



Minority Stress Considerations in Substance Use Treatment for LGBTQ People

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Session Outline

- The Unequal Impact of SUDs on LGBTQ populations
- Minority Stress Theory
- Four Studies applying Minority Stress Theory
- Implications for Clinical Approaches and Public Policy
 - Public Policy/Advocacy
 - Addressing Community Needs
 - Individual Needs in Treatment
- Case Studies – Treatment Planning



Terminology

General Categories

- Sex
- Gender/Gender Role
- Sexual Orientation
- Gender Identity

Other relevant terms:

- Cisgender
- Non-binary, gender fluid

Descriptions

- Lesbian
- Gay
- Bisexual
- Queer
- Female
- Feminine
- Transgender
- Heterosexual
- Male
- Masculine



Unequal Impact of SUDs

- SAMHSA's National Survey on Drug Use and Health
 - 2015 results include information on sexual minorities for the first time
 - Sample size: 68,073 total
 - 51,118 surveys from adults 18+





Sexual Minorities

- 94% identify as sexual majority
- 4.3% identify as sexual minority
- 1.7% unknown

Table 1. Sexual Orientation Questions in the 2015 National Survey on Drug Use and Health

Sexual Attraction¹	Sexual Identity
<p><i>People are different in their sexual attraction to other people. Which statement best describes your feelings?</i></p> <ul style="list-style-type: none">- I am only attracted to males- I am mostly attracted to males- I am equally attracted to males and females- I am mostly attracted to females- I am only attracted to females- I am not sure	<p><i>Which one of the following do you consider yourself to be?</i></p> <ul style="list-style-type: none">- Heterosexual, that is, straight- (If female respondent) Lesbian or Gay- (If male respondent) Gay- Bisexual

¹ The table shows the response options for the sexual attraction question for female respondents. For male respondents, the response options were presented in reverse order (i.e., from "I am only attracted to females" to "I am only attracted to males"), except for "I am not sure."



LGB demographics

- Approximately 3000 completed interviews from 18+ adults who self-identified as sexual minority (4.3%)
- Tend to be younger (18-25)
- 1.8% identify as gay or lesbian
 - 42% women, 58% men
- 2.5% identify as bisexual
 - 73% women, 27% men





General Conclusions

- Sexual minorities were:
 - more likely to have substance use and mental health issues across subgroups defined by sex and by age group
 - more likely to be current substance users
 - more likely to have substance use disorders
 - more likely to need and to receive substance use treatment
 - more likely to have mental illness and to receive mental health services



