Tailor Therapy for GLBT Substance Abusers

BY SHERRY BOSCHERT

FROM THE ANNUAL MEETING OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

SAN FRANCISCO — To help sexual minorities with addiction, physicians need to consider factors ranging from details in their waiting rooms to the attitudes of their patients and themselves.

Not all treatment providers are comfortable with patients' sexual diversity (see box). Physicians who are uncomfortable treating GLBT patients and other sexual minorities either can obtain education and experience to desensitize themselves, overcome prejudices and become more accepting, or they can refer these patients to other providers who might better meet the patients' needs, Dr. Penelope P. Ziegler suggested.

Those who are comfortable treating sexual minorities still have extra work to do. They can ensure their offices or treatment programs let patients know it's "okay" to be a sexual minority by including art work or literature relevant to sexual minority cultures and by designing intake forms so that same-sex relationships or diverse sexual identities can be reported.

When treating sexual minorities, it's essential to know the developmental stages of "coming out," said Dr. Ziegler, medical director of Virginia Health Practitioners Intervention Program, Richmond.

Patients can start addiction treatment at any of the six stages of self-discovery of sexual orientation. The stages start with an individual's confusion about sexual identity to comparison (accepting the possibility of being gay, lesbian, and so on), followed by tolerance of a sexual identity, then acceptance, pride, and finally synthesis of the identity into the patient's life.

Similarly, there's a continuum of sensitivity to sexual minorities in addiction treatment programs, she added. Some are actively antigay, especially some faith-based programs, whereas others are traditional heterosexist programs. Then there are the GLBT-naive programs that assume everyone there is heterosexual,

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DR. ZIEGLER

which sends a message that no one should be queer. Better programs are tolerant, and then sensitive, and finally affirming of GLBT patients, Dr. Ziegler said.

"Everyone in the addiction field needs to have some training to overcome heterosexism, shock, and revulsion toward sexual minorities," she believes. It's important to reinforce boundaries for practitioners and patients so that value judgments aren't verbalized and attempts to direct behavioral changes are based on patient need, not the practitioner's values.

Residential treatment programs should examine any heterosexist rules dealing with roommates and address any homophobia being acted out in the community, she suggested. In group therapy, the treatment leader should know whether a sexual minority patient is "out" to the other members, and know how to interrupt heterosexist or homophobic behavior.

In individual therapy, besides addressing the patient's stage of self-awareness of sexual identity as it relates to addiction recovery, the provider should consider specific risks or triggers for relapse that might be related to the patient's sexual identity. Social settings such as clubs and bars or sexual practices that commonly involve drug use increase the risk of relapse.

In 12-step recovery groups, facilitators need to put extra thought into whether a sexual minority individual may do better with a sponsor of the same or opposite sex, gay or straight, and whether some gay 12-step meetings may or may not be better than "regular" meetings for some.

Support groups or treatment programs designed specifically for sexual minorities have advantages and disadvantages, and aren't available everywhere, but mainstream programs can take steps to enhance the treatment experience for GLBT patients, Dr. Ziegler said.

Try adding a "special interest" group with regular group therapy sessions, she suggested. Develop contacts in the GLBT community to find people in addiction recovery to act as volunteer sponsors. Provide in-service training to all staff so that all can help GLBT patients. "It is not cool to have a designated queer on your staff" to be the only one doing this work, commented Dr. Ziegler, who said she has no pertinent conflicts of interest. ■

An Acronym for Sexual Minorities

The ingredients of the sexual minorities "alphabet soup"—GLBTQQAAi2S—include the following:

Gay: Males attracted to males.

Lesbian: Females attracted to females.

Bisexual: People attracted to both sexes.

Transgender: People whose gender identity does not match their birth sex.

Queer: An all-encompassing term for orientations other that heterosexual.

Questioning: Individuals who are exploring sexual orientation or identity.

Asexual: Not sexual.

Allies: Important to sexual minorities.

intersex: People born with ambiguous genitalia. (The intersex community chose the lower-case "i.")

