem of lesser magnitude or reporting. This is further evidenced by lack of mention or evidence that men requested segregation from cisgender women or queer people for reasons of personal safety or comfort. Conversely, women will request segregation from men, as mentioned by Participant 2:

> *I'm just speaking from what I've seen. The reason was comfort. I think the female patients wanted their own group. If memory serves. So the female sex addicts didn't want to be in the group with the male sex addicts.* (Participant 2)

This calls to question that if targeted treatment programmes and materials can be developed for cisgender women to address problems more relevant to their context, can the same be done for queer people? Queer people are not only left out of programme materials, but generally not included in data collection (Jacobs, 2021). This is a matter of concern, just as it was a matter of concern when cisgender women were, and still are, insufficiently researched and treated for their experiences of SUD.

A more complete discussion of how adherence to the gender binary negatively affects the healthcare of queer people is beyond this study, however, evidence from the two studies compared in this work suggest that it is quite impactful in multiple ways. These range from individual cases of stigma, discouraging someone from treatment or meeting a practitioner who is unable to provide equal healthcare, to systemic issues such as the historic position of men as a default target for treatment materials. The examples noted here are only a curated slice of the greater healthcare challenges existing for queer people.

5.11. 'Targeting services to a specific gender identity'

Jacobs (2019) identified the practice of targeting treatment services differently between the binary genders as a separate theme. I characterised this practice as a component of my Gender binarism in SUD treatment theme as the only time services were targeted or deployed differently on the basis of gender were between men and women. This action inadvertently reinforces the gender binary in pursuit of improved treatment access for women. While reinforcing the situation of women to be on par with that of men is well-meaning and relevant to improving SUD treatment for women, this can develop new spaces that exclude genderqueer people. These spaces have their own eligibility criteria, access barriers and sometimes direct forms of discrimination that serve to marginalise queer people, the same way in which historically men's spaces have marginalised women to the point of requiring special measures. Jacobs' (2019) participants identified several key areas of SUD treatment that affected queer clients negatively. These included a gender disparity in treatment which favours cisgender men, targeted discrimination, resulting in a sense of unease, and a lack of promotional and treatment materials tailored their particular needs. To this, Jacobs (2019; p. 189) writes:

> "*Based on these excerpts one could infer that the inclusion of only binary ("our audience is male") options for SUD treatment, creates assumptions that binary gender is the only valid form of treatment.*"

Similar patterns are identified amongst my participants. Participants report a need for privacy and safety as a requirement among women, which manifests as a willingness to

segregate themselves. This applies to issues characterised as ‘women’s issues’ such as sex work, intimate partner violence and abortion, as mentioned by Participant 5:

> *We have far fewer women than men and that could put them in a vulnerable place. For example, in group therapy when sharing personal things about abortion or prostitution and they’re in a group with men who they could perceive as similar to the people who have abused them.* (Participant 5)

The sentiment is echoed by other clients who desire a space away from men when discussing taboo topics, such as in Participant 2’s excerpt regarding a sex addiction treatment group conducted at their facility. The gender disparity between men and women also manifests in the form of participants indicating that they are willing and able to run women’s groups, if not for a lack of women entering treatment at their facility.

> *Yes, we find that when it comes to women, we will then hold a women’s-only group if we have enough numbers. At the moment in our treatment programme, we only have two women so then we’ll do a co-ed group.* (Participant 1)

> *Although we’ve been keen to actually also do the Matrix women’s sessions, we’ve never had enough women to actually constitute a group to actually run sessions.* (Participant 3)

> *We do individuals and meetings. The body of the programme is also inclusive of groups – as I said, a men’s group and a woman’s group if at all possible.* (Participant 5)

This is the ground-level manifestation of a reality represented in the South African Community Epidemiology Network on Drug Use’s (SACENDU) statistics. Throughout my interviews, participants regularly describe tailor-made programming and special treatment groups targeted at women or process addictions. Although men’s specific programmes were not mentioned, this does not preclude their existence. There was, however, a general absence of cisgender men requiring special arrangements in participant responses.

An interesting deviation from Jacobs’ findings is that participants in my cohort did not report gendered targeting in their promotional materials. All but one participant worked in facilities, and nobody indicated that gendered language was a component of promotional material. Rather, my cohort reports that gender-neutral or directed genderless language is the

standard in promotional and treatment materials. The most common variant is genderless and direct, aimed at the client or potential client.

> *So a lot of our literature is, I think, gender-neutral, because we use manuals and stuff. Instead of saying 'he' or 'she' we say 'the recovering person'. Or a lot of the literature's written from the perspective of, 'I will conduct myself', 'I will help you to think,' or 'patients stopping their use.'* (Participant 1)

In Participant 1's case, this line of query prompts self-reflection on their own presupposed use of gendered language. They note that they did not even notice the existence or non-existence of gendered language in manuals, and how it might be pertinent to some clients.

> *...because we're working with a manual at the outpatient centre, a lot of the questions are around 'has this been difficult for you?' or 'in what ways were you struggling with XYZ?' So it's not 'he' or 'she'. You see this is what I'm saying - one of the issues I need to work on is I wasn't even conscious of the fact. Which is bad, and I need to start working on that.* (Participant 1)

> *No, we keep everything vague. So it's more about what we do, more about our services, and its more termed of, 'should you feel like you would like to get treatment' It's more personalised but not anything termed of male/female, nothing like that... Or we'll say, 'if you are feeling this, this, this, and this, or, 'if you are experiencing this, this, this, and this.' But it's not anything to do with anything male/female or gender or sexuality or anything like that. Because it's about the addiction, not about the person themselves, if that makes sense? Because the addiction is the problem, 'you' are not the problem. So, we kind of separated them.* (Participant 6)

Meanwhile, Participant 6 describes their facility's use of directed language such as, "*you,*" as a tactic to reach potential clients through the difficulties that they are experiencing regardless of who they are. This essentially converts the experiences of SUD into a generic message that can apply to anyone experiencing problematic substance use. In this case, not mentioning any identity categories ensures that the message is widely applicable and also separates the addiction from the person's identity so that they are less likely to characterise addiction as an inseparable part of their personhood.

An awareness of gendered language use was illustrated by Participant 2.

> *But I did notice the other day, one of my worksheets that I need to change - I do a group on love languages, and in my worksheet it says 'he' or 'she'. I forget what it was speaking about in the worksheet, but I clocked that, and I thought 'ooh I need to re-phrase that pronoun or change those pronouns to be more inclusive.'* (Participant 2)

Their action is a case of a practitioner recognising something they have characterised as an error and actively adjusting it to be more inclusive. However, this commitment to gender-neutrality does not necessarily extend to data or literature noted by participants, who tend to report that data and literature utilised categories that corresponded with the gender binary. I discuss this in greater depth in Theme 1: Gender Binarism in Substance Use Treatment, with one particular area I highlight being gender-coding on intake forms. Two participants identify intake forms as an area where the gender binary is especially prevalent.

> *So when one's looking at application forms for programs, or if one is looking at assessment or intake forms, it's the standard sort of tick male/female, you know? There isn't any acceptance or space for people who identify themselves differently.* (Participant 3)

> *Yes. It's something that we've discussed before you. I think maybe at the beginning of this year, or the end of last year. It's a topic of discussion that's come up like, "okay, how're we going take this forward?" You know, when we're asking for gender on our assessment form, what space are we going to give there? Because it's the usual male/female thing.* (Participant 1)

Participant 1's organisation had identified the issue of exclusionary documentation prior to our interview and was in discussions to address this. Much like Participant 2 adjusting a worksheet, there are places in South Africa where greater inclusion of diverse identities is underway. However, both examples described were instances of practitioners identifying the shortcomings in the systems they worked under and consciously changing them. This suggests that the materials used by practitioners to fulfil basic functions have shortcomings which warrant change, and in some places, practitioners are taking notice of this.

Intake forms are a point of contention for queer people using healthcare, and this is a recurrent topic in the literature. At macro and micro-levels, it results in the erasure of gender and sexual identities besides that of cisgender and heterosexual (Bauer et al., 2009; Jacobs,

2021). Forms and paperwork are a point of contention for clients attempting to access healthcare (Goins & Pye, 2013; Hudak & Bates, 2018; Jacobs, 2021), where they can be exclusionary of client's identities and act as a reminder that the healthcare they need does not even recognise them on paper. This can be an unsettling prelude to the discrimination or ignorance that follows and is one contributor to negative queer healthcare experiences (Bauer et al., 2009; Lykens et al., 2018). Authors have also noted that requirements to disclose sexual orientation or sexual history, as part of treatment, leaves queer clients fearing discrimination or misunderstanding as a result of this disclosure (Goins & Pye, 2013; Hudak & Bates, 2018). There should be no mistaking the fact that direct, unfair discrimination can override the work done elsewhere instantaneously. Efforts made toward inclusion amount to nothing if a gay man who suffered a homophobic attack disclosed his sexuality to the treating nurse and was told by the nurse that he, "*got what he deserved.*" Such is the case of Thabo, an openly gay man from South Africa (Müller, 2016, p. 200). The manifestation of harmful heteronormativity and cisnormativity are present in cases from the mundane to the severe. Sometimes, client information is recorded inaccurately by limited forms and presented as fact. In other cases, queer people are disparaged in treatment by medical practitioners for their queerness (Jacobs, 2019; Müller, 2016). Moreso, the harm appears in a multitude of places and interactions between queer people and healthcare. Examples reported by my participants include discrimination from clients, exclusionary documentation, exclusionary treatment materials and familial discrimination. As Meer and Müller (2017) write of Thando:

> *Thando's experience demonstrates that focusing on any single constituent aspect of the healthcare space may not reveal the entire picture, and that remedying any single aspect may not have wholly positive results. Were there queer-focussed information materials in the clinic, Thando may have been encouraged to approach the nurse anyway, and he likely would still have received the same homophobic response, or they simply may not have been able to assist him due to a lack of knowledge. As Heyes et al. (2016: 146) observe, "…almost all healthcare spaces are by default heteronormative, some queer-positive signs are helpful, but need to be carefully indexed to the realities of the staff and protocols in the space." (Müller, 2017, p. 97)*

As multiple studies have identified, on-paper recognition is a valuable boon to queer people in statistics and institutions (Bauer et al., 2009; Goins & Pye, 2013). Simultaneously, the queer client's navigation of healthcare can be fraught with the risk of discrimination, misunderstandings or having to further explain oneself to a healthcare provider – hurdles that

are relatively unknown to others (Hudak & Bates, 2018; Meer & Müller, 2017). The approach of exclusively using genderless or gender-neutral language is less exclusionary to queer people than language limited to the gender binary (Goins & Pye, 2013), but this is not the whole picture. I refer back to Meer and Müller's (2017) excerpt above, where they highlight the fact that healthcare spaces lean towards heteronormativity by default and simply stripping gender from them does not immediately make them more welcoming to queer people.

This is the impetus for queer people's search for queer-friendly healthcare (Glick et al., 2018; Hudak & Bates 2018). The underlying experience of queer people is that standard or neutral healthcare is not in fact neutral, and is the source of much anxiety and uncertainty (Glick et al., 2018; Hudak & Bates, 2018). Worse still, when direct discrimination occurs (Glick et al., 2018; Müller, 2016) it confirms that the anxiety experienced was valid and that the threat of the standard space, being discrimination, was made prior to treatment and then realised by discrimination during treatment. The many negative healthcare experiences queer people have in supposedly standard or neutral spaces is indicative of the untruth inherent to characterising standard healthcare as neutral for queer people. This drives a search for queer-friendly healthcare (Glick et al., 2018; Hudak & Bates, 2018; Martos et al., 2018), where queer people establish a complex array of criteria and signs which are used to evaluate potential healthcare providers for their queer-friendliness. 'Queer-friendly' healthcare is often openly so, with healthcare providers specifically advertising a focus on queer issues and setting an expectation that the client will be well-received. Rather than standard healthcare presuming to be safe and user-friendly to all, queer-friendly healthcare assures safety for queer people and by extension, anyone else who is not queer. The fact that queer-friendly healthcare is openly advertised and searched-for is a worrying implication: queer-friendly healthcare is friendly to queer people, therefore standard healthcare is unfriendly to queer people. Referring to standard healthcare as unfriendly is a glib euphemism that means discriminatory and exclusionary. On occasions such as Thabo's (Müller, 2016) standard, queer unfriendly healthcare may involve a violation of a person's right to dignified treatment in a healthcare setting.

To summarise, Jacobs (2019) and I both identified areas of SUD treatment which are gender specific. The genders targeted in these areas conform quite rigidly to heterosexual and heteronormative binaries, leaving queer people in the position of having to fit in, or risk misunderstanding and mistreatment. This situation is not new to South African SUD

treatment and is observable in non-specialised healthcare too (Meer & Müller, 2017). Jacobs (2019) characterises treatment settings as inadvertently creating an assumption that binary modes of treatment are the only valid form of treatment, thus excluding queer people. My findings concur. The development of improved treatment for queer people is not as simple as merely improving intake forms, erecting posters featuring queer people, or educating practitioners on the value of names and pronouns. While all of these recommendations are widely called for in the literature, I argue that healthcare is systemically discriminatory against queer people and no single point of failure is responsible for the entirety of the harm incurred. This should not be mistaken for a statement of hopelessness, but instead a proposal for hopeful change; that attitudes, materials and training can be shifted in order to build a better place for queer people in SUD treatment and beyond. The discriminatory experiences of queer people in healthcare are supported by socially constructed conceptualisations of gender which problematise queerness. Dislodging these constructions with ones of equity and understanding is a possibility that could greatly improve the healthcare conditions of queer people. Participants in my cohort, reporting that they were considering inclusive intake paperwork, or adjusting a gendered worksheet to be gender neutral, are a sign of shifting attitudes, but much work remains to be done.

5.12. 'A need for gender-sensitivity training'

The concluding theme for Jacobs' (2019) paper was an identified need for gender-sensitivity training. Principle reasons identified by the participants included the need for training to treat clients more equitably, addressing the stigma of queerness which still exists in healthcare and shifting the view of gender away from one that is binary. Other areas of improvement identified, included addressing queerphobic discrimination from other clients and broader psycho-social education that can sensitise people to queerness. Likewise, my participants generally express a similarly unanimous interest in training which I consider potentially valuable for improving their treatment of clients:

> *How does that person feel, and how can I be respectful of that person? And especially if I'm going to be seeing this patient, my transferences need to be considered, but how can I do that if I don't know what I am dealing with? What that person is experiencing—I need to try to understand to the best that I can so that I can make*

> *sense of their life and their experiences and help them with that. But if I don't even know, how can I do that?* (Participant 6)

An interesting divergence between the two participant groups is that my participants reported no direct discrimination toward clients by practitioners and even reported instances of support toward queer clients:

> *There's actually a client I'm working with right now. He's quite young. He's twenty-three and he had a really bad experience of sexual abuse from a male relative. So I think this is where it comes from, these homophobic, queerphobic feelings. What happens is, we work through that. Once he was in the group, I have a queer man in group who actually responded. The queer client of mine is quite empathetic and nurturing. And I think what happens is in the group dynamic, the client who is queerphobic picked up and realised that this man isn't at all like what he thought it was, and through my client's nurturing behaviour, they actually formed quite a bond. So it actually worked out quite nicely. You just go in with all these misconceptions and these pre-conceived ideas and you really have your tail up, and in the meantime this queer client met him with kindness, compassion, and empathy. It was a wonder from his side.* (Participant 1)

> *I can't recall any specific reaction, anything adverse in that regard. The other thing that one needs to take into account is that in the Western Cape and Cape Town, it's a much more open community. It's not unusual to come across people who identify themselves as gay or lesbian. So in communities and in Cape Town, it's not such an issue I've found. So the responses from other clients have been… I can't pick up. And it wasn't reported to me that there was actually any kind of a verbal backlash or any non-verbal sort of dark looks, or anything threatening behaviour. That's to say it doesn't mean it didn't happen, but it wasn't reported to me.* (Participant 3)

Participant 1 was surprised when an initially homophobic client whose homophobia may have stemmed from same-gender sexual violence was received with empathy from the queer client in the group. This response of surprise speaks to the participant's understanding that queer people often endure discrimination as a norm and an event to the contrary is unexpected. With the support of the participant and a cooperative alliance between the clients, this instance resulted in a productive bond. Meanwhile, Participant 3 notes no specific discrimination. They hypothesise that their location in Cape Town, South Africa, is a reason

for the lower degree of discrimination experienced. Participant 3 highlights the distinction between discrimination which they observe or is reported to them and discrimination which occurs without their awareness. This all suggests a pre-existing knowledge around queer discrimination and a sense that they are monitoring it for its presence within treatment.

Participant 2 states that they had no reports of discrimination about queerness and would have addressed it if there were any: "Not that I know of. They never said anything about that. We would have addressed that if it had come up, but never had any complaints around that." Their claim that they would address any issues that arose is merited as their concern for the recognition of queer clients was expressed elsewhere, such as when they adjusted a worksheet to be gender neutral. They had also expressed frustration at parents in family therapy being unwilling to address their client by their chosen pronouns, saying that:

> *And then we have when the parent will refer to the patient by the wrong pronoun, you know? When I've been part of the previous discussion of "Mom, this is my pronoun", ten minutes earlier, you know? So there's just, like, no consideration for that, I suppose.* (Participant 2)

Participant 5 made an effort to integrate a transgender client into the gendered treatment group of their choosing I devote a substantial portion of my reflections to this. These responses are contrasted to Jacobs' (2019) group, whose participant-practitioners reported behaving "*unethically"* (p. 189) or being discomforted by gay clients (p. 188), whereas my participants did not. While a participant could lie to me, the private interview setting allows for less social pressure to save face compared to a group interview setting. In contrast, Jacobs' work was conducted in focus groups, where one might expect greater social pressure to conform and appear non-discriminatory to peers. Furthermore, my participant group includes responses to queer discrimination that are comparatively sympathetic and show a pre-existing knowledge of queer discrimination and a willingness to monitor and address it. This difference is unexpected and I have no knowledge of why it might be the case other than Participant 3's hypothesis that the area in which research has been conducted is more queer-friendly in some ways.

The existence of supportive behaviours toward queer clients does not negate the expressed need for gender-sensitive training. As numerous accounts from Theme 3 would indicate, even a cohort that showed a pre-existing knowledge of queer people expressed that training would be beneficial. They recognised that there were gaps in their knowledge in

areas such as queer literacy and expressed a desire that these be addressed. Others who had received gender-specific training pertaining to queer people responded positively and as Participant 5 noted, they actively sought out what little they could find:

> *There's very little actually, we sort of scratch around for stuff. It was somebody from some organisation who was very approachable who contacted us to find out about referring. And I just took the opportunity to grab him to come and present something on the area to our team.* (Participant 5)

Rather than treating the pre-existing knowledge in my cohort as evidence for a lack of need for training, I argue that it should only strengthen the findings first noted by Jacobs (2019). Jacobs' participants included those who reported discrimination and ignorance to queer clients, but still recognised a need for training. This is contrasted by my participants, who used the knowledge they had to address the discrimination they were aware of, yet also expressed a need for gender-sensitive training. As it stands, although these participant cohorts are separated by geography their opinions are mostly unanimous in that gender-sensitive training for SUD treatment practitioners is necessary.

5.13. Summary of Comparisons with Jacobs (2019)

To summarise, both Jacobs and I identified phenomena in SUD treatment that can be detrimental for effective treatment of queer populations. Characteristics of gender binarism were reported in both studies, with particular respect to the much higher intake of men as clients compared to any other population group. Consequently, this leaves other demographics on the margins, with women trailing behind men and queer people generally being ignored in gender data. Standard treatment programmes being best suited to treating men was noted, with materials being developed for women to supplement the inadequate care they would otherwise receive in standard treatment. However, developing programmes exclusively for the man/woman dyad without even mentioning the existence of queerness leaves queer people feeling marginalised and unnoticed. The development of programmes for men and women implies that those are the *normal* genders and the only genders which practitioners are trained to treat.

Yet, evidence suggests that practitioners see queer clients and feel unprepared to treat them adequately (Jacobs 2019). A practical result of binarised treatment planning was the development of special materials and private groups to meet the needs of women in treatment. Both studies indicate that where needed, treatment could be targeted differently, to different genders, but the targeted genders were still men or women. This uncritical adherence to the gender binary leaves queer people, particularly genderqueer people, in the precarious position of using the often-inadequate all-encompassing programme.

Our findings diverge in the area of language use in the targeting of treatment. Unlike Jacobs' participants, mine are generally adamant regarding the use of direct, genderless language. Their use of language is intended to be as broad as possible and use the second-person pronoun being you/your when and where possible in order to reach potential clients directly and omit any information that is not universally relatable. Another divergence is that members of my participant group show a pre-existing awareness or acceptance of queerness, and in some cases, actively work to challenge queerphobia such as adhering to a client's chosen pronouns or adjusting treatment materials to be more gender neutral. No concrete reason for this awareness of queer discrimination could be identified.

Lastly, both studies find a need for gender-sensitive training for practitioners working in SUD. All participants in my cohort report that such training would be useful, either to them as practitioners or to the wider area of SUD treatment in general. My finding that training is necessary, both from participant's direct reports and the presence of gender binarism in treatment, and participant knowledge gaps, is concurrent with Jacobs' (2019) findings. My participant group shows a pre-existing knowledge and concern for queer clients, but still reported that additional training is necessary and helpful.

5.14. Conclusion

The findings from this study are indicative of a need for gender-sensitive training for SUD treatment practitioners. This is concurrent with research in South Africa (Jacobs, 2019) and recommendations in the literature (Heng et al., 2018; Matsuno & Budge, 2017). Queer literacy is identified as a key area of improvement by participants, who express that they are not fully versed in the language and terminology related to queerness. Participants indicate that strengthening this knowledge will improve their ability to treat queer clients by

understanding their life experiences and personhood. This desire can stem from the rapidly growing awareness of queer people which has not been equally matched by updated training to improve the understanding of queer people.

Practitioners differ in their descriptions on what other kinds of training content should be delivered and also offered insights as to how it should be delivered, noting that training should be delivered in a manner that presents a range of evidence and offers room for debate and discussion. Some participants indicate that a dogmatic approach that prescribes a new system of knowledge without explanation would be ineffective.

The participants identify that the queer population are targets of discrimination, and some note that their patterns of problematic substance use may present differently to heterosexual and cisgender people due to these experiences. Discrimination and suppression of queerness are identified as factors that generate intense trauma and shame, which can be detrimental to the treatment process. In particular, they identify discriminatory family units and communities as being weak points in the support systems of queer clients, something that is not conducive to treatment approaches which rely on strengthening these support systems. Participant 1 notes that since being queer is often stigmatised, substance use is also stigmatised with a client who is experiencing both of these things standing to experience doubled stigma when they disclose this to their family.

> *I hate to say this, but sometimes more shame and guilt than someone who doesn't have to go through the experience of having to come out, you know? To open up to their families like, 'oh hey, I'm actually gay, and guess what I have a heroin problem." So it's almost like a double-whammy in some ways*. (Participant 1)

It is found that facilities in the sample tend to us a binary conceptualisation of gender in their daily operations. This binary approach considers the existence of two genders (men and women) and has little room for people who live outside of these bounds, wish to transition between them, or otherwise do not conform. Facets of the gender binary are observed in manuals used at facilities, academic literature, and documentation such as intake forms. The influence of the gender binary, often also attached to heteronormativity, is notable for its alienation of queer people from numerous public spaces, including healthcare (Müller, 2016, Scandurra et al., 2019). Some practitioners and facilities have noticed this and begun to make adjustments to make their materials more inclusive to queer people. Examples include facilities that are discussing how to modernise their intake forms, and a practitioner editing a

worksheet to reflect gender-neutral pronouns. These small changes are a hopeful and optimistic indicator of gradual change.

It remains apparent that the construction of gender as a dyad whose transgression is considered inappropriate can permeate SUD treatment in ways that are not obvious or even intentional. Rather than overt discrimination against or physical violence against queer clients being reported in this cohort, queer clients were instead being hampered by other avenues.