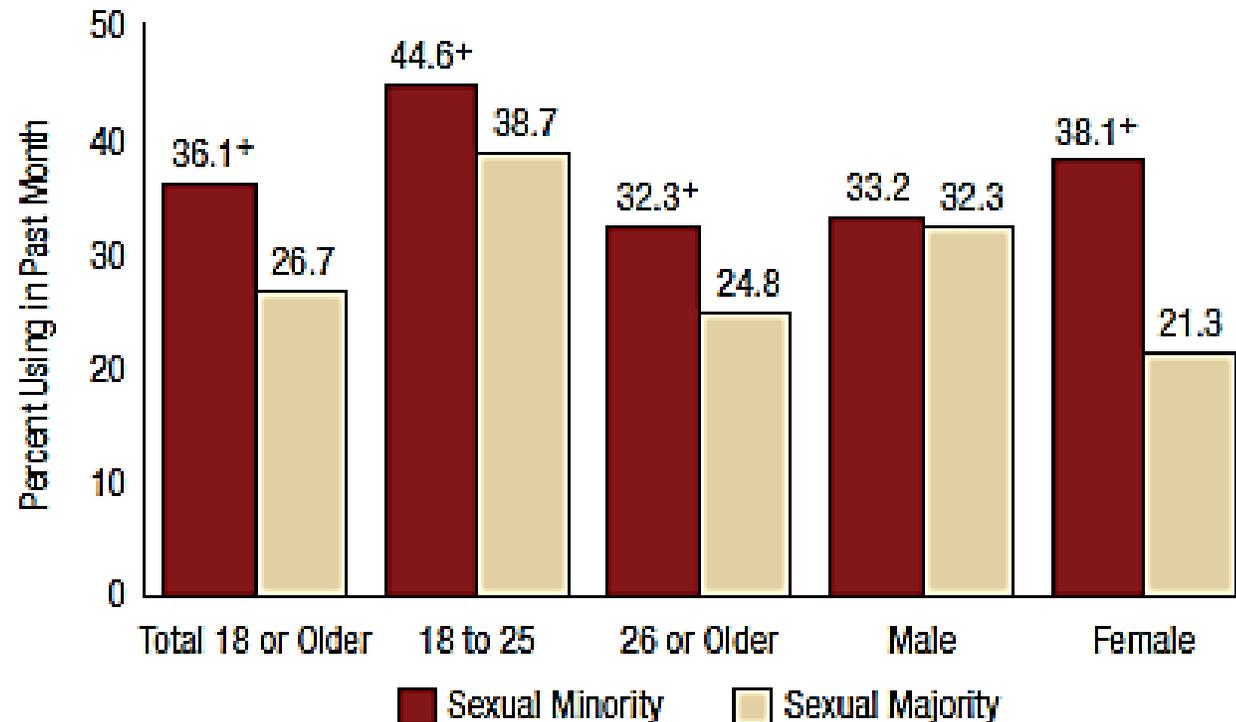
Illicit Drugs By Gender

- Sexual minority men use marijuana and prescription pain meds at about 2X the rate of sexual majority men.
 - Heroin use and misuse of Rx stimulants and sedatives were similar to sexual majority
- Sexual minority women use marijuana and prescription pain meds at 3X the rate of sexual majority women.
- Sexual minority men and women were more likely to be past year users of cocaine, hallucinogens, LSD, Ecstasy, inhalants and methamphetamines.



Past Month Binge Alcohol Use

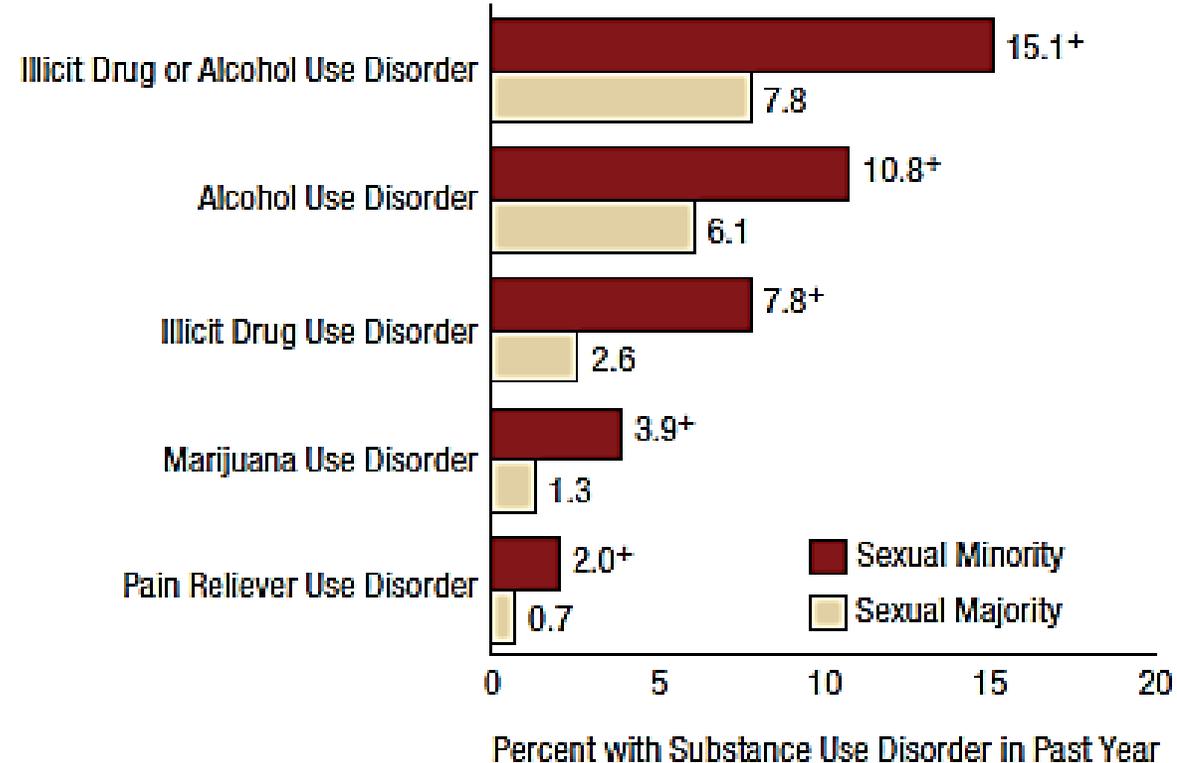
Figure 9. Past Month Binge Alcohol Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015





