CHAPTER 1 AN INTRODUCTION TO LGBT SUBSTANCE USE DISORDERS

CHAPTER SUMMARY

This chapter examines the evolution of LGBT substance use studies. It also examines the barriers that LGBT people encounter when seeking treatment.

OVERVIEW

Until 1973, the goal for those seeking treatment for homosexuality was to decrease the intensity and frequency of homosexual thoughts, feelings, and behaviors while simultaneously increasing heterosexual thoughts, feelings, and behaviors. The removal of homosexuality from the *DSM* that year led to efforts to promote the physical and mental health of gay men and lesbians, including an understanding of the impact of substance use by these populations. Early studies found very high rates of substance use. Later methodological improvements cast doubt on the conclusions of early studies but still found elevated rates of substance use. Later studies came to the same conclusion for bisexual and transgender individuals.

Treatment is also problematic. While the majority of individuals with a substance use problem do not seek professional help, LGBT individuals' reluctance to seek treatment often stems from a confluence of prejudicial treatment from health-care staff and a lack of knowledgeable providers.

KEY TERMS

DSM (*Diagnostic and Statistical Manual of Mental Disorders*); SAMHSA (Substance Use and Mental Health Services Administration); drug use prevalence; elevated rates of substance use; methodological limitations; treatment availability; barriers to treatment

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CASE STUDY

Patrice has "hit bottom," a term used by many in recovery to acknowledge that their life is out of control as a result of substance use. Even though Patrice's alcohol use has cost her most of her friends, her family, and a romantic partner, she had managed to hold on to her job. However, she got fired this morning.

Patrice begins to explore substance abuse treatment options for lesbians. An Internet search finds a handful of specialized facilities, but all are out of state, do not accept her insurance (which will end soon owing to the loss of her job), or are far too costly. She begins to search for local facilities but is concerned about their experience working with sexual minorities. How can she determine whether a facility has experience working with lesbians? To simply call and ask would not necessarily lead to truthful answers. She also questions the meaning of "specialized LGBT treatment." Is there a treatment protocol developed for lesbians? Is it the same protocol used for gay men, bisexuals, and transgender people? How is this treatment different from that for heterosexuals?

"I have too many questions," she says to herself in exasperation. "I don't even know where to begin."

For most of the twentieth century, research on lesbians and gay men focused on a limited number of topics. Homosexuality was classified as a mental illness, and until its removal from the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 1973, much of the research on homosexuality emphasized "curing" or treating same-sex desire and attraction. Other research sought to identify the prevalence of gay men and lesbians in the general population and to elucidate the origins of same-sex desire.[1] The deletion of homosexuality from the *DSM* markedly changed the research agenda and set the stage for later studies of bisexual and transgender individuals. At the time, the former barely registered in the research agenda, and the latter was a topic for sensationalistic news stories while research concentrated primarily on sexual reassignment surgery.

One of the earliest research topics after homosexuality was no longer classified as a mental disorder was alcohol use by gay men and lesbians, an area of exploration that would eventually expand to encompass all forms of substance use.

THE HISTORY OF LGBT SUBSTANCE USE STUDIES

The removal of homosexuality from the *DSM* was a watershed moment in LGBT history. Seemingly overnight, same-sex attraction and same-sex sexual behavior, which had been considered mental-health concerns warranting intensive (and often invasive) treatment efforts aimed at curing homosexuality, no longer necessitated such interventions. Until 1973, the goal for those seeking treatment for homosexuality was to decrease the intensity and frequency of homosexual thoughts, feelings, and behaviors while simultaneously increasing heterosexual thoughts, feelings, and behaviors. Many techniques and interventions were used. For example, psychoanalysis was a common treatment for those who could afford the often costly intervention, which purported to disentangle childhood traumas and parental interactions leading to same-sex attraction. For those with fewer financial resources, there were aversive therapies and other attempts at counterconditioning, including electric shocks or the ingestion of a nausea-inducing drug prior to observing arousing pornography. Desperate gay men, lesbians, and those attracted to both men and women underwent psychosurgeries and hormonal treatments theoretically designed to masculinize gay men or feminize lesbians. Families had same-sex-attracted individuals involuntarily

committed to mental-health facilities, often for years. Celibacy was a common suggestion after other treatments inevitably failed.