These include facilities that have not modernised their materials and forms, or practitioners who do not yet have a full grasp of queer literacy and feel unready to meet queer clients with the same degree of understanding as they would others. Queerness can impact patterns of substance use and recovery in unknown ways, and this lack of knowledge leaves a gap in treatment programmes. Where women and men have received additional research, specialist manuals and programmes to address their complex and non-universal needs, queer people have yet to see such substantial efforts. Where queer people are able to enter treatment, their best option is the generic programme, possibly facilitated by practitioners who do not always understand the queer client's life experiences. This understandably leaves them at a disadvantage compared to their peers, to say nothing of the other barriers they may encounter throughout their habilitation.

CHAPTER 6: IMPLICATIONS OF THE FINDINGS AND CRITICAL REVIEW OF THE RESEARCH

6.0. Introduction

This chapter is dedicated to my reflections on factors beyond raw data and methodological adherence which have influenced my research process. As a researcher, I am only human. I am beholden to the same forces as any other person – forces influencing how I react, think, perceive, examine, and process information. This study is a human creation, and an extension of the worldviews and thought processes of myself as the creator. In the spirit of addressing some of the influences and biases that drove this research, this chapter is a self-review of my work, both broadly and within reference to a very specific excerpt provided by Participant 5. This excerpt is particularly important as it is a living example of the complex challenges a queer person may encounter in SUD treatment. In addition, I reflect upon the excerpt's subject being a trans woman – and relate this to my own experience as a trans woman.

As an individual I make no claims to objectivity or neutrality. I characterise the pursuit of an idealised form of objectivity in a qualitative study to be infeasible (Bryman, 2016). From the moment I chose this research topic I was influenced by external factors including funding, the selection of supervisors, my interest in the topic, its feasibility to meet my thesis goals, to name a few. From the moment my participants spoke to me, they were subject to the limitations of their memory and the bias inherent to recalling personal encounters. This disclosure occurred with an awareness that they were being recorded, potentially altering their responses. As the data was being analysed it was processed through the mind of one individual who imposed an educational background and worldview onto it. To try and address every source of potential error and external influence is futile, despite the necessity of maintaining good standards of research rigour. The strength of qualitative research is that it brings with it a different set of standards and capabilities to understanding the living world (Bryman, 2016). However, this exposes it to more human influence and interpretation than a set of figures, computerised analysis, or statistical formulae. In qualitative research, the researchers interpreting the data are the machinery through which data is processed. While these inputs personal influences and external factors are absorbed into the data. It is left up to

the researchers and readers to identify some of these external factors and determine which are appropriate or inappropriate to retain within the constraints of the agreed-upon ethical and methodological approach.

Perhaps the most pertinent of these personal influences is that I am transgender. I was assigned male at birth (AMAB) based on the opinions of those present. This had a profound impact on my life. Although raised to become a man, I have always had questions about who I wanted to be and how I wanted to appear to myself and the world, however I repressed such questions. The repression failed during the COVID-19 lockdowns while working on this study. I realised that I am deeply dissatisfied with being, appearing to be, and being treated as a man by the world at large. I commenced a gender transition. I will narrate parts of my transgender narrative below and discuss the way in which it influenced my view of this study for context before proceeding with the rest of the chapter. Although being transgender is only one facet of me, it is given priority in this context, due to its relevance to my research.

6.1. The Transgender Researcher

The realisation that I am transgender occurred after the first COVID-19 lockdown regulations in South Africa were implemented. Here, I was confined to my home with my partner. With no face-to-face socialisation, except for each other, and a sudden loss of social activities, I was left with time to think. I contemplated my previous interactions with gender. At the time, I was a cisgender man who cross-dressed. It's not unusual to find someone who cross-dressed. In fact, in the societies I have lived in, women have worn men's fashions for such a lengthy period of time that it became fashionable: Pants, no make-up, shirts instead of blouses, tomboy fashions and men's boxers to name a few. Men who dressed in feminine fashions is a bit taboo where I live. However, my university and friend groups were fine with it, so I dabbled. While it was out of the ordinary, it was not impossible for a cisgender man to have a wardrobe of women's clothing, enjoy make-up and wear feminine dress in public.

Being out with my friends, who were almost exclusively women, and wearing feminine dress brightened my life. I experienced camaraderie when I was invited to private, women's spaces with them – a camaraderie I never experienced in men's spaces. We packed ourselves into a women's residence room on Friday nights to do our make-up and pick outfits. There wasn't enough space to stretch one's arms out without hitting a friend or piece of furniture,

however, this was acceptable as we were together. Although I was still 'the crossdressing guy', I'd been invited to an exclusive space within an exclusive space. Not just a women's residence, but a room within the residence made private by people getting dressed. I felt a sense of ease and comfort at how my friends protected their space from men, but welcomed me. I took part in a ritual they saw as ordinary and taken for granted, but new and meaningful to me. The ritual of getting dressed, putting on make-up and making plans for the evening's club events. I never stopped feeling that camaraderie no matter how many times we did this, but I did not think much of it at the time. Reading accounts from queer, feminine people who wanted entry into such a safe and contained space, but being turned away, stands as a contrast to my early explorations in femininity. I think to the trans woman further along who sought out a containing space for needs much more serious than a night on the town and being turned away. I wonder how she felt. I suspect she felt the exact opposite of what I described above, albeit with much higher stakes.

I was surprised the first time we reached a nightclub, and I was duly informed that I was not to go anywhere alone for my safety, not even the restroom. I had never had that conversation as a man. The safety talk in my manhood revolved around avoiding fights, evading muggings, and watching one's belongings. The talk of bodily safety in the sexual sense was new. There was a dawning sense of horror and awe in that my friends saw me as feminine and treated me as such (awe). They believed that I was worth protecting as one of them (awe). In their opinion, I was going to be perceived as a woman (awe). My bodily safety and sexual autonomy were now at risk even in the most ordinary public spaces (horror). With the benefit of hindsight and quiet reflection, I now know that I was being taken through a process of feminine social interactions in the nightclub setting which is a complex intermingling of social norms, hedonistic behaviour, and risk management (Kovac & Trussell, 2015).

They took me along to restrooms so that I did not have to sit alone while men sidled up to me. I asked if I would be welcome in the women's room and their answer was uncertain, but re-assuring. There was no guarantee that I'd be welcome in the women's restroom since I was a man in a dress. However, they assured me that other women in the restroom would understand not leaving a feminine person alone in a masculine space. My dear friends delivered the course in Safety for Women that they'd received since adolescence. Pepper spray (storage, transport and deployment), how to signal to each other that your boundaries were being violated, observing for signs of date rape drugs, moving safely in groups and

pointers on ‘not being raped’. They did not yet see me as a woman, mainly because they respected my identity as a man, however, they were certainly treating me like one.

Everyone’s concerns were confirmed when the groping began, or strange men did in fact sidle into my booth while I sat alone to hold the table. I learned that when men shuffle past women on a crowded dance floor, they sometimes take them by the waist (non-consensually, of course) and shift them aside. That never happened when I looked like a man – which I found notable. Shifting a woman aside by grabbing her was the nicer version, seeing as a lot of the time they snuck an ass grab on the way past and melted into the crowd. The previous sentences bear repeating in accurate terms: moving someone aside physically without consent or inquiry was better than the alternative, which was casual sexual assault while people transited a public space. I learned that being perceived as a woman cut both ways: my friends invited me into their homes and spaces and confided in me with a passion and care I had never seen. I could lean on the women in my life for comfort and support anytime I wanted. On the other hand, I experienced all the sexual assault I had ever experienced in my life at once and for the first time a crowded street on a busy Friday night was unsafe to walk. Previously, this was a preposterous proposition – there are people everywhere! How could anyone feel unsafe?

Most relevant to the study was a better understanding of why women often travel and congregate in exclusive groups. In my experiences with nightclubs this was predominantly for safety and comfort (Kovac & Trussell, 2015) and this reason was re-iterated by my research participants. Theme 1 discussed a number of such examples related to women’s SUD treatment groups, which are aimed at providing privacy and protection from the potential trauma and harm that men are believed to represent. For many of the women in these groups, the trauma and harm that men represent to them is no mere possibility, but very real. Without the unfortunate experiences I had, I would not have as complete an understanding of why my participants repeatedly noted the need for special spaces for women in SUD treatment. I had lived my life with only a basic amount of threat against my person and was cast into the ‘other’ side without acclimatisation. A side that is told to dress differently in an attempt to manage the risk of sexual assault (Klettke et al., 2018; Süssenbach et al., 2015), cry ‘fire!’ if they are raped in public because people might be more likely to assist (Labhardt et al., 2017; Shotland & Stebbins, 1980) and not travel alone (Kovac & Trussell, 2015). While it is true that many of these rape myths are just that; myths - the reality

of an ever-present threat of sexual violence for countless women is very real (Kelland, 2011) and myths intended to 'prevent' rape are one response to the threat, even if untrue.

This extended period of reflection afforded by lockdown regulations led to a dramatic transition in my life. I came to terms with the insidious and quiet ways my dysphoria manifested. I was not the trans woman who 'always knew' that something was off, nor did my life align to the highly popular 'trapped in the wrong body' narrative (Putzi, 2017). Worse yet, the narrative of transgender life that permeates most of the world remains one of suffering. An invisible bar remains in the social and medical domains that one is only truly transgender if they suffer. Debilitating gender dysphoria, depression, suicidal ideation and internal conflict are part-and-parcel of transgender narratives (Konnelly, 2021; Sutherland, 2021) and this need not always be the case.

While it would be a bald-faced lie to say that transgender people do not experience suffering, being transgender is not itself defined by suffering or even dysphoria (Konnelly, 2021). The inevitable conclusion of that line of thinking is that a trans person freed from their pain ceases to be transgender. I categorically reject any assertion that my state of being is defined by suffering, even though I live in discomfort with my body, and I will endure discrimination for my path in life. To acquiesce view that being transgender requires suffering also implies that *not* being transgender is superior, because that does not require suffering as a prerequisite. While I did endure severe depression in the past and presently contend with anxiety, my gender dysphoria was never the source of any debilitating anguish. In fact, my experience of gender dysphoria went unnoticed until I started planning to live the rest of my life in my assigned seat: as a man. For some reason, the idea of becoming a well-spoken, handsome man with a bright future was unappealing to me. I quite literally could not look into a mirror and picture myself aging, because the middle-aged, masculine face I had to imagine was foreign to me. This is a terribly low bar to set for self-conceptualisation. Can I even imagine my own future? I failed to meet this low bar.

We were deep in lockdown and socialising as a means to discuss this was out of the question thus I turned to online spaces. I located an online discussion group of gender-questioning people. Being questioning of their gender placed them in an even less talked about position than transgender people: uncertainty. Like me, these were people whose lives deviated from the 'always knew' and 'born in the wrong body' narratives and I felt comforted in being able to wonder about my gender as long as I was the one making decisions. The

importance of self-determination to gender described by some advocates of GAH rang true for me (Oliphant et al., 2018). I was at my most peaceful with my inner self when I was in a supportive environment that respected my choices. I followed this discussion group into the resources they provided. After answering a discomforting series of questions about myself, I reached the conclusion that I am transgender, and that transition was worth experimenting with. Some would argue that this alone is a sign of being transgender – people who are comfortable with their gendered selves rarely 'try' a gender transition. Commencing transition healthcare is not the same as trying on new jeans.

Not long into the process of a medical transition, I began to learn how to navigate the complexities of healthcare access while being transgender. This requires having personal, taboo conversations with doctors who are potentially uncaring, ignorant and discriminatory (Hudak, & Bates, 2018). In addition to this, these conversations require avoiding eye contact with pharmacists who are wondering why a 'man' has a prescription for a large supply of estrogen. I grew accustomed to watching my pharmacists packing my prescription as on multiple occasions, they worked on autopilot and accidentally gave me half the prescribed amount. They mistook the prescription for a cis woman's and did not notice the much higher dose. This resulted in having to stand at the counter while the queue lengthened behind me and explain that the medium amount of estrogen is incorrect – I need a correct, large amount. This got some stares. These days, I have my medication couriered to me. I am in a position of privilege to afford that. Honestly, being transgender, I am privileged to even receiving the healthcare I need and not having to enlist in the depression and suicide rate that plagues so many others. On the scale of things having pharmacists misread my prescription and having to direct them to the correct amount was not the worst thing that could happen in healthcare. I would however, like to avoid having to explain my prescriptions while other people are listening and would much rather have my privacy protected. Dealing with unaware healthcare practitioners is part of a medical transition (Cicero et al., 2019; Lykens et al., 2018; Scandurra et al., 2019) and I evade the worst of it by utilising private healthcare. Those entering NGO care, or the public health system lack that privilege, and their conditions are considerably more precarious (Müller, 2016). In my life as a cis man making use of private healthcare, I never encountered a single problem. After commencing a gender transition, I am now subject to conversations with my primary care doctors about whether their religiosity

will interfere with my treatment, and having specialised medication[2] couriered to me to avoid embarrassment at the pharmacy.

My perception of the research changed as I began my transition. Estrogen therapy made me less anxious and jittery, as it does for many trans women (Nguyen et al., 2018; White Hughto & Reisner, 2016). However, my plan to enter this study as a detached investigator was in shambles. There is something extraordinarily impactful in seeing my outlook on the study change from, "wow, queer healthcare users go through some pretty rough things!" to, "This could be me." This catalysed a need to continue working, and when productivity came slowly, the drive to improve conditions for others like myself overmatched this tiredness. The idea of being a distant researcher nodding along blankly to answers was eroded and I *felt* what participants were saying. The pace at which I began incorporating the distant queer healthcare user into my in-group surprised me. Their pain and exclusion became mine. Time and time again, I was politely and correctly, reminded by my supervisor that this study was about practitioners, not clients. I was focusing too much on the client – the unseen person underneath the literature review. Taking the focus of my writing away from the client or healthcare user was always difficult for me, as I am a client too – not in SUD treatment, but in the same healthcare system as other South Africans. I am fortunate for being able to surround myself with supportive friends, but like most people, I am only a few misfortunes from being cast into a world without agency: poverty, deep mental distress, or addiction. If I ended up in that difficult position, swathes of legislators, community leaders, healthcare practitioners and family members would gladly abandon me because of who I am. I live such a precarious life, and the thought worries me.

If I am being honest, it angers me that my existence is such an inconvenience that people would try to erase it: via legislature, via casual disregard, via the denial of healthcare and occasionally via murder. It made me want to resist. However, public protest has never interested me. Instead, I turn to the paraphrased sentiment of my queer friends: "When your existence is a matter up for debate by the forces meant to care for you – relatives, government, healthcare institutions – every single day you survive is a protest. Every breath you draw is an act of resistance against the forces that seek to erase you." Previously, I was conducting this research because it was useful to me and would result in a degree. Now, I was

[2] Some of the medications used in HRT are only available through specialist compounding pharmacies in South Africa, further increasing the expense of the whole endeavour.

doing it because I cared about the people it might benefit, both practitioners and clients. I proceeded with this because I now cared about myself.

6.2. Reflections on the Research Process

I commenced this study with a multitude of expectations on how I would proceed and will discuss some of those expectations here. Other encounters of interest will be examined alongside this, more generally those of a personal nature and not sufficiently impactful or suitable to warrant reporting in the analysis of the study.

Of all of my expectations going into this study, the most ill-conceived one was that there would be no dramatic interference from external forces. None of my expectations involved an unprecedented global health catastrophe of a magnitude unknown to recent memory. However, the COVID-19 pandemic's direct impact on this study was mainly logistical, by enforcing a change in methodology and preventing the travel needed to conduct in person interviews. The impact of the COVID-19 pandemic has also been discussed elsewhere, and I will focus on reflection, rather than logistics here.

During the interview process, one unexpected pattern was the recurring theme of care which participants exhibited for queer people, as well as the relative lack of reported discrimination. The reason that I expected more overt discrimination was that this research was based off of an existing pilot study conducted by my supervisor (Jacobs, 2019). Aside from a general lack of readiness to treat queer clients among her participants, they also described acting unethically or feeling discriminatory toward queer clients. Reading this paper alongside literature which discussed queer healthcare experiences primed me for more difficult interviews. However, all participants in my cohort arrived with a pre-existing knowledge of queer people and the discrimination faced by them. Participant 7 specialised in treating gay men and men who have sex with men (MSM). Others, such as Participants 2 and 3 made conscious efforts to accommodate genderqueer people appropriately, using their facility's available resources.

> *It's something that we've discussed before you. I think maybe at the beginning of this year, or the end of last year. It's a topic of discussion that's come up like, "okay, how're we going take this forward?" You know, when we're asking for gender on our*

assessment form, what space are we going to give there? Because it's the usual male/female thing. (Participant 1)

But I did notice the other day, one of my worksheets that I need to change - I do a group on love languages, and in my worksheet it says 'he' or 'she'. I forget what it was speaking about in the worksheet, but I clocked that, and I thought 'ooh I need to re-phrase that pronoun or change those pronouns to be more inclusive. (Participant 2)

So when one's looking at application forms for programs, or if one is looking at assessment or intake forms, it's the standard sort of tick male/female, you know? There isn't any acceptance or space for people who identify themselves differently. Also I was thinking about it when you sent the information about the motivation for this research, it's just one of the things that sort of came up, that is something that we here need to look into, like how do we adjust - that's why I was also looking forward to this conversation, so that I could also learn and become more aware and improve my learning, awareness, and sensitivity around this. (Participant 3)

How does that person feel, and how can I be respectful of that person? And especially if I'm going to be seeing this patient, my transferences need to be considered, but how can I do that if I don't know what I am dealing with? What that person is experiencing? I need to try to understand to the best that I can so that I can make sense of their life and their experiences and help them with that. (Participant 6)

Participant 1's facility was in discussions to rework their intake documentation, a point of contention for many queer people (Hudak & Bates, 2018; Jacobs, 2021). Similarly in the area of making language more inclusive, Participant 2 was adjusting worksheets. Participant 3 reached the same conclusion as Participant 1: that their understanding of up-to-date language and processes was incomplete and could be improved. Participant 6 exhibited a continuous concern for their queer clients, particularly with regards to whether they were sufficiently knowledgeable to avoid negative countertransference in therapy.

This non-comprehensive list of examples illustrates a pattern of concern for queer people's healthcare challenges. As these participants have attested to, there is still much work to be done, but the most important aspect is already present: caring. I was surprised by this and continuously wondered about its source. I wondered whether Participant 3's description of Cape Town being a region that was relatively accepting of queerness was the cause, or if this was simply random chance during sampling.

> *I don't know in other areas in the country, but in the Western Cape people speak a gay language. People have different knowledge about that, because certain terms have become a part of mainstream, the way people talk.* (Participant 3)

This qualitative study is insufficient to establish a representative sample of opinions and was never intended to do so, however, my curiosity remains, as much of the literature painted a bleak picture of the situation (Müller 2016, 2017). This bleakness was countered by accounts of caring and understanding from my cohort. The presence of greater understanding of queerness in a given locale is encouraging for queer people entering healthcare. Although the situation for queer people in SUD care is far from ideal, progress is being made daily. This negative expectation of mine had primed me for a more incisive analysis and report-writing process. I essentially expected the participants to supply accounts of worrying or unethical behaviour resulting in me being a beleaguered researcher squaring off against an uncaring healthcare system. I did not look forward to this and I am grateful it never came to pass. While many parts of the South African healthcare system are deficient, it is by no means a monolithic entity and practitioners are often doing their best under relentless circumstances. In hindsight, I am concerned that I had begun to poise myself against my participants, almost as an adversary, rather than reporting their accounts accurately. I think back to Participant 5's interview, in which they reported that organisations that represent queer people sometimes take a combative and uncompromising approach, and this alienates the people they should be helping to educate.

> *It's that… and it's something even this interview I might be feeling to some extent. You've got to be so political correct. Do not say the wrong thing. As I said before, we've experienced it with groups that work in that field are militant and sometimes you just step on a button. "You can't say that and you can't assume that," I don't think it serves the actual people in that group that those that support them are militant and dogmatic. I think there should be more understanding that for most people that this is unfamiliar and quite new. Your average person or counsellor doesn't really know what are the right questions and wrong things to say… one is so careful and scared of making a mistake, and appearing to be politically incorrect…*
>
> *And you shouldn't assume that the average person or professional knows what they're supposed to know. I'm not really talking about you. I'm just talking about my experience – social workers working at the agencies that deal with that group… just*

> *people in life – my daughter will shout at me if I say the wrong thing 'cause she's very… politically correct about anything to do with gender. [laughter] I'm just laughing, but you know, you have to be careful. You just find yourself stepping on a button that you didn't know was there.* (Participant 5)

This exchange struck a chord with me, as I understand that this defensive or combative approach may stem from a lifetime of marginalisation and working with marginalised people. I have lived the frustration of having to face 'polite' healthcare practitioners whose knowledge is incomplete, however, they are unwilling to accept my input and as with most healthcare interactions, I stand to lose the most as the practitioner is in power. Yet, combativeness or hostility is hardly productive. I came close to establishing a combative approach in this study due to healthcare experiences that my peers and I have had. This would have come with detrimental results to participants and my work alike, and I can only hope that I avoided the worst of it.

Elsewhere in the 'pleasant surprise' line of inquiry were cases where participants used the interview to reflect on their own encounters with queerness in treatment spaces. To cite a few examples Participant 1 attended the interview with their facility's treatment manuals in hand so that they had materials available on demand. When the questions turned toward the representation of various people in the available manuals being a standard manual and a women's manual, the participant spoke to whether there was sufficient discussion of gender-based issues in the manuals. They questioned whether there was sufficient representation of different ethnicities in the manuals relative to the ethnic backgrounds which their clients come from, noting a general lack of people of colour in the manuals even though the majority of their client base are people of colour.

> *Yes, exactly. I'm trying to find other examples, because we're working with a manual at the outpatient centre, a lot of the questions are around 'has this been difficult for you?' or 'in what ways were you struggling with XYZ?' So it's not 'he' or 'she'. You see this is what I'm saying - one of the issues I need to work on is I wasn't even conscious of the fact. Which is bad, and I need to start working on that…*
>
> *It seems very gender-neutral to be honest with you. Like the images are men and women. What I do notice on a different talk altogether, is it definitely doesn't include people of colour that much. So there's like a few pictures, but I think our treatment*

> *manuals need to include more LGBTQ and people of colour and then we're good to go.* (Participant 1)

Participant 5 noticed during the interview that they felt defensive, as some of their past encounters with organisations representing queer people's interests had been combative. This participant felt as though an atmosphere of political correctness was stifling their willingness to engage with queerness. This reflection yielded valuable data on the importance of presenting training materials in a non-combative and open manner to better reach an audience that may already be feeling defensive.

> *It's that… and it's something even this interview I might be feeling to some extent. You've got to be so political correct. Do not say the wrong thing. As I said before, we've experienced it with groups that work in that field are militant and sometimes you just step on a button.* (Participant 5)

As mentioned previously, Participant 6 expressed a concern for what they perceived as a lack of knowledge around queer people and wondered whether this was impacting their countertransference. At the end of the interview, they asked me questions pertaining to the meaning of 'LGBTQI+' to improve their knowledge. This on-the-spot education on the topic seems emblematic of Participant 5's description around practitioners having to, "scratch around" for information about queerness and take whatever was available. Participant 6 came away from the engagement satisfied, reporting that they would, "…tell my staff that. So I can go and tell them what those things mean too, and these things will be more sense of what's what." As a queer researcher (Misgav, 2015) who cares about participants and clients alike, the happiness I felt in this exchange is immense. There was a sense of encouragement in watching Participant 6 reflect on their experiences with queer clients, identifying a gap in their knowledge and actively working to fill it in a single conversation. Simultaneously, my position as a queer researcher had me reflecting on my relationship with the participants. Rather than being a passive observer, the above represents me as getting involved with the participants and undergoing a state of flux between an investigator and an educator. No matter how brief the interaction was, I was now in the inverse position of imparting my opinions and knowledge to someone who was previously a participant. In the interaction with Participant 6, I saw a glimmer of what I hope this research will contribute to: Educating and updating the knowledge of mental healthcare practitioners in a non-judgemental manner.

I experienced the analysis process alongside a changing understanding of my own identity which deepened my interest in my body of work. This was not all beneficial as the state of healthcare for visibly queer people is often poorer than others. Moments of happiness toward a responsive participant cohort were met with the grim feeling of being transgender, as I was now the subject of other people's research into dissatisfactory healthcare experiences. Seeing the participants consider the specific experiences of queer clients was balanced by the mountain of literature describing poor treatment.

