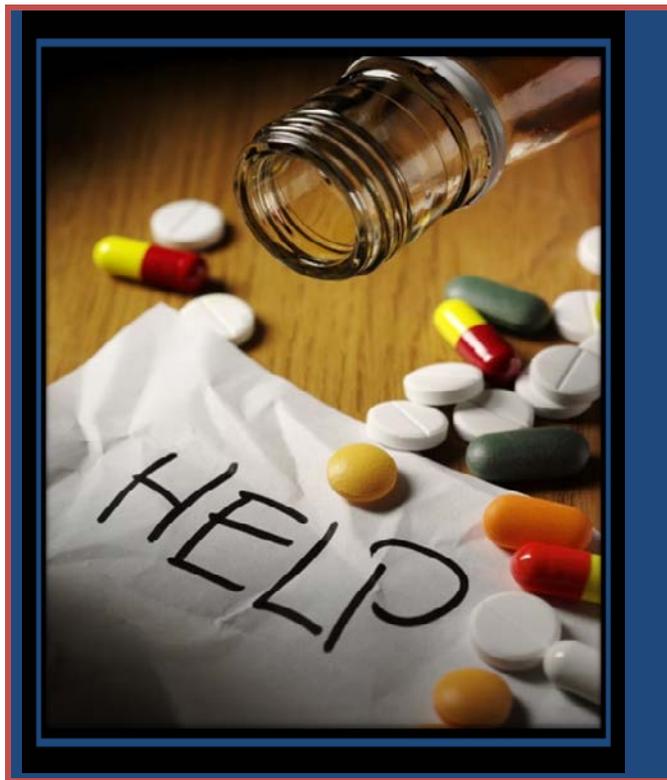




Department of
**Mental Health &
Substance Abuse Services**



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Substance Use Best Practice Tool Guide

APPENDIX D: Sexual Minority Populations

Division of Clinical Leadership in Collaboration with the
Division of Substance Abuse Services

Sexual Minority Populations

It is not surprising that individuals classified as sexual minorities have substance use issues. Sexual minorities face stigma, prejudice, heteronormativity, rejection, and internalized homophobia on a continuous basis (Dentato, 2012). Moreover, the mere fact that an individual falls into the sexual minority category also appears to place the individual at elevated risk of substance use problems and addictions (Hartney, 2014).

Sexual minorities comprise groups of people whose sexual characteristics, sexual orientation, or gender identity differ from the presumed majority of the population. Basically the term is used to describe individuals with a sexual orientation that is not exclusively heterosexual (Hartney, 2014; Math & Seshadri, 2013; Telingator & Woyewodzic, 2011). Lesbians, gays, bisexuals, and transgenders can be subsumed under the sexual minority category. Most often, however, individuals in these four groups are referenced as LGBT (SAMHSA/CSAT, 2012). Sexual minorities who are younger in age, especially those under the age of 18, may instead be referenced as LGBTQ. The “Q” represents the questioning phase of adolescents around their gender identity and/or sexual orientation (DHHS/OAH, 2015).

We do not have an accurate count of persons that identify as sexual minorities. The stigma and other negativity around the issue prevent many sexual minorities from opening up about their identity. The Kinsey Report, based on data collected by the Institute, estimates that 10 percent of the male population and five to six percent of the female identify as preferring same-sex relationships. The Report uses sexual behavior, as reported on a survey, to construct these estimates. Sexual behavior is a continuum that is rated on a scale from zero to six. Higher values are represented of more same-sex behavior. The majority of the Kinsey survey participants reported behavior in the bisexual range. For minority racial and/or ethnic populations, in particular, it appears to be a more acceptable to report bisexual behaviors versus homosexual behaviors. Estimates for transgender persons are substantially more difficult to establish. Nevertheless, projections hover around one percent (SAMHSA/CSAT, 2012).

