Discrimination Drives Substance Abuse in Some

BY BETSY BATES

LOS ANGELES — Lesbian, gay, and bisexual adults have a higher risk of substance use disorders than do heterosexuals, but this risk is not uniform among sexual minority groups, according to data from the population-based National Epidemiologic Survey on Alcohol and Related Conditions.

The data also pointed to profound differences in substance abuse rates within commonly grouped sexual orientation categories when participants were categorized not just by the way in which they described their sexual identity (lesbian, gay, bisexual, or heterosexual), but also by the way they described their sexual behavior and attraction.

Two-thirds of 577 lesbian, bisexual, and gay adults reported being discriminated against on the basis of their sexual orientation, gender, race, or a combination of these.

About half of individuals who had experienced all three kinds of discrimination met criteria for a substance use disorder, and among those exposed to "very high levels of discrimination" (above 70 on a 0-72 discrimination scale for overall discrimination in the past year), the probability of a substance use disorder was almost 100%, Dr. Sean Esteban McCabe said at the annual meeting of the American Academy of Addiction Psychiatry. Discrimination was measured by using questions derived from the Experiences of Discrimination scales.

A clear dose-response relationship was seen between scores on the discrimination scale and substance use disorders, both for lifetime discrimination and for past-year discrimination, with a sharp increase seen in such disorders beginning at low to moderate discrimination scale scores among people who had recently experienced discrimination.

Conversely, members of a sexual minority group who had not experienced discrimination had rates of substance use disorders "comparable to heterosexuals," said Dr. McCabe, a psychologist at the Substance Abuse Research Center and Institute for Research on Women and Gender at the University of Michigan in Ann Arbor.

The finding confirmed Dr. McCabe's hypothesis that cultural and environmental factors are the most likely explanation for elevated substance use disorders among sexual minorities—"not… sexual orientation itself."

Overall, substance abuse disorders were substantially higher among lesbian, bisexual, and gay respondents than among heterosexuals in Wave 2 data from NESARC, a representative survey of nearly 35,000 adults—including the largest national sample of minority sexual groups ever enrolled in study on alcohol and drug use.

Past-year prevalence for any substance disorder was 25.8%, 24.3%, and 5.8%, respectively, among lesbian, bisexual, and heterosexual women, and 31.4%, 27.6%, and 15.6%, respectively, among gay, bisexual, and heterosexual men.

However, "risk was not uniform across dimensions of sexual minority women and men," emphasized Dr. McCabe. For example, women who reported exclusive same-sex sexual behavior had a past-year prevalence of substance use disorder of 9.1%, statistically similar to the 5.8% rate among heterosexual women.

In contrast, women who reported sexual behavior with both sexes had a past-year prevalence rate of substance abuse of 26.8%, a highly significant elevation over rates in other women.

Women who reported attraction only to the same sex had a past year prevalence rate of substance use disorders of 11.4%, not dissimilar to rate seen in women who said they were attracted equally to both sexes (9.6%), those who said they were mostly attracted to the other sex (13.2%), and those who said they were only attracted to the other sex (5.6%). Among women, the highest past-year prevalence rate of substance abuse disorders was highest, by far, among those who said they were mostly attracted to the same sex, at 24.2%.

Among men, differences were seen among past-year substance use disorder prevalence rates depending on how they described their sexual behavior, but those differences were not as striking as those seen among women.

For example, men who reported only same sex sexual behavior had a rate of 17.9%, compared to a 15.7% rate among men who reported only having sex with women. Men who reported sex with both sexes had a significantly higher rate of substance use disorders—26.3%.

Dr. McCabe reported no disclosures. ■

MY TAKE

Heightened Awareness Is Crucial

Dr. Sean Esteban McCabe's presentation underscores the importance for health care providers to consider lifestyle differences in identifying individuals at greater risk for substance use disorders. Initial screenings should include questions regarding issues of sexual orientation, sexual behavior, and attraction. Further, providers need to develop a heightened awareness for substance use disorders in individuals identified to be in sexual minorities. Brief screening tools, such as the CAGE, should be employed to identify individuals in this population at risk of substance abuse. It is imperative the clinician identify patients in a sexual minority and develop a further understanding of the prevalence of substance use disorders, treatment needs, and appropriate interventions for this population.

