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Society Identity, and Meaning: Alcohol and Other Drug Prevention/Interventions for Mental Health Professionals Working With Gay, Lesbian, Bisexual, and Transgendered Clientele

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Studies suggest that the rate of alcohol and other drug (AOD) use among the gay, lesbian, bisexual, and transgendered (GLBT) populations ranges from 10% to 30%. This rate is three times higher than the general population in the United States (DeBord, Wood, Sher, & Good, 1998). Since this segment of our society is not always readily visible or accepted, this is probably a modest estimate. As such, researchers have been unable to provide accurate alcohol and other drug abuse estimates among GLBT individuals. The purpose of this article is to serve as a primer for counselors that may work with these populations.

Prevalence

Nearly 60% of gay youth recurrently use substances as a coping response or lifestyle response related to socializing and meeting potential partners (Savin-Williams, 1994). Being in the closet, or hiding one's sexual identity, has been correlated with "negative health and mental health outcomes, including substance abuse, suicide, depression, and high risk behaviors" (Ryan & Futterman, 1998, p. 21). Estimates range that indicate 20% to 42% of GLBT adolescents have attempted suicide "with higher percentages in GLBT youth who are homeless, runaways, and victims of sexual abuse or violence" (Ryan & Futterman, 1998, p. 60). A recent study showed pervasive and regular use of substances among gay, lesbian, and bisexual youth with implications that lesbian youth may be at an even higher risk for substance abuse than gay male youth (Rosario, Hunter, & Gwadz, 1997).

There is controversy about the exact prevalence of substance abuse in the GLBT world. Some researchers (DeBord et al., 1998) questioned the findings of earlier studies on alcohol and other drug use in the GLBT community. Research flaws have ranged from inadequate measures of sexual orientation, to the sampling bias of recruiting participants from gay bars, to methodological flaws. However, estimates do exist that suggest a higher rate of alcohol use among

GLBT adults, college students, and adolescents (Tait, 2005). Given all of these findings, it is essential that appropriate mental health, programming, and social services are available to GLBT youth and adults.

GLBT Identity Formation

Cass' seminal work in 1979 and 1984 led to a theoretical model of homosexual identity formation, based on six stages of development. This coming-out journey begins in different ways for different people, starting with an early awareness of feeling different to the development of an integrated identity, and takes many years. The first stage, *identity confusion*, is characterized by the individual beginning to question their sexual orientation. In *identity comparison*, the second stage, the person accepts the possibility of being homosexual. The third stage, *identity tolerance*, involves an increasing commitment to a homosexual identity, although the person still separates public and private identities. *Identity acceptance*, the fourth stage, is characterized by acceptance, rather than tolerance, of the homosexual identity. Disclosure of the identity remains selective. The fifth stage is *identity pride*, characterized by immersion into the homosexual culture, rejection of heterosexual values, and increased anger, pride, and activism. The sixth and final stage, *identity synthesis*, fuses the homosexual identity with all aspects of the self, and individuals no longer dichotomize the heterosexual and homosexual world (Cass, 1984, pp. 143–167).

The reasons that people may move from stage to stage, or fail to move, are complex. Societal attitudes are important in affecting the development of a person's positive identity. Being able to create and maintain a positive identity may present daily challenges and stresses for the GLBT individual. Issues of rejection, internalizing societal antigay attitudes, having a minority sexual status, and low self-esteem can lead to self-hatred and self-devaluation (Beatty et al., 1999).

This model can assist both clients and professionals in conceptualizing and normalizing the process of developing a GLBT identity by allowing the counselor to be aware of the coming-out process, and individual differences related to race, gender, age, religion, geography, and socioeconomic status (Tait, 2005). There have been criticisms and revisions to the theory (Cass, 1984), but the model remains useful in conceptualizing the complex issues of sexual orientation.

Not all gays come to this level of acceptance of their identity. Many GLBT individuals remain hidden or closeted for fear of reprisal due to their sexual orientation. In addition to these stressors related to the developmental processes of identity formation and coming out, such factors as lack of societal supports, the socioeconomic and psychological conditions associated with minority status, self-rejection, and the social role of the gay bar can all be factors in the etiology of substance abuse problems (Beatty et al., 1999). Other contributory factors to substance abuse include homophobia (the failure to accept oneself as gay) and the failure to mature by using alcohol to forestall the coming out process (Barret & Logan, 2002, pp. 116–118).

The Bar Scene

The importance of the bar scene in the GLBT community has often been underestimated by counselors. Historically, gay and lesbian bars have been protected places where gay men and lesbian women could meet, socialize, make sexual contacts, and be the predominant culture (Beatty et al., 1999). The bar is often one of the few, if not the only, social institutions in a community created specifically for gay and lesbian people where they can congregate and not have to worry about feeling different or being accepted (Barret & Logan, 2002). For many, the bar is the center of their social and cultural lives, and is subsequently associated with alcohol use.