Substance Use Disorders

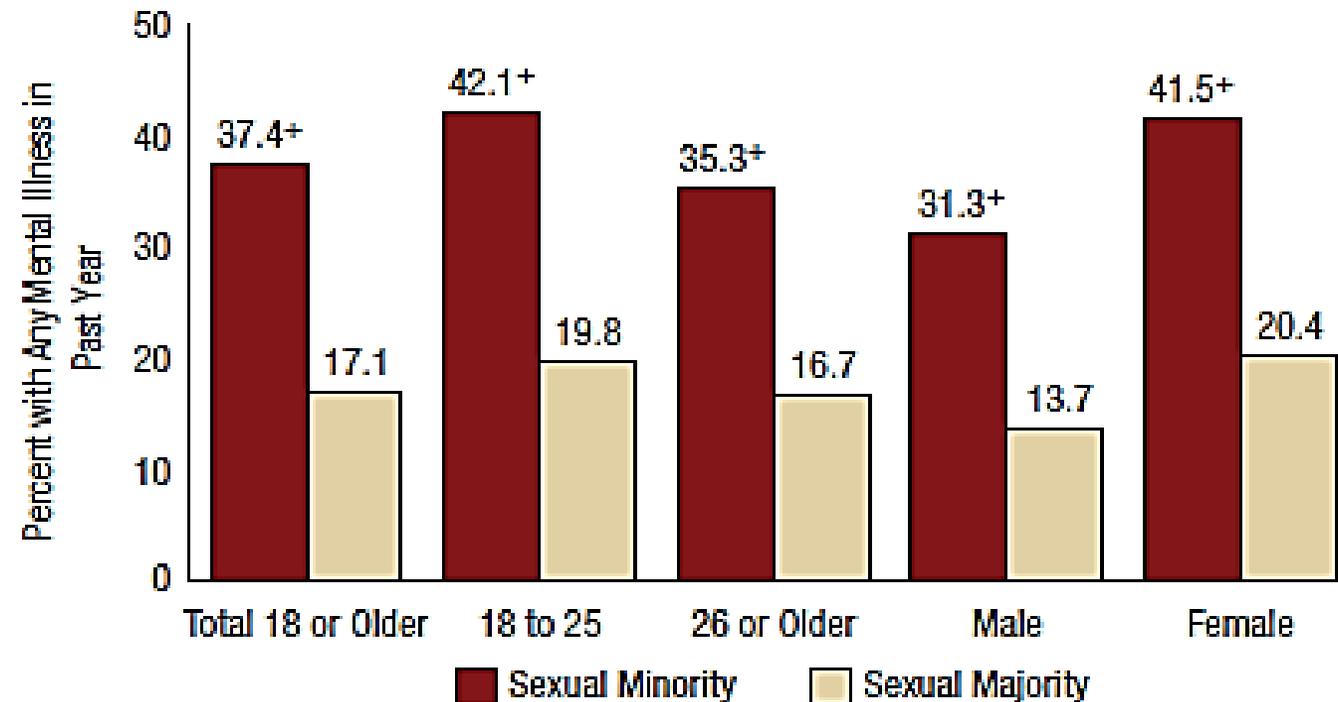
Figure 11. Substance Use Disorder in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older: Percentages, 2015