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Unusual Treatments Considered for Resistant Anorexia

BY PATRICE WENDLING

FT. LAUDERDALE, FLA. — What do atypical antipsychotics, an analeptic, and targeted magnets have in common? They all might play a role in the treatment of anorexia nervosa.

"When you have a disorder that is so treatment resistant, it's like metastatic breast cancer; you have to think outside the box for new interventions," Dr. Allan S. Kaplan said at a workshop on eating disorders at the annual meeting of the American College of Psychiatrists.

Current statistics indicate that 20% of patients diagnosed with anorexia are resistant to any intervention. The needs of these patients have been largely neglected, even though their numbers continue to grow as a result of the mortality decreasing from 22% in older studies to about 8%-10% today, said Dr. Kaplan, professor of psychiatry at the University of Toronto.

In his experience, many of these patients are now in their 40s and 50s and have been ill for 20-30 years. Most have significant medical complications: renal failure, cardiac arrhythmias, and osteoporosis with resulting hip fractures that have left them wheelchair-bound.

"They are unbelievably disabled," he said. "They are more disabled on quality-of-life scales than a comparative group of schizophrenics in the hospital."

One novel approach that might be useful is use of repetitive transcranial magnetic stimulation (rTMS), which has been shown to be effective in some patients with depression, schizophrenia, and obsessive-compulsive disorder. Current magnets stimulate superficial cortical areas of the brain, but Dr. Kaplan suggests that a better target might be the insula—a cerebral cortex structure that plays a role in interoceptive awareness and motor control. His group recently completed an unpublished meta-analysis of neuroimaging studies in anorexia that provides evidence for overactivity in the insula.

The team members have subsequently contracted with an Israeli biotechnology firm to construct a patented magnet for rTMS that will specifically target the insula.

The approach is not without controversy, Dr. Kaplan acknowledged. Although the seizure rate with rTMS is very low in patients with depression, patients with anorexia are at an increased risk for seizures at a rate of about 10% in general.

Atypical antipsychotics have come under increased scrutiny for anorexia, but with limited success in the few small studies and case reports to date. A recent meta-analysis of 43 publications concluded that there is not enough evidence in anorexia to confirm that these medications increase weight (Eur. Eat. Disord. Rev. 2010;18:10-21).

Olanzapine is the atypical antipsychotic that has been the most reported drug in the literature for treating anorexia and has been the subject of three small randomized controlled trials. Researchers in Ottawa showed that 10 weeks of olanzapine plus intensive day treatment resulted in faster weight gain and a greater decrease in obsessive symptoms than placebo in 34 patients with anorexia, but overall the same amount of weight gain (Am. J. Psychiatry 2008;165:1281-8).

Dr. Kaplan and Dr. Evelyn Attia of Columbia University reported in a separate unpublished trial in 2005 that patients gained a mean of almost 2 kg after 8 weeks of up to 10 mg olanzapine. Patients credited this not to an increase in hunger, but to being less anxious and consumed by thoughts of weight and shape. Importantly, there was no change in lipids, glucose, or insulin sensitivity, suggesting something might be different about the way the anorexic brain handles these drugs, he said.

Positive results on both weight gain and cognition have been seen with ziprasidone and quetiapine, but their use has been limited by concerns about QT interval prolongation, which is already an issue in anorexia. Because of this concern, olanzapine was selected instead of ziprasidone as the study drug for a large multicenter anorexia trial that is planned, he said.

Finally, workshop attendee Dr. Charles Price reported an acute response in a single patient with anorexia given modafinil and followed for 6 months. In a counterintuitive finding, the drug did not have the weight loss aspects observed with other stimulants.

"Basically, it cured her anorexia; now it is an 'N' of one," said Dr. Price, who is in private practice in Reno, Nev.

Dr. Kaplan reported having no conflicts of interest. Dr. Attia reported having received research support from Pfizer and Eli Lilly. ■