# Stress, Coping, and Context: Examining Substance Use Among LGBTQ Young Adults With Probable Substance Use Disorders

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**Key words:** Alcohol and drug abuse, LGBTQ community, Sexual and gender minorities, Young adults, Substance use disorders, Minority stress

## Abstract

**Objective:** The authors qualitatively examined how lesbian, gay, bisexual, transgender, and queer (LGBTQ) young adults with probable substance use disorders conceptualized their substance use vis-à-vis their LGBTQ identities.

**Methods:** Individual, in-depth, semi-structured interviews were conducted with 59 LGBTQ young adults (ages 21–34) who were participants in a larger longitudinal cohort study and who met criteria for a probable substance use disorder. Data were analyzed via iterative, thematic analytic processes.

**Results:** Participants' narratives highlighted processes related to minority stress that shape substance use, including proximal LGBTQ stressors (e.g., self-stigma and expectations of rejection) and distal LGBTQ stressors (e.g., interpersonal and structural discrimination) and associated coping. Participants also described sociocultural influences, including the ubiquitous availability of substances within LGBTQ social settings, as salient contributors to their substance use and development of substance use disorders. Participants who considered themselves transgender or other gender minorities, all of whom identified as sexual minorities, described unique stressors and coping at the intersection of their minority identities (e.g., coping with two identity development and disclosure periods), which shaped their substance use over time.

**Conclusions:** Multilevel minority stressors and associated coping via substance use in adolescence and young adulthood, coupled with LGBTQ-specific sociocultural influences, contribute to the development of substance use disorders among some LGBTQ young adults. Treatment providers should address clients' substance use vis-à-vis their LGBTQ identities and experiences with related stressors and sociocultural contexts and adopt culturally humble and LGBTQ-affirming treatment approaches. Efforts to support LGBTQ youths and young adults should focus on identifying ways of socializing outside of substance-saturated environments.

Youths and young adults who identify as lesbian, gay, bisexual, transgender, and queer (LGBTQ) or as other sexual and gender minorities experience disparities in substance use and disorders (1–7). These disparities have been predominantly explained by minority stress theory, which posits that LGBTQ-related stressors shape negative mental health outcomes and associated coping behaviors, including substance use (8–11). Emerging from research on racial minority stressors and health (12, 13), minority stress theory identifies proximal (i.e., intrapersonal) and distal (i.e., interpersonal and structural) stressors experienced by LGBTQ individuals, such as self-stigma and discrimination, as determinants of health.

Although minority stress theory describes how stress and coping shape health among LGBTQ individuals, it does not provide a nuanced perspective on why some LGBTQ people develop substance use disorders, whereas most do not. LGBTQ youths initiate substance use earlier and escalate use more rapidly than their non-LGBTQ peers (14–17). How youths cope with LGBTQ-related stressors during identity development may shape substance use disorders in adulthood. For example, adolescents who employ avoidant coping strategies (e.g., substance use) in response to LGBTQ-related stressors experience more stress (18), lower self-esteem and life satisfaction (19), and lower educational attainment (20), compared with those who employ more healthful coping strategies.

Sociocultural influences, such as more permissive substance use norms (21, 22) in the LGBTQ community and targeting of LGBTQ people by alcohol and tobacco companies (23–25), also contribute to substance use disorders among LGBTQ people. Bars frequented by LGBTQ people may be especially relevant, because such establishments offer “paradoxical space” for community building and high levels of substance use and other risky behaviors (26, 27), contributing to substance use and other health disparities (24, 28, 29).

Few studies have qualitatively examined relationships between experiences of LGBTQ-related stressors, substance use, and sociocultural influences in adolescence and young adulthood. This research is needed to understand youth substance use initiation and escalation, how these processes contribute to the development of substance use disorders, and effective substance use disorder prevention strategies (24, 30, 31). This study qualitatively examined narratives from LGBTQ-identified young adults about their substance use initiation, escalation, and use in adolescence and young adulthood vis-à-vis their LGBTQ identities.