According to Grey and colleagues, the removal of homosexuality from the *DSM* in tandem with the growing organization of gay men and lesbian women led to a remarkable growth in supportive treatment efforts that had until then been carried out primarily on the periphery and were unsanctioned by the general treatment community. Priorities that would have been unthinkable a few years earlier became the norm, including:

- Efforts to promote the mental health of gay men and lesbians
- Efforts to assist individuals to successfully work through a coming-out process
- The creation of gay-affirmative therapies assisting men and women to thrive in an inhospitable and unsupportive culture
- Efforts to assist gay men and lesbians to recognize, process, and overcome their internalized homophobia[2]

Research into the substance use behaviors and patterns of LGBT individuals also began in the mid-1970s, and investigations of the alcohol use patterns of gay men and lesbians were the first forays into what was then a highly controversial field. Studies of substance use among bisexual and transgender populations would not be conducted in earnest for another two decades, a point hammered home in a 2002 synthesis of the research, which, at that point, could find very few studies on which to base meaningful conclusions regarding those groups.[3]

Early studies painted discouraging pictures of gay and lesbian demographics, concluding that one-third of gay men and two-thirds of lesbians engaged in problem drinking.[4] A decade later, during the HIV epidemic in the United States in the late twentieth century, unprecedented collaboration among researchers, frontline clinicians, academic centers, and public health centers led to the first large-scale surveys of LGBT individuals. These surveys included questions about substance use, as it had been determined that such use played a significant role in the transmission of the disease, either directly or indirectly. These surveys, too, found elevated rates of substance use in LGBT populations.[5] Conclusions were summarized in the groundbreaking 2001 document *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*, released by the Substance Abuse and

Mental Health Services Administration (SAMHSA). This was the first federal document on LGBT substance use, and it reviewed studies (including those few examining bisexual men and women and transgender individuals) from the 1970s through the 1990s. It concluded that "LGBT people are more likely to use alcohol and drugs, have higher rates of substance abuse, are less likely to abstain from use, and are more likely to continue heavy drinking into later life."[6]

However, even prior to the release of SAMHSA's *Provider's Introduction*, some researchers were already reevaluating earlier studies, calling attention to flaws in the methodology, and questioning the conclusions.[7] For example, an oft-cited early study was Lohrenz and colleagues' 1978 examination of alcohol use by gay men in four urban areas in Kansas, in which they concluded that one-third of the men surveyed were alcoholics.[8] Early in the study the researchers acknowledged that the subjects were not a representative sample; their methodology consisted of distributing to "leaders" in the homosexual communities a letter of introduction, a multiple-choice questionnaire, a consent form, and a return envelope, and those individuals then disseminated the materials to other gay men; gay men's organizations; and men in gay bars or at a university-based gay dance. Obviously the subjects who responded did not represent the overall gay male population of the United States, but the survey results were generalized as such.

In her 2009 review of the research, Sandra Anderson reported that early research overestimated the prevalence of LGBT substance abuse, owing to several biases in the research methods used.[9] For example, samples were small and subjects were often recruited in bars, measurements of substance abuse were not standardized, and sexuality was not consistently defined. In addition to such methodological biases, Hughes and Eliason have pointed out other problems with early studies:

- Reliance on self-reports
- Reliance on white, middle-class samples
- An inability to access individuals who were not open about their gender or sexual nonconformity
- Limited funding for research on these populations[10]

Although some studies sampled bisexual populations, they were not well represented. Even in studies that claimed to represent bisexuality, bisexuals typically made up no more than 10 percent of respondents.[11]

Finally, the few studies that examined the transgender population's substance use patterns were based primarily on convenience samples (particularly, transgender female sex workers) and could not be generalized to the entire population.[12]

RECURRENT METHODOLOGICAL PROBLEMS

A 2013 study, "Research Funded by the National Institutes of Health on the Health of Lesbian, Gay, Bisexual, and Transgender Populations," reviewed abstracts of NIH-funded research from 1989 through 2011.[13] The study found that only 0.5 percent of 127,000 abstracts made any mention of LGBT populations. Furthermore, of 628 studies that focused on LGBT concerns, the vast majority focused on sexual health: 79.1 percent of LGBT-related projects focused on HIV/AIDS, and 30.9 percent focused on illicit drug use and 12.9 on alcohol use.[14] Healthcare services, homophobia, violence, homelessness, tobacco use, and obesity were each addressed in fewer than twenty-five studies. Other findings on early studies:

