Addiction Treatment Needs for Sexual Minorities

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The following developers and planning committee members have reported that they have no commercial relationships relevant to the content of this module to disclose: PCSS-MAT lead contributors Adam Bisaga, MD; AAAP CME/CPD Committee Members Dean Krahn, MD, Kevin Sevarino, MD, PhD, Tim Fong, MD, Tom Kosten, MD, Joji Suzuki, MD; and AAAP Staff Kathryn Cates-Wessel, Miriam Giles and Blair–Victoria Dutra.

Frances Levin, MD is a consultant for GW Pharmaceuticals and receives study medication from US Worldmed. This planning committee for this activity has determined that Dr. Levin’s disclosure information poses no bias or conflict to this presentation.

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Target Audience

- The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.
Educational Objectives

• At the conclusion of this activity participants should be able to:
  ▪ Articulate and utilize understanding of specific needs of lesbian, gay, bisexual and transgender patients in addiction treatment
  ▪ Recognize and include relapse risks for LGBT patients in treatment planning
  ▪ Modify treatment environments and treatment provider attitudes to decrease stigmatization and heterosexist/cis-gender assumptions
Outline

• Sexual Orientation
  ▪ History
  ▪ Sexual orientation minorities and substance use disorders
  ▪ Complications in treatment/ recovery for LGB patients
  ▪ Applications in MAT

• Gender Identity
  ▪ Gender identity spectrum
  ▪ Complications in treatment/ recovery for transgender/ non-binary patients
  ▪ Applications in MAT
Sexual Minority Alphabet Soup

GLBTQQQNBAAI2S
Sexual Identity
4 Components

• Physical Identity: Biological sex
• Gender Identity: Psychological sense of being male or female
• Sex-Role Identity: Interests, attitudes, appearance and behaviors-masculine, feminine, androgynous
• Sexual Orientation: Gender/sex to which attracted sexually and romantically
  ▪ Heterosexual
  ▪ Bisexual
  ▪ Gay
  ▪ Lesbian
Kinsey Continuum

Heterosexual  Homosexual

0----1----2----3----4----5----6
Some Demographic Data

• NESARC data (2013)
  ▪ Lesbian and bisexual women three times more likely than heterosexual women to have lifetime alcohol use disorder and lifetime substance use disorder
  ▪ Gay and bisexual men have significantly higher odds of lifetime drug use disorder than heterosexual men, but not higher odds of alcohol use disorder
  ▪ Bisexual men and women have highest rate of receiving treatment for substance use disorders
  ▪ Sexual minorities less likely to have insurance for treatment

• Green and Feinstein Review (2012)
  ▪ LGB individuals, particularly women, at greater risk of SUD
  ▪ Bisexual identity further elevates risk in both men and women
  ▪ Minority stress model
Continuum of Sexual/Gender Orientation

- Patients come to addiction treatment in various stages of “coming out”
  - In denial to self and others
  - Sees self as “probably homosexual” or “maybe trans” but sees this as a bad thing
  - Accepts self as homosexual, but not out to others
  - Out to family, friends
  - Out to everyone, most comfortable in GLBT community
  - Out and comfortable in any social situation

- Treatment planning must be individualized with this factor taken into consideration
Stages of Acceptance in Treatment Providers and Staff

- Homophobic
- Heterosexist
- Tolerant
- Accepting
- Affirming
Continuum of Sensitivity in Treatment Programs

- Anti-GLBT Programs
- Traditional/ Heterosexist Programs
- GLBT-Naïve Programs
- GLBT-Tolerant Programs
- GLBT- Sensitive Programs
- GLBT- Affirming Programs
Research on LGBT-Sensitive Treatment

• Very few studies or outcome reports
• Shoptaw and colleagues studied culturally specific CBT for gay and bisexual men addicted to methamphetamine who engaged in high-risk sexual behavior, which was more effective than treatment with standard CBT, CM or combined CBT/CM in decreasing risky sexual behavior and equally effective in decreasing drug use*
• This culturally specific protocol has not been widely adopted by other treatment programs