## Methods

Data were collected between 2015 and 2017 from participants in an ongoing, U.S. longitudinal cohort, the Growing Up Today Study; this study originally enrolled participants in 1996 or 2004 (N=27,805). Participants in the cohort are children of nurses enrolled in the Nurses' Health Study II. They complete paper or Web-based questionnaires covering a variety of health-related domains annually or biennially. More information about the cohort is available elsewhere (32, 33).

In 2015, we invited recent Growing Up Today Study responders (N=13,340) to complete a questionnaire assessing lifetime and current substance involvement, past 12-month probable substance use disorders based on DSM-IV criteria, and substance use treatment histories (response rate of 73%, N=9,683). Among those meeting criteria for a substance use disorder or reporting a history of substance use treatment (N=1,789), we purposively sampled a subset of participants based on sexual orientation and gender identity to participate in a follow-up qualitative telephone interview (N=179).

A total of 126 participants (70% of those invited) engaged in semi-structured interviews with trained interviewers (average duration, 1 hour; range 18–150 minutes). First, interviewers

asked participants about their use of specific substances by gathering a detailed substance use history. If a participant indicated use, the interviewer asked follow-up questions about the context of the participant's use of each substance, such as How old were you when you first used [X]? How did your use change over time? and What factors contributed to that change/increase/decrease in use?

Next, interviewers asked participants open-ended questions about their current sexual orientation and gender identity, including specific categories to select from if necessary (i.e., Are you completely heterosexual? mostly heterosexual? gay or lesbian? bisexual? pansexual or asexual? Or, are you not sure? Are you male, female, transgender, or another identity?). Interviewers then asked participants to describe how their gender or gender identity and sexual orientation influenced their substance use: How has your gender/gender identity and experiences as a [gender identified by the participant] influenced your substance use? and How has your sexuality and experiences as a [sexual orientation identified by the participant] influenced your substance use? When further response seemed relevant, interviewers elicited elaboration. Interviews were audio recorded, transcribed verbatim, and deidentified. Participants provided informed consent and received a $50 gift card for their time. We obtained ethics approval from Partners Healthcare Human Research Committee/Institutional Review Board.

For the study reported here, we analyzed data from participants explicitly identifying as LGBTQ in the interview (N=59) by using an iterative, thematic analytic process to examine participants' narratives within their own social and historical contexts (34). We developed a codebook of a priori codes (e.g., "substance use in the context of sexual orientation") and codes grounded in the data (e.g., "influence of relationships on substance use"). Two analysts (including L.K.) tested codes on transcripts (N=13), resolving discrepancies until achieving

sufficient agreement. The two analysts then coded the remaining transcripts based on the revised coding schema (84% reliability). We identified emergent themes via analysis of coded excerpts, code co-occurrence, analytic memos (applied throughout data collection and analysis), and discussion with the study team (34–36).

## Results

Characteristics of the sample are summarized in Table 1. The mean±SD age of participants was 28±3 (range, 21–34). Most participants were non-Hispanic white (78%); 49% of participants identified as cisgender female, 39% as cisgender male, and 12% as gender minorities (i.e., transgender, gender nonbinary, or gender queer). Most identified as lesbian or gay (58%), with the remainder identifying as bisexual (36%) and queer (7%).

### *Minority- and LGBTQ-Related Stressors and Coping*

Participant narratives highlighted experiences of stress and coping in response to LGBTQ-related stressors. Most participants described coping with specific stressors in adolescence and young adulthood via substance use. Generally, participants described proximal stressors (those internal to the individual) during adolescence and distal stressors (those outside the individual, at the interpersonal and structural levels of the social ecology) during young adulthood.