Like their non-LGBT counterparts, members of sexual minority groups experiment with substances, including alcohol. However, the literature indicates their level of use may be exceptionally high, especially when compared to the general population. Sexual minorities experience undue stigma and tension as part of their marginalized community (SAMHSA/CSAT, 2012). If they seek help and/or care, they typically encounter culturally incompetent health care (i.e., behavioral and physical health) services that add to the rage, resentment, and devaluing thoughts and feelings that serve to fuel substance use (Hunt, 2012). Issues with health care providers additionally lead to considerable distrust by persons identifying as sexual minorities, hence reducing the likelihood that treatment will be sought (Bauer & Wayne, 2005). As youth, they are under pressure to conform so “coming out” can be particularly difficult, even traumatic. Young people who identify as LGBT or LGBTQ may be subject to greater exploitation and/or sexual abuse related to their low self-esteem and insecurity. Families and/or friends may not be kind to these youth if they “come out”. Consequently, they may become targets of physical and verbal abuse and may even run away from home and find themselves trying to make it on the streets. As the youth get older and move into young adulthood or simply get tired of the “in-house” rejection, their social lives may commonly revolve around bars or other settings that promote substance use (SAMHSA/CSAT, 2012).

Sexual minorities, especially gay and transgender populations, are disproportionately represented in substance use where percentages range from 20 to 30 percent compared to nine percent for the general population (Hunt, 2012; Redding, 2014). They even smoke cigarettes at higher rates than

Sexual Minority Populations

the general population. Fallin, Goodin, Lee, & Bennett (2015) studied the smoking characteristics of individuals identified as LGBT. They found that women identifying as bisexual had the highest proportion of current smokers, followed by lesbians, then heterosexual women. The same pattern was found for men. When initiation age was examined, women identifying as bisexual started at the youngest age, followed by lesbians, and finally heterosexual women at the oldest age. Females that identified as bisexual were most likely to report illicit substance use, compared to their heterosexual counterparts. For males, gays were older when they smoked their first cigarette than their heterosexual peers (SAMHSA/CSAT, 2012). About 25 percent of sexual minorities use/misuse alcohol compared to between five and 10 percent of the general population (Hunt, 2012). Certain substances also appear to be more popular in the sexual minority community (SAMHSA/CSAT, 2012).

A study by Woody and colleagues found men who acknowledged as gay 21 times more likely to use nitrite inhalants than their non-gay peers. These men were four to seven times more likely to use sedatives, stimulants, tranquilizers, and hallucinogens than their non-gay counterparts. Weekly use of marijuana, cocaine, and stimulants was two times more likely and weekly use of inhalant nitrites 33 times more likely for men identifying as gay versus the non-gay peers. Another study by Cochran and her research partners observed higher rates of alcohol use for lesbians than for heterosexual women. Compared to heterosexual women, lesbians were four times more likely to get intoxicated every week, five times more likely to use alcohol every day, and two times more likely to have used alcohol in the past month (SAMHSA/CSAT, 2012). More frequent heavy drinking also has been reported for women identifying as bisexual and lesbian versus heterosexual women, especially for the 20-34 year-old age group (Green & Feinstein, 2012).

In particular, women identifying as LBT (i.e., lesbian, bisexual, and transgender) appear to have elevated stress that contributes to their use of alcohol and other substances. Some programs have conducted focus groups with these women and found the term 'stress' was used an inordinate number of times. Of further note is the fact that the mention occurred in the context of school, family, peer relationships, housing, and/or in association with being a woman identifying as LBT. Use of the term 'stress' was entirely unsolicited (Stevens, 2012).

Not surprising, issues that contribute to substance use in sexual minorities seem to be amplified for persons who identify as transgender (Stevens, 2012). Methamphetamine use has increased dramatically among transgender individuals, specifically male-to-female. Its use is still prevalent among men who identify as gay and some groups of lesbians as well. Methamphetamine use has become an integral part of sexual activities for a certain segment of men identifying as gay, especially in a number of urban communities. In addition, urban studies have shown that men identifying as bisexual and gay and also use speed, either alone or in combination with other substances, tend to have much higher seroprevalence rates than other men. Included in the other men are those identifying as gay and bisexual who do not use speed and/or its combination, as well as heterosexual men who inject drugs. Those who inject drugs are a very stigmatized and hidden group and many times includes individuals who identify as LGBT. Unfortunately, public health efforts primarily target heterosexual men that inject heroin and hence miss the mark for the untargeted users. Party drugs such as methylenedioxymethamphetamine (MDMA), 'Special K', and gamma hydroxybutyrate (GHB) have further become increasingly popular at celebrations like raves and circuit parties and at dances aimed at individuals subsumed under the sexual minority heading (Green & Feinstein, 2012; SAMHSA/CSAT, 2012).

