



Substance Use Disorder and LGBT Communities

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Who are we?

There are no clear definitions of the terms lesbian, gay, bisexual or transgender (LGBT). There are various dimensions of these terms, including behavior, identity, and attraction. Although there is some overlap, most lesbians and gays acknowledge their sexual identity, behavior and attraction are not consistently same-gender (Finnegan & McNally, 2002). Sexuality is often fluid rather than static and research has not illuminated the definition of LGBT. Researchers have not agreed on definitions of sexual orientation, sexual identity, or sexual attraction. It is often left up to research subjects to define these words for themselves. In addition, these terms have different meanings in different cultures. Researchers rarely collect information on individuals that do not conform to societal perceptions of male or female. Usually transgender individuals, because of their low prevalence, are ignored.

Bisexuality is a much more common occurrence than is generally acknowledged (Klein, 1993). Blumstein and Schwarz (1977) note that a mix of heterosexual and homosexual behaviors in a person's erotic biography is a common occurrence and that it is entirely possible to engage in anywhere from a little to a great deal of homosexual behavior without adopting a homosexual lifestyle. Klein further adds

that bisexuality is neither disguised homosexuality nor is it disguised heterosexuality. It is another form of sexual expression. Bisexuals represent the both/and rather than the either/or of the sexuality continuum.

Cbaj (1989) identified three characteristics that distinguish sexual minorities from everyone else: (1) Having a sexual orientation that leads to the desire to have affectional, sexual, sexual fantasy, and/or social needs met more often by a same-sex partner; (2) Needing to negotiate a process of self-identity and self-recognition as a gay man or woman who is different from the majority; (3) Confronting widespread, culturally sanctioned, and insidious dislike, hatred, and/or fear of gays, homosexual sexual activity, and homosexual feelings, known as homophobia.

Human sexuality is a dynamic, changeable condition. A fairly large number of people shift their positions on the continuum of sexual/affectional orientation during the course of their lifetime. It is extremely important, therefore, to understand that any of these labels—homosexual, heterosexual, bisexual, asexual—can be misleading because they do not account for the subtleties and intricacies of human emotions and behavior or for changes in the human condition (Finnegan & McNally, 2002).

“Human sexuality is a dynamic, changeable condition.”

“Sexuality is often fluid rather than static...”

LGBT Substance Use Disorder Research

Earlier research (Fifield, DeCresenzo, & Latham, 1975; Lohrenz, Connely, Coyne, & Spare, 1978; Sahgir & Robins, 1973) has reported rates of alcoholism and problem drinking to be about 33% of the gay population as compared to 10-12% of the general population. However, these early studies have methodological dilemmas (e.g. poor controls, poor samples, and failure to have uniform definitions of alcohol dependency and homosexuality).

Bux (1996) drew four conclusions from a comparison of previous and recent research relative to lesbian's and gay men's use of alcohol. First, gay men appear to be less likely than heterosexuals to abstain from alcohol consumption. Second, gay men appear to exhibit little or no elevated risk for alcohol abuse or heavy drinking, (using categories defined by the National Institutes of Alcoholism and Alcohol Abuse as 60 or more drinks per month), when compared to heterosexual men. Third, lesbians appear to be at a higher risk for heavy drinking and possibly for drinking-related problems, than heterosexual women. At times lesbians have been found to match gay heterosexual men in rates of heavy and/or problem drinking. Fourth, studies examining trends in drinking have reported recent decreases in drinking and alcohol-related problems among gay men.

Chemical dependency problems are widespread in the transgender population. Valentine's study (1998) of intake records at the Gender Identity Project in New York City showed high rates of substance use disorder in the transgender populations: 27.1% reported alcohol abuse, 23.6% reported drug abuse. Of the three hundred and ninety-two transgender persons who participated in Clements study (1999), twenty-one-percent (82) identified as bisexual. Sixteen-percent of the total number revealed they

had received treatment for alcohol problems and 23% for drug problems. Lifetime use of marijuana-90%, cocaine-66%, crack-48%, and heroin-2% was reported. Of the 252 participants in Xavier's (2000) Washington, DC study, 13.1% (33) self-identified as bisexual. Thirty-four-percent of all the participants stated that alcohol was a problem for them while 36% reported drugs to be a problem.