*Proximal stressors: identity formation and disclosure and substance use in adolescence.*

Cisgender participants detailed exposure to and experiences with intrapersonal LGBTQ-related stressors—i.e., internalized stigma, concealment, and fear of identity disclosure—in early and middle adolescence, concurrent with sexual orientation development. Often, these stressors were related to fears of rejection, rather than to actual rejection. In fact, some participants

described relief and decreased stress after disclosing their sexual orientation to supportive friends and family. For example, one participant explained that prior to coming out, he used substance use as a coping strategy for dealing with identity concealment (Table 2, excerpt 1). After coming out to a supportive family, his fears and stress decreased, but his substance use continued.

Similar to cisgender participants, participants who identified as a gender minority (N=7) described intrapersonal stressors related to identity development. Their narratives, however, suggested more severe self-stigma, concealment, fear, and experiences of rejection. Participants who identified as gender minorities also described developing and disclosing their gender identities at older ages and experiencing less acceptance and more negative consequences while coming out. One participant reflected on how youths who identify as a gender minority may miss developmental milestones during adolescence, because their primary need is to address a discordant gender identity (Table 2, excerpt 3).

*Distal stressors: interpersonal and structural stressors and substance use in young adulthood.*

Participants highlighted distal stressors in the context of young adult relationships and settings, including family, work, and college, and associated coping via substance use. For example, one participant explained that her substance use decreased after distancing herself from an unsupportive family (Table 2, excerpt 4), whereas another explained that marijuana use was a key coping mechanism for dealing with negative reactions and family rejection (Table 2, excerpt 5). These two narratives suggest that distance from an unsupportive family may decrease stress and substance use for some LGBTQ young adults and increase or compound stress and substance use for others.

Participants also reflected on structural-level LGBTQ-related stressors (e.g., discriminatory laws and policies) and substance use. Some described general structural stressors

(e.g., "living in a predominantly hetero world"), whereas others explained that specific governmental policies (e.g., "Don't ask, don't tell") engendered stress and increased substance use. A few participants specifically reflected on the interaction of multilevel stressors in shaping substance use. For example, one participant commented that stressors affecting LGBTQ people individually also affect LGBTQ communities broadly (Table 2, excerpt 7). His discussion of being stressed out "as a queer person" living in a country with a president who is widely perceived as anti-LGBTQ provides an example of how structural factors can influence stress and coping among LGBTQ people, even in the absence of specific intrapersonal or interpersonal stressors.

***Sociocultural Influences: Outsider Identities, Community Norms, and the "Gay Bar"***

Intersecting with participants' descriptions of LGBTQ-related stressors and coping were discussions of sociocultural influences and substance use. Many participants described predominantly socializing with LGBTQ peers in substance-saturated environments (e.g., "gay bars") and at substance-saturated events (e.g., Pride parades) (Table 2, excerpt 8). Although participants appreciated the historical and cultural significance of these environments for LGBTQ people, they suggested that overreliance on gay bars may contribute to the development of substance use disorders among LGBTQ people, with one participant explaining that sobriety and gay bars are "incompatible" (Table 2, excerpt 9).

Several male participants (both cisgender and gender minority) discussed feeling social pressure to use substances while spending time with LGBTQ friends. For example, one participant explained that he would be "overjoyed" if "the predominant gay activity" were to go on a hike rather than to a gay bar, because he often had to choose between spending time with his gay or straight friends (Table 2, excerpt 10). Similarly, some male participants (both cisgender

and gender minority) described internal and external pressures to use substances to "fit in" with LGBTQ peers, especially during identity development (Table 2, excerpt 11).

### *Intersection of Sexual- and Gender-Minority Identities and Substance Use*

All participants who identified as a gender minority also identified as a sexual minority (i.e., LGBQ). Because of their intersecting "minority" identities, these participants often reflected simultaneously on how both sexual- and gender-minority–related stressors and sociocultural influences shaped their substance use. A few participants who identified as a gender minority described having more than one period of identity development and disclosure (one for sexual orientation and the other for gender identity), each with its own unique stressors. For example, a transgender man described substance use escalation following rejection by his family after coming out as a lesbian and then again when transitioning to a different gender (Table 2, excerpt 12). Another participant, who identified as gender queer (i.e., outside the gender binary) described their gender and sexuality as "intertwined," reflecting on substance use as self-medication during adolescence—a time when they could not imagine a path to societal acceptance of their identities. Although this participant described decreased use over time, they also explained that persistent gender-identity–related stress shaped their current substance use (Table 2, excerpt 13). These findings suggest that adolescents and young adults who are both sexual and gender minorities may have compounded "outsider" identities that make identity development and disclosure processes more complex and that this group may experience intersecting stressors, shaping substance use and disorders over time.