Stresses youth identifying as LGBTQ encounter put them at greater risk for numerous behavioral health issues, including substance use and depression (CDC, 2014). A study examining the relationship between neighborhood factors and illicit substance use among youth that were sexual

Sexual Minority Populations

minorities found significantly greater prevalence of marijuana use for these young people in neighborhoods with a higher prevalence of LGBT assault hate crimes. The relationships were not observed in their heterosexual peers. Moreover, the results were specific to LGBT assault hate crimes. There was no link to the neighborhood's overall crime rate (Duncan, Hatzenbuehler, & Johnson, 2014).

A study by Kecojevic et al. (2012) explored initiation of prescription drug misuse for LGBT and heterosexual high-risk young adults (ages 16-25). Participants came from two major cities in the United States: New York and Los Angeles. Prescription drugs included stimulants, opioids, and tranquilizers. Results showed that for young adults that identified as LGBT: 1) the age of first prescription was associated with initiation; 2) there was earlier initiation of tranquilizers and prescription opioids; 3) there were more reports of childhood abuse; and 4) there was earlier misuse of tranquilizers for those experiencing emotional abuse.

Treatment

Providers should understand that sexual minorities do not know the reaction they will get if and when they mention their sexual orientation. Many times, these individuals have been the target of threats and nearly one fourth have reported physical attacks because of their sexual orientation. As a result, staff may not be aware that they are treating individuals that identify as a sexual minority. Furthermore, substance use treatment programs may not be aware that they have staff members who identify as a sexual minority and who could be a great resource for treating clients who have so identified (SAMHSA/CSAT, 2012).

Treatment providers would do well to consider the children, family of origin, partner, and/or family of choice when providing care. Issues of concern for persons who identify as sexual minority as they grow older might be the human immunodeficiency virus- (HIV-) losses they have experienced, not having children, and/or being isolated from their family of origin. Moreover, providers need to remember that persons who identify as a sexual minority live and work in all segments of society just as individuals that are not part of that population. Some live in rural communities and others come from urban areas. Hence, providers of substance use

treatment services must understand the struggles of persons who identify as sexual minorities and create a safe and supportive treatment space (SAMHSA/CSAT, 2012).

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In general, successful substance use treatment programs that treat the LGBT community will be particularly sensitive about maintaining confidentiality. Such information can be safeguarded by:

- Educating staff and clients about regulations affecting persons in their jurisdiction who identify as a sexual minority.
- Encouraging clients to conduct legal inventory of their parental, marital, and employment statuses. Also assess the steps they might take to protect themselves and their rights.

Sexual Minority Populations

- Cautioning clients to think carefully about how to self-disclose, how that information will be received, and whether their privacy will be respected before disclosing their sexual orientation to others.
- Respecting the confidentiality of clients and establishing a written policy that ensures that information about sexual orientation is confidential. Policy and procedures should be in place to ensure that such information will not be communicated to any persons outside the program without their consent (SAMHSA/CSAT, 2012).

Counselors and therapists with clients who identify as sexual minorities contend that traditional approaches work but the provider must be culturally sensitive in delivering them. Therefore, the gay affirmative practice (GAP) approach has been highly recommended to facilitate delivery of services that incorporate cultural sensitivity. This approach offers guidelines for beliefs and behaviors, primarily for social work practice, in working with this population (Redding, 2014). The six guiding principles of the GAP model are:

1. Accept identification as gay, lesbian, or bisexual as a positive outcome of the helping process.
2. Become knowledgeable about different theories around the coming-out process.
3. Believe that homophobia in the client and society is the problem as opposed to sexual orientation.
4. Deal with one's own biases around heterosexual and homophobia.
5. Do not assume that a client is heterosexual.
6. Work with clients to reduce internalized homophobia that they may be experiencing so they can achieve a positive identity (Redding, 2014).