Sensitivity in MAT Programs

- No systematic research
- Some methadone programs in New York City and San Francisco are providing staff training
- Most MAT programs have not explored this issue in any systematic way
  - What percentage of your patients are members of sexual minorities?
  - Does your staff have specialized training in working with LGBT patients?
  - Is your program open to improving its ability to meet needs of these patients?
Moving Your Treatment Program Along

• Make the environment “LGBTQ-friendly”
  ▪ Pictures on walls of rainbows, Wizard of OZ, gay families
  ▪ *The Advocate* on coffee table along with *Time*, *People*
  ▪ Consider a non-binary poster

• Revise forms, questionnaires to remove heterosexist bias
  ▪ __single__ __married__ __divorced__ __widowed__
  ▪ __partnered__
  ▪ Sex: ___Male ___Female ___Other
  ▪ Age at first sexual activity with an adult? ______ (rather than *History of childhood sexual abuse?___*)
Moving Along (Cont.)

- Increase staff knowledge, sensitivity and comfort via didactic and experiential training
  - Attendance at workshops
  - “Homework” of noticing heterosexism and homophobia in group, community, cafeteria, etc.

- Avoid trap of having the single gay counselor be the go-to person for all LGBT concerns
- Start a group for LGBT patients in your program
- Incorporate discussion of sexual orientation into patient lectures on sexuality in recovery
Case Study #1

- 27 year old gay man, medical professional, entering treatment after multiple relapses on injection opioids diverted from his workplace.
- Had had three previous short-term residential treatment experiences in which he had been open about his sexual orientation but have never discussed his sexual behavior with therapist (this was considered an “outside issue”).
- Despite periods of 9-12 months of abstinence from opioids, he continued to engage in compulsive anonymous sexual encounters, visiting gay clubs.
Case Study #1 (continued)

- Patient was started in an intensive outpatient program with the following treatment plan
  - Inducted on buprenorphine, stabilized on 16mg/d
  - 9 hours weekly of therapy groups and education
  - Individual psychotherapy weekly with gay-sensitive LCSW
  - Active 12-Step participation with 2 LGBT meetings weekly
- At 12 weeks, treatment plan was amended to
  - Weekly continuing care group for 6 months
  - Monthly buprenorphine visits with physician
  - Continued individual therapy and 12-Step meetings
- Doing well at 2 years, continuing in monitoring, weekly monitoring groups and individual therapy
Psychological Complications in Recovery for Gay and Lesbian Addicts

• Internalized Shame and Self-Hatred
  ▪ Contributes to depressive symptoms
  ▪ Relapse risk when incorporated into denial
  ▪ Often repressed, hidden under bravado and activism

• Fear and Mistrust
  ▪ Contributes to anxiety and insomnia
  ▪ Blocks full participation in treatment

• Trauma and Abuse History
  ▪ Manifests as isolation and avoidance
  ▪ Patient appears numb and detached, dissociated
  ▪ May be aggressive, insensitive to others’ feelings
Critical Issues of Sexuality for Addicted Gay Men

• How is your addiction intertwined with your sexuality?
  ▪ Drugs of choice that increase sexual arousal
    – Crystal methamphetamine (“Tina”)
    – Cocaine
    – MDMA (“Ecstasy”, “X”)
    – Other “Club Drugs” (Ketamine, GHB, etc.)
  ▪ Social settings
    – Bars, clubs, discos
    – Circuit parties
  ▪ Sexual enhancement substances
    – Nitrates (“poppers”, “Rush”, “Locker Room”)
    – Viagra© et al

• Is compulsive sexual behavior part of your addiction?
• What relapse risks involve your sexuality?
  ▪ Internal
  ▪ External
Critical Issues of Sexuality for Addicted Lesbians

• How is your addiction intertwined with your sexuality?
  ▪ Drugs that increase sexual arousal
    – Stimulants
    – Cannabis?
  ▪ Drugs that decrease inhibitions and trauma-related symptoms
    – Alcohol
    – Sedatives
    – Opioids
  ▪ Social settings
    – Bars
    – Sports activities

• Is sexual and/or relationship compulsivity part of your addictive disorder?