Any Mental Illness in Past Year

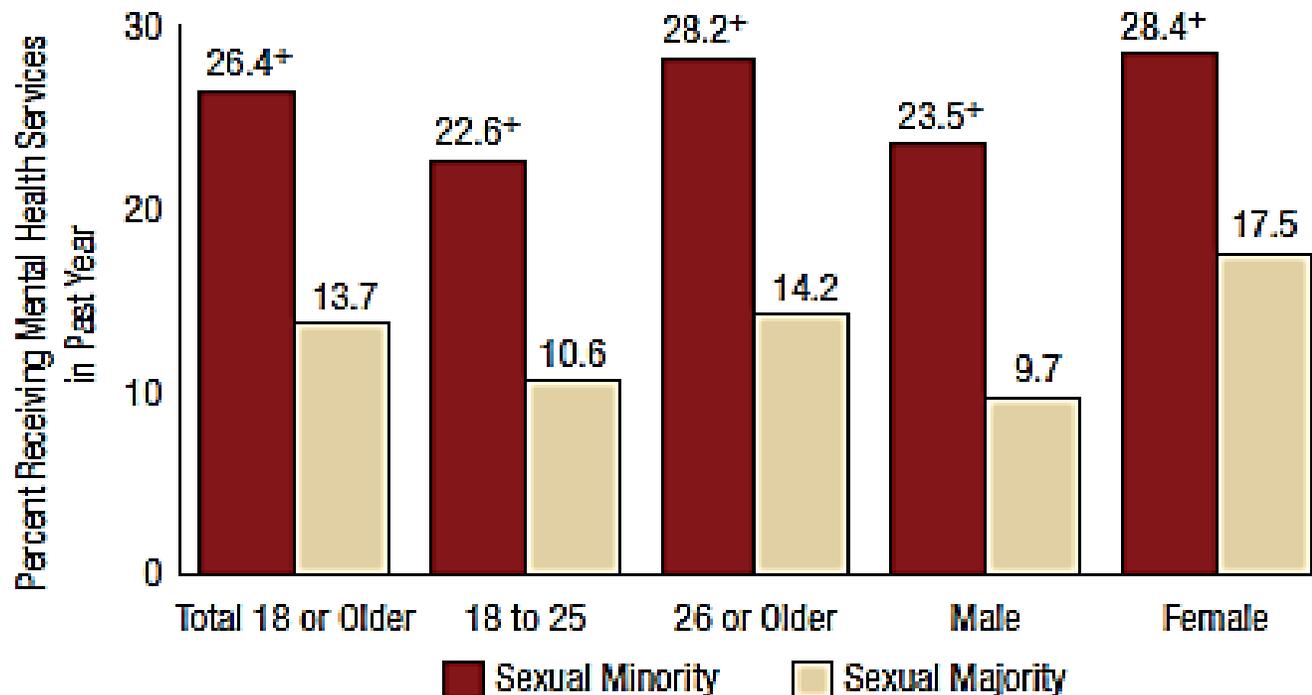
Figure 13. Any Mental Illness in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015





