Introduction

Goals of the Book

Treatment of substance use disorders in lesbian, gay, bisexual, and transgender (LGBT) clients is critically important, yet underexamined, in the professional research and clinical literature. Human service professionals who work with these clients must have access to the latest research on the treatment of substance use disorders as well as current knowledge of the unique challenges of working with LGBT clients. This book aims to bring together the most up-to-date knowledge bases in both of these areas, to provide the reader with state of the art information in treating substance use disorders in LGBT clients. Substance use disorders and sexual orientation and gender identity are defined, and heterosexism, relevant diversity issues, ethical challenges, and assessment and work with LGBT clients are examined. Practice with individuals, couples, families, and small groups, as well as practice at the program level, is discussed. Case materials are derived from the independent practice of the author and from social service agencies that treat LGBT clients with substance use disorders.

Particular attention is given to evidence-based treatment models. To date, there are insufficient numbers of controlled trials demonstrating superior differential outcomes of specific interventions for LGBT clients with
substance use disorders. Given this, it is reasonable to first become familiar with treatment models that have proven effectiveness with substance use disorders in heterosexual clients and then apply, adapt, and evaluate these models in respect to LGBT clients. Effective models include motivational enhancement therapy, contingency management, the matrix model, and community reinforcement. It will be made clear throughout the book which treatment approaches have been evaluated with LGBT clients, which have shown some degree of efficacy with these clients, and which remain to be tested with them. Although this book focuses on problems, it should be recognized that the majority of LGBT individuals are well adjusted and do not suffer from substance use disorders.

Connection Between LGBT Issues and Substance Use Disorders

People who are LGBT and those with a substance use disorder often share a history of social oppression and neglect. Although there is no agreement about the exact incidence and prevalence of substance use disorders in LGBT individuals, most studies conclude that these disorders are more prevalent in this population. Gay men report more cigarette smoking than men in general and are at high risk for abuse of specific substances. A high percentage of aging LGBT people suffer from alcoholism, and lesbian and bisexual women report higher incidences of cigarette smoking and heavy drinking than their heterosexual peers. LGBT youth have higher rates of cigarette smoking and alcohol and other drug use than their heterosexual peers. Few studies currently focus on substance use disorders in bisexual or transgender individuals, but the latter group appear to have a high rate of substance abuse, including injection drug use. Specific prevalence rates will be discussed in chapter 2.

The connection between sexual orientation and substance use disorders is often mediated by internalized homo/bi/transphobia, which can result in profound feelings of shame, depression, and self-hatred. Substances can then become part of a person’s coping system. Stress resulting from lack of validation and victimization puts many LGBT individuals at risk for substance use disorders.

In addition, gay bars and dance clubs continue to be an important part of life for many, and “club drug” use is popular among many gay and bisexual men. Because of the emphasis on body image and sexual prowess
in gay male socialization, many use alcohol and other drugs to elevate their self-esteem when searching for sexual partners.

Among youth, alcohol abuse is a “gateway” to other drugs, since it can lead the user into social environments where other drugs are abused, and experimentation with alcohol and other drugs is beginning at earlier ages. LGBT youth may develop substance use problems, homelessness, and prostitution. Homeless LGBT adolescents involved in prostitution are at very high risk for substance use disorders, hepatitis C, HIV disease, and suicide.

Consequences of Substance Use Disorders

LGBT individuals experience the general consequences of substance abuse and dependence. Substance use disorders are implicated in premature deaths, health problems, employment disruptions, child abuse and neglect, domestic violence, crime, and prenatal development problems, and as a co-occurring feature of many psychiatric disorders. Causes of alcohol-related deaths include liver and pancreatic disease, cardiovascular disease, and various cancers. Gay men and lesbian and bisexual women, with their high rates of cigarette smoking, are at increased risk for cancers, lung disease, and heart disease. In addition, people who smoke are much more likely to drink, and those who are dependent on tobacco are four times more likely than the general population to be dependent on alcohol (Grant, Hasin, Chou, Stinson, and Dawson 2004). Tobacco and alcohol are particularly dangerous when used together, dramatically increasing the risk for certain cancers (Pelucchi, Gallus, Garavello, Bosetti, and La Vecchia 2006).

HIV disease is also highly prevalent among those with substance use disorders. Anal sex is the main transmission route of the HIV virus in gay and bisexual men and, since substance abuse lowers inhibitions, the risk of unsafe sex (unprotected anal intercourse) increases with use (Cabaj 1997; CDC 2007). Unsafe sex practices also increase when HIV positive gay and bisexual men use alcohol, amyl nitrate, crack cocaine, or “club drugs” (Clatts, Goldsamth, and Yi 2005; Robins, Dew, Kingsley, and Becker 1997).

Sharing drug-injection equipment is another major route of HIV transmission, also putting at risk both LGBT and “straight” individuals who have sex with injection drug users. In addition to HIV disease, the use
of shared injection equipment can result in tuberculosis, cardiovascular disease, pneumonia, and hepatitis. Turning to prostitution to support a substance use disorder results in a high incidence of sexually transmitted diseases when unsafe sex occurs (O’Connor, Esherick, and Vieten 2002).