- 86.1 percent focused on sexual-minority men
- 14 percent examined lesbian health issues
- 6.8 percent studied transgender populations
- 10 percent mentioned LGBT youth health issues
- Fewer than 1 percent mentioned LGBT elder health issues

The dearth of LGBT research is reiterated in a 348-page report titled *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, released by the Institute of Medicine (IOM) in 2011.[15] The report examines the myriad physical and mental-health needs of LGBT people, including needs related to substance abuse. Bradley Jacklin, policy manager at the National Gay and Lesbian Task Force, commented: "This [report] is historic. This is the first time the federal government has laid out a blueprint of the health challenges facing the LGBT community."[16] The IOM report was an eye-opening surprise for many. According to a member of the committee supervising the IOM report, "No matter what we looked at, there was a paucity of research in the available literature."[17] The committee found a number of problems:

- Research tended to rely on convenience samples.
- Most of the research focused on adults, not youth.
- Most study participants lived in large cities. ("We don't know what it's like to be LGBT and live in rural Illinois or the suburbs. There was no literature out there for us to pull from."[18])
- Most of the research focused on lesbians and gay men, and comparatively little on bisexual and transgender individuals.
- Much of the research was based on white individuals, and people of color were underepresented.

One of recurrent challenges in research studies is defining *lesbian, gay*, and *bisexual*. Studies primarily define sexual orientation based on attraction, behavior, or identity.[19] Is a woman a lesbian if she has a strong attraction to other women but is married to a man and has never engaged in same-sex sexual activity? Is a man who has sex with other men but considers himself "straight" really gay? Does simply labeling oneself a lesbian or gay man make one so? Researchers must consider questions like these in their study design, and until recently, studies typically included just one of these components of sexual orientation.

McCabe and colleagues have repeatedly called for studies of substance use to include all dimensions of sexuality (attraction, behavior, and self-identification), and as an apt example, their 2009 study found that prevalence rates for substance use in the past year and substance dependence varied among sexual minorities across the three dimensions of sexual orientation.[20] For example, 13.3 percent of women who identified as lesbian, 5.1 percent who reported attraction only to women, and 4.0 percent who had only female sex partners met criteria for alcohol dependence in the past year. Additionally, women attracted only to females had greater odds than those attracted only to males of heavy drinking, marijuana use, and marijuana dependence. However, women whose lifetime sex partners were exclusively female did not differ from women whose lifetime sexual partners were male.[21]

The word *queer* has become more widely accepted among younger generations of LGBT individuals. As an example, in its 2009 *Safe Space Kit*, a resource that helps educators to create safe spaces in school, the Gay, Lesbian, and Straight Education Network (GLSEN) offered definitions of the most common terms that teachers and other school staff are likely to encounter. It defined *queer* as "an umbrella term used to describe a sexual orientation, gender identity, or gender expression that does not

conform to heteronormative society."[22] However, older generations have not always embraced the term, mostly because it had pejorative connotations in the not-too-distant past.

In summary: Much research in the field has made use of convenience samples only and focused on epidemiological studies of the prevalence of substance use or analyses of those entering treatment for a substance use problem. Research has tended to focus on easily accessible LGBT individuals, typically those who are publicly out and living in large urban areas, or gay and lesbian college students, who are often mandated to participate in a study as part of their psychology courses.

RECENT STUDIES OF LGBT SUBSTANCE USE

With the aforementioned methodological issues in mind, the following is a snapshot of recent studies of LGBT substance use. Fortunately, methodology became more rigorous in many later studies, meta-analyses of existing studies have now been done, and several large-scale national probability surveys have included questions about substance use and sexual or gender orientation, thus offering us a better understanding of substance use by LGBT individuals. Also, Internet-based surveys are beginning to overcome historical obstacles. Reisner, Greytak, Parsons, and Ybarra, for example, used data from the Teen Health and Technology Study, a national survey of 5,542 adolescents ages thirteen to eighteen, and found that transgender youth were more likely to have used alcohol, cigarettes, marijuana, or nonmarijuana illicit drugs at any time in the preceding twelve months than cisgender youth (i.e., those whose gender identity aligns with what they were assigned at birth).[23]