To outline one example taken from my life, my general practitioner is a charming middle-aged man. He also happens to be devoutly religious, with his office bedecked with the symbols of his faith, photographs of his pilgrimages, and religious artwork. I have been treated by him as a man for over half a decade with no issue, and I saw his religiosity as a charming idiosyncrasy. When I sought out hormone replacement therapy (HRT), I did so with a different, queer friendly practitioner – a living example of the queer-friendly practitioner described by Hudak and Bates (2018). My transition doctor resides in another province of South Africa, and my day-to-day general practitioner is still the religious man I had known for half a decade. The first time I had an appointment with him after I began HRT, I realised that if he continued seeing me, he would notice my body changing in response to HRT. Questions would arise. I preferred to deal with this sooner rather than later and asked him directly at that appointment if he had any qualms about treating a transgender client. He seemed surprised and indicated that no, he would never deny life-saving treatment to anyone who came to his office for any reason and would happily keep seeing me. However, he did clarify that he would not provide transition care for religious reasons, however, he would treat any other ailments I had. Pragmatically speaking, I was satisfied with the answer as the doctor I had been seeing for half a decade would not deny me treatment because I was transgender[3]. Personally and through an academic lens, I was dissatisfied with the answer as he did not characterise gender transition as 'life-saving' care. While not immediately lifesaving, it is an effective way to improve transgender quality of life and reduce depression, the latter being a well-known correlate of suicide (Baker et al., 2021; White Hughto & Reisner, 2016). He stated that he would not provide transition care for religious reasons. I very much question someone's suitability to a profession if they are qualified to render their profession's services, but are unwilling to. My fear of healthcare discrimination is echoed in work such as Jacobs' (2019, p. 188) where gay clients request

[3] At times, the expectations that transgender people have in healthcare are very low.

treatment from women for fear of discrimination, saying that "We have had instances where male gay clients have requested a female social worker instead of a male. The reasons are usually that gay males feel judged by cisgender males." The threat of healthcare discrimination is one which constantly lingers on queer people regardless of their identity (Cicero et al., 2019; Lykens et al., 2018) and when this threat is realised (Müller, 2016), it can have a permanent effect on one's opinion of their healthcare system.

I tell this story as it is a rare and uncomfortable situation which few people will ever have to consider. Very few people must contend with the possibility that changes in their life would lead to a primary care practitioner refusing treatment due to discrimination. As HRT affected my body, the changes would become unmistakable. My doctor would see breast development or skin texture changes and I would have to explain them. I certainly did not want my breast development to be misidentified as a hormonal disorder, requiring correction[4], such as gynecomastia. I felt pressed to explain myself on my terms, by having a conversation with a medical practitioner that most people do not even consider. As I suspected, his religiosity impacted his willingness to deliver healthcare which he is qualified to provide. These negative experiences of mine, or others gleaned from literature, resulted in low expectations for what my participants would provide. This cloud of preconceived judgement lifted when my participants described meeting queer clients with concern and kindness as far as they could. Although I endeavoured to separate my negative experiences from my participant's words and give my participants a fair accounting in my study, I leave it to the reader to decide whether these efforts were sufficient.

6.3. One Transgender Client's Experience in SUD Treatment

While this study focusses on the needs expressed by mental healthcare practitioners there is another important group to consider being the clients. The goal for this study is to benefit people affected by SUD who may experience treatment alongside the complexities brought about by their queerness. These complexities are largely unacknowledged and disregarded in a South African context and can be detrimental to the treatment process. This study sought out healthcare practitioners to address their training needs, however considering

[4] The idea that this doctor might see the breasts I am spending money to grow and advise me to 'correct' the issue with a different, costly treatment is morbidly amusing to me.

practitioners without thinking about their clients would leave the work incomplete. One particularly rich segment of data from Participant 5's interview is ideal for a reflexive interpretation, combining social research and my own experiences as a transgender person. After some explanations of concepts, what follows is my reflexive interpretation of Participant 5's account alongside existing literature. The aim of this chapter is to supplement previous findings by presenting a baseline example of the unique challenges queer people face when seeking healthcare treatment, as reported by a research participant and interpreted by a transgender researcher.

A desire to analyse Participant 5's account in an in-depth manner, came about once I saw a reflection of my own fears and anxieties as a new trans woman while engaging with the transcription. As Participant 5 recounted the challenges they had faced with integrating a trans woman into women's treatment, I began to feel empathetic towards the client being discussed. She was not merely an awkward social interaction, a point of data, or an example of queer people in SUD treatment to me. She was a person looking for healthcare, just like myself. The circumstances were different, however, the underlying feeling was not. This trans woman whom I was hearing about, embodied my fears of being denied access to healthcare. She had lived through my nightmare of being rejected by people who she considered as being her peers. Her difficult position at the door of a substance use treatment group reminded me of my vulnerability in this world. It could be me entering a healthcare space where my health depended on the kindness of others, and they might reject me. In addition to this, I may be outed to an uncaring practitioner or a treatment group because I look different. I have had disconcerting conversations with healthcare practitioners and have reached fortunately lukewarm outcomes, but sooner or later, luck runs out.

Contained in Participant 5's account was a rich and personal experience of healthcare for a queer person. I was compelled to speak further to this. I was provided with a direct account of the trials which queer people experience, and I would be doing the work a disservice if I were to ignore this. Perhaps most importantly, it was reported by the participant as an event they personally experienced, placing it squarely in their lived experience. With the subject of the excerpt being transgender, many aspects of the interpretation are specific to transgender people's healthcare experiences. Queerness is an umbrella which encompasses diverse forms of gender and sexuality and there are no universal experiences shared by all queer people. Consequently, the terms explained below are largely explained in relation to transgender people.

Assigned Female/Male at Birth (AFAB/AMAB) – Terminology which aims to accurately capture the lived experiences of trans people will often refer to their assigned sex, generally as Assigned Male at Birth or Assigned Female at Birth. This reflects a key factor of gender development: that sex categories are normally assigned to people at or before birth, predominantly on the basis of external genital appearance (Forcier et al., 2020; Tate et al., 2013). Although it would be unreasonable to expect a new-born to make decisions regarding their gendered being, gender begins as something that is largely outside of a person's control until they develop more agency. Gendered behavioural conditioning, the provision of gendered toys and clothing, or gender-segregated play are some of the ways in which gender socialisation manifests. Terms such as AMAB and AFAB acknowledge that for any person raised by other humans, their initial gender category was issued to them and not self-selected.

Another important aspect of gender addressed by these terms, is the recognition that if gender is assigned at birth, it is possible to change it later. This is a critique of the cisnormative view that gender is immutable and innate (Oakleaf & Richmond, 2017), and points out that gender is partly socially assigned and developed. A large component of any person's gender is in effect socially constructed and the implication is that this can be reconstructed. Describing a transgender person as AMAB or AFAB describes their pre-transition gender assignment and highlights the possibility for change. Likewise, being called AMAB or AFAB is not an insult but merely describes a person's gendered origins.

2. **Passing** – Passing refers to whether a person can seamlessly appear as a member of one of the binary genders (Anderson, 2020; Bischoff, 2012), therefore passing themselves off as a member of that group. Passing or not passing is a frequently discussed aspect of being transgender, with meaningful consequences attached, be it evading detection and harm, or living a fully realised life as their gender. Passing can be a validating experience for transgender people who wish to pass, because they can live a life in alignment to their desires (Bischoff, 2012). This passing may be considered undesirable as the person may be identified as queer, resulting in discrimination (Anderson, 2020; Fuller et al., 2009) or they may simply not be able to live life as desired. Passing is not a value-free concept and the emphasis on passing has been criticised for prescribing that presentation as a man or a woman is ideal, which strengthens a binary idea of gender (O'Shea, 2019). An elaboration on this term is of importance as passing is fundamental to many forms of discrimination. Someone who passes in a group is unlikely to receive discrimination as a result of their differences, unless they are otherwise exposed. This phenomenon is well-observed among queer people's use of

impression management as a tool to negotiate potentially discriminatory spaces (Carrasco & Kerne, 2018; Miller et al., 2019). Being visibly queer is the opposite of passing, and can occur by choice through disclosure, or unwillingly when a person is identified as queer while trying to conceal it.

3. **Clocking –** In transgender parlance being 'clocked' is being identified as a member of a person's assigned gender despite efforts to pass as a different one, such as being identified as AMAB when attempting to present as a woman (Shelton et al., 2017). Clocking is the opposite of passing and can be an anxiety-inducing experience which exposes a person as queer (Sevelius, 2012). At its most mild, being clocked means that a transgender person was unable to meet a goal that is important to them and at worst, it can lead to violence (Brumbaugh-Johnson & Hull, 2018).

4. **Social and Medical Transition –** Gender transition is a complex, multi-faceted process and two of its possible components are changes made in the social and physiological spheres. In a social transition, the transitioning person adopts visible behaviours, dress and roles which align with their internal sense of self (Oliphant et al., 2018). This can include different names, dress, and gendered behaviours. This is in contrast to a medical transition, where someone undergoes medical treatment to change their physiology to match their internal sense of self (Chang et al., 2018; Oliphant et al., 2018). The social and medical components of gender transition are not the only parts of a gender transition, and the extent to which a person partakes in either is dependent on a range of factors including costs, accessibility, stigma, and interest (Oliphant et al., 2018).

6.4. Participant 5's Account

Participant 5's account was given when asked whether their facility gave queer clients any special consideration or treatment. This account is quoted below, with notes for clarity given in square parentheses where required

> *That would be wonderful, but there are not enough participants to even create a feasible group of three or four. We might have a person here and there, and if there were enough, we would try to create a group space specifically for that group. As an NGO with very limited government funding and constant financial challenges, we*

can't have endless options, programmes and social workers. There are realistic limitations on what you can offer. But yes, if there were… we would like to offer a group especially for them.

In particular, I want to share with you a challenge we have. It's a very diverse group in my understanding and you're going to have situations where in terms of the physical body, they have a man's body and dress as a female, for example. That creates a problem with gender-based groups. The person doesn't fit in well… though they have a man's body, they don't identify as male and probably don't want to be put into the men's [therapy] *group and they don't particularly fit in the woman's group and while it's confusing to explain every time that 'we were told this was a women's group and this person is dressed as a woman'. You know, it's just difficult.*

An even greater difficulty is, and I hope I'm not being politically incorrect; of what we see as the integrity of a woman's group. Our women are generally abused in various ways – who've experienced sexual promiscuity and prostitution that they carry enormous shame about. They've neglected children through what addiction does to people. They've maybe had unplanned pregnancies and aborted… a lot of things through which they carry pain or shame. What we feel is very important in how we start these groups is to give a guarantee every single week that there are only women in this group, and though we have men counsellors on staff, we always guarantee that men will never run this group. If we perhaps have some people who are physically perhaps have a man's body. They might feel that they identify with a women's group but we would be breaching our contract with women if we allowed that. Do you understand that?

We have had this difficulty and we accommodate it this way: if a person doesn't really – because of how they identify and express themselves and how they dress – don't fit into a men or women's group, we accommodate by giving them an extra group. We have an art therapy group that is optional for other people, but we'll make the art therapy group compulsory for you so that you still get the same number of groups per week. (Participant 5)

6.5. Passing in Healthcare Settings

I am of the belief that the queer person described in the example is a transgender woman – someone who was AMAB, but whose internal sense of gender differs from this assignment. The AMAB assumption is evidenced by statements such as, "where in terms of the physical body, they have a man's body," as well as, "we perhaps have some people who are physically perhaps have a man's body." Participant 5 also characterised the client's physiology as being masculine in their description.

The person's identification as a woman and their efforts to transition and pass are evidenced by statements such as, "they have a man's body and dress as a female," and, "though they have a man's body, they don't identify as male and probably don't want to be put into the men's [therapy] group." In accordance with Arayasirikul and Wilson's (2018) work, she is putting in the work of being transgender by going out of her way to dress, present and integrate themselves into spaces that affirm her gender. These conscious decisions to avoid the masculine and integrate into the feminine strongly suggest that the client is a transgender woman and someone who was assigned male at birth and disagrees with the assignment.

The trans woman in the excerpt is characterised by others as someone who, "…don't particularly fit in the woman's group and while it's confusing to explain every time that 'we were told this was a women's group and this person is dressed as a woman'." These observations are indicative of being clocked. Participant 5 characterises the trans woman as a person who is physiologically male and does not identify closely with masculinity, but rather with the members of the women-only group who were less charitable and characterised the client as a man in a dress. The conceptualisation of trans women being men in dresses who are out to invade women's safe spaces, such as restrooms and support groups, is an unpleasant and pervasive form of discriminatory rhetoric (McKinnon, 2014; Outten et al., 2019). Clocking and identifying the trans woman as a man in a dress' frames the participant in a manner that is incompatible with the treatment group's interests. These interests include being a space exclusive to women, however, what constitutes womanhood is not made clear. This presents a problem for Participant 5 who is required to negotiate the desires of the client alongside their mandate to ensure a women's treatment space which is free of men.

Participant 5's decision was to place the group's values and needs above the transgender client and accommodate the trans woman elsewhere to the best of their ability. This resulted in the client's placement in an art therapy group that was normally optional, but made mandatory to make up for lost group treatment hours. This compromise recognises the client's demands to not be involved in group treatment with men, addresses the discomfort expressed by the cisgender women in the group, and ensured that the transgender client still received as many treatment hours as others. The compromise was imperfect but made via Participant 5's interpretation of their practice agreements and facility resources.

The instance presented here is an illustration of transgender people's anxieties related to being clocked and mistreated (Brumbaugh-Johnson & Hull, 2018; Shelton et al., 2017). The mistreatment varies, with examples ranging from denial of opportunities to direct physical violence (Brumbaugh-Johnson & Hull, 2018; Noack-Lundberg et al., 2019). In the case of a women's treatment group formed with an explicit need to prohibit men due to a traumatic threat they present, the rational assumption is that group members characterised the trans woman as a man and therefore, as a threat. If the trans woman was made aware of this, she would learn that not only was she clocked and ejected from an affirming healthcare space, but because she was presumed to be a danger to those she considered as peers.

Passing or managing impressions in healthcare settings is a challenge for queer people due to some of the unique circumstances which healthcare settings introduce. Acquiring effective healthcare is at minimum, a quality-of-life improvement and at most, a life-or-death endeavour. The risk of worsened treatment due to discrimination, or an ill prepared practitioner, is a threat readily faced by queer people. Healthcare settings present a power dynamic in which the client is placed in a position of less expertise, risking dismissal if they were to speak up (Jagosh et al., 2011). Healthcare settings may require the disclosure of information that would expose somebody as queer to a practitioner, and if that practitioner is discriminatory, they have just been handed privileged information that further enables discrimination.

In effect, clients are left in a position where alienating their practitioner runs the risk of losing their current form of treatment, however, disclosing their personal information as normal, risks alienating their practitioner. This was the impetus for my uncomfortable conversation with my physician. Despite knowing full well that there is nothing wrong with me for needing to transition, I know that some people do not see it that way. I raised the issue

so that I did not alienate him in a situation that was not on my terms, risking an all-together less pleasant response. I was ‘lucky’ to hear that my doctor was merely morally against conducting a gender transition but would be happy to keep treating me for anything else. One South African gay man was not so lucky: he was informed by nurses treating his broken limbs that he deserved the injuries for being gay (Müller, 2016). It is difficult to articulate how such an encounter can impact the well-being of someone seeking medical treatment for limb-threatening conditions, especially when this sentiment is expressed by the very people treating the condition.

The literature is replete with lesser incidents, and I recounted one of my own. I will add another example of mine related to the anxiety of being queer in healthcare: monitoring the progress of my HRT requires regular blood tests to check the levels of various hormones. In my case, more blood tests were conducted at the beginning of my treatment process to ensure a smooth adjustment to the new hormones, as well as to safely adjust my dosage to a satisfactory level. During my third visit to the pathologist, the nurse who had drawn my blood each time asked me why I kept returning to have the same set of tests done. My anxiety over healthcare settings had already prepared me for this. I gave a prepared answer that was both completely true and evaded the question. I told the nurse that I had a hormone deficiency and my doctor needed to monitor my hormone levels over time for treatment.

Whether or not it is appropriate for a nurse to inquire about a client’s reasons for needing blood work was secondary a concern to me. My main concern was that I presented in a masculine fashion and wanted the world to see me as a man so as to avoid discrimination. I was presented with the opposite situation of the trans woman in Participant 5’s facility. I wanted to pass as a man in individual healthcare treatment, but there was evidence suggesting that I was not the man I claimed to be. The nurse who had seen me three times in several months had seen the tests ordered, which were all assessing the levels of male and female sex hormones in my body. Once the results were processed, they would pass through their office to be e-mailed to my doctor. The nurse and her administrator could view them anytime and see that I had a high level of estrogen in my body for a ‘man’, and it was steadily rising. I wanted to pass as a man and the privileged information being divulged to my healthcare practitioner threatened to expose my queerness to uncertain consequences.

In that instance, the nurse accepting my vague answer and nothing further came of it. This was another lukewarm encounter, however, I live in fear of encountering practitioners

such as Thabo's (Müller, 2016). Practitioners such as his were professional until they saw the queerness in someone and degraded them while actively treating them. While anyone can be mistreated by a medical practitioner, people are generally not mistreated due to perceived queerness unless there is queerphobia present. Queer discrimination adds another barrier to accessing healthcare in addition to other barriers already permeating my life. I resent having to live in a world where I must selectively manage my presentation and the information which I provide to medical practitioners for fear of humiliation or targeted discrimination. If I cannot trust medical professionals with detailed information regarding my mental state and physiology, then who can I trust with such information? I have navigated a few such situations to mild success, but I fear that as the number of practitioners I see increases, my probability of encountering a discriminatory practitioner approaches absolute. What then?

My thoughts return to the non-passing trans woman in Participant 5's interview. From my reading of the excerpt, it is deduced that she too was using her appearance to convey a message of femininity and sameness to others in the women's group. The decision to self-identify as, and dress as a woman, speaks to the intention of finding solidarity with other group members in shared femininity. More pragmatically, passing as a woman in a women's space would simply result in seamless inclusion. Participant 5 notes that the decision was driven by a desire for a woman to avoid the men's therapy group, a sentiment that was frequently reported in interviews. The minimal outcome of this trans woman's interaction is that she was denied her healthcare of choice and the solidarity it would entail.

Participant 5 applied the ad-hoc solution of placing her into an art therapy group as a compromise between all parties' needs. The occurrence of this event in a group treatment context adds another dimension of complexity not seen in medical settings which only have client-practitioner interactions: other clients are also a potential source of discrimination (Jacobs, 2019). Healthcare practitioners may be held to a basic standard of professionalism, good conduct, and expertise, however, the same cannot be guaranteed for other clients. Here, the client faced mistreatment from other clients while practitioners attempted to accommodate them. This is only one possible form of healthcare denial experienced as a result of discrimination against queer people. In this case, the client's visibility as a trans woman was relevant and if she was substituted with someone who passed fully for a woman, they would have gone unnoticed. The irony of this account is that if its subject had passed, she would simply be another woman in a woman's group and therefore, be seen as someone mundane.

The successful inclusion of visibly queer people into treatment is unlikely to be as simple as educating practitioners on up to date terminology, or making adjustments to intake documentation with the aim of inclusivity, although these are all important and recommended components of GAH (Cicero et al., 2019). Clients involved in social healthcare settings such as group and family therapy bring their own conceptualisations, assumptions and anxieties related to queerness that may impact the treatment process for all involved. Participant 1's interaction with an initially homophobic client who developed a bond with a queer client and went on to support each other through treatment is one such interaction. Homophobic opinions, both overt and covert are not uncommon. This may be another point of friction in therapy settings that are already delving into personal and traumatic topics. Fortunately, Participant 1's interaction resolved in a favourable and supportive outcome0, however, this cannot be expected to be a norm. Any training process aimed at sensitising practitioners to the needs of queer clients must recognise the diversity of queerness and develop an awareness of different queer healthcare experiences. This knowledge could then be used to supplement existing conflict mediation skills with an enhanced understanding of the clients' experiences and needs. This could effectively integrate new knowledge into existing systems of practice and improve practitioner readiness to treat queer clients while alleviating anxieties.

6.6. Being a Woman

'Being a woman' is taken for granted, and there is a presumption that people going about their lives are aware of who they are in relation to womanhood. Namely, whether they 'are', or 'are not' a woman. Activities as mundane as using gendered restrooms, filling in gender fields on forms or requesting feminine forms of address such as 'ma'am', 'sis' or 'miss' require a person to know whether they are a woman or not. The surface implication appears to be simple. If one is certain that they are a woman, they can proceed as such. In reality, the definition of womanhood is contested, and self-identification or assertion of a gender identity is not always sufficient to establish this as fact to others. A self-declaration of womanhood is often inadequate to 'prove' that one is a woman in social settings. Womanhood is socially mediated through pressures pertaining to appearance, dress, and participation in appropriate activities, to name a few (Schilt & Westbrook, 2009). Debates on what constitutes womanhood continue, even involving genital configuration and

chromosomal arrangements (Schilt & Westbrook, 2009; Westbrook & Schilt, 2014). The dispute over what combination of characteristics defines womanhood is ongoing and is much more than theoretical. Disagreement over what constitutes a woman has practical implications, including for SUD treatment.

In SUD treatment, the primary criterion to be part of the women-only treatment group is to 'be' a woman. However, this criterion is only simple if it is understood equally by everyone involved. Womanhood is often characterised by the embodiment of feminine physiological characteristics (Schilt & Westbrook, 2009) and the visible performance of feminine behaviours (Butler, 2002) and when it is transgressed, friction may occur. Participant 5's description of a non-passing trans woman being rejected by a women-only treatment group for being, 'a man in a dress,' is an interaction that is revealing of what the treatment group considers womanhood, as well as the importance of passing as a safety measure to many transgender people.

For the subject in Participant 5's facility, wearing a dress and signing up to woman's SUD treatment was insufficient to be considered a woman. A trans person's effort to change their appearance, often with a motive of personal safety is described by Arayasirikul and Wilson (2018) as 'trans work'. Trans work describes the labour of performing gender in a body that was assigned differently at birth. It relates to both the considerable effort required to pass in public for trans people compared to those who are unmistakably their gender, and the fact that many transgender people's language for being transgender alludes to work. Transgender people living permanently as their gender may describe themselves as living 'full-time'. Someone who adjusts their presentation depending on their social context could be considered 'part-time'. The authors (Arayasirikul & Wilson, 2018 note that trans work requires conscious effort and concentrated learning, rather than being developed from socialisation much earlier in life. People who transition later in life generally do not receive the gendered upbringing which teaches the skills and rituals of their gender, and must instead learn through social groups and informational sources.

For a trans woman accessing SUD treatment, her trans work begins long before arrival – with the consequences for 'failing' to pass being an integral consideration. Arayasirikul and Wilson (2018) write:

> *While transition work and passing are foregrounded social processes, the anticipation of being clocked is omnipresent. Gender minority stress and*

> *microaggressions are the co-creation of transition work and the anticipation of being clocked. Imagine the stress of having to play to an audience on stage and seek respite backstage, only to be surprised that there is a second audience there whose gaze is focussed solely on you. This vigilant surveillance is central to and productive of gender minority stress and microaggressions. One participant discussed this stress saying:*
>
> *There's all this self-consciousness, worries about self-appearance and worries that, you know, if they did find out, or if I end up telling them something, and I wish I had not told them it is going to be on all these things. So there are more things to consider now than before. (M., 21)*
>
> *She described anticipating being clocked, or having others "find out" that she is trans. This caused her distress or worry. She worried about this to the point that she is "self-conscious," taking on the sole responsibility of self-surveillance or policing of what she says.* (Arayasirikul & Wilson, 2018, p. 1426)

The non-passing trans woman in Participant 5's account transgresses the gender binary by embodying characteristics considered both masculine and feminine, while asserting her own womanhood by self-identifying as feminine. However, her vision of herself is incompatible with the treatment group who see her as a man in a dress and therefore, a potential threat and source of suffering rather than a peer. Her rejection is illustrative of Butler's (2006) concept of precarity, which suggests that people's lives are dependent on others and in a precarious state that is vulnerable to outside forces. The trans woman here is dependent on the actions of others for access to healthcare, and this can be denied by forces and people beyond her control. Participant 5's account could even be considered as optimistic, with the practitioner attempting to accommodate a transgender client in their chosen treatment space and when that failed, arranging a different treatment space as a compromise. Other clients are not so fortunate, facing rejection at the door or sustained bullying until dropping out of treatment (Jacobs, 2019).