Specialized substance use treatment programs that only serve persons who identify as sexual minorities have been shown to effectively serve the population. However, such programs are scarce and unavailable in a majority of communities. Some researchers, however, argue that the substance use treatment needs of persons who identify as a sexual minority should be met in a mixed setting. Of course, other experts support the need for both types of programs. There are a multiple ways to effectively and efficiently serve this population (Stevens, 2012).

Primary care physicians may be the most common service provider for persons that identify as a sexual minority, even for substance use treatment. Thus, it is imperative that medical students, medical doctors, and other health care professionals receive specific training around how to work successfully with this population. Assessment should be non-judgmental and include sexual orientation. The initial assessment should be thorough, collecting information around all experiences, positive and negative. During assessment and treatment, every reasonable effort should be made to refrain from making assumptions about social norms and health risks associated with identifying someone as a sexual minority. For example, staff should not make the assumption that “Sally” does not have HIV because she has identified as a lesbian. Women identifying as lesbian, particularly if they are also bisexual, have often engaged in risky intimate behaviors with at-risk men. Additionally, women identified as lesbian tend to report using drugs involving needle use to a greater extent than heterosexual women (Stevens, 2012).

Language is another critical aspect of treatment for people who identify as a sexual minority. Stereotypic language and jokes about the any segment of the population should not be used. Communication with the client should involve asking which pronoun that he or she prefers to go by as well as encouraging other clients to use the pronoun of choice. It is further possible that the counselor may need to develop his or her own materials for use with the client. Many treatment

Not all persons who identify as a sexual minority will disclose such information (SAMHSA/CSAT, 2012).

workbooks use heterosexual examples, which can turn off clients who have identified as a sexual minority (Stevens, 2012).

Let us be clear: Not all persons who identify as a sexual minority will disclose such information. However, they must be able to say “I am who I am, and I accept myself as myself” (p.64) (SAMHSA/CSAT, 2012). For some clients who identify as a sexual minority, having a counselor who can accept and validate his or her attractions, experiences, feelings, and identities will play an important role in helping the client move toward sobriety. Other clients may need more help. For the latter clients, counselors can assess the stage of coming out and understand the needs and risks of the client at that stage, using Cass’ or a similar identity stage model. The most effective identity-stage models resemble Prochaska, Norcross, and DiClemente’s stages-of-change model (SAMHSA/CSAT, 2012).

Youth who identify as a sexual minority have issues similar to those of adults. Moreover, people are no more tolerant of adolescents as with adults. In fact, they may even be less tolerant. Many youth identifying as a sexual minority live in hostile environments and must try as best they can to create or locate positive environments. For many, substance use is their plan of escape (SAMHSA/CSAT, 2012).

College campuses sometimes provide the same unwholesome environment for people who identify as a sexual minority as the larger society. These students experience incivility, e.g., rudeness and a lack of dignity and respect, and hostility on campus. They also feel unsafe, with many being harassed and subjected to violence. Similarly, the college campus is a place where sexual minorities witness incivility and hostility toward their peers in general. Results from a study by Woodford, Krentzman, & Gattis (2012) showed that experience or perception of incivility increased the odds of any drinking by 39 percent and of problematic drug use by 58 percent. Helping students who identify as sexual minorities develop effective coping mechanisms when faced with campus-based mistreatment will be critical.

Working with Clients Who Identify as Lesbian.

Regardless how much (or little) the counselor knows about persons that identify as lesbian, he or she must be caring. Furthermore, the counselor should be informed and sensitive. Start with what is known about women and take the time and make the effort to understand the special problems of individuals that identify as lesbians. Treatment suggestions include:

- Empowering the client.
- Honoring diversity.
- Using nonjudgmental language.