Lesbians and Gay Men

One of the first studies surveying a national sample was published in 2000. It used data from the 1996 National Household Survey on Drug Abuse, a federal health survey monitoring substance use in the U.S. population, to determine alcohol use patterns for lesbians and gay men. In 1996 the survey had asked about the gender of participants' most recent sexual partner. The analysis of the results determined that "homosexually active women" reported using alcohol more frequently and in greater amounts than other women; they also experienced more alcohol-related morbidity.[24] A follow-up study in 2004

used the same data set to examine nonmedical drug use. The study concluded the following:

- There were consistent patterns of elevated lifetime drug use for those who reported having a same-sex partner during the past twelve months.
- Men reporting a same-sex partner during the past year were more likely to report use of marijuana, cocaine, and heroin, and women with a same-sex partner during the past year were more likely to report use of marijuana and analgesics.
- Both homosexually active men and homosexually active women were more likely than exclusively heterosexually active respondents to report at least one symptom indicating dysfunctional drug use across all drug classes, and to meet criteria for marijuana dependence syndrome.[25]

A 2001 study examined data from a survey sent to a sample of random women enrolled in an HMO. Women who identified as lesbian or bisexual were compared with women who identified as heterosexual. The study found that women between the ages of twenty and thirty-four who identified as lesbian or bisexual were less likely to abstain from alcohol, and they also reported more frequent heavy drinking.[26]

A 2005 study used a national representative sample to assess alcohol use according to measures of self-reported sexual behavior and sexual orientation. Results indicated few differences between heterosexual and sexual-minority men; however, exclusively heterosexual women were more likely to abstain from alcohol than lesbians, bisexual women, and heterosexual women with same-sex partners. Lesbian and bisexual women were also more likely to report alcohol-related problems.[27]

Cigarette smoking is also problematic. A 2013 examination of LGBT health disparities in New York City determined that almost half (49 percent) of white LGB youth smoked, compared with just 17.1 percent of their heterosexual counterparts. While heterosexual black and Latino/Latina youth were less likely to smoke overall than white youth, black and Latino/Latina LGB youth were nearly three times as likely to smoke as their heterosexual counterparts of the same race or ethnicity.[28] Similarly, a 2013 study by the New York State Department of Health found that the smoking rates of lesbian and gay New York adults were 40 percent higher than those of heterosexual adults.[29]

College Students

As stated earlier, college students are often used in research. A notable 2005 study by McCabe and colleagues used a comprehensive definition of sexual orientation (identity, attraction, and behavior) in a large random sample of undergraduate students. Their study revealed that men attracted only to men were more likely to report past-month marijuana use than men attracted only to women. Additionally, women who identified as mostly heterosexual or bisexual, or who were attracted to or had sex with both men and women, reported greater substance use than those who reported only heterosexual identity and opposite-sex attraction/behavior.[30] Ford and Jasinski analyzed data from the 1999 College Alcohol Survey, a nationally representative sample of U.S. college students, and found no significant difference in illicit substance use between homosexually experienced and exclusively heterosexual individuals.[31] A 2007 follow-up study examining binge drinking found gay men were less likely to engage in binge drinking or to endorse norms supportive of binge drinking in comparison with straight men. There was no significant difference between lesbians and heterosexual women.[32] A 2014 study used existing data from the American College Association–National College Health Assessment (a national survey of college students' health habits, behaviors, and perceptions) and determined that alcohol, tobacco, and other drug use was more prevalent among LGB college students than among their heterosexual peers.[33]

Bisexuals

As stated earlier, the research rarely separates bisexuals from gay men and lesbians, and much more research is needed on the bisexual population. The few relevant studies include a 2010 project that used data from the Behavioral Risk Factor Surveillance System in Washington State, which examined health disparities between lesbians and bisexual women. Compared with lesbians, bisexual women were more likely to be current smokers and acute drinkers, and bisexual women showed significantly higher rates of poor general health and frequent mental distress.[34] A 2013 report concluded that smoking rates for bisexual adults were 70 percent higher than those of heterosexual adults.[35] Also, a 2014 study using data from the American College Association–National College Health Assessment study found that bisexual college

students had the highest rates of substance use.[36] In general, studies have found that bisexual individuals are more likely to report alcohol, nicotine, and drug use than heterosexuals, gay men, and lesbians.[37]