In thinking about Participant 5's transgender client and the disapproval she met in search of treatment my prevailing thought was that *this could be me*. The negative encounters I have described in my reflections all occurred in the first year of my transition and I suspect there will be more in future. I have yet to meet such a disconcerting situation where I sought out healthcare that could alter the course of my life, but the possibility of rejection and

relegation into second-line care is always on my mind. Having become a trans woman, I now live a more fragile life than before and I am never more than a few discriminatory misfortunes away from addiction, homelessness or being the victim of unprovoked violence (McCann & Brown, 2021; Stotzer, 2009). Will I be able to depend on the support structures that others use when they meet misfortunes? Would a women's substance use group or facility take me if I do not pass? How about a homeless shelter for women, many of whom were victimised by men and might see me as a potential threat? If I slip into crime and am arrested, how will the police treat me (Miles-Johnson, 2015)? Will it be a men's holding cell or a men's prison, with the extraordinarily high rates of sexual violence for trans women within these spaces (Edney, 2004; Rodgers et al., 2017)?

The work of being trans (Arayasirikul & Wilson, 2018) can involve navigating administrative structures in search of accurate documentation and the financially burdensome acquisition of medical care and gender-affirming apparel[5]. Much of this expenditure in resources and effort is aimed at being identified and recognised as one's gender. Consequently, not being recognised as one's gender and being clocked is seen as a failure to meet one's objective, with potentially serious consequences. Previously, I discussed some of the fears that transgender people have about being clocked, such as exposure to direct violence or other forms of discrimination. There is yet another fear specific to trans-womanhood that is not fully known: being regarded a threat to women. Participant 5's transgender client was regarded by members of the women's group as a man in a dress, rather than a woman. The women's group has a clear mandate being the exclusion of men, who may represent a threat to the vulnerable and oft-traumatised clients within. Taken together, the implication is that the trans woman was seen as a potential threat and representative of men in their space. In this I saw a fear of mine crystallised in the discourse excluding transgender people from gendered spaces and being regarded as a danger.

The assertion that trans women pose a threat of bodily or sexual harm to others has been a long-running component of transphobic rhetoric (Bender-Baird, 2015; Lenning et al., 2020; Westbrook & Schilt, 2013). The bulk of this construction of transgender women as a threat to the vulnerable other hinges on two constructions; gender as irrevocably attached to assigned biology, and a protectionist claim for women and children.

[5] Beyond the expenses of acquiring clothing suitable for a trans person's needs, there also exist specialised, gender-affirming apparel. These include chest binders, breast forms, phallic packers and tucking underwear.

Authors writing on the topic describe trans women in women's spaces, such as public restrooms[6], as being constructed as male due to their genitalia (Bender-Baird, 2015; Westbrook & Schilt, 2013). Irrespective of any other factors, the presumed existence of a penis on a trans woman is sufficient to mark her as a man under this absolute construction of gender. The stereotype that men are perpetual sexual predators is then applied to trans women (Lenning et al., 2020; Westbrook & Schilt, 2013), leading to the conclusion that permitting them access to women's spaces would be dangerous to women. Since predators are defined in relation to prey, the stereotype of women and children being perpetual victims of male violence is applied to others present in that private space (Lenning et al., 2020), creating a fallacious argument that is summarised as, transgender women should not be permitted into women's restrooms because they are actually men, and are therefore a threat to women.

The resulting argument is not just empty oratory, but is used by nations to enact laws that criminalise trans women's use of their choice of restrooms (Bagagli et al., 2021; Sanders & Stryker, 2016). Throughout history, a protectionist argument using stereotypes of predation and victimisation has been used to prohibit women (Kogan, 2007), gay men (Stone, 2018) and people of colour (Spence-Mitchell, 2020) from public restrooms as well. In the case of trans women, the population in need of this protection varies, but women and children (Bagagli et al., 2021; Lenning et al., 2020; Stone, 2019) are among those cited as potential victims for the stereotypically predatory trans women. Whether overtly or covertly, the subtext for the argument is that trans women are men and like other strange men, are sexual predators in waiting.

The impact of policing people on their use of public restrooms is very real. Access to public restrooms is a requisite for participation in public life, as public restrooms fulfil a universal human need. As with times in history (Kogan, 2007; Spence-Mitchell, 2020; Stone, 2018) when women, gay men and people of colour have been prohibited from using public restroom facilities, the immediate result is denying these marginalised groups full participation in public life. As Kogan (2007) states, the uproar over introduction of women's restroom facilities, as women entered the workforce in greater numbers, was not merely a benign debate over human bodily functions. This concealed efforts to deny women access to employment and participation in public life, and the increased societal influence that came with these activities. For transgender people, lack of access to public restrooms or harassment

[6] Public restrooms are not the only private space which exists, but are frequently debated in efforts to deprive me (and other transgender people) of our right to the effective disposal of bodily waste.

in public restrooms, reduces their ability to access education and employment as others (Herman, 2013). In the same study (Herman, 2013), transgender people with inadequate access to public restrooms developed health problems associated with retaining biological waste for extended periods of time. Denying people access to restrooms has physiological, psychological, and social consequences alike, all impeding their ability to participate in public life.

This is relevant to Participant 5's treatment group rejecting a trans woman because my reading noted the same rhetoric there as with the transgender 'bathroom debate'[7]. A trans woman sought out access to a women's space for reasons that would improve her well-being and she was turned away. As with the construction of transgender women as threats in women's restrooms, the reasoning for her rejection was twofold. Firstly, a construction of sex and gender which prioritises biology was applied to her visibly masculine features, resulting in people characterising her entirely as a man, or as someone in a "man's body," who claimed to be a woman. Then, a protectionist claim of women needing protection from men is applied. In this case, this is applied through the treatment space's mandate to exclude men due to the trauma they represent to a group that is often victimised by men. The result of this is that the trans woman's ability to fully participate in a healthcare environment is restricted.

The first time I read the Participant 5's excerpt in depth, I experienced a sense of fear that I did not understand at the time. Once I began parsing it alongside the harmful experiences that transgender people face, rather than a broader queer umbrella, a picture of why I felt fear emerged. I am all too aware of the common forms of discrimination transgender people deal with such as medical gatekeeping (Tomson, 2018), lack of recognition of their identity (Baldwin et al., 2018) and other assorted violence. Living under the threat of these ills is a component of most transgender people's lives. I have wondered if I too will be beaten for using a public restroom (Bender-Baird, 2015), or have a sexual partner fly into a rage upon learning that I am transgender, murder me and proceed to use this as a legal defence (Lee & Kwan, 2014). It is telling that we still transition in the face of these psychological costs because somehow, transitioning is still worth it. The rhetoric in the excerpt was to me undeniably similar to the claims made elsewhere that exclude trans women from public life: using a stereotype to deny a marginalised group access to something important and justifying it through a protectionist claim of perceived threat. I saw a

[7] Despite the extraordinary joy that a gender transition has brought into my life, I do miss the days when my urination was not up for debate. I knew that transition was not going to be pure positivity, but this is a bit much.

microcosm of my fears as a trans woman, being seen as a predator by the people I consider peers. Plain harassment, workplace discrimination and the threat of physical violence are all worrisome. Yet in my eyes, these standard fears are miniscule compared to enduring the labours and trials of being transgender only to be regarded as worse than a failure, but a predator. Putting my anxieties and fears aside, the comparison between the rhetoric used in Participant 5's excerpt and the transgender bathroom debate should be placed within context. I use it to highlight the similarities between rhetoric used to discriminate against marginalised populations and a scenario in my data. I elaborate on why this might be unsettling. The comparison does have limitations, which are described below.

Although protectionist claims have been leveraged against marginalised populations in the past to deny them access to public life (Sanders & Stryker, 2016; Spence-Mitchell, 2020; Stone, 2018), their existence is not meritless. Women's SUD treatment is a context where clients who have suffered greatly can co-exist safely to address their experiences. The clients are vulnerable in many ways, if not from the addiction, then from the intersecting factors that drive or support their addiction such as a burden of trauma, shame, gender-based violence and poverty. SUD treatment is a form of therapy and therapy should have protective, containing elements, being that containment is exactly what some of my participants described as beneficial to their clients. Denying a group's containment, even if based on flawed perceptions, for one individual's needs is questionable at best. Equally important to consider is that public restroom access does not necessarily hold the same importance as access to a specific SUD treatment group. While I do consider SUD treatment to be a component of healthcare and therefore a human right, functional ablutions are generally considered a higher priority substance use healthcare.

I detect no malice in Participant 5's words, and I see this as a case of queerness meeting a healthcare system unprepared to integrate queerness, rather than active discrimination from a healthcare practitioner's part. The result was that someone in a position of authority had to make a discomforting discussion to place the needs of a group above one person and try to accommodate their individual elsewhere. This does not negate the fact that the same basic rhetoric and thought process that undergirds discrimination was used to deny a person from their first choice of healthcare. I must make it clear that I am not attempting to present Participant 5 as a villain. Rather, I characterise the larger problem as societal, one where a society that lacks knowledge about queerness meets queerness in the flesh to predictably mixed results.

6.7. A Trans Woman in Treatment

As a researcher this segment of data was rich beyond words. As a trans woman, it was harrowing to analyse. Yet I can only hope that the hours spent poring over it, with my lived experiences in mind, have yielded a useful piece of interpretation which highlights some of the complexities which transgender, and other queer people, can expect to face. With the reflections addressed there remains a question. What could be done about this? For this specific client I am bereft of solutions and only know what should not be done. I will discuss this below. The bulk of my recommendations are described in following section.

I cannot advocate for the sudden and total integration of every queer person into their choice of gendered healthcare, despite my desire to see each queer body receive the same standard of healthcare as everyone else. Given the extraordinary bureaucratic momentum and inconsideration of queer people in healthcare systems, I cannot see total integration of queer people being a smooth or viable process. For non-passing transgender people, strictly gendered spaces will likely remain an area of contention and anxiety for some time to come. SUD treatment is undeniably gendered, even if it is sometimes for valid reasons. As noted earlier, a protectionist claim can also have good reason to exist in therapeutic spaces. Furthermore, prioritisation of care is a necessary if undesirable component of healthcare. Participant 5 said elsewhere in their interview that they are a resource-scarce NGO at the best of times, and while they would prefer to fully support every client who arrives, it is beyond their means.

However, these challenges should not be viewed as a hopeless prognosis where the solution is to ignore queer people. Despite the diversity and scale of the challenge, there are still areas which can be incrementally addressed for a more equitable system of treatment for all. Healthcare structures and the research which they are founded on still use a binary and heteronormative understanding of gender (Laiti et al., 2019; Shannon et al., 2019; Zeeman, 2019), to say nothing of the prejudices and misconceptions that clients and practitioners might hold toward queer people. My recommendations for future research and action are outlined below.

6.8. Recommendations for Future Research

All participants consider potential gender-sensitive training to be a beneficial concept, even if they have different focus areas in mind. The broad range of priorities that is cited by participants is suggestive of how many areas are required to be addressed before practitioners feel as at ease with their queer clients as their cisgender and heterosexual clients. While actual training endeavours are not within immediate reach, research on SUD treatment practitioners' training needs, with regards to treating an emerging and marginalised demographic, should continue in earnest. Studies similar to Jacobs (2019) such as this one, conducted in different South African locales, can help to establish a qualitative understanding of practitioner treatment experiences and training needs that can converge on practical measures with the aim of improving practitioner readiness. It is hoped that in the future there will be sufficient research to update existing SUD training and treatment materials, or deploy training that can reconstruct practitioner knowledge about queerness to improve treatment outcomes for queer clients.

This study and its participants noted a lack of research into queer people's experiences of problematic substance use in South Africa. In general, information about cisgender men and women is available however, queer gender identities barely exist in South African data. As research is a force that often shapes interventions, manuals, and materials, this may explain the lack of queer representation in materials used by practitioners. Among this study's participants, the result was that practitioners felt inadequately prepared to see queer clients and searched for information about queerness in an informal fashion. Improving the knowledge of queer people's healthcare needs is a recommendation made in the literature. The case is no different in South Africa.

Participants in this study express different ways in which queerness can impact substance use or its treatment. These range from specific substances that are prevalent in different queer populations to the impact of queerphobic discrimination on the treatment process. These observations are made by skilled practitioners and each conceals another point of friction relevant to the queer population. Studying these differences, trends and characteristics should be conducted to generate data about an excluded population and could yield insights that are beneficial to queer and non-queer clients alike.

As it stands, research of any kind into treating queer people with SUD in South Africa is minimal. There are numerous key areas in need of being addressed including surveillance data, treatment access and retention, interpersonal experiences and constructions of problematic substance use, and practitioner training and experiences. As queer people find it safer to leave the proverbial closet and live as themselves, a better understanding of their experiences and identities is needed to best address their needs and desires in society. As the awareness of queerness increases, the healthcare institutions they use must be kept abreast of new developments to maximise readiness for treating everyone fairly.

6.9. Recommendations for Gender-Sensitive Training

Responses from participants not only resulted in interesting accounts of treating queer clients, but opinions on how training would best be implemented. In the interests of contributing useful data to potential training endeavours, this section is dedicated to recommendations for the deployment of gender-sensitive training in SUD treatment contexts.

Areas of improvement described by participants are diverse, but the most common one is training on queer literacy to improve their understanding of different identities and what differentiates them. Good education on queer literacy does not simply coach people on a glossary of terms in a scholarly fashion. Rather, the education provided should explore some of the complex ways in which language interacts with queerness and should present a clear case for why terminology matters to queer clients. This is important in the usage of a person's indicated names and pronouns (Baldwin et al., 2018), where a preferred name may differ from a legal name, or the choice of pronoun not matching presumptions. Other key concerns include the de-stigmatisation of queerness in the practitioner's eyes and developing an understanding of risk factors and behaviours observed in queer people, that can differentiate their substance use from other demographics.

Unlike most forms of healthcare, SUD treatment is often deployed in group settings. Gender-sensitive training for SUD practitioners should be developed in a manner that is mindful of the social context of SUD treatment. The literature is replete with suggestions aimed at facilities to improve the experiences of queer clients (Glynn & van den Berg, 2017; Hudak & Bates, 2018; Oggins & Eichenbaum, 2002), such as modernising documentation and intake forms (Jacobs, 2021), sensitising staff to queer issues and creating gender-neutral

spaces (Lombardi & van Servellen, 2000). While helpful, the importance of integrating this knowledge into practitioners' existing training on group facilitation is noteworthy. The often social nature of SUD treatment should be accounted for in any process of updating training materials so as to make best use of practitioner's existing capabilities and methods.

Perhaps most importantly, training programmes are about practitioners first and foremost. Participants in this study described the importance of training to be approached in a manner that is non-condescending, open to error, and free to discussion and learning. Training described as dogmatic or prescriptive of a single 'right' way to treat queer clients was characterised as both hostile and condescending. It is therefore recommended that training be treated as an open space that presents up-to-date information about queerness, with robust supporting arguments and ample room for discussion. Training spaces should enable practitioners to address their concerns, misconceptions, and discriminatory beliefs about queerness in a safe and open manner – similar to group therapy itself. Improving practitioner confidence and readiness to treat queer clients is as much a matter of willingness and empathy as it is learning. This should be considered at all levels of training.

6.10. Critical Review of the Research

In addition to personal reflections which discuss my viewpoints and impact on the study, a methodological review is valuable for highlighting the study's mechanical limitations. This section discusses and addresses the limitations of the study and its methodology.

As a qualitative interview study, this research features many characteristics of qualitative research, being that there is no hypothesis testing, there are small sample sizes, and there is an emphasis on subjective interpretations of data and high depth of data (Bryman, 2016). A qualitative approach suits the study's goal of addressing the variable needs and experiences of SUD practitioner training needs and reporting on them, however, the final product has the characteristic limitations of any qualitative research. Perhaps most notably, the results are not generalisable to any particular population. The participant group involved is not a representative sample of all SUD practitioners. For that reason, interpretations of the participant's interviews are developed with the aim of describing their experience and

elaborating on it from an academic perspective. This is in contrast to a quantitative approach which may seek out a measurable, detached fact of the matter at hand.

Sampling bias is a possibility and there is a likelihood that people who were disinterested or opposed to gender-sensitive training simply ignored the opportunity to participate. This could result in the study simply reporting back findings from a cohort of practitioners who are particularly interested in queerness, or at least had more to say on the topic. Furthermore, state-operated treatment facilities could not be accessed for recruitment, as the City of Cape Town, South Africa, requires approval for research in state facilities. This approval was sought, but was not received in time for data collection due to office closures during the first wave of COVID-19 lockdowns in South Africa. To counteract possible sampling biases, the results from this study are supported by existing literature in many areas, especially those on queer healthcare and GAH. A participant's response should be considered in the context of the wider state of healthcare for queer people in South Africa and beyond to develop a more complete picture of the situation.

While low sample size and a qualitative approach are key factors that make the study's results non representative of a larger sample, the study's aim was never to be representative. Rather, the aim was to learn about participant's experiences in treating queer people, and to outline, in depth, any training needs they might have for the treatment of queer people. To that end, richer and deeper reporting of results, alongside literature and even the researcher's experiences in healthcare, can give weight to the perspectives involved in healthcare processes for queer people.

6.11. Concluding Remarks

SUD treatment practitioners are meeting with more queer clients as the societal acceptance of queerness grows. This growing number of queer clients is not equally met with improved knowledge of the contextual factors surrounding their substance use which contributes to a feeling of unpreparedness among practitioners. SUD treatment practitioners' desire for increased training in this study and elsewhere (Jacobs, 2019) is indicative of a need to improve their knowledge and confidence in seeing queer clients. A need for training is expressed by practitioners in this study, and their perspectives are centred in the research. Alongside the recommendations of international and South African research, this thesis

sought to identify and contextualise SUD practitioners' needs for gender-sensitive training and contribute to a body of knowledge which can improve practitioner and client experiences in the long term.

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Appendix A – Communique to Postgraduate Supervisors

RHODES UNIVERSITY

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1 May 2020

Dear Colleagues

Communication for postgraduate project supervisors

Let me start by thanking you for continuing to support your students during the national lockdown – we have received some very warming expressions of appreciation from postgraduate students for the ongoing support received under difficult circumstances.

Following yesterday's national address by the Minister of Higher Education, Science & Innovation, postgraduate supervisors are justifiably concerned that the prolonged delay in the return of their students to campus may adversely affect their progress towards completion. In response to a question on who could return to campus, the Minister indicated that it would be final year students in medical fields who will be allowed to return to campuses and those engaged in research directed towards addressing the COVID-19 pandemic. We are seeking clarity from the ministry about this, and in addition, representations will be made through USAf for the return of those postgraduate students for whom the Universities can put in place all the necessary preventative measures to comply with the prescribed protocols.

There are a number of factors that have become clear enough for us to have some parameters around which to formulate plans in support of research students, and research productivity generally:

1. The lock down will be lifted in stages, as it is deemed safe to do so, and may revert from a lower level of restriction back to a higher level if there is an upsurge in infections in our greater geographic area, driven by scientific and medical advice from the Ministerial Advisory Group to the National Command Council on COVID-19;
2. Restrictions on travel will be in place for some time to come;
3. When we commence on site work, it will be under strict conditions of hygiene and social distancing;
4. There is an evident strategy from the ministerial task team responsible for our sector to keep the student population on campuses low for some time to come;
5. Contact teaching programmes and face-to-face teaching are likely to remain closed for some time;
6. Academic continuity measures should emphasise online and remote productivity;

7. Research and product development which will assist the battle against COVID-19 should be prioritized.

Many of the considerations that we see coming from national discussions have focused, understandably so, on undergraduate contact programmes and how to facilitate keeping that large group of students academically engaged. We mostly need to make our own sensible value judgements about how guidelines relate to the research components of postgraduate work, but we will have to comply with national regulations.

In planning for the point where we are able to bring some staff and students back onto our campus, a set of health measures in compliance with the relevant legislation is being drawn up, which is intended to mitigate the risk of transmission. Many of our laboratory facilities already operate under sterile conditions. It is important to also consider the people density in laboratory and equipment spaces, and the potential for viral transmission in the spaces outside of the laboratories, and in the general premises as people come and go. Students and staff with pre-existing health conditions need to receive special consideration. When allowing students to return to campus, it will be important for us to prioritise those who need the facilities of the campus to make progress on their theses, notably equipment and laboratory facilities. Postgraduates who are able to make progress on their theses remotely, should work in that mode for the foreseeable future. Laboratory based postgraduate students, who are already in town, are likely to be the easiest to accommodate. We are already making exceptions for students and staff who have to tend to live creatures, plants, or cultures. Careful consideration will need to be given to students who have to travel from other areas to return to the campus. Thought is being given to a protocol to be followed for this category of research student.

A particular concern for us are students whose projects require them to undertake field work within communities, particularly in the social sciences, and in education working in schools. Where students are in the early phases of a qualification, it might make sense to consider whether the project proposal can sensibly be re-scoped to obviate the need for social engagements in the next few months. Where it is possible to do so, please get your students to undertake survey type data collection by e-mail, telephone or other electronic means, so that their progress is not delayed. It is not necessary to seek re-approval from your higher degrees committee or ethics committee if the data collection modality changes without affecting the base principles of the research.

Another category of postgraduate students where I request supervisors to take pro-active action is those with time bound and structured programmes such as honours students and coursework masters, where the research project is a minor component of the overall assessment for the degree. Our recommendation to supervisors is not to delay in recasting this category of projects away from undertaking fresh field work, and towards existing data sets and desktop research, so that these students are not held to ransom by shifting conditions and possible extensions of limitations in the way we can operate. Where field work on the part of current students is part of an undertaking with

funding partners, we will have to engage with these partners about a reasonable restating of the project scope.

Field work in general remains a question mark – whereas we might feel that certain kinds of field work, for example in the biological sciences, can be undertaken safely, we will need to navigate national directives and travel restrictions as we move forwards.

The decision of the University to purchase data bundles for students across the board was made with research students in mind, who do not benefit from zero-rated sites where the bulk of course material is hosted, and who need access to meeting software and cloud hosted information resources that are not within the zero-rated URL sites. Please have your supervisees use this data allocation productively.

International students who are currently outside of the country remain a real concern as travel restrictions might apply to them for some time, and zero-rated sites and data bundles only benefit mobile data users within the borders of South Africa. The International Office has been collecting information about the challenges faced by this group of our students. If you have ideas which are practical and affordable, we will be glad to hear suggestions from you on how best to support your international supervisees who are currently outside of the country. The Department of Home Affairs has issued a communique about flexibility for people already in the country whose visas have been affected by the lock down process, particularly relevant for students currently within the country whose visas are expiring. The International Office will be able to provide more guidance about this as things unfold.

We have been involved in a number of national engagements involving the sector, with the DHET, USAf and the NRF. For the most part, these forums have responded sympathetically and promptly to systemic challenges. You will have seen the notice from the NRF about extended deadlines for calls and reports. It is important that we keep a balance of delaying deadlines, and allowing time for the reviewing and processing of submissions, so that we do not get ourselves into situations where we have large gaps between funding cycles. The NRF has indicated a willingness to be flexible about things like running costs being used for data during this period, but has stopped short of issuing a blanket permission to reallocate travel funds, indicating that it is too early to make this decision.

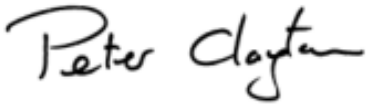
A very big concern that is on all of our minds is how the NRF and other funders will respond where students overrun their funding period because of research delays caused by the COVID-19 crisis. This has been raised with the NRF, DHET and USAf as a national concern. It is on the agenda, with a "keep an eye on it" kind of response until the magnitude of the problem is better known.

We have found the National Ministerial Task Team to be responsive to our requests to allow the delivery of consumables for keeping scientific equipment operational, and I envisage the same degree of responsiveness if we struggle to source reagents and other kinds of consumables to remain research productive in the coming months.

Where you have new students to the University who need to be registered at this time, the Registrar's Division will go ahead with the registration online, and adjust their in-attendance status when the student is able to come onto the campus. This process needs a brief statement from the supervisor indicating that they are satisfied that the student will be in a position to start making progress under these conditions. This is required in order to protect the University from entering into a relationship with a student where no progress is feasible under the circumstances.