The social isolation gay men and lesbians experience as a result of rejection from their own or from mainstream society represents a significant risk factor that can lead to alcohol and drug use. The use of alcohol and other drugs can evolve into abuse as the individual relies on these substances to maintain denial of his or her identity, cope with the rejection of an oppressive society, adjust to the demands of the gay and lesbian cultures, and deaden feelings of alienation, guilt, anxiety, and depression (Beatty et al., 1999).

Therapeutic Interventions

The GLBT client seeking therapy often faces homophobia, heterosexual bias, offensive comments, and misinformation (Center for Substance Abuse Treatment [CSAT], 2001). Research has indicated that some mental health professionals maintain heterosexist or homophobic assumptions and societal stereotypes about gay men and lesbian women, which may distort professional practice issues (Davies & Neal, 1996). When a GLBT client presents with alcohol and other drug issues, therapists have been found to incorrectly conclude that substance abuse is the cause of the client's homosexuality rather than explore issues of depression, relationships, anxiety, and self-esteem. On one hand, therapists need to be cautious in order not to minimize the importance of the client's sexual orientation, but on the other hand, they should not focus on the client's sexual orientation as the source of all of the client's problems (Tait, 2005). To provide effective therapeutic intervention, therapists must be knowledgeable, sensitive, and open to gay and lesbian issues as well as to chemical dependency issues. Mental health professionals first and foremost need to examine their awareness of sexual orientation and how it may impact the therapeutic relationship.

While chemical dependency programs are crucial to deal with alcohol and other abuse, there seems to be an absence of gay-oriented treatment options, and programs seldom seem to address issues of GLBT sexuality and/or intimacy (Barret & Logan, 2002). It comes as no surprise that GLBT clients are generally more willing to seek out treatment programs that address GLBT issues, have visible GLBT staff members, and provide culturally relevant interventions (Beatty et al., 1999). These considerations may explain why one study found that though lesbian communities had higher rates of alcohol abuse, fewer than 5% of lesbian women had gone to therapy to work on substance use issues (Sorensen & Roberts, 1997). Traditional chemical dependency counseling offers some obstacles for GLBT clients. It may be difficult to accept the traditional, male-dominated Alcoholics Anonymous (AA) model. Clients may fear prejudiced or hostile treatment staff. There may be few gay-only or gay-oriented treatment facilities, especially in smaller cities; or clients may fear ostracism from staff and peers (Browning, Reynolds, & Dworkin, 1991).

Recovery Issues

Significant elements of recovery for the GLBT individual include many more things than simply the

cessation of substance abuse. Counselors need to feel comfortable with and appreciate their own sexuality and strive toward elimination of homophobic feelings that could interfere with therapy (Barret & Logan, 2002). A major therapeutic concern when providing counseling services to GLBT clientele is to provide a safe and affirming environment which encourages the exploration of self-identity issues. Providing such an environment allows for the discussion of a client's sexual orientation and acknowledgment of the impact of sexual orientation on life issues.

Mental health professionals should encourage clients to establish a gay and lesbian support system as a significant element of their treatment. A negative or intolerant reaction from family or friends can have a devastating effect on the client. A support group such as the organization PFLAG (Parents and Friends of Lesbians and Gays) may be useful for clients who have unresolved family issues (CSAT, 2001).

Many other therapeutic issues may be important to the client's recovery. Such things as the learning of relapse prevention skills, placement in a treatment setting that is positive toward GLBT lifestyles, increased self-awareness, addressing unresolved family issues, a positive support group, discussion of difficulties in intimate relationships, recognition of sexuality and its impact upon substance abuse, and issues of conflict in employment, finances, and social life can all be woven into the therapeutic relationship (Beatty et al., 1999; CSAT, 2001).

Conclusion

Several themes emerge from the discussion of drug and alcohol abuse in gay and lesbian populations. First, it appears that many gays develop serious substance abuse problems in comparison to their heterosexual counterparts. This may be due to issues such as homophobia, lack of socialization options, or to "numb" internalized shame or guilt. The second theme is the availability of appropriate treatment options that are supportive and accepting. Future research may explore what needs to be done at the community level so that GLBT individuals have options to build community in settings as varied and diverse as those enjoyed by heterosexual individuals.

Another theme is recognition of sexual minority status. GLBT individuals have to learn how to be proficient operating socially both within the mainstream and within the gay and lesbian community. This learning of bicultural skills is not only the responsibility of the minority population, but also is rather the responsibility of all. Finally, struggles with identity development are core to one's personality, and

unresolved issues can lead to further psychological disorders, such as low self-esteem or depression, which in turn may lead to substance abuse (Tait, 2005).

These themes speak to the need for mental health workers to broaden their perspectives of the world. The challenge is to develop an awareness of how we perceive clients with sexual orientations and sexual identities different from our own. In developing this awareness, we must make the effort to learn about the history and background of gay and lesbian clients in order to address their issues in a way that is relevant to the context in which those issues are presented. By doing so, we will not only serve our clients' needs more fully, but we will also assist in their empowerment through advocacy and the counseling process.

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