Received Mental Health Services

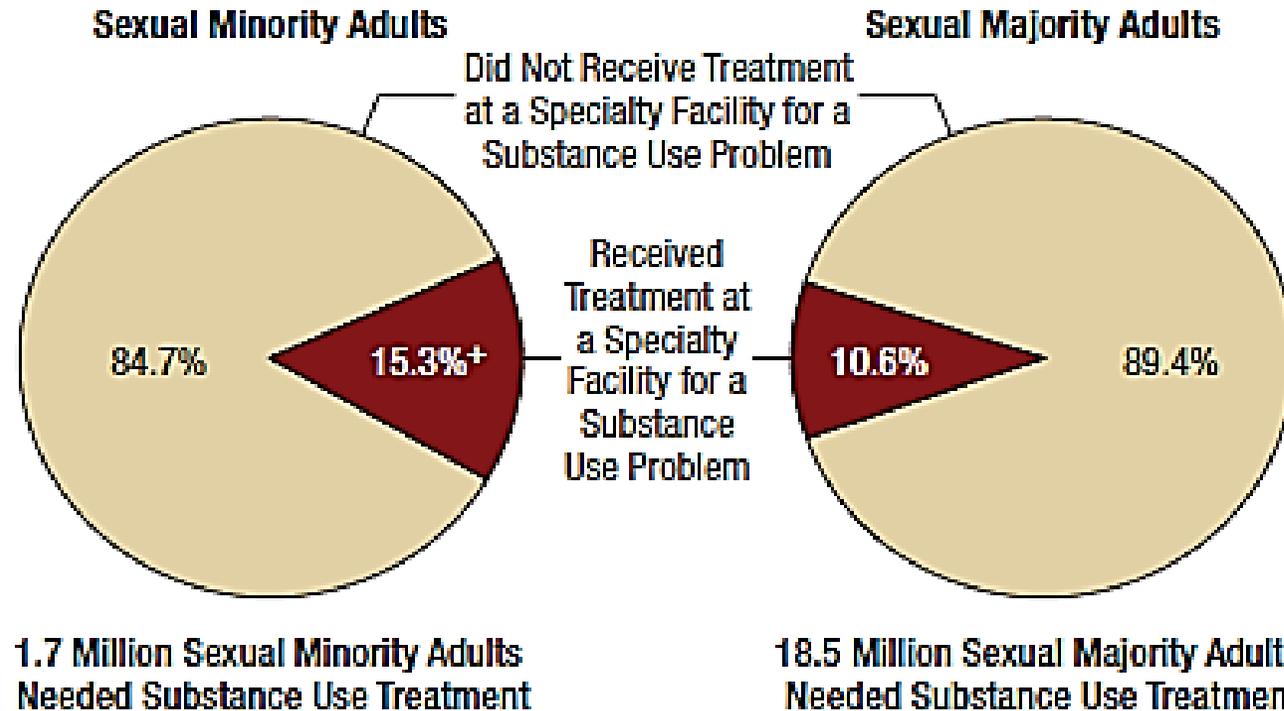
Figure 16. Received Mental Health Services in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015





Received Substance Use Treatment

Figure 12. Receipt of Specialty Treatment in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older Who Needed Substance Use Treatment: Percentages, 2015





Minority Stress Theory

- Model developed by Ilan Meyer to explain higher prevalence of mental health disorders among LGB people.
- Hypothesis:
 - Stigma, prejudice and discrimination create a stressful social environment;
 - Additional stressors are added by the expectation of stressful events and conditions and the vigilance required by this expectation;
 - Further stressors can be attributed to the internalization of negative social attitudes and resulting concerns about disclosure.
 - Coping mechanisms are inadequate to deal with these conditions.
- Stress process is further complicated for those with multiple, intersecting identities (i.e. gender/race/ability/class).



Lesbian and Bisexual Women

The Impact of Minority Stress on Mental Health and Substance Use Among Sexual Minority Women
(Lehavot and Simoni 2011)

- Significantly higher (2-3x) use of alcohol and other drugs than sexual majority women.
- Gender expression was a stress factor:
 - Greater expression of masculinity was associated with more frequent LGB victimization but less internalized homophobia and concealment.
 - Greater feminine expression was associated with greater internalized homophobia and concealment.
- There are direct links from LGB victimization and internalized homophobia to substance use.
- Dealing with multiple identities – sexism, racism, homophobia.