Please keep in contact with and encourage your students over this period, and stay safe yourselves.

Sincerely,



Dr Peter Clayton
Deputy Vice-Chancellor: Research & Innovation

Appendix B – Participant Information Sheet

Information for Prospective Participants

Participants who wish to engage in the research study are informed of the following:

1. Nature of the Research and its Purpose

a. This is a staff-supervised, student-run project and its purpose is to conduct a gender-sensitive training needs assessment of substance use disorder (SUD) treatment clinicians in order to improve treatment outcomes.

b. There is presently a massive lack of research on gender-mainstreaming and gender issues in SUD treatment settings, and preliminary information suggests that further training is required, and access for queer people is limited.

c. This research is needed in governmental, non-government and private SUD treatment arenas to fill a possible gap in services that creates awareness of gender equality in treatment.

d. The time and effort required to conduct a needs assessment is likely to result in a more efficient programme, increased client and stakeholder satisfaction, and a stronger case for support of funding future programmes.

2. The Participant's Part

a. You are asked to give their time for a one-on-one, audio interview to provide their perspective and experiences of the issues at hand. Topics include the use of gender-sensitive language, equal access and utilisation of services and social dimensions such as age, ethnicity and income in relation to gender.
b. There is a battery of guiding questions and topics, but you are free to give answers as they wish. The interview is expected to last an hour or more.
c. Harm reduction is reduced by limiting your part to only one step of the process - a single, private interview. Measures are also taken to protect your identity as much as possible, such as the use of pseudonyms and private data collection in a one-on-one setting.
d. Participation is of course, voluntary and you are free to withdraw at any time, for any or no reason.
e. The interview audio will be recorded and a separate audio recording consent form is provided. The recording is to ensure accurate transcription and by extension, the validity of the project.

3. Anticipated Risks

a. There is a possibility that participants may be embarrassed when asked about the treatment's inclusivity of the gender nonconforming population.

b. However, this is the very reason why this needs assessment is conducted - to raise awareness and to investigate if participants have a comprehensive understanding of the way in which SUD treatment currently is conducted and the way in which it should be in order to fill a possible gap in services that creates awareness of gender equality in treatment.

c. The purpose of this research is not to cause harm or embarrassment, but to highlight the challenges experienced by participants and clients when faced with gender-based issues. There is also a possibility that third-party organisations may be embarrassed by participant responses, but this is addressed by not naming any specific organisations.

4. Expected Benefits of the Research

a. Creating awareness of gender equality in treatment is an added treatment benefit.
b. To find out more about how other treatment facilities and practitioners are conducting SUD treatment,
c. Identifying possible gaps in services that creates awareness of gender equality in treatment.

5. Protecting Information

a. The researcher, supervisor and RUESC will observe methods to protect the confidentiality of the participants. This includes the option to limit participant information disclosure to just their names on confidential consent forms and there being no requirement for disclosing any further details. The use of online one-on-one interviews also ensures privacy between participant and researcher by limiting in-person contact.
b. You are free to withdraw any time without penalty or reason. In the event of an unexpected withdrawal, you are requested to contact the researcher and notify of this, so that the withdrawal is not mistaken for a technical issue.
c. The data collected from this project is only visible to the researcher, project supervisor and university ethics committee. The data will be stored securely on private devices with restricted access.
d. Participants are provided with the contact information of the project supervisor and the RUESC contact person in the event of ethical issues.

6. Additional Information

a. This project has received ethical clearance from the Rhodes University Ethical Standards Committee (RUESC)
b. There is no reimbursement for participation in this research
c. This research is not presently sponsored by any party
d. There are no conflicts of interest to declare at this time
e. Your participation will be integrated into a research report toward the completion of a Masters by Thesis degree in Psychology.
f. There is a possibility of the report or its contents being published in a peer-reviewed, academic journal.
g. If you are interested in receiving reports and publications produced from this project, you are welcome to leave contact details.
h. All documents given to participants are approved by the Rhodes University Ethical Standards Committee (RUESC), contactable via the RU Ethics Coordinator (s.manqele@ru.ac.za), and is under the supervision of Dr Liezille Jacobs in the Psychology Department at Rhodes University, who may be contacted on 046 603 7383 or 0613958619 or liezille.jacobs@ru.ac.za. The researcher may be contacted at gender.sensitive.sud.project@gmail.com

Appendix C – Research Participant Consent Form (audio interview)

Consent form

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY
AGREEMENT BETWEEN RESEARCHER AND RESEARCH PARTICIPANT

I _____ (participant's name) agree to participate in the research project of Lane Tao, entitled, Gender-Sensitive Training Needs Assessment for Alcohol and Drug Treatment.

I understand that:
1. The research project has been approved by the Rhodes University Ethical Standards Committee (RUESC), contactable via the RU Ethics Coordinator (s.manqele@ru.ac.za), and is under the supervision of Dr Liezille Jacobs in the Psychology Department at Rhodes University, who may be contacted on 046 603 7383 or 061 395 8619 or liezille.jacobs@ru.ac.za. The letter of approval from the RUESC was attached to the initial correspondence, and can be dispatched again by request.
2. The researcher is interested in determining the training needs of employees and organisations for gender-sensitive training in alcohol and drug treatment facilities.
3. My participation will involve an audio interview responding to questions on: (1) the use of gender-sensitive language; i.e., choice of images when preparing public relations material/advertising for events, internet and forms/documents used; (2) data represented by gender and to investigate social dimensions such as age, ethnicity, income, level of education; (3) equal access to and utilization of alcohol and drug treatment services (4) whether women and men are equally involved in decision making in the organisation (5) whether equal gender treatment is integrated into the organisations steering process. My participation is voluntary. I am not coerced in any way to participate in this study. I am informed of the purpose of the research and the importance of the research study being conducted. I am also informed of the duration of interviews. I am aware of the possibility of the research being published in an academic research journal.
4. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions in the interview. I may choose to limit disclosure of personal details entirely to the consent form and give no identifying information as part of the interview.
5. I am invited to voice any concerns I have about my participation or consequences I may experience as a result of my participation to the researcher, and to have these addressed to my satisfaction. Referral to a psychologist in the area may be given for further support if need be.
6. I am free to withdraw from the study at will. If I withdraw unexpectedly, I am asked to contact the researcher to clarify that I am withdrawal so that my withdrawal is not confused with internet connectivity issues that may arise during the interview.
7. The report on the project may contain information about my personal experiences, attitudes and behaviours, but the report will be written in such a way that it will not be possible for a general reader to identify me.

Signed on (Date): _____
Participant: _____
Researcher: Lane Tao
gender.sensitive.sud.project@gmail.com
079 323 9505

Appendix D – Research Participant Consent Form (e-mail interview)

Consent form (e-mail interview)

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY
AGREEMENT BETWEEN RESEARCHER AND RESEARCH PARTICIPANT

I _____ (participant's name) agree to participate in the research project of Lane Tao, entitled, Gender-Sensitive Training Needs Assessment for Alcohol and Drug Treatment.

I understand that:
1. The research project has been approved by the Rhodes University Ethical Standards Committee (RUESC), contactable via the RU Ethics Coordinator (s.manqele@ru.ac.za), and is under the supervision of Dr Liezille Jacobs in the Psychology Department at Rhodes University, who may be contacted on 046 603 7383 or 061 395 8619 or liezille.jacobs@ru.ac.za. The letter of approval from the RUESC was attached to the initial correspondence, and can be dispatched again by request.
2. The researcher is interested in determining the training needs of employees and organisations for gender-sensitive training in alcohol and drug treatment facilities.
3. My participation will involve an asynchronous e-mail interview responding to questions on: (1) the use of gender-sensitive language; i.e., choice of images when preparing public relations material/advertising for events, internet and forms/documents used; (2) data represented by gender and to investigate social dimensions such as age, ethnicity, income, level of education; (3) equal access to and utilization of alcohol and drug treatment services (4) whether women and men are equally involved in decision making in the organisation (5) whether equal gender treatment is integrated into the organisations steering process. My participation is voluntary. I am not coerced in any way to participate in this study. I am informed of the purpose of the research and the importance of the research study being conducted. I am also informed of the duration of interviews. I am aware of the possibility of the research being published in an academic research journal.
4. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions in the interview. I may choose to limit disclosure of personal details entirely to the consent form and give no identifying information as part of the interview.
5. I am invited to voice any concerns I have about my participation or consequences I may experience as a result of my participation to the researcher, and to have these addressed to my satisfaction. Referral to a psychologist in the area may be given for further support if need be.
6. I am free to withdraw from the study at will. If I withdraw unexpectedly, I am asked to contact the researcher to clarify that I am withdrawal so that my withdrawal is not confused with internet connectivity issues that may arise during the interview.
7. The report on the project may contain information about my personal experiences, attitudes and behaviours, but the report will be written in such a way that it will not be possible for a general reader to identify me.

Signed on (date):
Participant name:
Researcher: Lane Tao
gender.sensitive.sud.project@gmail.com
079 323 9505

Appendix E – Research Participant Audio Recording Consent Form

Consent Form for Tape Recording
RHODES UNVIERSITY – PSYCHOLOGY
USE OF AUDIO RECORDINGS FOR RESEARCH PURPOSES
PERMISSION AND RELEASE FORM

USE OF AUDIO RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM							
Declaration (Please Initial/tick blocks next to the relevant statements)							
1. The nature of the research and the my participation have been explained to me	**Verbally**		**In Writing**				
2. I agree to be interviewed and to allow audio recordings to be made of the interviews	**Yes**		**No**				
3. I agree to take part in, and allow audio recordings to be made	**Yes**		**No**				
4. Recordings may be transcribed for research purposes	**Without conditions**		**Only by the researcher**		**By one or more nominated third parties**		
5. I have been informed by the researcher that recordings will be erased once the study is complete and the report has been written							
6. OR I give permission for the tape recordings to be retained after the following conditions:							
Signatures							
Signature of the participant						**Date**	
Witnessed by the researcher							

Ethical clearance was granted by the Rhodes University Ethical Standards Committee (RUESC)

For queries:
Supervisor: Dr. Liezille Jacobs (liezille.jacobs@ru.ac.za)
Researcher: Lane Tao (gender.sensitive.sud.project@gmail.com)
RUESC Coordinator: (s.manqele@ru.ac.za)

Appendix F – Interview Question List and Research Terminology Guide for Participants

Gender-Sensitive Training Needs Assessment for Substance Use Disorder (SUD) Treatment

Questions

Note: Participation in this research or any of its questions is optional and the participant is welcome to adjust questions where applicable.

Workplace questions

1.1. Do you work in an NGO, government organisation, private practice or multiple?

1.2. Do you work with individuals, groups, both or in other treatment configurations?

1.3. Does your work mainly consist of in-patient or out-patient treatment?

General gender issues

2.1. What does being 'queer,' 'gay,' 'lesbian,' 'bisexual' or 'transgender' mean to you, in your line of work?

2.3. Have you noticed any specific gender-related trends in the broader SUD treatment sector?

2.4. In your opinion, how accessible are SUD treatment services for queer clients?

Treatment and planning processes

3.1. Are there any special considerations given to different genders in treatment planning, whether in programmes, promotional materials or therapy?
3.1.1. What do you think of the current form of treatment and promotional materials with regards to how they treat different genders?

3.2. How are queer populations considered in planning processes, if at all?

3.3. Have you encountered or treated any queer clients?
3.3.1. If so, how did you find out that they were queer?
3.3.2. If so, how are they treated by other clients if they encountered them?
3.3.3. If so, are there specific processes or measures taken in treating them?

3.4. In your experience, are people of all genders involved in the planning and treatment process?
3.4.1. Have you noticed any patterns in the organisation of treatment and materials aligning with gender?

Language usage

4.1. Does the language used in preparing materials such as public relations dispatches, treatment plans, advertising or other documentation reflect any gender categories?
4.1.1. If so, what categories are normally reflected or mentioned?

4.2. Does the data you've seen include queer or non-binary categories in addition to common demographic categories like male/female?

Training needs.

5.1. Do you think that additional training may be required in the area of gender-sensitivity toward queer people?

5.2. Do you think that additional training may be required in the area of gender-sensitivity toward women or men?

5.3. If yes to either of the above, are there any specific recommendations or areas of improvement that come to mind?

Clarity of Terms

Terminology in the area of gender-sensitivity can be a sensitive topic. This project works from certain paradigms and assumptions and uses a chosen set of terminology in its materials.

Some of these terms are outlined below, but please do not consider this a prescription for what to say, as I am interested in your views and experiences above all. This section is intended to clarify the researcher's meaning in the questions and no value judgements are made of participants who use different terminology.

1. **Queer**: A person whose gender (or sexual) identity does not align with the predominant gender or sexual binary. In essence, a person who is *not* cisgender or heterosexual. The term 'queer' was at one point a slur but has largely been reclaimed by people and is often used as a signifier to represent that a person is gender non-binary, not heterosexual or both.

In this project, 'queer' includes any of the categories below and is used as an umbrella term to cover more specific terms.

2. **Gender non-binary**: A person whose gender identity does not align with the predominant genders: man/male and woman/female.

3. **Gay:** A male-identifying person who experiences romantic or sexual attraction to other male-identified people.

4. **Lesbian:** A female-identifying person who experiences romantic or sexual attraction to other female-identified people.

5. **Bisexual:** A person who experiences romantic or sexual attraction to male and female-identified people.

5. **Man who has sex with men (MSM):** A male-identifying person who forms sexual relationships with other male-identified people, but specifically does not identify as gay or bisexual.

4. **Transgender:** A person whose gender identification is different from that which they were assigned at birth. This includes people who identify as women, but are considered men by broader society, paperwork, etc. This also includes people who were assigned to a gender and have elected to transition to a gender identity they find more suitable.

Appendix G – Interview Transcripts

Participant 1's Interview

Would you please give me an overview of your work experience and past?

I have an Honours in Psych and I'm a registered social worker. I did a four-year degree, I think in 2012. I've been working in an outpatient facility, or I've been working with outpatients specifically since 2011. I work in an outpatient basis here at [facility]. On the side, I actually work with people in recovery using mindfulness. So we use mindfulness-based interventions, and I do that privately with a business on the side.

Have you seen any gender-specific issues in SUD treatment?

We do have a lot of issues regarding gender, especially with women. I've personally found that when it comes to females accessing treatment, or treatment modalities or theories or programmes that are not designed or supportive of issues regarding females like topics of discussion that are related to woman issues or female issues. Women really can't - they don't access treatment as often as men access treatment for many reasons. For one, we don't have childcare facilities, there's a lot of shame, there's a lot of trauma when it comes to females. So that's what I've personally seen with regards to the female/male gender gap, I guess.

On the LGBTQ thing, we've had clients who came in for assessment who are part of the LGBTQ community, and not many of them make it past the screening and assessment because of a lot of the shame and guilt that they carry. And feeling uncomfortable, not feeling like they're going to fit in, feeling judged and stuff like that. That's what I've identified thus far.

Is gender-based violence or intimate partner violence a factor with some clients?

Yes, a lot. A lot of gender-based violence and childcare. The sex worker thing is huge, too - not feeling safe around men. It's quite a complex issue.

Have you seen any gender-specific issues in SUD treatment?

Yes, many. I've worked with a lot of gay men actually. That's who I see more often: gay men and lesbian women. Trans? I haven't personally worked with anyone, but my colleague has. That's just pure coincidence due to scheduling. She's worked with a few. I've just worked with gay men and lesbian women.

Does your workplace have any in-house definitions of terms like 'queer', 'gay' 'transgender' or similar?

No, we don't actually. It's shocking. Yes. It's something that we've discussed before you. I think maybe at the beginning of this year, or the end of last year. It's a topic of discussion that's come up like, "okay, how're we going take this forward?" You know, when we're asking for gender on our assessment form, what space are we going to give there? Because it's the usual male/female thing. Those kind of conversations have come up, we haven't put them into policy or procedure yet. But we have spoken about it. So we kind of have to figure it out.

Are there any considerations made for cisgender people in your programmes or promotional materials?

We do have literature and manuals that are specifically designed for women. And we're not doing it at the moment, but we have had specific groups treatment groups only for women. At the moment, we're doing mixed co-ed groups. We have a specific manual for females, and we have specific literature for females in recovery - for women in recovery.

Are these materials no in use for logistical reasons?

Yes, we find that when it comes to women, we will then hold a women's-only group if we have enough numbers. At the moment in our treatment programme, we only have two women so then we'll do a co-ed group. If I pick up in the group or in the treatment programme that there are specific issues related only to women, I will then single out the two women and have another group on top of their programme. So then they'll just come in for an extra day or two or three, and we'll discuss specific issues that pertain to them. Otherwise, it's co-ed and also COVID is making things very difficult for our groups.

Are there any considerations made for queer people in your programmes or promotional materials?

When it comes to the materials and the programme outline and stuff, no. There isn't any specific literature or topics that we cover. However, when it comes to the treatment plan we do take it into account. It's obviously a very big part of the recovering process, and the person's recovery and treatment plan as an individual. So yes, that's where we do consider those kinds of issues. But there's no literature - we don't have actual literature or programme. The actual manual has nothing in there that talks about it, or mentions it or addresses it.

Is it the case that the manual doesn't have a specific section pertaining to queer clients, but there is a wildcard section for improvisation for each client?

Yes. As a professional counsellor, social worker, or therapist, I think you know you're

ethically and responsibly obligated to make sure that you manage that kind of thing effectively.

Would you elaborate on your experiences of treating queer clients?

My experience working with them is I feel that you need to be a little bit more empathetic and understanding. A lot of the clients come with a huge amount of trauma regarding their queerness or lesbian or gay status - whatever they identify with. It's usually a big part of the treatment plan, whether it's trying to help them work through accepting who they are, or trying to help mend family relationships, because you know the family relationships a lot of the time are broken because the person has come out. On top of the fact that they're having a problem with drugs and alcohol and by coming out, they've had to deal with huge amounts of abuse from other people or within their families. So yes, they're quite complicated cases. Lots of shame - I hate to say this, but sometimes more shame and guilt than someone who doesn't have to go through the experience of having to come out, you know? To open up to their families like, 'oh hey, I'm actually gay, and guess what I have a heroin problem." So it's almost like a double-whammy in some ways.

I've had a lot of my clients who've come out who have a lot of sexual abuse stories. So it's just about being really sensitive and empathetic and understanding that this particular clientele has quite a traumatic past, and will continue to do so. It's just something you have to help them work through, I guess.

Were the queer clients you treated out of the closet to other clients?

Most of them have come out. Not necessarily all of them have told their families or their loved ones. Another thing that's also quite common is that a lot of my clients come out and have children from straight relationships - from heterosexual relationships. So they haven't come out necessarily to their kids. So that's something I see quite often as well. So they've come out, but not to everyone. And it's helping them, or working with them to get to that point. That's why I say it's like "oh hey, I'm queer and I have an alcohol problem". [Laughs] I mean I'm laughing about it but that's usually what has to happen.

In the times your queer were out of the closet to other clients, were they treated differently?

There have been times where there's been discomfort in the group, but we have a very strict agreement. Before a client enters the treatment group, when we go through the contract and the confidentiality agreement, there is a big section in our contract that talks about

acceptance, realising that people are going to go in a group with people from different cultures, different races, different sexualities, all that kind of stuff. So it's how we actually prepare clients before going into group. There has been a time when I've picked up that a client has a problem with people who are homosexual, and then we actually have a session about that before he comes to the group. More often than not, when clients who have a problem with people who are queer, it comes from their own trauma, their own history, and their own experience. And once they're in a group with people, it actually kind of works out quite nicely and quite well, and they're like, "Oh it's not that bad, I'm more accepted than I thought I was going to be." That kind of thing.

Was there a specific story about a time when a client started off with trauma-related queerphobia or homophobia and it later smoothed out?

There's actually a client I'm working with right now. He's quite young. He's twenty-three and he had a really bad experience of sexual abuse from a male relative. So I think this is where it comes from, these homophobic, queerphobic feelings. What happens is, we work through that. Once he was in the group, I have a queer man in group who actually responded. The queer client of mine is quite empathetic and nurturing. And I think what happens is in the group dynamic, the client who is queerphobic picked up and realised that this man isn't at all like what he thought it was, and through my client's nurturing behaviour, they actually formed quite a bond. So it actually worked out quite nicely. You just go in with all these misconceptions and these pre-conceived ideas and you really have your tail up, and in the meantime this queer client met him with kindness, compassion, and empathy. It was a wonder from his side. And then it just worked out which I thought was quite nice. It's quite a cool story. It's not some spooky person, it's just a normal person. But I think that's one of the challenges of recovering for any mental health is that everyone comes in with pre-conceived ideas. Even about themselves. So it's just a process of having to break down barriers and walls.

Would you say that queer people have an additional risk factor for substance use related to their trauma?

Absolutely, yes. I think that's what I'm trying say. It's that there's an added risk factor there, definitely. And especially the communities here in Somerset West, what I've found is that the Somerset West community is a very conservative Christian community. Or it's a very conservative Muslim community. And in those communities in and of themselves it's a

challenge just to be queer, never mind having a drug or alcohol problem, but to come out. So it's quite challenging here in Somerset West. Particularly from a religious point of view.

In preparing programmes and promotional materials is there any specific gender-sensitive language used?

That's one of the things I struggle with personally - well not struggle with - but I'm just not conscious of it and I haven't put effort in, which is bad from my side. It's one of the things that I think we have to work on - I actually wrote it down on my piece of paper. The biggest space is our issue around language. What term do you use? What is the correct language? I don't think it's something we have necessarily focussed on. So a lot of our literature is, I think, gender-neutral, because we use manuals and stuff. Instead of saying 'he' or 'she' we say 'the recovering person'. Or a lot of the literature's written from the perspective of, 'I will conduct myself', 'I will help you to think,' or 'patients stopping their use.' So it's quite gender-neutral.

Are people of all genders involved in the planning and treatment processes at your facility?

There should be, yes. The organisation I work for, unfortunately it's all women. It is taken into account and I'm sure that with some of the stuff that we've created, there were males in the process who were helping, when we've done anything for the past eight or nine years, we're a completely women-run organisation. We have made a concerted effort, I know this past year or two, our board does include men and women. So the board is, but they're not necessarily involved in day-to-day running.

You know what? I actually don't know the question, but for me personally, it's been ignorance and lack of education or even just thought that even though I've worked personally with lots of queer men and women, I haven't even had the thought to change - to even think about going, 'oh maybe we should adapt and change.' What's happened now is that we've had to rely on the queer community making a noise big enough for us to go, 'oh wait a minute, we were doing this wrong in the first place'. So I don't actually know. I mean it's unfair, and I can say that from the very beginning we try and be as accepting and understanding as we can, but, you know, this is a systematic thing that needs to change.

So the manuals have a fair amount of language related to the client-therapist interaction, rather than individuals?

Yes, exactly. I'm trying to find other examples, because we're working with a manual at the

outpatient centre, a lot of the questions are around ‘has this been difficult for you?’ or ‘in what ways were you struggling with XYZ?’ So it’s not ‘he’ or ‘she’. You see this is what I’m saying - one of the issues I need to work on is I wasn’t even conscious of the fact. Which is bad, and I need to start working on that.

Do the manuals make any references to queer people?
No, they don’t unfortunately. These manuals are quite old.

Do they make any specific mention of any genders or gendered individuals?
I’m trying to find this… Other than the women’s manual, I don’t think men or women are mentioned. The concept ‘man’ and ‘woman’ isn’t mentioned at all. I’m trying to find an example and I can’t find one. So this particular manual that we use; that’s why I think they designed the women’s manual, because the women’s manual does discuss the sex work thing. Because even when we have a topic in our manual on sex and recovery, when we talk about sex it’s very much about sex and recovery, it never mentions gender. It just discusses intimate relations, impulsive sex. Yeah, there’s no ‘men’ here. Nothing.

Are the manuals you have on hand essentially a default manual and a women’s manual?
Yes.

Do you see any indication that the default manual was developed with a specific gender in mind?
It seems very gender-neutral to be honest with you. Like the images are men and women. What I do notice on a different talk altogether, is it definitely doesn’t include people of colour that much. So there’s like a few pictures, but I think our treatment manuals need to include more LGBTQ and people of colour and then we’re good to go.