Skinner (1994) in a mail survey of 1,067 self-identified lesbians and gay men living in and around Lexington and Louisville, Kentucky found: (1) Lesbians are more likely than gay men to experiment with different types of drugs sometime in their life, but do not currently use these drugs; (2) Lesbians are more likely to be current users of marijuana than any other illicit drug; (3) Gay men are significantly more likely than lesbians to have ever used and to be current users of inhalants; (4) Prevalence rates for past-year and past-month use of stimulants and sedatives are also significantly higher for gay men than for lesbians; (5) Gay men are significantly more likely to be current users of alcohol while significantly less likely than lesbians to have ever used or to be current users of cigarettes.

DuRant, Krowchuck, and Sinal (1998) reported adolescent males with same-sex behavior have increased rates of tobacco use relative to other peers. Stall, Greenwood, et al. (1999) found that 41.5 percent of gay male adults smoke, a rate far above the national rate of 28.6 percent of the general male population (CDC, 1994). Skinner and Otis (1996) report that lesbians smoke more than their gay male counterparts. Bradford and Rothblum (1994) found that 30 percent of the lesbians they surveyed smoked cigarettes on a daily basis, an additional 11% smoked occasionally, and that 49% of African American lesbians surveyed regularly used tobacco.

... it is important to not only address the addiction ...



... it is also critical to explore the timing of coming-out to the family.



LGBT Treatment Considerations

... LGBT issues are often more imbedded with emotions.

In the current era of heightened awareness of cultural sensitivity, it is important for all working in the field of addictions to have knowledge of those concerns specific to lesbians, gays, bisexuals, and transgenders. Lacking such knowledge may lead to poor treatment and even false accusations toward both staff and patients. The LGBT population is comprised of a unique group of individuals with a special set of commonalities. It is important to note that LGBT is not synonymous with addiction and, as with addiction in general, not all LGBTs who work in the field are from an addictive family or an addictive background.

The therapeutic relationship remains vital. One of the first decisions that the therapist must face is whether or not they are willing to work with those identified as LGBT. If not, a proper referral is to be made, as it is not the role of the therapist to force opinions or beliefs on a patient. The environment in which the treatment is to occur, including the staff, literature and the decorations, is also important. Those struggling with addiction are well versed in guilt and shame. Those who are additionally dealing with LGBT issues are often times even more imbedded with these emotions. As a result, it is necessary to have an environment that supports and encourages the growth, not regression, of the individual.

Numerous articles and models are available on what is known as the process of *coming out* (Coleman, E., 1985; Cass, U.S., 1979; Kus, R.J., 1990). Generally these models begin with an individual recognizing something is "different," and end with the individual being open with family, friends, etc., regarding his/her sexuality. The phases in between will vary but can include acceptance, coming to terms with a new identity and choosing whether or not to act. How each person moves through this process is not only individualized, but motivated by the complete environment and the time period in which they live. History has been both kind and punitive to those

within these groups. There have been time periods where the LGBT population has openly flourished. There have also been times of serious persecution, legal or otherwise.

There is some suggestion in journals that the *coming out* process is primarily a white, Western, middle class phenomenon (Smith, 1997). This may mean that those of other ethnic cultures may not experience this process in the same manner. Or it may also suggest that those of non-white backgrounds are viewed as *selling out* (Chan, 1995) to the values of another culture. This may also lead to an additional level of shame for the individual involved.

There may be others within the LGBT population who never experience this process as it is currently defined. And still others who are fully intent on never acknowledging their homo-bi-trans-sexuality, thus possibly using substances to keep these concerns well-beneath the surface.

A traumatic experience is generally identified as one that occurs suddenly and/or unexpectedly and may overwhelm a person's sense of control (Finnegan, D.G. & McNally E.B., 2002). Addictions are generally viewed as being traumatic (Clark, 2001 & McCann, L. and Pearlman, L.A., 1990) to the addict and possibly to the addict's family. However, many individuals are unaware of the traumatic experience faced by some, but not all, within the LGBT population. This trauma may occur in the forms of family, community, or religious ostracism, possible physical beatings, as well as minimal legal protection for housing, employment, and custody concerns. The clinician should be aware, then, that the LGBT patient may present with two sets of trauma—the trauma

of addiction and the trauma of past experiences.

Given such conflicting information, it is easy to see why those who work with or who want to work with addiction in the LGBT population have to work hard to understand the individuals within this large, vast, and diverse group.

The LGBT population is comprised of a unique group of individuals with a special set of commonalities.

Treatment

One of the first tasks of the therapist is to determine at what stage, if any, of the coming out process the patient is in.