Gay Men

Minority Stress, Masculinity, and Social Norms Predicting Gay Men's Health Risk Behaviors
(Hamilton and Mahalik 2009)

- Higher use of all types of drugs than sexual majority men but especially hallucinogens and stimulants: ecstasy, methamphetamine, cocaine, inhalants.
- Masculinity significantly predicted riskier health behaviors; men who adopted more traditional masculine traits and roles were at higher risk for substance abuse and higher risk sexual practices.
- Perceptions of peer norms are influential in predicting individual health behaviors.



Sexual Minority Adolescents

The Application of Minority Stress Theory to Marijuana Use Among Sexual Minority Adolescents
(Goldbach et al 2015)

- Preference for marijuana over alcohol and other drugs
- Significantly higher rates of use over sexual majority teens
- Complex relationship between internalized homonegativity, community connectedness and marijuana use:
 - Coming out may bring increased violence and victimization resulting in increased distress.
 - Greater connection with larger LGBTQ community is associated with lower internalized homophobia and with increased marijuana use.
 - Internalized homonegativity is associated with greater marijuana use,



Transgender Adults

Substance Use and Treatment of Substance Use Disorders in a Community Sample of Transgender Adults
(Keuroghlian et al 2015)

- Transgender adults with recent substance use and lifetime SUD treatment are more likely to be:
 - Older
 - On the Male-to-Female spectrum
 - Access gender affirming medical care
 - Have lower incomes but higher educational levels
- They experience disproportionately high rates of:
 - Intimate partner violence
 - PTSD, depression, other mental health concerns
 - Unstable housing and engagement in sex work



Bisexual Invisibility

- Roughly half of LGBTQ+ people identify as bisexual
 - About 2/3 of sexual minority women identify as bisexual
 - About 1/3 of sexual minority men identify as bisexual
- Higher rates of illicit drug use and alcohol use than L or G populations.
- Overlooked in research
- Bisexual persons may be discriminated against/misunderstood by both sexual majority and minority people
- Subject to heterosexism and internalized bi-phobia



Time for a PSA





Public Policy, Community and Individual Needs

Implications for Policy and Treatment



Implications for Public Policy

- Civil Rights have proven health impact
 - 7% decline in teen suicide rates in states that legalized same sex marriage in years prior to nation-wide legalization.
- Economic benefit
 - Nation has 442 billion dollar SUD problem – a disproportionate share is being caused by minority stress factors
- Same sex marriage did not grant equal rights to LGBTQ people
 - Employment Non-Discrimination Act
 - Housing Opportunities Made Equal Act
 - Enforcement of anti-bias laws
 - Anti Bullying and Safe Schools programs
 - Inclusion of demographic questions about sexual identity in all data collection
 - Workplace practices



Community Considerations

- Community based activism and advocacy is needed (HIV/AIDS activism as model of effective engagement)
- Insist on
 - inclusion of sexual minorities in discussion and development of evidence based treatment modalities;
 - representation in organizations that address mental illness and SUDs
 - educating treatment providers on needs of LGBTQ clients



Addressing Minority Stress in Mainstream Treatment Settings

- How do treatment providers work with sexual minority clients to address minority stress factors:
 - Victimization
 - Discrimination
 - Internalized homonegativity
 - Concealment
 - Community norms that may support substance use
- Goals of Treatment
 - Integrate sexual identity
 - Become more self accepting
 - Heal from shame resulting from heterosexism, internalized homonegativity, and substance use



Institutional Readiness

- Institutional
 - Review of discrimination policies to insure inclusion of sexual and gender identity
 - Forms! Do they provide for self-identification, preferred names and pronouns that may not match legal ID, use of neutral terms like “Parent Name” rather than “Mother/Father.”
 - Are all staff trained/educated in anti-bias/sensitivity for a range of populations including LGBTQ+?
 - Gender neutral options for bathrooms available?
 - Visible signs of welcome and inclusion – LGBTQ+ symbols, magazines in the lobby, etc.
 - Inclusion of family – including chosen significant others – in treatment.