I mean I know that drug and alcohol treatment manuals and treatment programmes were designed around the experiences of men. I know that history quite well. I think they did a fairly good job on the manual we’re working from. It was developed in the eighties but then they revised it in 2010 and they’ve done a fairly good job at that point.

Do you read much literature or data in the area of substance use?
I don’t necessarily read too much. I read a lot of information about substance use disorders and treatment, but it’s not necessarily the like. It’s just stuff that I pick up because as a professional you have to have weekly supervision, you’re given weekly readings and stuff

like that. And then obviously for my own interests I'll read books and all sorts of interesting things.

How accessible do you think substance use treatment is for queer people?
I don't think it's very accessible. I don't think so. You know, I'm thinking about our treatment programme, but if I think about treatment in general, specifically in the Western Cape and the type of treatment available, I don't think it's accessible. Because there's still so many conservative religious treatment programmes that I think may put clients off. Treatment in general, even all these years, isn't accessible for many people. Not for people of colour, not for people who are of the LGBTQ+ community, and just people who are seeking treatment in general. There's still barriers. There's still stigma. So it's even harder for people who are LGBTQ.

The reason I bring up the religious programmes so much is just because of where we stay in the Western Cape, there's just so many of them. And from personal experience with clients, that's always been a huge issue, because it's just everywhere. Yeah, it's crazy.

Do you think that additional training in the area of gender-sensitivity for queer people is required for practitioners?
Yes, I do think so.

Are there any specific areas of gender-sensitivity training that you think are necessary?
Professionals need training to learn the correct language to use. I think we need training to understand the different, you know, how people identify, what makes them different. I think even though we have people who are trained in psychology or social work or counselling or whatever it is. Maybe because I was trained long ago, but I don't think any of our training touches on any of these issues at all. And I think there should be. Or we need to revise our literature. I think we need to revise our protocols, all sorts of… I don't know, so much. It's a big question.

Do you have any opinions on how queer people or organisations might be able to meet you halfway?
It's just about having the discussion, you know. I think we need to get comfortable talking about the things that make us uncomfortable. So if they're coming into a programme, for example, like practically, and I'm not addressing you correctly, or you feel that the treatment programme isn't working or isn't aligning to those kinds of things, to be able to go, 'listen

this is not working for me, can we add more of this, can we do more of that?' I think just having conversations, open dialogue, talk.

There's so many different things happening in the world at the moment, but if there is one thing that is definitely coming across for people of colour or the LGBT community, is that everyone just needs to shush and just listen. We all need to just sit down and listen to people who are marginalised, who are struggling to be heard. I think that's where it's starts. Because we've been talking about it, and also because of the context we live in in South Africa where the majority of our population is people of colour, where never mind people who are LGBTQ where they struggle because they're marginalised, what about people of colour who are trans or people of colour who are part of the LGBTQ community. That's even more challenging. That's another risk factor on top of everything.

Thank you for taking part in this interview. If there is anything you would like to add, or want to reach me, you have my contact information.

Okay thanks.

Participant 2's Interview

Would you please give me an overview of your work experience and past?
Sure, okay. So I did my undergrad degrees at Stellenbosch University. So I did my three year BA in Social Dynamics at Stellenbosch, and then I went on to do my Honours at Stellenbosch, and then straight after that I went into Master's, which I did at the Pearson Institute in Johannesburg. It was in MGI and then changed to Pearson. So that was a two-year Master's in Counselling Psychology. And then I did my internship on the Wits hospital circuit in Gauteng. So I worked for government for my internship. I did a year there. And then I started working for private psychiatric hospitals. And that's where I'm currently working. So I'm in my second year now of working for them, and I'm between two of the hospitals at the moment. It's a more recent thing. So the hospital I started at is a dual-diagnosis unit, and the other hospital that my time is split between is a general psychiatric - it's got a general psych ward. There you've got the adolescent ward, and they've got also DDU. So my time at the moment is split between the two. So I work at both. And then I'm doing my PhD at the moment as well.

Does you tend to work more with individuals, groups or a combination?
Both, but mostly individuals. So most days I run a group or two, and then the rest of my time is filled with individuals, and sometimes family sessions. But it's not a family-therapy or a couples' therapy, it's a conjoint. So the patient is my patient, but they want to have a session with their family so that we're all on the same page.

Inpatient or outpatient, or a mixture?
A mixture. But only for the individuals, the groups are all inpatient. And then individuals are mostly inpatient, but some outpatient.

Has the COVID-19 pandemic necessitated any adjustments to that normal procedure?
Yes, definitely. So that's where we started with the outpatients as well. It was a recent thing. We adjust, hey?

Does your workplace have any in-house definitions of terms like 'queer', 'gay' 'transgender' or similar?
I speak under correction. I don't think there are actual definitions written. Not in that specified sense that I know of. I suppose our general professional 'we're conducting business' applies. I do feel we're very respectful and, you know, meet the patient where they're at. So if I had a patient whose pronoun was 'they,' and then it's 'they.' And that's

how we operate. So there's nothing that I know of that's written. I'm sure there might be, but I haven't read that. Beyond the general respect for the patient, and for their preference.

Have you seen any gender-specific trends in SUD treatment?

So, I think about practitioners, our team is mostly a female team - well actually the actual in-house therapists are female. We did have male members of staff at a stage. And in our other departments we do have doctors and so on, we do have males. But the actual team, we are all female, so I think that's something to note.

And any gender-specific trends noted among your patient populations?

Okay, so alcoholism from what I've seen, I think it lends itself both ways. Males and females. Maybe slightly more males than females. But it's not significantly more. So that's on alcohol. Pills: split. Both males and females. I haven't noticed a trend in one of the… so when I say pills I mean your benzos, that kind of thing. Concerta. Ja, that kind of addiction. Your sex addiction… Is this only for chemicals, or are you also asking about process addiction?

We can include process addictions, too.

Okay, so your sex addiction goes both ways. But it's often the males who - I don't know if they're often the ones that present with the sex addiction, or the ones who just speak about it. Eating disorders: more in the female population. So that's also process. Gambling: more in the male population. Cocaine is more a social/economic status thing than a male/female thing. It's an expensive drug, so it's people in a higher social economic status. Tik is more male. Your crystal meth is more male, but not only. But it lends itself more to… I've seen more male patients. Put it that way.

It's interesting seeing how use of drugs can be mediated by socio-economic status and gender.

Absolutely. And which are accompanied with a process addiction. 'Cause often you come in for your chemical addiction and when you get here you find that there's actually a process addiction.

How accessible do you think substance use treatment is for queer people?

I hear you. I'm just trying to think if there's anything that patients have mentioned. No, I don't think any of my queer patients have said anything along those lines. But I mean that's already when they're in treatment. Do you know what I mean? They've already accessed treatment. I do think, you know, feeling like you are the minority, it must be difficult coming

into treatment. I know that you don't know what you're walking into and it's already very stressful coming into an inpatient facility. It's very, very anxiety provoking, so coming in and feeling like you're in the minority group - I can't imagine that must be easy. But yes, the people I work with have already gained access.

Are there any considerations made for gender in your programmes or promotional materials?

Within the inpatient? No, there isn't. At times when we feel the need, if there are people battling with a sex addiction, we might have a group, if we feel the need to. We do work it into our program. But it's happened in the past where we feel we need a separate group for those battling the sex addiction. 'Cause there's a lot of shame around that. Then we will have a separate group, and we did split that according to gender, if I remember. It's been a while since we've done that, but we did split it. So the female sex addicts and the male sex addicts had their own space to speak about it, but beyond that, no, we don't really separate.

So it's more of an ad-hoc procedure where a separate group might be formed when necessary, and people are available?

Correct.

In the case where the sex addiction group was split by gender, was there a specific reason given?

Ja, I think the reason was - now it wasn't a group that I run, so I'm just speaking from what I've seen. The reason was comfort. I think the female patients wanted their own group. If memory serves. So the female sex addicts didn't want to be in the group with the male sex addicts.

It fairly common in treatment to have a dedicated space for women to separate them from men and discuss taboo topics?

Yes, absolutely.

Does your facility run any women's groups of that type?

Not that I know of, no. I think often those kinds of topics will come up in the individual stage, with the individual therapist. And they'll, you know, discuss on that platform in the individual sessions. Ja, but I mean sometimes if they're sharing, and they want to speak about the intimate partner violence, or if they're a sex worker, and they feel comfortable they might mention it in the bigger group. But often the bigger groups are very skills-based. It's imparting skills and those kind of things they bring to the individual therapy space. Yes, so

we do have our process groups and our psych groups, and sometimes things like that come up. But sometimes not. It just depends on the person, and how they feel. Do they trust the group? But often they mostly just process that in their one-on-one. And they all have an individual therapist. So our patients get 2-3 hours of individual therapy a week. Usually two, but it's on a needs basis.

I am under the impression that your hospitals are quite well funded. Is that the case?
Yes, and a lot of patients have medical aid.

In preparing programmes and promotional materials is there any specific gender-sensitive language used?
Let me think. I think for the most part, it's 'the patient'. But I did notice the other day, one of my worksheets that I need to change - I do a group on love languages, and in my worksheet it says 'he' or 'she'. I forget what it was speaking about in the worksheet, but I clocked that, and I thought 'ooh I need to re-phrase that pronoun or change those pronouns to be more inclusive.' I think, you know, if you're looking at a worksheet and it doesn't include your pronoun, I just think it's like the worksheet just being for females, you know? You don't feel like you can connect to it. So, yeah it was just from that perspective, the pronoun needs to change.

For the most part it's 'the client' or whatever. But that is something that I have noticed, for example. Work in progress. It doesn't help that we say "what's your pronoun? We'll respect your pronoun," and then you've got a worksheet that says 'he or she'.

Or for example, what if the practitioner is on the client's side, but the manual isn't and there is a breakdown between sources of information?
Exactly, it's not consistent. It's not containing. And I know that I had a patient whose pronoun was 'they', and they said "eventually you get tired of correcting people." The client said "No, it's not 'he,' no it's not 'she,' I prefer 'they/them', you know?" But eventually you're not going to interrupt the conversation every time for that, but you clock it, and you feel it, and it hurts, and it feels like a rejection. Even though you might not be saying something every single time, you know? So I think it's important for us to be mindful and respectful in terms of that.

Have you treated any queer clientele?
Yes. So I've told you about my patient who was an adult patient, but they preferred the pronoun. I've also had an adolescent patient who preferred a different pronoun. And then in

terms of sexuality, we often get male and female patients who identify as homosexuals, and they're quite open about that in our treatment space. And I do find that they've expressed that and it hasn't really been an issue for them in terms of feeling included in the group space. So they've mentioned it and it comes up when they discuss their partners or their families. So we often do get patients who identify as queer.

You mentioned an adolescent and an adult queer client – how did they identify?
So the adolescent was only my patient in a group setting. I am not sure what their sexual orientation was. But their pronoun was 'they/them/their.' And then the other patient, the adult patient, was bisexual. They preferred 'they.'

With respect to the queer clients you've treated, did you note any gender-related issues they raised?
I know that parents have been a big thing. Parental rejection, parental abandonment, parents not understanding the patient and their gender identity or their sexual orientation, and feeling rejected on that front. Which is quite a big thing, because if that's not accepted, them "I'm not accepted." If that is rejected, then, "I'm rejected."

Does this weaken the support structures around the person?
Absolutely. I don't know about specific links to substance use, but I know in terms of the object that you internalise, and your attachment, and all of that. And connecting to this parent - that is impacted. But I'm not sure what the link is with the substances. And you know, what I'm thinking about now, which often comes to mind is they feel like their parents are trying to fix them. Not just the alcoholism. You know that, "I am broken." And that hurts deeply. Remember I told you about those family meetings we had? And then we have when the parent will refer to the patient by the wrong pronoun, you know? When I've been part of the previous discussion of "Mom, this is my pronoun", ten minutes earlier, you know? So there's just, like, no consideration for that, I suppose. So the parents are a big thing, and it's not only in gender identity now. It's not only in that, it's across the board. A lot of patients we see have a lot of pain from their parental relationships.

I mean the patient needs to be discharged right back into that family system. And that's often what they say is: "Here I'm protected, but I need to go back into the world at some point."

How did you learn that your queer clients were queer?

They just tell you. So, often upon introduction, when you meet, you introduce yourself and you get to know each other. That comes up in the first couple of minutes. Or, if they hadn't told me, I get hand-over before I see a patient, so I get feedback from Nursing. It will say, "patient pronoun is they/them," you know?

Did any other clients treat queer clients difficulty with regards to queerness?
Not that I know of. They never said anything about that. We would have addressed that if it had come up, but never had any complaints around that.

Are any special considerations taken in the treatment processes for queer clients here?
Yes. So usually you have your females in a room and your males in a room or in a section, whatever. I think Nursing would discuss with them, and if we can, if they prefer, we can do a single room if they are not comfortable. But I'm not part of those logistics. If it was an issue, then I would get involved. If a patient said that they're not happy and comfortable, then I would obviously take it to Nursing. But I think Nursing is sensitive to that. They do have those discussions of, "what would you prefer." We'll chat to the patient or, "patient has said they prefer this," and we try and adjust.

I wasn't aware of the individual rooms here – most of the time, it's shared quarters or a dormitory.
Yes, we've got a lot of rooms, so if we're not fully booked we can try and make arrangements. And we do have one room that specifically is only an individual room, and sometimes we just block a room off as an individual room, for various reasons. Sometimes it's for other reasons.

Do you read much data or literature as part of your work?
To be honest, I read the CPD points I have to do. And then I read for my PhD. I think I could do more reading, but sadly not. I mean if I have a topic that I need to explore for a patient, then I'll go read up on it. Sometimes, if I need to look something up for a patient, or if I want to plan something for a patient session, or plan a new group, then I read up.

What gender categories do you normally see reflected in the materials you read?
I was going to say, I think it's very much the 'he/she' narrative that plays out, but I don't think that's always true. I think that's probably mostly true, but I have found some literature - whether it's textbooks, or your academic articles, and your various sources of literature - that are pronoun sensitive. And more inclusive in terms of the gender. But I would say it is more the 'he/she' narrative.

In what ways were some of these works more gender-sensitive?
Being gender neutral. So not just saying ‘he or she’, but saying ‘they’ or ‘the patient’, or something like that, that’s not like “ooh you’ve left something out there”.

Do you think that additional training in the area of gender-sensitivity for queer people is required for practitioners?
Yes, definitely. I know that I was trained on it in my training, but I definitely do think additional consideration, you know, just across the board for all practitioners would be helpful. I also do think that as psychologists we are trained in that, but some other practitioners might not be.

Do you think it’s the case that biomedical-leaning practitioners like doctors and nurses might receive less of this kind of training because of their heavy curricula?
Yes.

You mentioned receiving training in the area of gender-sensitivity. What form did this take?
That was in my Master’s. It was more in relation to transgender - we had some people come speak to us about it, people who were trans spoke to us about their experiences, their difficulties, what they prefer. Sorry, it was one person, not people. Yes, it was one person. So we had that and we had lectures. So that kind of thing was great, but I definitely do think there’s space for more. That was really awesome.

What was that speaker’s general role? Were they a practitioner, or a service-user?
It was someone known to one of our lecturers, and they had said that they would like to come speak with us, so the lecturer said that would be awesome. So I think it was part of the person’s journey, was to share this. So it wasn’t a patient, it was just someone that one of the lecturers knew, and they wanted to come chat to us, and so they did.

Do you think additional training in gender-sensitivity is necessary for cisgender men and women?
I do, I really do think that would be more helpful. Maybe they could incorporate CPD training or something like that, because I think that would be great across the board for all health practitioners.

Are there any specific areas of gender-sensitivity training that you would think are necessary?

I think just in terms of the different categories, you know? Just to outline that, because I know that people don't always know 'cisgender'. They don't always know those kind of things. Which is ignorant, but I do think training in that would be great for the sensitivity to it. Not teaching them to be sensitive, but teaching them what the categories entail. Their different personal identities and so on.

So training to put words on different experiences, and making people aware that different kinds of people exist?

Absolutely.

Do you have any experiences not covered by a previous question that you'd like to add?

No.

Thank you for participating!

You're very welcome.

Participant 3's Interview

Would you please give me an overview of your work experience and past?
Okay. I qualified as a social worker at the end of 1992 from the University of Cape Town. Then in terms of qualifications, in 2000 I did my Honours in Social Work, well, Social Development in Probation. My qualification was specialising in probation and correctional practice. In 2007, I obtained my Master's degree in Social Development in Probation and Correctional practice. In 2015, I obtained a Postgraduate Diploma in Addictions from the University of Stellenbosch. So the Honours and Master's and my Bachelor's degree were all at UCT and the postgraduate diploma was at Stellenbosch University. In addiction specifically: throughout my work, there would be people who had alcohol problems and all that - but I started dealing much more with people with alcohol and drug use problems, started when I worked at NICRO. I worked at NICRO for about nine and a half years, and for the last two years at NICRO I became more and more exposed to drug using people. I became more interested through professional connections with other people working in the field, and attending courses, talks and all of that.

I left NICRO and I worked for exactly eleven months at a rehabilitation inpatient program for adolescents. I worked there as a… what they told us what would be a [unintelligible] for social workers. I then got this opportunity that was coming up to work at [facility] where I'm at currently. The director at that time asked me "listen, I want you to go and study the Addictions course, because the department of Social Development is also providing bursaries for people to actually study the course". So that's what I did. Officially I started working at [facility] in June 2014. So if you're looking at sort of direct practice work in the addictions field, that would be eleven months I worked at the inpatient facility for adolescents. Then working here since 2014, although I did my practical work in [unintelligible] for those early months also at [facility]. As I said, I'd already started some work with people with addiction problems when I was at NICRO.

How would you define the various queer terms, such as lesbian, gay or transgender?
What it means to me is just a person who identifies themselves differently than the sort of the mainstream norm of being heterosexual, male, female. You know, in those categories. So it's people who just identify themselves differently from those categories.

Have you treated any queer clients directly?
Male - so male gay clients. I've had two older male clients during my time here. My

colleagues have had others. When I was at the Youth, I think we had one of the issues where if one doesn't ask, one isn't necessarily going to find out. It's not necessarily going to be volunteered. Unless the person is quite open about it.

So when one's looking at application forms for programs, or if one is looking at assessment or intake forms, it's the standard sort of tick male/female, you know? There isn't any acceptance or space for people who identify themselves differently. Also I was thinking about it when you sent the information about the motivation for this research, it's just one of the things that sort of came up, that is something that we here need to look into, like how do we adjust - that's why I was also looking forward to this conversation, so that I could also learn and become more aware and improve my learning, awareness, and sensitivity around this. It's not an issue that really gets much attention when one is at workshops, or when one is at training around working with people with addictions.

I'm just thinking now, last year we had a queer person who came and in Matrix with the programs. There wouldn't be people here who have issues with difference, otherwise you wouldn't be working here. So when asked about 'what came up' and 'how did you deal with it,' I didn't have a problem with it because she already asked, 'what do you want to be called?' or 'what should I record on your form.' I'm just thinking of that case. There were certainly a lot of trauma issues. The person didn't continue, not necessarily because of their gender identity but the severity of the substance use. After a few sessions, they didn't return and then came back and didn't turn up again for appointments, and made another appointment and didn't return again. It's a particular challenge to your community-based services. Because one of the main aims we work on is that the client returns for the next appointment. So it's not a captive audience like an inpatient, you know?

Just to clarify, did you mention that one of the staff seeing a queer client asked what they wanted to be called?

No, she asked, "what should I write down? How do you identify yourself? And what name do you want to be called?"

Did the queerness of some of these clients come up in the group, or private setting?

At that time I wasn't running the. When I think about it, it would have come up not necessarily initially, but maybe later on in the group setting as people become more comfortable with each other in the group setting and they know what these sessions are about. And it also depends on who is in the group. Keeping in mind that our group sessions for the

Matrix are open groups. They are not closed groups. So people join wherever they are ready to actually join the treatment program. Most of the discussion and revelation would happen then. For some, it would be already at assessment if we talked about their support structure or partners or that in their lives, you know, if they are married and that. But I think most of it would come up in the individual sessions.

When it arose in the group setting, were there any reactions from other group members?

I don't think so. I can't recall any specific reaction, anything adverse in that regard. The other thing that one needs to take into account is that in the Western Cape and Cape Town, it's a much more open community. It's not unusual to come across people who identify themselves as gay or lesbian. So in communities and in Cape Town, it's not such an issue I've found. So the responses from other clients have been… I can't pick up. And it wasn't reported to me that there was actually any kind of a verbal backlash or any non-verbal sort of dark looks, or anything threatening behaviour. That's to say it doesn't mean it didn't happen, but it wasn't reported to me. None of the clients mentioned anything. I think also just considering that those that would talk about it are already comfortable in themselves. So they've identified themselves quite a long time, their families knew, it wasn't that they'd just come out of the closet kind of thing. It was just 'by the way.' It wasn't an issue that the therapist would focus on that.

In Matrix, it's very much that everybody is welcome and everybody is accepted. There's very high regard for being non-judgemental. And that is the kind of behaviour and thinking that we try to build and emanate in the group for patients for other clients. Not to say it didn't happen, but none that I can recall or that was reported to me.

Are there any considerations made for cisgender men or women in your programmes?

We don't. I should explain the kind of services we offer. We're registered with the department of Social Development as a community-based facility. So that means that we provide services in an outpatient environment. We get funding to present the Matrix treatment program, which is an intensive outpatient treatment program, but our services are quite broad. Basically if somebody walks in and says "listen, you know, I need help" or "I don't know if I need help" or "I don't know if I have a problem" or "I've been sent here", we will go through a process with a person, in terms of going through a screening and assessment process, and then discussing findings and recommendations with regards to

further treatment steps or anything else that needs to be done. So the programs we do offer in terms of treatment, it would be a shorter, brief intervention for people who don't need intensive, longer treatment. And then our longer treatment program is the Matrix intensive outpatient program. That is a minimum sixteen-week program where people come in on average three times a week to our offices.

It's mainly group based, but there's also individual sessions with the person, and there is significant family involvement also. So I'm mentioning that because the Matrix is a set, manualised program. It's aimed at males and females and whoever else comes to the program. In addition to the Matrix manual, they have an additional few sessions for women that specifically focusses on the kind of issues that women who deal with - women who have substance use disorders. But the problem is, for example, because of the very low numbers of women who actually come for help, it's mainly male. Like ninety nine percent of people who actually walk into our doors is male. Maybe not ninety-nine, but, you know, it's a very high percentage. Although we've been keen to actually also do the Matrix women's sessions, we've never had enough women to actually constitute a group to actually run sessions. For whoever's in the group, the focus is on issues of addiction and the main aspects surrounding that. The individual sessions would then be the space to deal with issues particular to that person. So, I think in the individual sessions are when you'd have the opportunity to deal with any specific issues related to a person from the LGBTI community.

So that I think would be the only sort of experience we get specifically - and then it would specifically be around how that identity impacts on the substance use disorder. We don't deal with any, for example, trauma related to my identity, or maybe what 'I've experienced in the past, be I male or female,' whatever. It would focus on the substance use disorder. Not to say that we don't recognise the significance of it, but working with people with substance use disorder, the main focus is always getting the person sober and stable in their sobriety, and being able to work through recovery. Once they're able to do that, it creates the space for better ability for dealing with other issues that they may need to work on or resolve, that kind of thing - depending on if they feel the need to actually continue. This idea of 'people are using substances because of their race' or because they never had a father figure in their life', dismisses, or is totally from their perspective of being ignorant about what substance use disorder is about. It's an ideology that takes on very much a life of its own independent of the person's past or their current circumstances in terms of what they are experiencing in that

regard. It could make a [unintelligible] and I think that it's not the kind of thing that people say 'they must go live somewhere else and then they would [unintelligible]'.

Is it correct to say that your programme is a general-purpose programme whose materials are aimed at a broad spectrum of sex and gender, but mainly men and women?

Yes. It's a very broad-based programme.

In preparing programmes and promotional materials is there any specific gender-sensitive language used?

No, we don't. The information that we give would be about age, because we are only registered to render services to adults. We would say 'for everybody, males and females' because if one looks at programs, people would ask 'is it for males or women and men?' Because inpatient programs would usually focus on men or women, you know? Have that separation. It would then be that we would say, 'males and females.' You know, anybody is welcome to come. And then I think also just to add in to be more specific also to the geographical area - because our services are registered for a specific area.