### *Divergent Cases: "I've Never Really Thought About It Like That"*

Our analysis yielded a small proportion of thematically divergent cases. These participants (all cisgender) perceived little or no relationship between their sexual orientation,

related stressors, sociocultural factors, and substance use. For example, one participant explained that he had "never thought about" a connection between his experiences as a bisexual male and his substance use (Table 2, excerpt 14). Another participant also did not perceive a connection between sexual orientation and substance use, suggesting that her experiences as a lesbian were positive (Table 2, excerpt 15). Finally, a bisexual female participant indicated experiencing few LGBTQ-related stressors because she is perceived as heterosexual. She explained that when perceived as "not entirely straight," however, her social interactions are more negative (Table 2, excerpt 16).

**Discussion**

Substance use among LGBTQ young adults with probable substance use disorders may be understood within the context of multilevel LGBTQ-related stressors and coping (10) and sociocultural influences (21). Similar to results of other studies of LGBTQ stress, coping, and health (18, 19), our findings highlight adolescence as a critical period shaping substance use and substance use disorders over time, including use of substances as an avoidant coping strategy in response to intrapersonal stressors during LGBTQ identity development (8, 37). Our findings also contextualize previous quantitative research identifying adolescence as the developmental period with the largest disparities between LGBTQ and non-LGBTQ individuals in substance use initiation and escalation (14, 38–40).

Several cisgender participants in our study described decreased stress after coming out to family or accepting their sexual orientation, aligning with research findings that identity integration (e.g., disclosure) may be protective for health (41). For these participants, substance use may have become a habitual coping strategy that they continued to employ in the face of stressors, even those that were not LGBTQ related, leading to the development of substance use

disorders over time. Participants also described coping with distal stressors, such as family rejection, and structural stressors, such as an anti-LGBTQ political climate. This emphasis on structural stressors aligns with research highlighting the link between "structural stigma" and higher rates of substance use among LGBTQ youths (42, 43).

It is critical to highlight the age of our participants. Because all are young adults now, the adolescent experiences they described occurred between 5 and 20 years ago. We found that regardless of whether these experiences occurred in the 1990s or the 2010s, participants detailed similar intrapersonal stressors in adolescence. This finding suggests that LGBTQ-related intrapersonal stressors may affect contemporary LGBTQ adolescents, despite growing acceptance of LGBTQ people nationally, echoing findings of persistent disparities in substance use among LGBTQ adolescents, even as overall adolescent substance use declines (44).

Overlapping with LGBTQ-related stressors were descriptions of sociocultural influences on participants' substance use, including the role of gay bars and other LGBTQ-specific environments (e.g., Pride events). Despite the importance of such venues, participants described them as contributing to a culture of normative substance use. As in other research on identity construction among LGBTQ people (45), some participants described pressures to use substances in order to be part of the LGBTQ community.

Gender-minority participants described experiencing unique stressors, often intersecting with their sexual-minority identities. This is an important nuance emerging from our data and supported by a recent study of substance use among young adult transgender women in which researchers found that sexual-minority transgender women (i.e., lesbian, bisexual, and queer) evidenced greater disparities in heavy episodic drinking and illicit prescription drug use than did heterosexual transgender women (46).