Individual Readiness

- Individual
 - Honest self-appraisal of knowledge and comfort level talking about LGBTQ+ relationships
 - i.e. gay men are more likely to have long term committed relationships which also permit the partners to engage in sex outside of the relationship.
 - Talking about sex and sexual practices is required – are you okay with this? Really? Be honest!
 - Your concept (standard) of a healthy relationship is irrelevant as a measure. Are you able to set it aside and focus on helping the client find congruence within themselves?
 - Don't make assumptions about identity (or anything else) – just ask!



Assessments



- Begin with a thorough understanding:
 - Natal Sex
 - Gender Identity
 - Gender Dysphoria
 - Sexual Behavior
 - Sexual Orientation
 - Internalized Homo-negativity



Assessments

- Family Relationships
- Sexual History
- Depression
- Anxiety
- Trauma History





Substance Use History

- First use of each substance
- Changes in use over time
- Use related to life events – trauma, relationships, achievements





Treatment Concerns

- Group therapy – may be difficult if heterosexism and homonegativity are present in staff or group members. Staff must insure safety by sending strong message that negativity will not be tolerated.
- Family counseling – ruptures over sexual identity may have occurred; for LGBTQ+ clients, family may not have the traditional membership.
- “Passing” is a form of survival that may have far reaching consequences in cognitive-behavioral distortions.
- Need for social supports and networks – identify resources such as LGBTQ+ 12 Step groups, sober organizations, healthcare providers who serve LGBTQ+ people, cultural resources such as Pride celebrations, etc.



Selected Treatment Issues

- Shame
- Trauma/Abuse
- Isolation – Connection - Friendships
- Health Risks especially STDs
- Sexual Activity in Recovery
- Family Relationships
- Romantic Relationships
- Religion and Spirituality





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Another PSA for you





Case Studies

- Groups of 4-5 to work as treatment team
- Review the case study you are being handed
- As a group, come up with the following:
 - ID the 3 most important issues to address in the first month of treatment and work up a brief treatment plan
 - ID 3 critical components for aftercare/discharge planning
- Have a spokesperson share these with the larger group.
 - Read case aloud
 - Report issues, treatment plan and discharge plan



Case Study #1 - Denise

- 20 year old who identifies as white cisgender female
- Inpatient treatment following hospitalization for alcohol poisoning and a suicide attempt
- Has disclosed her attraction to other women during assessment
- Has been living at home
- Says that her parents are homophobic and she is not out to them
- Has signed release for contact with parents



Case Study #2 - Vanessa

- 26 year old who identifies as white, heterosexual, female and is transgender (M to F)
- Uses alcohol and benzodiazepines
- Diagnosed with anxiety
- Has been supporting herself by sex work and wants to stop
- On hormones, breast implants, no surgery to date
- Wishes to be placed in women's group



Case Study #3 - Brad

- 45 year old who identifies as African-American gay cisgender male, in open relationship with much younger man.
- Professional, out at work
- Family is religious and disapproves of Brad's "lifestyle"
- Frequents gay clubs and uses crystal meth
- Has begun to experience health problems and relationship issues due to more frequent meth use



Case Study #4 – Michelle

- 35 year old, cisgender female who identifies as Asian, bisexual and is exploring open relationships with both men and women.
- First generation – comes from traditional Vietnamese family
- Working in family owned business
- Living with roommates who are casual users of alcohol and marijuana
- Using opioids and comes to treatment following overdose



Case Study #5 - Chris

- 25 year old self identified “gender-queer” person who is bi-racial.
- No significant romantic relationships at present
- Diagnosed with depression and anxiety
- Heavy marijuana use, some alcohol
- Living at home, not working, after finishing college
- Single mother finally has gotten fed up with Chris not doing anything and is insisting on treatment or Chris has to move out.