Transgender People

With regard to transgender people, some research points to a high prevalence of substance use, particularly for transgender women. The 2001 Los Angeles Transgender Health Study found that 8 percent of the participants had injected drugs for the purpose of getting high in the previous six months. Many study participants reported noninjection drug use in the previous six months, with the most frequently used substances being alcohol (77 percent), marijuana (39 percent), "crystal" methamphetamine (28 percent), powder cocaine (25 percent), crack (15 percent), amyl nitrate or "poppers" (10 percent), and ecstasy (7 percent).[38] The Virginia Transgender Health Initiative Study, which was conducted between 2005 and 2006, found "strikingly high" rates of tobacco use among its 387 participants; almost one-fourth of those surveyed reported a past or current alcohol problem.[39] While a survey of New York state adults found that the prevalence of smoking for transgender adults was less than that for LGB individuals, one of largest surveys, the 2011 National Transgender Discrimination Survey (based on a national sample of 6,450 transgender and gender-nonconforming individuals), found much higher rates of substance use (including nicotine use) for transgender persons in comparison with the general population.[40] Finally, a 2014 study of 230 transgender women living in the metropolitan New York area found the prevalence of substance use was very high; more than 75 percent of participants reported using alcohol or some other substance, and one-third indicated polysubstance use.[41]

Meta-analyses

Meta-analyses of existing studies also find elevated rates of LGBT substance use. Several notable examples include a 2008 meta-analysis of LGB adolescent substance use. It determined that the odds of substance use for LGB youth were, on average, 190 percent higher than for heterosexual youth and substantially higher within some subpopulations of LGB youth (340 percent higher for bisexual youth, 400 percent higher for females).[42] Another 2008 meta-analysis included studies on LGB

mental-health conditions and concluded that the risk for alcohol and other substance dependence over the preceding twelve months was 1.5 times higher than it was for heterosexuals, and that lesbians and bisexual women were particularly at risk of substance dependence.[43] A 2007 meta-analysis examined HIV disparities among black and white men who have sex with other men (MSM) and found black MSM reported less overall substance use.[44] A 2012 review of research found that lesbians and bisexual women were at greater risk for alcohol and drug-use disorders, and gay and bisexual men were at greater risk for illicit drug use.[45]

The IOM's 2011 report *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* concluded the following:[46]

- LGB adults might have higher rates of smoking, alcohol use, and substance use than heterosexual adults.
- Rates of smoking, alcohol consumption, and substance use may be higher among LGB youth than heterosexual youth.
- At the time of publication, there was very limited research on trans individuals, and what research there was indicated that substance use was a concern for this population. Fortunately, there has been a marked shift in research priorities regarding the trans population since the release of the IOM report, particularly regarding trans youth, and substance use prevalence and patterns among trans people are becoming clearer.

In summary: Recent studies and meta-analyses find that, in comparison with heterosexuals and gender-conforming individuals, LGBT individuals demonstrate elevated rates of substance use disorders, but also that those rates are substantially lower than the rates reported in earlier studies.[47] Finally, there is variability in patterns of substance use by sexual orientation, gender, age, and race/ethnicity.

TREATMENT AVAILABILITY

The much-heralded 2012 report *Addiction Medicine: Closing the Gap between Science and Practice*, published by the National Center on Addiction and Substance Abuse at Columbia University (CASA), sought to explain why addiction and substance abuse, which CASA called "this nation's largest preventable and most costly health problems," continue to remain undertreated in an era of runaway health-care costs.[48] It concluded that

15.9 percent of the U.S. population ages twelve and older—40.3 million people—met diagnostic criteria for addiction (excluding nicotine) and 31.7 percent of the population (80.4 million), while not addicted, engages in risky use of addictive substances in ways that threaten health and safety. Still, almost nine out of ten people (89.1 percent) who meet diagnostic criteria for addiction involving alcohol and drugs other than nicotine report receiving no treatment at all.[49] Why does such a chasm exist between those who need treatment and those who receive it? The CASA study identified ten obstacles or barriers confronting individuals who seek substance abuse treatment, or impeding their successful completion of treatment (table 1.1). Rarely does an individual encounter only one barrier.[50]

TABLE 1.1 MOST COMMON OBSTACLES TO SUBSTANCE ABUSE TREATMENT

Misunderstanding of the disease
Negative public attitudes and behaviors toward people with addiction
Privacy concerns
Cost
Lack of information about how to get help
Limited availability of services
Insufficient social support
Conflicting time commitments
Negative perceptions of the treatment process
Legal barriers

Source: National Center on Addiction and Substance Abuse (CASA) at Columbia University, *Addiction Medicine: Closing the Gap between Science and Practice* (New York: CASA, 2010).