Do you think that additional training in the area of gender-sensitivity for queer people is required for practitioners?

I think definitely. It's an area that is neglected. I'm thinking back to a symposium two years ago where one of the speakers spoke about the issues that the LGBTI community faces and the impact. Relating to that, the increased vulnerability and the extent of substance use in the community. Specifically trauma-related stuff which came out. Exposure to trauma and violence.

Again, I think the problem is that much of the research and much of the focus of programming is usually aimed at males. So even understanding substance use disorder for women is quite lacking. The research focusses on the male body. So, the people who partake in the research would be male. There's very little focus. And now there is starting to be, I think, more of the recognition of the need to look at researching the impact, you know, how SUDs show themselves in women, in terms of the aetiology, in terms of the progression of the disease particular to the female physiology. But also related to what women experience with a substance use disorder and how that impacts on their lives and interacts with other factors in their lives. So, there is that component very much so, so one can already think that if women also are neglected, how much more people in the LGBTI community?

Certainly, I think there is a need for that. For at least the awareness, the sensitivity, the start of the conversations around that. And then I think making those specific concerns more visible, more mainstream in a sense. As I said, it's because there isn't recognition given on the forms even. There's no space for anything different to male or female. So it does become… everyone just becomes [unintelligible] in a sense.

Are there any specific areas of gender-sensitivity training that you would think are necessary?

One area would be assessment. So assessing and exploring issues specifically around the experience - but again, I think one needs to be careful because it's relating to how it impacted on the substance use disorder. One of the pitfalls of assessment is that it's very easy to get side-lined by all the trauma somebody has experienced, and focusing on that when they are not ready to deal with the emotional baggage that actually comes with it. In assessment, it's about finding out if there is anything in that regard, and whether that may help go in depth into it. Because it is an assessment phase, being able to assess any specific issues related to gender identity and how it impacted on substance use in part or at current would help - if it is still very much an issue currently in the person's life.

I also think of family-related matters, because the issues of disorganisation in the family, judgement and acceptance in the family and support structures are also important. That is going to determine a person's ability to deal with the substance use - whether they have a healthy, positive support system that they can lean on. If that support system isn't there, then it's working with the person in identifying and developing a support system.

In training, it's also important to look at one's own issues around gender identity and acceptance of the fluidity, the variety. So practitioner's personal issues, personal concerns, personal judgements during training is going to be important, too. Especially as it comes up in supervision. So the aspect of professional supervision is very important too. This is sort of what comes through. There could be others but I can't think of anything else now at the moment.

I'm also thinking of dealing with one's own knowledge of the various terms. So information on that in training would be important. To know the various terms. I don't know in other areas in the country, but in the Western Cape people speak a gay language. People have different knowledge about that, because certain terms have become a part of mainstream, the way people talk. But coming back to the aspect of supervision, certainly for practitioners, it's

going to be important to be aware of one's own issues, concerns, own identity, own results around gender identity and that.

So there is an emphasis here on practical knowledge for day-to-day matters, like terminology and meeting people?
Yes.

Would you please give me an overview of the Matrix system you use?
The Matrix itself, as the name would imply, is a combination of a number of modalities approaches in working with people. So the program comes from very much an MI (motivational interviewing) approach: psycho-education, CBT. Those are the main traditional approaches and theoretical approaches of the actual program. So psycho-education education involvement is very important. The longest components of the program are called Relapse Prevention sessions. Those sessions focus on helping a client remain sober in about thirty-four sessions. Then one has Early Recovery Skills. Early Recovery Skills are how to help the client to get clean and how stop using substances. It's more practically oriented. Relapse Prevention is how to stay clean, so more in-depth stuff.

Your Early Recovery Skills consist of eight sessions. Relapse Prevention is thirty-four. Then we have Family Education sessions as well. Early Recovery and Relapse Prevention: those are client group based, only for clients. And what would usually happen is that clients would come in on a Monday morning and Friday morning, and have double-booked sessions. So first session would usually be an Early Recovery Skills session, the second session would be a Relapse prevention session. Then usually on Wednesday evenings, we'd have what we call Family Education sessions. So the focus is on presentations - usually DVD presentations. Watching a DVD where there is a specific topic being focussed on. But the focus is not on, for example, support. It's not a support group. It's about information, it's about education. It's about helping the family understand 'what is this substance use disorder about?', 'how did it come about?' you know, 'how is it that my child, my spouse, my sister, brother developed this?', 'what can I do here?', 'what should I not be doing?', 'how do I prepare for what lies ahead, because this person is in my life?' Those sessions are usually DVD presentations followed by a guided discussion. There would be a hand-out, people would ask questions and then there would be discussion questions. Then there would be a topic for some education sessions - again, guided by handouts, questions being answered, new questions for

discussion. There are around none of these sessions. There could be one or two extra elective sessions, depending on if they find it's necessary in the group.

Then, you have individual sessions, so each client would also see their therapist individually. There are also conjoint sessions where the family or the support; whoever the support in the person's life is will also join. So I think just to say that when we talk about family in Matrix, it's used very broadly. It basically means who is the key support in that person's life? So it could be their spouse, could be a relative, could be a neighbour, it could be your pastor, could be a work colleague. So it's used broadly, but a key person who is your support during this process would be considered family. So there would be individual sessions, and there would also be sessions if there are any check-ins needed - maybe a therapist would identify 'I need to see this person. This has happened' or whatever. So it's flexible.

You have your set sessions but sometimes people need more, and that's fine. And then you have your separate sessions you do with your conjoints, which would be, for example, doing what we call a [unintelligible] checklist to discuss what families are prepared to do, what they are not prepared to do in the process. So that people know what is expected in terms of behaviour, for example. Just to say also the Relapse Prevention sessions, Early Recovery Skills sessions, are all manualised. They're all in sequence. There are sheets, discussions for each session where people read through, discuss the topic, share, complete questions. And then we also do drug testing, which is part of any substance program – just to monitor. And we make it very clear at the beginning that it's not used as a punitive measure, it's more a measure to help the therapists establish what they are working with. Just see how their program and how the person is progressing.

So it's much more focussed on information, practical steps to take, you know, how to deal with certain scenarios, and then to reflect back in terms of any relationship stuff. You know friendship, work issues. And of course the other aspect is sexuality. There is a session on sexuality, but we must say sexuality is more in terms of sex and addiction. So not necessarily gender identity. Things like sexually acting out and how that has impacted use. How substance use has impacted sexual activity, for example. Also looking at the aspect of porn use. Especially with your stimulant users. I know it's a lot, but there is a lot in the Matrix.

Am I correct in saying that Matrix is focussed on educating and building connections between clients and a support structure to facilitate recovery?

Those would certainly be the goals, but not the only goals. So the Matrix program would

focus on helping the person with information to understand the substance use, but also helping to understand the aspects of triggers, framing. You know, how does triggering happen? How does framing develop? How do they develop and what they can do to manage it. Because it becomes important if I can understand what a trigger is about, what they are - understanding what we call external triggers and internal triggers. If I know that and I can distance that, I can manage that better, I can have a plan of action to deal with that. So it becomes important to know knowledge of my own aspects of substance use, of triggering and that, and what I can do in my situation.

For example, dealing with common challenges for people who are in Early Recovery. For example, dealing with social situations like being invited to a work function where there will be alcohol, bearing in mind that it's usually family events like weddings. So having practical plans in place for how you're going to deal with it. Or maybe you're in a position where you're not able to go to an event where there's going to be alcohol, you know? So it's very practical. It's very much about 'how do I deal with it,' especially in Early Recovery Skills where it's developing skills. But as I say for the RP it's about understanding - in-depth reflection on how components of my life have impacted it. Especially because the other aspect which is very important with CBT are the thinking and thought patterns. What thought patterns in the past helped me to justify my behaviour? How quick to justify certain things I did or didn't do. And so it is about identifying that and being able to now develop new ways of thinking, new ways of approaching certain scenarios, certain situations.

For example in dealing with conflict, you know, dealing with issues that stress you - how do I think about that? Certainly, the thinking and cognition are important to look at, and how that impacts on my behaviour. And of course, the other aspect is emotional baggage. How I dealt with emotions in the past, and how that impacts on my behaviour, and on how I deal with certain situations, or how it impacts on relationships. And certainly how we use that to justify use in the past. In understanding how these three components - the way I think, the way I behave, the way I deal with emotions - all interrelate with each other, and what do I do now. What are more positive thinking patterns and ways of behaving?

Also, I think that one of the things you just need to be careful of is, you know, "Matrix programs" is being used a lot - the term "Matrix". But people would use some of the contents and certain things, but they're not actually implementing the full Matrix program. So not that Matrix is going to take them to court about it, but Matrix would have a problem with them

saying that ‘we’re a Matrix program,’ but they maybe only use ten percent of what the Matrix program is about. [Our facility] was one of the proponents who actually brought Matrix to the Western Cape. The previous director was key in bringing it. The city of Cape Town still does the fidelity to the Matrix program, and they have the most Matrix sites.

Do you think queer people face any specific access barriers for treatment?
I think there would be access barriers where for example, if they had to go to inpatient facilities. I think just in terms of the accommodation arrangements. Unless the accommodation allows for more privacy and one has one’s individual room. Some private facilities would have that, but certainly not for state facilities or state-subsidised facilities, which would usually be dormitories of say, six to a room. So it certainly becomes problematic and inpatient programs may not be as willing to therefore accommodate somebody from the community. With outpatient it’s much easier. As long, I think, as one is sensitive to and makes allowance for any issues particular to the community. For us here, that would very much still a learning experience, because I think it would be continuous; making sure that we do accommodate, that we are sensitive and that we do make provision. So it would mainly be checking with the person. Do they feel that they are being heard? That there is space for them? Anything particular to their experience?

As I say, I think it would be more learning experience for us, because we’ve only had gay males. I don’t think we’ve had gay females. Interestingly, more gay white males. Older males, not younger males. I can think of at least four, and they have been older males

If one looks at physical access, it would just be even walking into the building, you know? Is there a security guard? How is the security guard going to treat the person? Reception, for example - anybody else in reception, in the room. So there can be those before they actually even enter the therapist’s office. Already those kinds of barriers that they need to deal with. I suppose it is about how the person feels accepted, judged or not judged. Feeling that this is a safe space for them and if they are heard. And if not, do they feel that they can say something and that they will be heard and something will be done about it?

I mean all the gay males we had were, you know, they dressed - everything - as males. There wasn’t that obvious ‘you are queer’, you know? The one person we had last year, he was dressed as a queer person. He had the wig and everything. The makeup. When he came with his mother, also the heels. I always feel jealous because, ahh, you know, heels. I can’t wear heels. So that was the only person I could think of that dressed as a queer person.

Interestingly, one of the older gay males - he's in his sixties now. This individual spoke about how when he was in the army, how at that time it was identified as a mental health deviation, and then more. He was seen as a candidate for this electro-convulsive therapy kind of thing in Pretoria. He didn't do it, you know? One of his other friends sort of said 'no, no, no, that is not for you, you need to refuse it.' Which is interesting just in terms of having an experience like that, towards his identity. Although it was when he was very young, and he was in his sixties now. But it's one of those pretty terrible experiences. Thank god that he didn't allow it to happen to him.

Thank you very much for this interview. If there's anything else you would like to add, please go ahead.

Thanks, there's nothing else.

Participant 4's Interview (e-mail interview)

Do you work in an NGO, government organisation, private practice or multiple?

An NGO

Do you work with individuals, groups, both or in other treatment configurations?

Individuals, groups (i.e. workshops – community members / professionals) and families

Does your work mainly consist of in-patient or out-patient treatment?

Exclusively outpatient

What does being 'queer,' 'gay,' 'lesbian,' 'bisexual' or 'transgender' mean to you, in your line of work?

Individuals who are marginalized / vulnerable / stigmatized

Have you noticed any specific gender-related trends in the broader SUD treatment sector?

Not sure how to answer this question… I have noticed more individuals seem to feel a greater degree of freedom to express their identity in this regard though.

In your opinion, how accessible are SUD treatment services for queer clients?

Access to SUD treatment can be challenging for anyone …there generally is a great deal of shame attached to presenting for treatment, but again in my opinion, more so for an individual who is struggling with sexual identity / gender issues

Are there any special considerations given to different genders in treatment planning, whether in programmes, promotional materials or therapy?

I think consideration mainly given to the predominant gender i.e. females / women in treatment

What do you think of the current form of treatment and promotional materials with regards to how they treat different genders?

I don't think this is spoken of really or addressed… perhaps in individual counselling spaces where the individual may be more comfortable or relaxed, but not in group spaces necessarily.

How are queer populations considered in planning processes, if at all?

Planning by whom on what level? Again, I think that if we are talking on a macro / broader

policy level, then I don't see it reflected as clearly or visibly. I think there are different NGO's that may accommodate for this planning but more on a needs-basis?

Have you encountered or treated any queer clients?

Yes

If so, how did you find out that they were queer?

They told me this at the initial assessment meeting

If so, how are they treated by other clients if they encountered them?

Generally, they are accepted in group spaces, but we always vigilant (as counsellors) regards respecting diversity among group members. I think sometimes other group members feel uncomfortable and unsure of what to say or how to react around them

If so, are there specific processes or measures taken in treating them?

No special treatment really, except that we may place such individuals in a different group space, e.g. Art Group

In your experience, are people of all genders involved in the planning and treatment process?

Probably not.

Have you noticed any patterns in the organisation of treatment and materials aligning with gender?

Again, I have to say the focus would be on the predominant gender of women / females

Does the language used in preparing materials such as public relations dispatches, treatment plans, advertising or other documentation reflect any gender categories?

Not besides the predominant genders of male / female.

If so, what categories are normally reflected or mentioned?

As above

Does the data you've seen include queer or non-binary categories in addition to common demographic categories like male/female?

This does not appear to be the norm

Do you think that additional training may be required in the area of gender-sensitivity toward queer people?

Yes

Do you think that additional training may be required in the area of gender-sensitivity toward women or men?

I'm not sure what you mean…do you think training should be directed at women more so than rather men? Ok, this is how I will interpret it. Both then, as it will offer opportunities for building understanding.

If yes to either of the above, are there any specific recommendations or areas of improvement that come to mind?

Training should be conducted in a manner that allows for processing and discussion of individuals' different attitudes – my experience has been that queer individuals may be confrontational in their approach, defensive to the point of being militant…*this is not my experience with individual clients as such* - in fact, those clients have been generally quite respectful – it has been my experience more so with specific NGO staff that may be working with queer individuals.

Participant 5's Interview

Would you please give me an overview of your work experience and past?

I'm a clinical psychologist working in this organisation, first full-time and then after that, half-day for an overall of 35 years. This is an outpatient treatment programme for people with addictions – for the lower income community, mostly. In addition to that, I also have a private psychology practice in a fairly affluent/middle class area. There I would do private counselling with addicts – psychotherapy and addictions and people affected by that.

Is there quite a disparity in experiences and access to resources between your two workplaces?

Yes, but the dynamics of the illness are basically very much the same. They just have different monetary value attached to them. So a poor person might sell his mother's microwave and that impacts the whole family's whole livelihood, and a wealthy person might smash his father's Ferrari which is a deal for the father, for the family. So the monetary might be different, but the dynamics are the same.

Have you seen any gender-specific issues in SUD treatment?

Women are generally a minority group in this field. It's generally more men in treatment, and seeking treatment. We have far fewer women than men and that could put them in a vulnerable place. For example, in group therapy when sharing personal things about abortion or prostitution and they're in a group with men who they could perceive as similar to the people who have abused them. For that reason, we feel it is important to try and create a safer space for women. In practicality, we run a separate women's group and we ask people what gender they would prefer for their counsellor. And we make sure if a woman wants a woman counsellor - that is always accommodated.

In the same vein as the previous question, have you noticed anything related to queer clients such as trends driving substance use or treatment access?

I think that they are generally in a terrible position in society. I think that they are excluded, abused and just an incredibly vulnerable population. I think that would affect everything. Maybe struggling with identity issues might contribute to them seeking substances. We actually see addiction as an illness that you're predisposed to from birth, but it could have exacerbated that illness by having so much negativity directed to you. I just think it makes the situation that much more complicated. You have to 'come forward' for treatment when you expect to be rejected and abused. I think life is just that much harder for people in that group.

How would you define the various queer terms, such as lesbian, gay or transgender?
I think there's just a huge diversity of choices. In my workplace, I've had some exposure to people making different choices and having a different sense of identity. My understanding of gay people is they're people who choose to have relationships with someone of the same gender or sex as them. The other being a variety of choices and identities mixed up with choices of who you want to be intimate with, and how you define yourself and how you express yourself in terms of how your dress.

What kind of treatment configurations do you work in – groups, individuals or others?
We do individuals and meetings. The body of the programme is also inclusive of groups – as I said, a men's group and a woman's group if at all possible. They also have psycho-educational lectures. They are also required to attend the twelve-step fellowship meetings like Narcotics Anonymous or Alcoholics Anonymous.

Is the treatment programme derived from an existing twelve-step programme, then?
No, it's a bit confusing. We feel that the twelve-step fellowship is a very important part of someone's recovery, and we also offer a six week programme. We won't keep the person forever, but consider addiction a lifelong illness that is incurable that must be managed. We must introduce some way of maintaining recovery once they've finished the programme and we believe that the twelve-step fellowship is an excellent way to go about that. So right from their first week, we are already introducing them to the importance of those meetings. That is part of how we see their needs being met in the long term, but our programme is not a twelve-step programme, specifically. We are mostly not recovered persons, but professionals and are not offering ourselves as people in recovery. For example, we have a psychiatrist that comes in once a week if needed. We would use social workers and psychology training that would dictate how we proceed.

The model we use is motivational interviewing by Miller and Rollnick. It's a model of counselling – so you would counsel people in a certain way that helps them take ownership rather than advising them and telling them what's wrong. You work through the technique, getting them to take responsibility themselves to own their damages and motivations that way. It's a very popular work in addiction work. It works very well in our outpatient basis.

Would you say the programme's paradigm is to treat addiction as a lifelong, manageable illness and to equip people with resources and agency to manage this?
Yes, we adhere to the disease model, basically.

Are there any considerations made for queer people like those made for women in your programmes?

That would be wonderful, but there are not enough participants to even create a feasible group of three or four. We might have a person here and there, and if there were enough, we would try to create a group space specifically for that group. As an NGO with very limited government funding and constant financial challenges, we can't have endless options, programmes and social workers. There are realistic limitations on what you can offer. But yes, if there were… we would like to offer a group especially for them.

In particular, I want to share with you a challenge we have. It's a very diverse group in my understanding and you're going to have situations where terms of the physical body, they have a man's body and dress as a female, for example. That creates a problem with gender-based groups. The person doesn't fit in well… though they have a man's body, they don't identify as male and probably don't want to be put into the men's group and they don't particularly fit in the woman's group and while it's confusing to explain every time that 'we were told this was a women's group and this person is dressed as a woman'. You know, it's just difficult.

An even greater difficulty is, and I hope I'm not being politically incorrect; of what we see as the integrity of a woman's group. Our women are generally abused in various ways - who've experienced sexual promiscuity and prostitution, that they carry enormous shame about. They've neglected children through what addiction does to people. They've maybe had unplanned pregnancies and aborted… a lot of things through which they carry pain or shame. What we feel is very important in how we start these groups is to give a guarantee every single week that there are only women in this group, and though we have men counsellors on staff, we always guarantee that men will never run this group. If we perhaps have some people who are physically perhaps have a man's body. They might feel that they identify with a women's group but we would be breaching our contract with women if we allowed that. Do you understand that?

We have had this difficulty and we accommodate it this way: if a person doesn't really – because of how they identify and express themselves and how they dress – don't fit into a men or women's group, we accommodate by giving them an extra group. We have an art therapy group that is optional for other people, but we'll make the art therapy group compulsory for you so that you still get the same number of groups per week.

So we accommodate it. Furthermore, and I'm being really honest with you here is, the further problem is organisations that refer people from that group tend to be very... I'm just going to say my experience – dogmatic and militant. And are not happy with the decisions that we make that are practical decisions to make our programme work with limited resources. And we become quite unpopular with those organisations because we are not for example, allowing a person who has a man's body but identifies and dresses as a woman to go into our women's group and they're not happy with that. That's quite stressful. Do you understand that? We have to prioritise people with limited resources, and we prioritise the majority.

But apart from that, I mean. The person would be allocated individually to a social worker. We'd assist them in any way possible. The social worker would obviously be under supervision and get additional readings and training if they're not familiar enough with the issues that are going to come up with people of that group. We try to offer the absolute best service overall, but there would be limitations to which groups can access.

Do organisations, including those representing queer people reflect people to your facility?
Yes, we're very established and well-known. We would be the first port-of-call for many organisations.

What is this dogma that these organisations prescribed regarding the clients they refer?
They believe that the priority is to accommodate how the person identifies. I do understand that, but then the conflict comes in: they would feel that though the person has a man's body, they identify as a woman and therefore, we should expect on every level that the person is a woman. So then our conflict is that we know how they identify, but we cannot guarantee that the women in our women's group are in a group with exclusively women Actually, on a purely biological level it's not a woman.

You mentioned social workers might get additional training. What form does that take?
Well if there was a course in the community… some NGOs who work with that group might offer a course and we would definitely send someone on a course like that. Googling and accessing readings, that kind of thing. They would also work with a lot of support from their supervisor, such as the kind of counter-transference that comes up for them dealing with a client that they different.

Are there any other examples where genderqueer clients have been treated by clients or therapists?

No, not at all.

In preparing programmes and promotional materials is there any specific gender-sensitive language used?

Not really. Any documents would say she/he, you know. But I mean obviously that's just… what you have to do. That's normal. I don't know. What else one could do, really? I'm open to suggestions of how we should be doing that. Nobody has suggested anything different. If there was a better one, we'd be open to hearing it, you know.

In reading data or doing data collection, do you see any gender non-binary categories represented?

No. Not really.

What are some examples of women's specific issues that arise in treatment?

There are reproductive issues and health… that would also relate to sexually transmitted disease. Children as well - the fact that most clients are sort of in twenties to thirties, there might be children in their care. We have a somewhat different orientation which is a requirement of the department of social development. If they're caring for children but they're not capable, we'd have to request a social work intervention from the state and you know, access the family and look at care issues. There would probably be child neglect. We have a responsibility for that. Generally, there's also trauma but I think we've covered that. Most of the women have exchanged sex for drugs, or are active in prostitution or some other engagement for obtaining drugs. That's what comes to mind off-hand.

In the case of children, we are legally required to prioritise the interests of the child. If the client is a woman with a young child and she's not responsible and using drugs, and she is not happy with the fact that we inform her we have to get social development to intervene. The child might be removed and if that's not what she really wants, we still have to go ahead. It's a legal requirement for the minor. It's always difficult when you have a therapeutic relationship with the client but you have to do something where the child is going to be taken away. It's quite hard, but we have to do that. It happens less often than you'd think, though. They do understand and it's a turning point for some.

How accessible do you think treatment is for gender non-binary or queer people?
On a practical level, I think that most treatment centres would face the type of challenges that I described. Our programmes are set up for either straight man or straight woman. And identify as such. Even more so for the inpatient centres. We're outpatient, so there are no dormitories or shared bathrooms. And I would just guess if I had to go in for an inpatient programme, that that's going to be problematic for the organisation. Which dormitory do they put you in? I would just say practically… the whole facility and living arrangement would have to be changed.

I think the other thing comes out is about the self-esteem or self-concept of people in that group. Like I said at the start, life is really hard and they carry extra shame. They might just find it that much harder. It's hard for any addict to come forward, but if you carry shame about who you are, or have been abused for who you are… The referrals we get are usually from organisations where they're assisting people on the street, or definitely prostituting. All that shame carried. We would not judge them at all, we'd try to accommodate them and make it a positive experience as best as we could. But the first step is difficult if your self-esteem is so low and you experience so much rejection. I think it's hard. It's not a block in that the organisation is putting out a block, but how a person is feeling.