The number of LGBT specific treatment facilities, not large to begin with, continues to decline. Locating a secure facility with a knowledgeable staff is typically the first barrier a LGBT patient must overcome. At some point in its history, almost all substance use disorder treatment programs will have one or more LGBT patients. These individuals may or may not let their identity be known based on the history of the program, the comfort level of the program as expressed by its complete environment, or the personal feelings on disclosing staff attitudes toward LGBT issues. Nystrom (1997) reported that 46% of lesbians and gay men in treatment had homophobic therapists, 34% felt that their sexuality was seen as irrelevant, and 7% had therapists who made openly negative comments.

An initial concern for all who enter into substance use disorder treatment programs is the cessation of the drug use, regardless of sexual orientation or gender identity. As treatment progresses and these issues emerge, it is up to the patient and therapist to address substance use on some level. The therapist's knowledge, cultural sensitivity, awareness, and clinical abilities are all factors at this point of the therapeutic relationship.

One of the first tasks of the therapist is to determine the patient's stage, if any, of the *coming out* process. The level of patient comfort with their identity has to be determined to help establish what type of treatment plan is to be formulated. If the patient has no overt level of awareness nor the desire to express their identity, to not acknowledge this may result in the patient leaving treatment too soon. Another concern is the risk of relapse should these issues be left unattended.

The ability of the therapist to recognize this dilemma and effectively deal with it also depends on the therapeutic relationship. Simpson (2002) outlined several key elements of this relationship that develop over time to help support the impact of treatment. He, and others, have noted that attending counseling and group sessions helps to improve the therapeutic relationship, psychosocial functioning and the behavior changes that impact recovery. As part of

this relationship, it is also necessary to determine the treatment modality that best suits the individual patient.

Personal views, attitudes, and theoretical background are some of the ingredients that a therapist brings to the clinical situation. If homosexuality is seen as a "phase," bisexuality a transitional stage, and gender identity simply as confusion, the therapist may not be able to fully explore or may even miss issues critical to the patient's ability to maintain recovery. The question of whether or not the therapist discloses his or her sexuality may also have an impact on treatment. Such disclosure may prove helpful to the patient with the refusal to do so seen as further evidence by the patient to continue to hide, or even to deny, an integral part of themselves. Therapists working through their own issues of sexual identity may not be in a position to help others currently in the same process. As with any therapeutic situation, the degree of self-comfort on the part of the therapist is vital.

The involvement of support groups such as AA, NA, and/or CA becomes an issue when discussing the LGBT population. Although studies have shown that the inclusion of these support groups helps with the maintenance of recovery (Mathias, R. 1999), not all meetings are welcoming and those designated specially for LGBT individuals may be too much for the patient to handle. Thus it is important for the therapist to remain in contact with the pulse of the area's meetings to help assimilate the patient into an appropriate support group.

Another possible support system for those in recovery is the family. Numerous LGBT individuals were asked to leave their families when their sexuality and/or identities were divulged. As with several other cultures, when defining the "family," non-biological individuals may be listed. This may include not only the partner or significant other, but also surrogate parents, relatives such as cousins, and those friends identified as very close. There may also be one or more children involved as a result of a previous heterosexual relationship, adoption, or artificial means.

Clinical Concerns

It is important to work with each person to assess their unique individual contributing factors.

As with any patient who presents for substance use disorder treatment, it is important to work with that person as an individual. Just because a patient self-identifies as a member, or is assumed to be a member of the LGBT population, it does not automatically mean that the individual was abused or that the addiction is a result of their sexuality. It is important to work with each person to assess their individual contributing factors. For some it may include religious turmoil, societal/cultural implications, internalized homophobia, family discord and/or a long history of family addictive behaviors.

Physical differences in the processing of drugs/alcohol between men and women remain in effect. There are also those differences of behavior patterns between heterosexual women and lesbians, between gay and non-gay men and those within the bisexual and transgender communities in comparison to those with the general community.

Another concern is the sexual identity of individuals within the transgender community. For many, there is a desire to enter into a long-term heterosexual relationship with an individual of the sex opposite that of the transgendered sex. Coping skills that do not include substances may need to be identified, taught and practiced.

Research now suggests that the age of sexual identity may be as young as ten or eleven with the self recognition of being gay or lesbian occurring by the age of fifteen or sixteen (D'Augelli A. & Herschberger, 1993). Information on this process for bisexuals and transgenders is minimal. Issues surrounding sexual identity formation, added to the developmental tasks of the adolescent, may create increased turmoil for some. When working with this population, it is important to address not only the addiction, it is also critical to explore the timing of *coming out* to the family. Such disclosure may result in the child being not only excluded from the family system, and possibly denied financial support for things such as higher education.