### *Treatment Implications*

Based on our findings, we offer the following recommendations for treatment providers working with LGBTQ clients. First, providers should explicitly address experiences of multilevel LGBTQ-related stressors and sociocultural influences and concurrent substance use during identity development (especially among adolescents) and in personal and professional contexts (especially among young adults). Identification of harmful or avoidant coping strategies may be especially useful for preventing the development of substance use disorders among young adults.

Second, providers should embrace "cultural humility" as a guiding approach to their interaction with clients. Differing from more traditional, static "cultural competency," cultural humility requires ongoing, active learning about clients' intersecting cultural identities and how a lack of societal power and privilege shapes one's individual experiences (47–50).

Third, providers should stay abreast of current LGBTQ rights–related policies, because these may profoundly affect clients' mental health and substance use. For example, although the Supreme Court struck down state bans against same-sex marriage in 2015 (51), many state and federal policies continue to restrict LGBTQ rights and promote anti-LGBTQ sentiments (52). Therefore, LGBTQ people living in conservative communities may need additional support from substance use treatment providers during treatment interactions—something providers who are aware only of broad-scale, pro-LGBTQ policies may fail to provide.

Fourth, providers should discuss with LGBTQ clients their current social support networks and the role of substance use in social interactions. This may be useful for identifying and discussing concrete strategies to address substance use within clients' social contexts.

Finally, treatment environments should be welcoming to LGBTQ people (e.g., providing gender-neutral restrooms and LGBTQ-specific reading materials). Providers should adopt

LGBTQ-inclusive screening procedures and carry out LGBTQ-affirming interactions with clients. These affirming practices are critical to supporting LGBTQ people in substance use treatment (Box 1). (A guide for further reading is provided in an online supplement to this article.)

### *Study Limitations and Future Directions*

Our findings represent narratives of young adults with probable substance use disorders who are children of nurses and primarily non-Hispanic white. Therefore, the extent to which findings are generalizable to LGBTQ people broadly is unknown. Indeed, a robust theoretical literature (e.g., 53, 54), and to a lesser extent, a scientific evidence base (e.g., 55, 56), highlight the additional, intersecting stressors and health disparities experienced by LGBTQ people of color and of varying socioeconomic positions. Future studies should build on this work by further explicating how LGBTQ-related stressors and sociocultural contexts influence substance use and disorders across the life course among diverse groups of LGBTQ people.

Our sample included seven individuals who identified as a gender minority. Future research should explore the unique experiences of a larger sample of individuals with a gender-minority identity and probable substance use disorders to better understand and address the stressors and sociocultural contexts shaping their substance use and coping. Furthermore, research on substance use and disorders among gender minorities should also examine nuances at the intersection of gender identity and sexual orientation, because people who identify as both gender minorities and sexual minorities may have unique experiences and outcomes, compared with those who identify as exclusively heterosexual.

Finally, our study did not address alternatives for LGBTQ people to socialize and build community outside of substance-saturated environments, although such environments are

emerging in direct response to some of the sociocultural influences identified in our analysis (57). Future research should explore these alternative spaces and the needs and desires of LGBTQ subgroups with respect to opportunities for socializing and their potential to decrease substance use and disorders among LGBTQ people.

## Conclusions

Our study extends the literature by examining how LGBTQ young adults with probable substance use disorders perceive their substance use in the context of an LGBTQ identity over time. Our findings highlight the role of minority stress and sociocultural influences in adolescence and young adulthood in shaping substance use and disorders. These findings have implications for treatment providers and prevention researchers.

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Table 1. Characteristics of 59 participants in the Growing Up Today Study who identified as LGBTQ, 2015–2017

| **Characteristic** | **N** | **%[a]** |
|---|---|---|
| Gender identity | | |
| Cisgender male | 23 | 39 |
| Cisgender female | 29 | 49 |
| Transgender or other gender minority | 7 | 12 |
| Sexual orientation | | |
| Lesbian or gay | 34 | 58 |
| Bisexual | 21 | 36 |
| Queer | 4 | 7 |
| Age | | |
| 21–28 | 28 | 48 |
| 29–34 | 31 | 53 |
| Race-ethnicity | | |
| White, non-Hispanic | 46 | 78 |
| Other | 7 | 12 |
| Missing | 6 | 10 |
| Received treatment for a substance use disorder | | |
| Yes | 35 | 59 |
| No | 24 | 41 |

[a]Percentages sum to 100%, except for rounding error.