History of Mental Illness Diagnosis of Homosexuality

Prior to the 1950s there was an entrenched view of homosexuality as a pathology, resulting in its inclusion as a sociopathic personality disturbance in the first edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-I; American Psychiatric Association 1952). During the 1950s research findings began to emerge indicating that homosexuality per se did not constitute a psychiatric disorder. For example, Evelyn Hooker (1957) found no difference between nonclinical samples of heterosexual and homosexual men on projective test responses. The 1968 edition of the DSM reclassified homosexuality as an “other non-psychotic mental disorder.” On July 17, 1969, bar patrons resisted a police raid of the Stonewall Inn in Greenwich Village in New York City, resulting in the beginning of the gay and lesbian liberation movement. A reflection of this movement was the 1973 removal of homosexuality as a diagnostic category from the DSM (DSM-III; American Psychiatric Association 1980). A diagnosis of “ego-dystonic homosexuality” was added, addressing individuals who were distressed about their homosexual orientation, but this diagnosis was dropped from the revision of the third edition (DSM-III-R; American Psychiatric Association 1987). Subsequent studies, which will be reviewed in relation to assessment issues, have attributed differences between heterosexual, homosexual, and bisexual people on a wide range of psychological variables to the effects of stress from stigmatization and victimization. All major American mental health associations have taken the position that homosexuality and bisexuality are not mental disorders.

The diagnosis of gender identity disorder (GID) remains in the current edition of the DSM (DSM-IV-TR; American Psychiatric Association 2000). This disorder has been used to pathologize children and adults whose experience of their gender is opposite to that assigned to them at birth. Bartlett, Vasey, and Bukowski (2000) argue that this diagnostic category in children as currently conceptualized should be removed from the DSM. They note that very few children continue to have GID as adolescents or
adults, and that the most likely outcome is homosexuality. In adults, this diagnosis is also controversial, but it is currently the only diagnosis that allows transgender individuals to obtain insurance reimbursement for hormone therapy or surgery. Given this rationale for the diagnosis, it is interesting that few are ever actually reimbursed for hormones or sexual reassignment surgery.

History of Diagnostic Criteria for Substance Use Disorders

When addictive behaviors began to be scientifically studied in the 1930s, people addicted to drugs were described as immoral or criminal, which resulted in judgmental and punitive interventions. Currently drug addiction is defined as “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences” (National Institute on Drug Abuse 2007:5). The most commonly used diagnostic criteria of substance use disorders, the DSM-IV-TR, uses the term dependence instead of addiction, and separates substance dependence and substance abuse. The diagnosis of substance dependence disorder requires the presence of a maladaptive pattern of substance use, resulting in distress or clinically significant impairment and involving at least three of an additional seven symptoms (all of which must occur within the same twelve-month period). The diagnosis of substance abuse is made in the absence of physical and psychological habituation. Both substance dependence and substance abuse will be discussed in detail in the chapter addressing assessment issues.

It should be noted that the DSM criteria have been criticized by those who do not adhere to the disease model of addiction for dichotomizing dependence and abuse (when they view addiction as actually occurring along a continuum), not recognizing that many problem drinkers move in and out of dependent drinking, and using substance abuse instead of the more accurate use and misuse of substances (van Wormer and Davis 2003).

Conclusions

LGBT people have high incidence and prevalence rates of substance use disorders. Stress resulting from the internalization of homo/bi/transphobia and victimization significantly increases their risk for these disorders. Drugs
can provide relief and escape from stress, eventually leading to an addictive cycle. Dependence and abuse of particular substances may put LGBT individuals at risk for serious health problems, including HIV disease resulting from unsafe sex and the sharing of dirty drug-injection equipment.

Although homosexuality has been removed from the DSM as a diagnostic category, the controversial diagnosis of gender identity disorder remains. Substance dependence is no longer viewed by most as a sin or crime, but as a chronic brain disease characterized by tolerance, withdrawal, and a pattern of compulsive use.

Beginning in 1991, the Council on Social Work Education (CSWE), the accrediting body of social work education programs, required content on sexual orientation in social work programs. The National Association of Social Workers’ (NASW) Code of Ethics (1996) clearly states that practitioners cannot discriminate against clients or refuse to provide services because of a client’s sexual orientation. In spite of this and similar statements in the ethical codes of other professions, clinical education and supervision related to LGBT issues is quite substandard in social work, psychology, and medicine (Hellman 1996; Makadon 2006; Tesar and Rovi 1998). Corliss, Shankle, and Moyer (2007) found that curricula on LGBT issues extending beyond HIV/AIDS are uncommon in most public health school programs. Social work education related to substance use disorders is also very limited or nonexistent, even though social workers encounter substance use disorders in nearly all settings. While the market demand for professionals trained in substance use disorders is increasing, this continues to be a neglected component of MSW education (McNeece 2003).

Currently CSWE has no standard on substance abuse content for MSW programs (McNeece 2003), and substance abuse education is marginal to core courses. In 2001 a NASW survey found that only 38 percent of social workers reported any formal training in substance use disorders. A 2005 study examined substance abuse content in forty of the fifty MSW programs that were top-ranked by U.S. News and World Report in 2000. It was found that 60 percent offered just one course, 36 percent offered two or more courses, and two programs did not offer any substance abuse courses (Saarela 2005). Forty-five percent mentioned LGBT populations in their substance abuse courses, and 43 percent contained content on HIV disease. No program required a course in substance abuse disorders for MSW students.
Thus, in spite of calls by many experts to increase exposure to content on LGBT issues and substance use disorders, content in these areas continues to be limited. Sexual and gender identity and substance use disorders are interrelated in complex ways. LGBT clients have unique needs, and the professionals who treat those with a substance use disorder need to have solid, empirically based knowledge in both chemical dependency and the specific issues faced by being LGBT.