Several issues and areas of concern have been presented in this article. The impact of each separate issue, as well as collectively, creates a complicated clinical picture for the therapeutic team working with the substance using LGBT individual. It is important for those working with this population to be knowledgeable not only of treatment options but also resources and supportive groups/organizations locally available. In this way, the patient is provided with a complete continuum of care that includes treatment, relapse prevention, and recovery.

LGBT Substance Use Disorder Resources

The National Association of Lesbian and Gay Addiction Professionals: Serving the LGBT Communities Since 1979
NALGAP
901 North Washington Street, Suite 600
Alexandria, VA 22314
703-465-0539
nalgap.org

Healthy People 2010
Companion Document for LGBT Health
Chapter 26 - Substance Abuse &
Chapter 27 - Tobacco Use
Full document available for download at
glma.org and nalgap.org

A Provider's Introduction to Substance Abuse Treatment for LGBT Individuals
Center for Substance Abuse Treatment
DHHS Publication No. (SMA) 01-3498
NCADI Publication No. BKD392

Counseling LGBT Substance Abusers:
Dual Identities
Dana G. Finnegan, PhD, CAC &
Emily B. McNally, PhD, CAC
Haworth Press, Inc. 2002

Addictions in the Gay and Lesbian Community
Jeffrey R. Guss, MD & Jack Drescher, MD (Eds.)
Haworth Medical Press 2000

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Questions & Answers

1. Are there issues/problems a transsexual person encounters when in treatment?

The experience of transsexuals in pre-surgery status within inpatient setting ranges from policies of non-acceptance to acceptance with various conditions. These conditions may involve either separate living quarters and bathrooms or separate rooms with access to generic bathrooms marked for both men and women. Pre-surgery status in outpatient settings also ranges from non-acceptance to acceptance under certain guidelines such as which bathroom these individuals may use. At post-surgery, the person is the reassigned sex and is to be treated as such for both in and outpatient settings. In many situations it may not be known that a person is post-surgical, so this will not be an issue. Education for all staff, including administration and peers is important.

2. When does one raise the question of the patient's sexual identity if it appears to be a clinical issue?

The importance of the therapeutic relation cannot be over emphasized. Trust is a major factor along with environment—including physical, emotional, and structural. If offered as a clinical issue, then it may be relevant for the therapist to raise the issue. Asking non-threatening questions may open this process. If the patient remains closed and the topic clearly is a clinical concern, more direct questions, and statements may be posed.

3. Should one reveal one's own sexual identity?

If one is working in a facility already identified as LGBT, this may not be an issue except for non-LGBT staff. Non-identified facilities may have several concerns such as: safety for the staff person; acceptance by facility administration versus acceptance by facility peers; the purpose of revealing; the social lifestyle of the staff person; the size of the LGBT community; and the impact of this information being revealed.

4. Lately I have been hearing some television programs about intersexed persons. Who are they? I also see LGBT, GLBT and both often followed by a question mark. What is the Queer community?

Former literature referred to intersexed persons as hermaphrodites. These are people born with ambiguous or not clearly differentiated genitalia. Traditionally, these people have been assigned (socially, psychologically or, sometimes, surgically) to the female or male sex by the medical profession on the basis of their physical attributes and raised according to the gender role of the designated sex.

As this article relates to *LGBT*, the reference is to persons who are lesbian, gay, bisexual, and transgender. Some communities simply reverse the lesbian and gay. The question mark is an attempt to be more inclusive of youth and young adults who may be questioning their sexuality and not sure what label feels most comfortable. Sexual orientation is on a fluid continuum and therefore one can have many labels over time. *Queer* often refers to those who are not heterosexual or to those who refuse to be boxed in by restrictive gender and sexual orientation definitions. It was originally a demeaning term, now reclaimed by many as a power term, especially by younger LGBTs.

5. How concerned should we be with HIV antibody testing and counseling of our population?

Research supports sexual activity and substance use as strong HIV risk-related behaviors. The Centers for Disease Control and Prevention has established a goal of reducing the number of new HIV infections in the United States 50% by 2005. New infections can only come from those already infected. It becomes critical for persons to know their HIV infection status so that they can receive secondary prevention efforts to modify risk-related behaviors as well as have access to appropriate treatment when indicated. Therefore, patients in drug and alcohol treatment are prime subjects for HIV antibody testing and counseling.