CASA made it clear that its list was not exhaustive and that additional barriers to treatment exist. Research and surveys inform us that LGBT physical and behavioral-health treatment is often fraught with such obstacles, and they often lead LGBT individuals to refrain from or delay seeking help for an addiction problem.

LACK OF LGBT AFFIRMATIVE TREATMENT OPTIONS

A 2013 study by McCabe and colleagues based on a large national sample determined that the odds of substance use treatment utilization for sexual-minority women and men tended to be greater than for heterosexual women and men. Still, the study authors determined that many sexual-minority members who need substance use treatment do not receive it, and, for those who do, the quality of the treatment may be inadequate.[51]

In another study, using a sample of 305 former clients of substance abuse treatment programs, of whom 120 were LGB, Senreich asked participants about their perceptions of treatment. More than half, 57 percent, noted that being a sexual minority had a negative impact on their treatment experience. Four themes emerged: (1) treatment clients experienced homophobia from heterosexual clients, (2) they found it difficult to be honest and open about gay/bisexual issues, (3) they felt vulnerable and unsafe, and (4) they felt alienated and not understood. Several participants also reported feeling unsupported by staff. Finally, gay and bisexual respondents were significantly less likely to have completed treatment, and they were more likely to have left treatment because their needs were not being met.[52]

While research on the experiences of LGB individuals in substance-abuse treatment is inarguably limited, it is almost nonexistent for transgender individuals. Senreich completed one such study in 2011, based on his interviews with eleven transgender individuals and their experiences in treatment. The majority expressed negativity about their treatment experience. Themes included unsafe treatment milieus, unwelcoming staff, and disrespectful treatment by other clients.[53] A 2015 study found responses coalesced around similar themes, and also described incidents of discrimination, rejection, lack of support, and denial of services. Some study participants reported feeling as if their presence was a disturbance to others in treatment.[54] Experiences such as these

have led to calls for transgender-specific treatment programs, similar to Hicks's advocacy of LGB-specific substance use treatment programs.[55]

How available are LGBT-specific or, at the least, LGBT-sensitive programs? In 2007 researchers made telephone contact with 854 substance abuse treatment agencies that promoted themselves as offerning specialized programs for LGBT people. Each facility was presented with the same question: "Hi, I am calling because your agency is listed in the SAMHSA directory as one that provides special programs or groups for gays and lesbians, and I am interested specifically in what those programs are. Could you tell me more about them?"[56] Here are the results:

- Although all 854 agencies had indicated that they provided LGBT-specific services, at the time of the phone contact, 605 (71 percent) acknowledged that no specialized program existed.
- Sixteen of the agencies (2 percent) reported that they had offered those services in the past but no longer did so.
- Seventy-nine programs (9 percent) described themselves as "non-discriminating" (sample response: "We offer the same thing we offer straight people . . . we don't discriminate") and thirty-four programs (4 percent) described themselves as "accepting" (sample response: "We don't have special services for gays and lesbians, we just allow them in our groups").
- Only sixty-two agencies (7 percent) indicated that they offered specialized LGBT programs, and almost half of those agencies were in New York or California.[57]

How could it be that as recently as 2007 only sixty-two substance abuse treatment centers offered services for LGBT populations? And why did many other providers make their ambivalence toward LGBT populations so clear? SAMHSA's 2013 National Survey of Substance Abuse Treatment Services reiterated the dearth of LGBT-specific programming; it found that only 12 percent of treatment facilities had specialized programming for LGBT individuals.[58]

Fortunately, a 2012 review of research published since 1996 on sexual-minority substance abuse found limited evidence in support of the need for LGB-specific treatment. Current approaches, such as contingency management, cognitive behavioral therapy, and motivational interviewing, work just as well with LGB individuals as they do with heterosexuals. The review authors posit, instead, that current protocols already recommend individualized treatment, which will necessarily address LGB-specific needs. However, they highlighted the need

for cultural competence by service providers.[59] The clinical need for transgender-specific treatment programs and facilities is still uncertain.