• What relapse risks involve your sexuality?
Case Study #2

- 56 year old lesbian woman, partnered, with a history of severe, chronic back pain, increasing use of prescription opioids and obtaining multiple Rxs for short-acting opioids from 3 different physicians. This was revealed through a PDMP check.
- Patient was referred to an outpatient treatment program and started on methadone, but left the program stating she could not tolerate her pain on the dose of methadone provided, and was becoming increasingly depressed and suicidal.
- Patient entered specialized addiction/pain treatment residential program where she began methadone plus intensive physical therapy, acupuncture, pain management group and couples therapy with her long-term life partner.
- As she progressed in treatment she became more open with her therapist about her history of childhood sexual trauma.
Case #2 (continued)

- Patient was stabilized over next 3 weeks and discharged home with continuing care plan
  - OTP with continued methadone maintenance
  - Continued gay-sensitive couples therapy
  - Continued gay-sensitive, trauma focused individual therapy with psychologist
  - Attendance at Pills Anonymous and LGBT AA meetings 3-4 times weekly
- Patient continues in OTP and in individual and couples therapy with gay-sensitive PhD therapist. She has been able to return to work as an office manager and is participating in a Yoga group
What About Bisexuals?

• Very little meaningful research
• Stigmatized by both heterosexuals and homosexuals, which promotes secrecy
• Many sub-groups
  ▪ The “Down Low” and other cultural factors
  ▪ Young people who defy and resent categorization
    - “Queer”
    - “Gender Queer”
Gender Identity Spectrum

- Male comfortable in usual role expectations
- Male more comfortable with feminine qualities
- Male who dresses and acts as female
- Male who feels he was born into wrong body
- Male transitioning to or living as female

- Female comfortable in usual role expectations
- Female more comfortable with masculine qualities
- Female who dresses and acts as male
- Female who feels she was born into wrong body
- Female transitioning to or living as male
Transsexual, Transgender

- Transgender is a broad term; includes transsexual as well as transvestite, gender ambiguity and others
- Transsexual- Generally, a person who wishes to or has changed his or her birth gender assignment to that of the opposite sex
  - Preoperative
  - Postoperative
- Many transsexual persons have had an awareness of sexual (gender) identity dysphoria since childhood or early adolescence
- Not related to sexual orientation
A Broader Perspective on Gender Identity

• Some individuals and groups take exception to viewing gender identity as a dichotomy
  ▪ Why do I need to choose between being a male or a female?
  ▪ Evolving terminology
    – Genderqueer
    – Non-binary
    – Gender-fluid
    – Not conforming to “cis-normativity”

• Social expectations and perspectives are changing
  ▪ Facebook has 56 gender identity options
  ▪ Gender neutrality is evolving in language, style, the arts
  ▪ Medicine and psychiatry need awareness of this evolving area
Incidence of Addiction in Transgender Persons

- No real data
- Advocacy agencies suggest there is a higher than average incidence of alcoholism and other substance use disorders
- High incidence of secretive, “under-the-counter” usage of pharmaceutical agents
  - Anabolic steroids
  - Sex hormones
    - Estrogen in MTF
    - Testosterone in FTM
  - Opioids for pain
References


References


Follow-up Webinar

Tuesday, March 31, 2015
12:00 pm – 1:00 pm (ET)
PCSS-MAT Mentoring Program

• PCSS-MAT Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

• PCSS-MAT Mentors comprise a national network of trained providers with expertise in medication-assisted treatment, addictions and clinical education.

• Our 3-tiered mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.

• The mentoring program is available, at no cost to providers.

For more information on requesting or becoming a mentor visit: pcssmat.org/mentoring
PCSSMAT is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA) and American Society of Addiction Medicine (ASAM).

For More Information: [www.pcssmat.org](http://www.pcssmat.org)

Twitter: [@PCSSProjects](https://twitter.com/PCSSProjects)

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