I do a lot of training for counsellors as well. You have to train people – professionals to ask the right questions. Because if you don't ask something, then it creates the impression to the client that it's not okay to talk about that. Counsellors would perhaps make assumptions and they would be doing an interview with a guy that looks straight. And they ask him have you got a girlfriend or wife. And they don't first ask how you identify…

We obviously train people who ask the question to do that first. I do training with UCT and tell the students that you have to tell people you make a lot of assumptions. To take it a step further, people from the group that you're talking about – they wouldn't even know what to ask. That question of do you see yourself as gay, straight, bisexual… I mean, you'd probably have to know how to ask even further into that. I doubt that any of us know what to actually ask.

People also feel uncomfortable when somebody comes in and visually you're not really sure what their gender is. It just looks like someone could be a man or a woman for starters and you feel embarrassed to ask in case you insult them in some way. To say to someone "are you a man or a woman," I might see that offending people. "Of course I'm a woman, what do you

mean." It happens sometimes. Reception will first do the admin part of opening the file and they'll come to me and say, "what do I say to this person, I don't know?" We look at the name, and their name would be like 'Robin' and it could be a man or a woman and everyone's awkward. It's difficult. It doesn't happen often, but just an example.

You know what it is? It's that… and it's something even this interview I might be feeling to some extent. You've got to be so political correct. Do not say the wrong thing. As I said before, we've experienced it with groups that work in that field are militant and sometimes you just step on a button. "You can't say that and you can't assume that," I don't think it serves the actual people in that group that those that support them are militant and dogmatic. I think there should be more understanding that for most people that this is unfamiliar and quite new. Your average person or counsellor doesn't really know what are the right questions and wrong things to say… one is so careful and scared of making a mistake, and appearing to be politically incorrect.

Would you say that if groups representing queer people were gentler on the facilities, it might be helpful?

Yes, for sure. And you shouldn't assume that the average person or professional knows what they're supposed to know. I'm not really talking about you. I'm just talking about my experience – social workers working at the agencies that deal with that group… just people in life – my daughter will shout at me if I say the wrong thing 'cause she's very… politically correct about anything to do with gender. [laughter] I'm just laughing, but you know, you have to be careful. You just find yourself stepping on a button that you didn't know was there.

Do you attempt to locate additional training and information by whatever means you can?

Yes, it's not ideal and there's need for much more training. If I can take that up with the people in that field being too militant, they could redirect that energy into providing training for counselling professionals. There's very little actually, we sort of scratch around for stuff. It was somebody from some organisation who was very approachable who contacted us to find out about referring. And I just took the opportunity to grab him to come and present something on the area to our team. I had to take the opportunity for myself and it was extremely helpful, but it wasn't laid down on any level in our training in our community or organisations. There's a need, a huge need, even if it's all final year university social workers

getting a module that equips them for understanding. It's just that it's not readily available from the organisations that might be able to offer it. This guy I contacted. He wasn't even offering – I mean he was happy to do it and fantastic but that wasn't something his organisation was doing routinely. In various fields: substance use, family conflicts – people need to understand… and they don't.

Do you find that social workers feel insufficiently prepared for the clients they see?
Yes, for sure.

Can you think of any specific areas where training might be improved for treating genderqueer people?
There should be help for social workers to understand the different identities that people in that group experience. And how to speak in a politically correct, inoffensive way about those people and to those people. This could the main thing. I think your average social worker doesn't know the different identities are in that group. They have a vague idea, but they don't really understand. That's what was extremely valuable about the talk we had that the person helped to unpack. The different identities that people have and what those things actually mean. And how to refer to them, what pronouns to use. They introduced us to new words that we didn't know. There's a great lack of knowledge.

Do you think that training should be less prescriptive, but should be an educational space for debate?
Absolutely – with more understanding.

Just to confirm, the main thing that arose from training needs was learning how to navigate the world of queerness?|
Absolutely, that's a good way to put it.

Do you think that it would be helpful to separate training about sexual identities and gender identities?
It's hard for me to say. I see them as very intermingled, actually. If I was to get training, I would want it to cover both and cover the intermingling of the identity and sexual expression.

Great, thanks a lot for your participation. If you would like to add anything, please let me know.

Okay, thanks.

Participant 6's Interview

Would you please give me an overview of your work experience and past?
Where do I start? So I've got my BA, I've got my Psychology Honours, I've got my Psychology Master's in Counselling Psychology, and I'm currently busy with my PhD in Psychology. I work as the clinical head of a dual-diagnosis psychiatric hospital that deals with psych work and substances. This is my third year working there. I also do my own private practice on the weekends where I see patients for normal psychotherapy.

Is the facility you work at private, public or a public-private partnership?
It is a private hospital group. We fall under the Medicare hospital services. We are their psychiatric arm, essentially. **A** dual-diagnosis unit, so we're doing not just substances, but substances and psych. So any psychiatric diagnosis with substances - some of our sister hospitals do plain psych work, whereas we do both at the same time.

Your facilities seem well equipped?
Beautiful hospitals, yeah.

Does you tend to work more with individuals, groups or a combination?
Well, we do one-on-one sessions, but then we do a lot of group work. So, our program is very much centred around that. We do group lectures, we do group therapy, talks, group processes, and then we also do one-on-ones with your individual psychologists, and we've also got psychiatrists on staff that we work very hand-in-hand with as well as the medical team. A multi-discipline team works the best.

Is your work primarily inpatient?
So that's changed recently, but basically what we've been doing is that they come in and they are part of our hospital system. They eat there, sleep there, they are there 24/7. And some of them come in for a 24-day program, but we do run a 4-week primary care program and then a 6-week secondary care program. But what we've started to do recently, is we're doing outpatient work now. So we're trying to get that off. So basically we can see people onsite for a session and then they can leave. But they would be mainly focussed on one-on-ones or a family session.

Did COVID impact your ability to operate normally?
Yes it did. So we're trying to help and see what we can do. Look, we are quite full now, but I think it's still a service is needed because not all people, like you said, can come in for a 24-

day time. Off from work, or leave, et cetera. Or because of the financial component, so what we can then do is do more one-on-one sessions at the hospital or on Zoom, if somebody wants a one-on-one. Some help, basically.

Does your workplace have any in-house definitions of terms like 'queer', 'gay' 'transgender' or similar?

Not really. Should someone come in and say, 'oh by the way I am this or that,' then it's like okay. But it's not that we even speak about it really. It's just it's not a concern. The only thing that I have had before is I had a gender-neutral - they came in, and then they asked us to not say 'he' or 'she,' but they want us to say 'they'. So then we all try and do that. We would talk to them as 'they', et cetera and try and be as respectful as what we can. But there's no set rule of what's gay, straight, gender, or anything like that. We just take that as 'you'. I'm still trying to learn that too. It's hard for me to kind of keep track with what's what sometimes, and it's hard just to be respectful. Like, LGBQ-what? LGBTQ+… the 'I'. I don't even know what the 'I' means now, and obviously I'll have to go and find out, you know? And like it's bad.

Have you seen any gender-specific issues in SUD treatment?

No. I think what I've seen more is that it's not really up to their, you know if it's male/female or gender or things like that. It's more to do with personality. And it's more to do with people's level of motivation. So if someone was forced to go into a healthcare centre by their wife, spouse, children or something, then they are a bit more resistant than those that actually want help. But other than that, it's not about male/female or anything like that. It's just about 'do they want to be there'.

Sometimes I've got more females. Sometimes I've got more males. Sometimes I've got more people in their mid-20s at the moment, I think most of my house is about 40 years and higher. So I think we've got seasons. But I can't tell you that it's more male in substances or females. Because keep in mind it's substances: historically with more heroin, cocaine, that kind of substances, but nowadays we're seeing more pharmaceuticals. So females are more inclined to go the pharmaceutical route, just from what I've seen. That would also be dependent on their age. The amount of men I've seen in their 30s and higher are more to do with alcohol now. And the mid-20s range is more substance related. For now, anyway.

But I think substance usage now, I mean it's there and you get different types, but it's not that one is more than something else. And then also if you're thinking just substances, that's one component, but if you're thinking of a process, addiction's a whole different ballpark.

Would you elaborate a bit on process addictions?

Okay. So what I've seen mostly is that people with a sex addiction are mainly with males. I would say it's about fifty/fifty straight men as well as homosexual men, and from what I've seen, straight men tend to seek out a hooker. Straight men will have sex with a male or female, but they will still consider themselves to be straight. And then some of the homosexual males - some of them, not all of them by any means, do become sex workers, and they love their job. They're happy in their job. The females that I've seen are more to do with the love addictions. It's more about the love than about the sex. But sometimes what happens is because of the love side of things, they might tend to have sex or do sexual things because that's a way to feel loved, and to get love, and to make their partner happy, if I can say it that way. So that's what I've seen most at my work. And that's more the trend that I've seen.

How accessible do you think substance use treatment is for queer people?

So I think you would then have to consider if you're going the private route and you've got the finances. Because then you've got them on-hand, and you can just Google on your phone, you've got treatment centres. Then you've got those that are funded by non-profits, or they're funded by the government which are there. In my experience, it's not about gender or sexuality or things like that. From my experience what stops people from seeking treatment is all finances or stigma. So if someone feels that they can't seek treatment because, 'what's someone going to think?' 'what's someone going to say?' or 'will they be fine?'. In our hospital we've had people come in and they say what they think, how they feel, [unintelligible] what we don't understand. Then people make their own assumptions because they don't know how it works, or they [unintelligible].

Would you please give me an overview of the programme used here?

Sure, okay. DBT, so Dialectical Behavioural Therapy has been shown to work very well with personality disorders as well as with substance use, and that is evidence-based, so we use that as the theoretical basis. But we also do CBT, we do systems theory, we do attachment theory, and we generally focus a lot on person-centred and positive psychology. That's what I do, the positive psych side of things. And then we've also recently added acceptance and

commitment therapy as well. So that's the psych way when we run our groups, but how you as the psychologist run your one-on-one is up to you. We focus on group lectures where we discuss on/around a more psycho-educational level about different things. Such as people/places/things and, 'how do I cope?' And then we do talks, and then we also do group therapy where we can bring in a topic, or we just ask 'how are you doing right now?' and then as they talk and discuss, we do a facilitated group session. They do AA meetings, NA meetings, et cetera. We do the foundations of the Twelve Steps, but we are by no means a Twelve Step AA program. It's not helpful just to use that, so we use the foundations of that as well as behavioural change, as well as how to cope with life essentially. How to cope with your substance usage, and how to go forward and how we can build people back up when they leave the hospital. Does that answer your question?

Are individual psychologists trained in the broader understanding, but they exercise discretion in one-on-one sessions?

Yes, because as we know not all paradigms are suitable for all people, so you kind of have to see what would work for your specific client, and also what you are best trained in, and then go from there. I have in the past had to reassign a psychologist on their patient because of that. So if someone's not a good fit then we would rather change therapists to find someone that is a best fit for that person. I mean I had someone that was very spiritual, and then one of my staff members is a psychologist as well as a sangoma. Now I am by no means one of those spiritual people, so she was more of a suitable fit for one of my patients that had similar cultural beliefs. So that's why I would then reassign.

Am I correct in saying that the therapeutic alliance between practitioner and client can make or break the process?

A hundred percent.

Are people of all genders involved in the planning and treatment processes at your facility?

Not really. The only thing that I can think of is we are a female-strong clinical team. So that could make a difference. But in terms of any themes with the program itself and what happens with it, no. Strangely enough, most of my psychiatrists are female. I only have two that are male psychiatrists.

In preparing programmes and promotional materials is there any specific gender-sensitive language used?

No, we keep everything vague. So it's more about what we do, more about our services, and its more termed of, 'should you feel like you would like to get treatment' It's more personalised but not anything termed of male/female, nothing like that.

Is the use of first-person language in promotional materials aimed at targeting every person to stir something internally?

Yes. Or we'll say, 'if you are feeling this, this, this, and this, or, 'if you are experiencing this, this, this, and this.' But it's not anything to do with anything male/female or gender or sexuality or anything like that. Because it's about the addiction, not about the person themselves, if that makes sense? Because the addiction is the problem, 'you' are not the problem. So, we kind of separated them.

Would it otherwise feed into a mentality where the person is problematised instead of the addiction?

A hundred percent.

As a psychiatric hospital, would you say your overall approach is more medicalised?

I would say our approach is more westernised. So if someone comes in with psychosis - I do understand and we do take into account different experiences, different cultures, but our treatment would be based off of 'does this person need to be transferred to high care,' 'does this person need to be stabilised with medication,' et cetera. I'm not going to call a spiritual healer to come in. We would look more to the psychiatrists and see what they would say.

Would this be a biomedical approach rooted in the evidence-based tradition of medicine?

Perfectly said, yes.

Do you read and process any research data as part of your work?

If I have the time, yes. I don't always have the time, but that's why I have an awesome clinical team, and when we do things like our CPDs, that's when we do most of our journaling and our reading. When we do different talks or therapies or workshops then we'll change and update things. So I don't read as much as I would like to. You saw how hard it was just to sit down and have this conversation, so I mean just to read for fun, you know, it's hard. Because you are booked. Each hour of your day is booked for something, so it's very hard to do reading.

In the data you have read, have you encountered any data that includes non-binary gender categories?
Hardly. I think what I do see is 'gay or straight'. It's not really about anything else, and that's why I think a lot of the current work needs to focus on being more inclusive. A hundred percent.

When queer people are mentioned, does it sometimes appear as though queer identities are pathologised? For example in the case of queerness and HIV risk.
Yes. But I think they make it like, straight people do the same things, but it's not seen as a bad thing. It's just like, the norm. It's fine. Ja, so I do think there's a big, big space that needs to be filled.

Do you think that additional training in the area of gender-sensitivity for queer people is required for practitioners?
Yes. Because if I had more of that, I would be more prepared now. I really don't care if you are gay, straight, pink, purple, blue, ace, from space, I don't care, you know what I mean? But for me just to know what is the way to be respectful, and how to engage, et cetera. So I am kind of learning whilst I am there, but I think I would have needed to be more well prepared at my varsity. And so that now I'm not as in the dark about what is appropriate, what's not appropriate, et cetera.

Are there any specific areas of gender-sensitivity training that you would think are necessary?
When we started this talk, I mean I need to even now find out what is exactly the meaning of LGBTQI+. Things such as that, as what are the different subsets, you know? How does that person feel, and how can I be respectful of that person? And especially if I'm going to be seeing this patient, my transferences need to be considered, but how can I do that if I don't know what I am dealing with? What that person is experiencing? I need to try to understand to the best that I can so that I can make sense of their life and their experiences and help them with that. But if I don't even know, how can I do that?

Assumptions are a problem. We can't just make people gay or straight. It's not that simple. It's not that easy. And I think as a treating team, therapists need to see that, and need to know that, and they need to know how to navigate that in the best interests of the clients. We live in a society with so many national languages, and we have to take the culture into account, and et cetera. But do you think we also need to be a bit more sensitive to what people are

experiencing? Because we're so concerned with people's ethnicities and how to be sensitive towards that, but we also need to learn to be sensitive towards different sexualities and different ways that people identify themselves. We can't just be focussed on one component of a person, but not on their whole person. Assumptions. There's so many of those assumptions that float around, and people think they know but they don't know.

Are there any other things you'd like to add that wasn't covered by a previous question?

I think the work that you're doing now is needed. I think there is a big space in the field of not only substance use, but also in psychology, for this. And I think, I mean now even, it's not a pathology. Your sexuality shouldn't be seen as what is right or what's not right. It should be about a person. And I think it needs to be normalised, and it needs to be seen as not a thing that needs to be fixed, because there's nothing wrong there. And I think there needs to be more discussions around this. It needs to be taken from schools, to varsities, to treatments, to therapies, to CBDs, to talks, to everything. I think more people need to be talking about it, to make it normal, to make it okay. And I do feel that part of a psychologist's counter-transference needs to take this into consideration because I think that's not been happening.

At this stage, the researcher offers to take questions from the participant. The participant now asks questions and the researcher answers, and the participant's words are written in bold instead of the researcher's.

What does LGBTQ+I stand for? So I know the first four, but the rest - you have lost me by the 'I' and the plus.

So it starts with LGBT: the lesbian, gay, bisexual, transgender, right? Of which, three of them are sexually variant identities, and one is gender variant. And that has occasionally caused some misunderstandings, because then transgender people get put into a category of 'so is this something you do sex with? How does that work?', but anyway.

Once we go beyond the classic four - there are many, many different variant identities when it comes to sexuality and gender, and many of them are jostling for space to be recognised in the identity, but if we start putting in all of their letters, we're going run out of space on the keyboard and in the paperwork. [laughter]. So 'Q' is a fairly recent addition that stands for 'queer'. And 'queer' is used as an umbrella to cover any gender variant and sexually variant identity. Queerness includes being transgender, it includes being gay, it includes being bisexual, it includes being agender, asexual. 'Queer' in the dictionary definition just means

‘out of the ordinary,’ and it used to be a slur, but it’s since been largely reclaimed by the queer community to use as an umbrella term for all of us that are a little bit out of the ordinary. So it’s umbrella term.

If you ever see ‘I’, it’s is usually for ‘intersex’. Intersex conditions being normally medical or biological conditions that express themselves on a person’s body. But of course, whatever body you live in will eventually affect the workings of your mind and how you see yourself. ‘I’ tends to cover intersex and the experiences and conditions related to physiological intersex conditions. Such as variant genitalia. Being born with genitalia that don’t look like the predominant majority. Or chromosomal differences. What if you have an XX chromosome combination, but you have a penis? And so forth.

The plus sign… that’s not for a single category, the plus sign is just there for everyone else not listed.

So that’s [the plus sign] basically saying ‘et cetera’?
‘Et cetera’ or ‘et al’. You see a plus, that just means ‘et al’. Because inside the community we’ve been fighting for decades and decades about who deserves recognition, who should get recognition, whose acronym should be placed ahead of others. Just like a paper being authored, it matters who gets placed first and who gets placed last. Recently we’ve come to the realisation - and I can’t speak for the entire group of people on earth - that the infighting is not helpful. So there’s the plus symbol. The plus is for you if you’re not listed, and if you want to list yourself after the four main ones, or if you want list yourself anywhere, just go for it.

Ja, that’s why I was going ‘what?’ And now I can tell my staff that. So I can go and tell them what those things mean too, and these things will be more sense of what’s what.
Yeah, so the client you described earlier who described themselves as feeling more masculine or feminine on some days than others, but also wanted to be referred to primarily by a they/them pronoun? They could fit somewhere into the agender category because they don’t want to be referred to by any gender in particular, or they could be genderfluid because their mode of expression is fluid and changes from a day-to-day basis.

Okay, that makes perfect sense to me.
Yeah, honestly at the end of the day, when you break down the words they start to make sense. When you realise the word ‘queer’ just means ‘a deviation from the norm’, and that kind of covers all of us. Or ‘agender’ is the absence of gender, just like ‘asexual’ would be

the absence of sexual attraction. Then ‘homo’ and ‘hetero’ we all know. Homo: same. Hetero: opposite.

Thank you for taking part in this interview. If you have anything to add, or have any queries, you can always reach me.

Thanks.

Participant 7's Interview

Would you please give me an overview of your work experience and past?

I've worked in primary care, tertiary, outpatient, private, public, online practice. I've authored several books, and work closely with gay men and sex/love addiction.

Have you seen any gender-specific issues in SUD treatment?

I can't think of anything off hand that is problematic, but eating disorder groups tend to be more female-focussed. Much of the sexual practice among gay men involves drugs, especially methamphetamine. It seems that certain drugs facilitate sexual contact more than other drugs. For example, crack cocaine and similar stimulants may increase the feeling of being energised as opposed to depressant drugs like benzodiazepines.

Have you ever treated anyone gender non-binary?

No, I have not.

Do you have treat gender non-binary or queer clients any different to cisgender and heterosexual clients?

I think very little. Maybe with some homosexual male clients, there's a 'default' trend that there are specific patterns of substance use. Trends, not necessarily in published data. They're based on my experience and a significant percentage of male clients, possibly above 50% have some degree of sex addiction. This is especially with amphetamines and cocaine, or uppers. This is a serious factor to consider in post-treatment planning – the mixture of drugs and sexual behaviours, and venues of use such as gay clubs. This can result in unhealthy sexual behaviours – not unhealthy in a moralistic sense, but in that it can be linked to harmful substance use. There is also a component of love addiction, but it's mostly sex addiction. Females tend to show with more love addiction.

Would you elaborate on the differences between sex and love addiction?

I would characterise it as an unhealthy, pervasive attraction to people and situations, with the energy spent finding the feeling. We're not talking about love in a technical sense and it's not a healthy love. It would be related to infatuation, attraction and fantasy. In a way, being addicted to the romance aspect of relationships. There are further classifications such as being love-addicted or love-avoidant. These can be pervasive patterns of attraction to people/situations with large amounts of energy spent pursuing and attaining romance.

There are two main ways of maintaining post-treatment sobriety in love and sex-addicted people. The first is a relapse point of view – where someone has a sex addiction, and all sex addiction has a component of love addiction in it. Having programmes specifically about sex and love addiction can help, but what is important is to determine if the client has a sex, or similar addiction and how to treat them. This is similar to eating disorders – sex is part of our nature. It's harder to remove than even substances, possibly. This can often be more of a challenge for gay men, because they're quite sexually active. So that needs to be considered seriously – how they access affection without relapsing into substance use. If sex addiction isn't treated, it may lead to more substance use.

Have you noted any gender-sensitive language in promotional materials or treatment programmes?

Not so much in work, but much more in curriculums and academia. Quite often in academic settings, but not as much in treatment.

Would it be helpful if some of this language in academia entered treatment settings?

Some of it, yes, but much of it is nonsense and is not practically useful. I think that some of the gender-sensitivity in academic is completely overblown when in reality, it's not much of a big deal. There's also a danger of speaking for groups of people - like crusading for all addicts in the world as a single person. This can be the case for people speaking for the blanket of queer people in the same way that the 'gay community' is referenced. Just like the 'white community' or 'black community' or 'addict community', these are only one aspect of complex identities and there is no united community. In the real world, there is not much traction for this and a lot of humanities research methodologies give the impression of being scientific, but they lack validity. The humanities fields have many opinions, with not enough to back up those opinions with reference to how things really are.

Psychology has also been politicised too much, such as via the 'social justice movement'. Social justice is a political ideology and I feels that it's really dangerous to bring politics into psychology. The goal of psychology should be to help, not politicise. So when it comes to social justice, people seem okay with political opinions being projected onto clients. This is similar to religious-based counselling modalities which project an ideology onto the client alongside treatment. The APA has specifically said that people have moral obligations to act for social justice, which I think is just absurd, because political ideologies are very complex and mercurial. I don't understand how the psychological fraternity can allow a point of view

to dominate. A mental health worker should not project any ideology, religious or political onto clients.

Do you think that additional training in the area of gender-sensitivity for queer people is required for practitioners?

I think yes and no. It's a difficult topic and I'm no expert, but there are a lot of conflicting opinions around gender-sensitivity. I wouldn't have a problem with presenting new points of view, but I do have problems with someone with someone who has a specific idea that they think is right. I want people who are experts to do the teaching and for gender, it would not be great to teach it as dogma because that would be highly problematic. It should be about teaching varying points of view and new ideas - then it's better. I have written on ideology addiction and I propose that people often choose an ideology that suits them. Ideally, training should not be prescriptive, but training that presents new data, new information, new research. Especially so if there are counter-arguments and a presentation of many different theories.

Thank you very much.

You’re welcome.

Appendix H – Ethical Clearance Letter

Human Ethics subcommittee
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NHREC Registration no. REC-241114-045

23 September 2019

Lane Tao

Review Reference: 2019-0451-909

Email: g15t3993@campus.ru.ac.za

Dear Lane Tao

Re: Needs Assessment for Gender-Sensitive Training in Substance Use Disorder Treatment for Gender-Nonconforming People

Principal Investigator: Dr. Liezille Jacobs

Collaborators: Mx. Lane Tao

This letter confirms that the above research proposal has been reviewed and **APPROVED** by the Rhodes University Ethical Standards Committee (RUESC) – Human Ethics (HE) sub-committee.

Approval has been granted for 1 year. An annual progress report will be required in order to renew approval for an additional period. You will receive an email notifying when the annual report is due.

Please ensure that the ethical standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the ethical standards committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloging number allocated.

Sincerely

Prof Joanna Dames

Chair: Human Ethics sub-committee, RUESC- HE