2-Spirit people: Native American or indigenous Canadian term for gays and lesbians.

Combo Therapies Deliver Best Smoking Quit Rates

BY HILLEL KUTTLER

FROM THE ANNUAL MEETING OF THE SOCIETY FOR RESEARCH AND NICOTINE AND TOBACCO

BALTIMORE — Using a nicotine patch or bupropion with a nicotine lozenge was the most effective of five therapies tested for promoting smoking abstinence and avoiding a lapse or relapse into smoking, according to a prospective study of 1,504 smokers.

The therapies were "significantly better than placebo in promoting initial abstinence" and were effective int preventing relapse, reported Sandra Japuntich, Ph.D., a postdoctoral fellow at Massachusetts General Hospital's Mongan Institute for Health Policy, Boston.

The study's importance lies in its examination of the effects of each therapy closer to the smokers' targeted quit dates, she said.

The placebo-controlled trial sought to identify the effects on smoking cessation milestones of five pharmacologic therapies: nicotine lozenge, nicotine patch, bupropion, bupropion with a nicotine lozenge, and nicotine patch with a nicotine lozenge.

The milestones were one period of 24-hour abstinence within 2 weeks of a target quit date, lapsing with at least one cigarette, and relapsing into regular smoking for at least 7 consecutive days.

A total of 70% of smokers on placebo initially abstained, compared with 92% of those using a nicotine patch with a lozenge, 86% on bupropion with a lozenge, 81% on bupropion, 81% on a lozenge, and 88% on a nicotine patch.

Of those who initially abstained, 83% on placebo lapsed, compared with 70% those using a patch with a lozenge, 71% on bupropion with a lozenge, 74% on bupropion, 73% on a lozenge, and 76% on a patch.

Of those who lapsed, 69% on placebo relapsed, compared with 61% using a nicotine patch, 64% on bupropion with a lozenge, 63% on bupropion, 62% on a lozenge, and 61% on a patch with a lozenge.

The strongest treatment effects happened in the first week or two, she said. Those patients who do not stay abstinent might need to try another therapy.

Dr. Japuntich reported no conflicts of interest. One coinvestigator has served on research projects sponsored by a number of pharmaceutical companies. ■

Performance-Enhancing Drugs Raise Risk for Substance Abuse

BY MARK S. LESNEY

FROM THE JOURNAL OF STUDIES ON ALCOHOL AND DRUGS

Male college athletes who used performance-enhancing substances reported more problematic alcohol-use behaviors, and more alcohol- and drug-use–related problems than did nonusers, according to the results of an anonymous, self-reported questionnaire.

In addition, the performance-enhancing substance (PES) users were more likely to report use of tobacco products, proscribed drugs, and prescription drugs without a prescription within the past year.

The study comprised data from 233 male varsity student athletes with a mean age of 20.1 years, 84% of whom identified themselves as non-Hispanic whites. These students were divided into two groups based on their responses to the anonymous questionnaire that was administered at a single university during 2005-2006.

There were no differences between the groups in age or race. The 73 PES users were defined as those who self-reported use of a broad array of performance-enhancing substances, including stimulants, hormone precursors, and nutritional supplements, during the past year. The remaining 160 athletes were defined as non-PES users, reported Dr. Jennifer F. Buckman and her colleagues at Rutgers University, Piscataway, N.J.

"[The study] does suggest that PES users also often use other recreational drugs that themselves carry high addiction potential," they wrote.

The PES users reported using the following substances within the last year: ephedrine (7%), banned substances (31%), weight-loss drugs (22%), and stimulants (73%).

They also reported significantly more frequent alcohol use than did nonusers. This included twice the number of episodes of heavy drinking, a significantly higher number of drinks on the heaviest drinking day, and significantly more alcohol-related problems (J. Stud. Alcohol Drugs 2009;70:919-23).

The study was sponsored by grants from the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

The investigators reported no relevant disclosures. ■