BEST PRACTICES REPORT

Best Practices for Lesbian/Bisexual Women with Substance Use Disorders

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Every substance abuse treatment or prevention agency struggles with identifying evidence-based or best practices that work for the majority of the populations they serve. The reality is that many subpopulations have not been adequately studied, thus there are no evidence-based practices for those groups (Eliason, 2005). This is definitely true of sexual minority populations. The few intervention studies available have focused on gay/bisexual men, and there are currently no experimental studies that focus on lesbian or bisexual women. This paper will briefly review what we know about substance abuse patterns among lesbian and bisexual women and suggest state-of-the-art best practices.

Summary of Research on Substance Use and Abuse in Lesbian/Bi Populations

Alcohol

Several studies have identified higher rates of alcohol-related problems in sexual minority women (Bloomfield, 1993; Dibble et al., 2002; Drabble & Trocki, 2005; Hughes, 2003; Hughes, et al, 2006; McKirnan & Peterson, 1989; Skinner & Otis, 1996; Wilsnack et al. , 2008). A recent study of U.S. midlife adults reported that rates of alcohol dependency in the past year were higher for lesbians (12%) than heterosexual women (3%) (Mays & Cochran, 2001). Sexual minority young adult women may drink at comparable rates to their peers, whereas older lesbians and bisexual women may drink at higher rates. In the general population, most adults "mature out" of heavy drinking that occurs mostly in late adolescence and young adulthood. As people marry, have children, and establish their careers, they go to bars and party less often. A subset of sexual minority women who do not (or cannot) marry, do not have children, and/or live in neighborhoods or communities where bars or parties with alcohol are readily available, may continue to drink at higher rates through their midlife and older years, especially if they have found their partners and close friends through these drinking circles. Several studies have noted that lesbian/bi women report more negative consequences of drinking than heterosexual groups (Hughes & Eliason, 2002), go to bars more often, and consume more alcohol in bars and at parties than do heterosexual women (Trocki & Drabble, 2008).

Drug Use

There is also evidence of higher lifetime and current use of illicit drugs in female sexual minority populations (Drabble & Trocki, 2005; McKirnan & Peterson, 1989; Skinner & Otis, 1996). Drabble & Trocki (2005) found that lesbian and bisexual women were 5-6 times more likely than heterosexual women to report past year marijuana use. One study of lesbian and bisexual women from low income households found a lifetime rate of injection drug use at 22% compared to 3% for heterosexual women (Scheer, Parks, McFarland et al., 2003).

Potential Reasons for Higher Rates of Substance Use and Abuse

Research on LGBT people and communities is a relatively recent phenomenon, and contemporary scientific views of sexual orientation as a normal variant of development have not yet received widespread acceptance in the society at large. It was only in 1973 that "homosexuality" (an archaic term slowly being phased out of scientific studies today) was removed from the Diagnostic and Statistical Manual as a diagnosis of mental illness. The prevailing science points to the stigma of being different as the risk factor for unhealthy adjustment rather than sexual orientation per se, in similar ways that the stigma attached to race/ethnicity, class status, and sex/gender contribute to health problems and access to quality health care (Eliason et al, 2009).

Stigma contributes to substance abuse in many ways, through the mechanisms of internalized oppression (homo/bi/transphobia or minority stress), and external social stigma which can result in exclusion, discrimination, harassment, and violence. Gay bars became one of the central institutions for social support against stigma, as one of the few safe spaces where LGBT people can congregate and be themselves (Warwick et al., 2003). Smoking and drinking are the primary activities in a bar, and if one meets friends and partners in bars, they are more likely to develop social networks of smokers and drinkers. Stigma creates a great deal of stress for many lesbian and bisexual women. Some, from racial/ethnic, family, or religious backgrounds that are more negative about same-sex behaviors may use substances to overcome shame and guilt about sexual activities (Amadio, 2006). Yet others self-medicate the stress of living as sexual minority in an often hostile society. Tobacco and alcohol companies have recognized the niche market in LGBT communities and target ads to sexual minority women (Smith, Offen & Malone, 2005). Oppressed minority populations are ripe for targeted advertising, because they do not often see themselves reflected in the media. Advertising that

addresses them specifically may be validating, and thus more influential than it is for mainstream audiences.

Lesbian and bisexual women are exposed to at least two forms of stigma: sexism and homophobia, and many lesbian/bisexual women also face oppression based on their ethnicity, national origin, class status, or other differences. The more forms of oppression, the greater the risk for using substances to self-medicate the stress (Mays et al., 2002).

Current Treatment Modalities/Settings

Lesbian and bisexual women may choose from a variety of settings for treatment: 1) LGBT-Specific Services, which are tailored for the LGBT population, 2) Women-Specific Services, 3) Generic Services, and 4) other settings such as AA/NA or other social support types of programs, alternative or complementary services, mental health settings, primary health care settings, or a variety of other types of treatment options.

LGBT-Specific Services

There are a few LGBT-specific treatment programs in the United States, including several in California (for example, Alternatives in Los Angeles and Palm Springs; New Leaf Services For Our Community (San Francisco), Van Ness Recovery House (Los Angeles), and the LGBT Community Center in Los Angeles. While LGBT-Specific Services would theoretically be ideal, the vast majority of lesbian and bisexual women in need of treatment services do not have access to LGBT specific treatment, and in reality, most of the LGBT specific services serve mostly gay and bisexual men who have very different substance use patterns and issues than do lesbian and bisexual women.