- Avoiding labeling.
- Support and exploring, but not confronting the client.
- Respecting the client's position, whatever that may be (I'm a lesbian and proud of it!; I'm confused; I'm not a lesbian!).
- Respecting the unwillingness of some individuals who identify as lesbians to attend Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). They may consider these programs "male" institutions with no room for them as women and especially as persons who identify as lesbian. Such meetings may also be resisted because of the emphasis on powerlessness, which they feel emphasizes their status as victims (SAMHSA/CSAT, 2012).

Working with Clients Who Identify as Gay.

Similar to counselors working with people who identify as lesbians, the counselor working with men who identify as gay must be caring, sensitive, and informed. In particular, the counselor likely needs to deal with the client's denial. Used as a defense mechanism, denial appears to be particularly strong with amphetamine use/misuse. Many men who identify as gay use 'speed' intravenously and do not think they have a problem with substance use. The counselor will need to point out the current and possible effects of such use, e.g., loss of time at work or health problems (SAMHSA/CSAT, 2012).

Even for men who report that they have come out and are very comfortable being gay, the client may not have addressed the internalized homophobia they picked up from growing up in a homophobic society. The counselor will need to discuss self-acceptance with the client and any shame and/or doubt that he may be dealing with (SAMHSA/CSAT, 2012).

Counselors further have to work with the client in exploring other social avenues and/or developing new skills to avoid alcohol and substance use in the current environment. The counselor will have to address the possibility of the client's making new friends. Encouraging safer sex practices and providing or referring him to information regarding such practices and their benefits should also be part of the intervention (SAMHSA/CSAT, 2012).

Working with Clients Who Identify as Bisexual.

Recovery from substance use and addiction for these individuals will be facilitated by counselors who are empathetic and nonjudgmental and support their clients in:

- Recovery from substance use and addiction for these individuals will be facilitated by counselors who are empathetic and nonjudgmental and support their clients in:
- Becoming more self-accepting.
- Healing from the shame cause by internalized biphobia and heterosexism

- Referring them to either gay/lesbian or straight 12-step fellowships, or both, depending on what is more appropriate to their recovery needs (SAMHSA/CSAT, 2012).

Working with Clients Who Identify as Transgender.

Persons who identify as transgender share many of the issues that led to substance use/misuse by those who identify as lesbian, gay, and/or bisexual. However, violence and discrimination may be more pronounced for these clients (SAMHSA/CSAT, 2012). Researchers Lombardi, Wilchins, Priesing, & Malouf (2001) found that 60 percent experienced some form of violence and/or harassment sometime during their lives and 37 percent experienced some form of economic discrimination.

Hence, there are a multitude of issues that must be addressed when working with clients who identify as transgender, including what to call the individual. Every effort should be made to prevent staff from making transphobic comments or putting these clients at risk for sexual or physical abuse or harassment. A provider's introduction guide to LGBT provides critical do's and don'ts (SAMHSA/CSAT, 2012)

Other Resources

A multitude of clinician resources can be obtained from the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. The Web site can be accessed from <http://www.algbtic.org/>. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a practitioner's resource guide to engage and help families and caregivers to support their children who have identified as a sexual minority (Redding, 2014). This resource can be downloaded or ordered from <http://store.samhsa.gov/shin/content//PEP14-LGBTKIDS/PEP14-LGBTKIDS.pdf>.

Conclusion

While recommendations and resources for treating persons who identify as sexual minorities exist, the extent to which treatment facilities implement these approaches remains questionable at best. The literature indicates that a number of substance use treatment counselors do not feel that their training has been adequate for them to work successfully with persons that identify as LGBT. Fortunately many counselors report having accepting and/or neutral attitudes toward individuals that identify as lesbian and/or gay. However, their attitudes toward clients that identify as bisexual and transgender are not positive. In fact, they may be viewed as negative, close to hostile. Counselor training will be essential in helping them better understand and provide the appropriate treatment needs for their clients that identify as sexual minorities. Such training will allow the counselors to examine their own biases as well (Stevens, 2012).

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Sexual Minority Populations

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