National Alcohol & Drug Addiction Recovery Month

September 2003 marks the 14th annual *National Alcohol and Drug Addiction Recovery Month*. The month is set aside to highlight the strides made in substance abuse treatment, and to educate the public that addiction is a chronic, but treatable, public health problem that affects us all. This year's theme, "Join the Voices for Recovery: Celebrating Health," encourages everyone to help incorporate community treatment and recovery services as an integral part of the public health system.

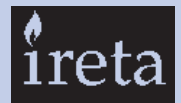
National Alcohol and Drug Addiction Recovery Month celebrates the tremendous strides taken by individuals who have undergone successful treatment, families in recovery, and those in the treatment field who have dedicated their lives to helping people recover. "Join the Voices for Recovery: Celebrating Health," invites all segments of society to join the recovery community in improving the quality of treatment programs and coordinated services in an effort to eradicate the disease of addiction.

For more information: www.recoverymonth.gov or call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCAD) at 1-800-729-6686 or 301-468-2600 or 1-800-487-4889 (TDD); or contact the NeATTC at 1-866-246-5344 or www.neattc.org.

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SUBSTANCE USE DISORDER AND LGBT COMMUNITIES

POST-TEST

You are eligible to receive two (2) Continuing Education (CE) credits by completing this quiz based on this issue of Resource Links. **INSTRUCTIONS:** Select correct answer to each of the following questions and return the completed test and application form (on back) with a check for \$20 to The Institute for Research, Education and Training in Addictions.

PLEASE CIRCLE THE CORRECT ANSWER

1. Researchers rarely collect information on individuals that do not conform to societal perceptions of male and female.
A. TRUE B. FALSE
2. Human sexuality is a changeable condition that allows a person to shift their position on the continuum of sexual/affectional orientation during the course of their lifetime.
A. TRUE B. FALSE
3. The therapist, who is extremely knowledgeable in addictions, can treat the addicted LGBT population regardless of their limited knowledge of specific concerns/issues of this group.
A. TRUE B. FALSE
4. The "coming-out process" is very individualized and motivated by the complete environment and the time period which the LGBT person lives.
A. TRUE B. FALSE
5. When a therapist is treating an addicted client from the LGBT population, it is not necessary to determine what stage, if any, of the coming-out process that the patient is in.
A. TRUE B. FALSE

PLEASE CIRCLE THE CORRECT ANSWER

6. The best treatment plan can be formulated once the patient's comfort level with their identity has been determined.
A. TRUE B. FALSE
7. Most members of the LGBT population have been abused and their addiction is the result of their sexuality.
A. TRUE B. FALSE
8. Conclusions from previous and recent research suggest that gay men appear to be less likely than heterosexuals to abstain from alcohol consumption.
A. TRUE B. FALSE
9. Conclusions from previous and recent research suggest that lesbians do not appear to be at higher risk for heavy drinking and possibly drinking related problems, than heterosexual women.
A. TRUE B. FALSE
10. Which of the following apply to possible traumatic experiences of the LGBT population:
A. Family
B. Community
C. Religious ostracism
D. Minimal protection for housing
E. Unacceptance in certain support groups
F. All of the above



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www.neattcc.org contains a variety of resources for the addiction treatment professional. Within the site you will find...

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NeATTCC Resource Disc: the first of a series of discs developed to aide in the dissemination of evidence based practices.

TRAINING
A list of relevant trainings within the NeATTCC target region

LINKS
A page of links to substance abuse resources.

INFO SEARCH
The NeATTCC provides information services to New Jersey, New York and Pennsylvania.



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and Retention

October 1 - 3, 2003

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— REGISTRATION FORM — SUBSTANCE USE DISORDER AND LGBT COMMUNITIES

NAME AND DEGREE AS YOU WISH THEM TO APPEAR ON YOUR CERTIFICATE (PLEASE PRINT):

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I confirm that I personally have completed the above test, and I am submitting it for evaluation and certification

SIGNATURE: _____ DATE COMPLETED: _____

Evaluation: Overall, this issue of Substance Abuse and Coexisting Disabilities (circle appropriate response)

PROVIDED INFORMATIVE UPDATES	5	4	3	2	1	WAS NOT INFORMATIVE
EXPANDED MY KNOWLEDGE	5	4	3	2	1	DID NOT EXPAND MY KNOWLEDGE
PROVIDED USEFUL RESOURCES	5	4	3	2	1	DID NOT PROVIDE USEFUL RESOURCES
WAS APPROPRIATE FOR MY TRAINING LEVEL	5	4	3	2	1	WAS NOT APPROPRIATE