Finally, it must be acknowledged that there is no prototypical "gay" health-care experience; race, class, age, and gender play pivotal roles in access to services, quality of treatment, and outcomes. The multiple and intersecting identities that make up every LGBT person must also be considered. Consider Lambda Legal's Healthcare Survey, which found that a higher proportion of LGBT respondents who were people of color and/or low income reported receiving discriminatory and substandard care.[60] An African American gay man who has a high school education and lives in a rural setting will confront challenges to accessing behavioral-health care that are very unlike those encountered by an affluent, professional white lesbian living in an urban area.

CASA delineated several "special populations" that may intersect with an LGBT identity, including individuals with co-occurring disorders, pregnant and parenting women (a third of lesbians are parents), adolescents, older adults, the homeless, veterans and active-duty personnel, rural populations, Native Americans, and those involved in the criminal justice system.[61] When one or more of these identity markers is combined with an LGBT identity, the list of challenges to seeking help for an addiction problem may be further complicated. A 2014 study by Bostwick and colleagues supports this idea. Using a national sample of self-identified LGB individuals, the researchers found that nearly two-thirds of those in the sample reported at least one experience of discrimination in the past year based on sexual orientation, race, ethnicity, or gender. Also, higher numbers of discrimination types were generally associated with a higher probability of reporting a past-year mental-health disorder. While discrimination based on sexual orientation alone was not associated with higher odds of a mental-health disorder, respondents who reported both sexual orientation and racial or ethnic discrimination, *or* sexual orientation, racial or ethnic, and gender discrimination, were significantly more likely to meet criteria for a mental-health disorder.[62]

CONCLUSIONS

Research on LGBT substance use has progressed markedly from its earliest days, when researchers simply handed gay men and lesbians questionnaires about their substance use habits as they entered or exited

a bar or club. And while early estimates of substance use within these demographic groups were inflated owing to a myriad of methodological problems, more recent research has made it clear that LGBT populations do indeed have elevated rates of substance use compared with the heterosexual and gender-conforming populations; an ever-growing number of meta-analyses, research reviews, and national surveys all attest to this conclusion. They have also determined that age, gender, and ethnicity have an impact on use patterns.

Treatment availability remains an issue. Few specialized programs exist, and LGBT individuals often find themselves placed in treatment facilities with staff and other clients who are unknowledgeable about their needs or, even worse, possibly antipathetic, unwelcoming, or ambivalent about their presence. This treatment atmosphere only compounds a plethora of non-LGBT-specific obstacles to treatment initiation and completion.

- The APA's removal of homosexuality from the *DSM* in 1973, along with the growing numbers of organizations for lesbians and gay men at the local and national levels, led to a remarkable growth in supportive and affirmative treatment efforts. Nonetheless, much work remains to be done in this area.
- Research into the substance use behaviors and patterns of LGBT individuals began in the mid-1970s, and those early studies found alarmingly high rates of drug and alcohol use. Many of the studies were flawed owing to methodological issues.
- Several common research problems have been recurrent, including the challenges in defining *lesbian, gay*, and *bisexual*, and researchers' reliance on easily accessible LGBT individuals.
- Methodology in later studies became more rigorous, meta-analyses of existing studies have been carried out, and several large-scale national probability surveys have included questions about substance abuse and sexual or gender orientation. These changes offer the opportunity to gain a better understanding of substance use by LGBT individuals. More-current research indicates that LGBT individuals have elevated rates of substance use in comparison to the general public. Still, there is variability in the patterns of substance use according to sexual orientation, gender, age, and race/ethnicity.
- LGBT individuals face barriers to entering treatment and challenges while in a treatment setting—particularly, prejudicial and discriminatory treatment from staff and peers.
- There is a paucity of LGBT-specific substance use treatment programs.

DISCUSSION QUESTIONS

1. What are some of the recurrent challenges of conducting research with LGBT populations? What additional challenges occur when researching LGBT substance use in particular?
2. How have LGBT counseling approaches changed since homosexuality's removal from the *DSM* as a mental-health diagnosis?
3. Only a minority of individuals with a substance use disorder access treatment. What are some of the reasons for this, and how does LGBT status further compound already existing obstacles?
4. How do intersecting identities affect treatment for a substance use disorder?
5. Only a few publicly funded treatment facilities are prepared and willing to work with LGBT individuals. Why do you think this is the case?
6. How would you determine if a treatment facility or provider is competent to work with LGBT substance abusers? What questions could you ask at intake that would indicate whether a provider is a good match for an LGBT client?

NOTES

NOTES TO CHAPTER 1

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