Women-Specific Services

There are many more women-specific treatment agencies or programs than there are LGBT-specific services. However, women-specific services are tailored to the needs of heterosexual women and may or may not be open and welcoming for lesbian and bisexual women. While there may be similarities in treatment issues based on gender, such as experiences of childhood sexual abuse, sexism, and reproductive health concerns, lesbian/bisexual women also have to deal with homophobia and heterosexism and may face negative treatment from staff members or other clients in women-specific services, or have to figure out how to adapt programs developed for heterosexual relationships to their same-sex relationships.

Treatment of Lesbian/Bisexual Clients in Generic Treatment Programs

Most lesbian and bisexual women attend treatment programs or self-help groups that are designed for heterosexual people. In these programs, lesbian/bisexual women may face the same prejudices and discrimination from staff and other clients as they do in everyday life, but at a time when they are even more vulnerable and need support for sobriety or stability (see Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004). Generic services exist on a continuum from openly hostile and rejecting, to open and inclusive (Eliason, Dibble, DeJoseph, & Chinn, 2009).

Treatment in Other Settings

There are over 500 Alcoholics Anonymous or Narcotics Anonymous groups specifically for LGBT people, but like LGBT-Specific treatment, they are often male-dominated. Joanne Hall (1994) reported that many lesbians do report benefits from 12 Step programs and groups, but others find them to be unwelcoming and sexist, and some find the concepts of powerlessness and a patriarchal higher power to be obstacles to their recovery. There is also some evidence that lesbian and bisexual women may be more likely than heterosexual women to seek out alternative and complementary therapies for their mental health and substance abuse issues, such as acupuncture, herbal therapies, massage, and others (Matthews et al, 2005).

Studies of Treatment Issues

Only a handful of studies have explored whether substance abuse treatment interventions that are used in the general population are effective and none of the clinical trials have focused on lesbian or bisexual women. Some data support the use of contingency management, cognitive behavioral interventions, and motivational interviewing for gay/bisexual men with methamphetamine dependence. Thus far, there are no treatment efficacy or effectiveness studies that focus on lesbian or bisexual women. This means we must rely on indirect means to theorize best practices for lesbian and bisexual women, based on what we know about their characteristics.

One recent study did examine treatment seeking and found that 40% of lesbian/bisexual women with alcohol and other drug disorder diagnoses received treatment

compared to 50% of heterosexual women. However, of women who had both a mental health and alcohol/drug diagnosis, 80% of lesbian/bisexual women and 71% of heterosexual women got treatment (Grella et al, 2009). Other studies have also found that lesbian/bisexual women without a mental health disorder may seek mental health treatment to improve the quality of their lives, but less is known about seeking treatment for alcohol and drug problems.

Characteristics of Lesbian/ Bisexual Substance Abusers

The richest data we have about substance abuse and lesbian/bisexual women comes from Tonda Hughes, who has conducted longitudinal research on over 350 lesbians for nearly ten years. Hughes and colleagues have reported that compared to heterosexual women, lesbian and bisexual women have higher rates of childhood sexual abuse experiences, depression, drinking in bars, and more sustained drinking over the life course (Hughes et al, 2006; Parks et al, 2008;Wilsnack et al, 2008).

One of the few studies to report what lesbian/bisexual women entering substance abuse treatment are like comes from Cochran and Cause (2006) who reported on the people entering generic treatment in Washington state, the first state in the U.S. to collect sexual orientation data on their statewide data collection system. They reviewed records of nearly 25,000 clients, and found of those with sexuality data, 90% reported heterosexual identity, 1% gay, 1% bisexual, less than 1% lesbian, and less than 1% transgender. Upon entry into treatment, there were differences in substance use patterns: The lesbian/bisexual women were more likely to report smoking and heroin abuse than heterosexual women and a higher frequency of drug use prior to entry to treatment than heterosexual clients. Substance abuse data collection systems typically lack any questions that might shed light on the unique stressors of LGBT people, and this study does not report treatment outcomes.

Recommendations for Best Practices

1. The first and most important step is for an agency to become LGBT-Responsive. This means revising agency policies and procedures to be inclusive of LGBT people: (e.g. in nondiscrimination or patient rights statements, written forms, having brochures and pamphlets geared to lesbian/bisexual women), and having openly LGBT individuals on staff, the board of directors, and among sponsors and mentors. All staff members have received training on culturally appropriate treatment for LGBT clients. Any advertising or outreach materials include LGBT populations. See www.lgbt-tristar.com for detail on how to become LGBT-responsive.

2. Trauma-informed treatment. Like many heterosexual women, lesbian and bisexual clients in substance abuse treatment are far more likely to have experienced childhood and adult sexual abuse, and unlike their heterosexual counterparts, may have also experienced discrimination, harassment, and violence based on their sexual identities. Trauma treatment, and trauma-informed treatment climates are a necessity, because many women are triggered by experiences that make them feel vulnerable. Establishing a climate of safety for all clients is important in treatment retention.

3. Assessment procedures and treatment planning takes into account sexual identity and gender issues, such as coming out, relationships, the role of gay bars, need for clean and sober sponsors and social networks for recovery, etc. Lesbian and bisexual women must feel safe and included, so that they can address their treatment needs while in the relative safety of treatment.

4. Lesbian and bisexual women are encouraged to be out and participate fully in treatment groups; homophobic and sexist remarks and behaviors are not tolerated from staff members or other clients. Safety is violated when staff members participate in or do not challenge homophobic, racist, sexist, or other derogatory language.

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