Table 2. Excerpts from interviews of participants in the Growing Up Today Study who identified as LGBTQ, by theme

| Theme and excerpt | Participant | Narrative |
|---|---|---|
| **LGBTQ-related stressors and coping** | | |
| **Proximal stressors[a]** | | |
| 1 | Cisgender man, gay, age 32 | [When I was younger] I was dating a guy and was lying to everyone. It was so much work and was hard to lie. I was in a bad way having to deal with that before I came out. After I came out [at 19], it was a huge weight off my shoulders—my family welcomed me with open arms and had no problem with it. It put me in a way better place. After that, I wasn't using [drugs] as a coping mechanism [anymore], it was just kind of still part of my day to day, but I was in a positive state of mind so it was different usage. |
| 2 | Transgender man, pansexual, age 24 | When I was younger, before I accepted myself, I felt such a disconnect with my body and loathed it. I literally hated my body, so self-destructive things were oddly pleasing. [Substance use] was like [having] some control over my body since I had been placed in this situation I didn't want. My mom accepts me now, but initially she just didn't know. It was such a new thing, so definitely [I feared] rejection by family and peers. The drinking made that stuff not matter to me; the drugs also helped that not matter. |
| 3 | Transgender woman, bisexual, age 31 | I think trans[gender] people have like a 43%–45% suicide attempt rate, and I am definitely part of that number. Like, that the idea of having to come out as trans[gender] [in early adolescence] drove me to drink. I think having gone through those issues in formative years, two things happened. One, it crowded out doing the heavy lifting that you normally do of finding yourself and figuring out what you want to do with your life, like the sh-t you are supposed to do in your twenties, I didn't do. I was working on figuring out my own gender identity. Two, coping with the feelings in the unhealthy way still resonate through me—you drink yourself into oblivion or the way you cope with a feeling is, well, suicide is always on the table type of thing. |
| **Distal stressors[b]** | | |
| 4 | Cisgender woman, bisexual, age 29 | Almost 2 years ago, I finally came out to my parents. That's when my drinking got much heavier. Only within the last 6 to 9 months, I've been able to, very consciously and intentionally, cut back on my drinking, which is directly related to distancing myself from my parents and my family and learning other ways to replace that pain. |
| 5 | Cisgender man, gay, age 30 | Coming out in terms of the family was entirely negative. Things like "you'll never see my kids"—siblings saying that—or "When we have kids, you'll never see our kid, you're going to hell." All that kind of stereotypical, conservative Christian family response to homosexuality was pretty much given to me, and so as a result of that, I don't talk to any of them anymore. I maybe see them once a year kind of thing. My friends were exactly the opposite. . . . You're normal, you're okay, there's nothing wrong with you, so I naturally gravitated and spend more time and still do with my friends |

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| | | than any of my family members. . . . I would literally credit [marijuana use] with taking me out of depression, making me not suicidal, enjoying life, keeping calm and not being anxious or stressed out. Marijuana was a huge, huge part of that. |
| 6 | Transgender woman, bisexual, 31 | I went to the psychologist [at work] and the whole trans[gender] thing finally came out. . . . At first they were just going to bounce me out of [state A] and send me to [state B] and just make the problem ago away. But at that point, they were just like, "Well, you are not able to [work here] anymore." . . . They blamed it on like bipolar, but like even now today I [know] it was more of a trans[gender] thing than anything. Ultimately that experience still travels with me—I think the emotional baggage and hurt is still there. |
| 7 | Cisgender man, queer, age 31 | I think substances are used more in LGBTQ communities because there's a lot more stress and trauma in those communities. So, even if I'm not going through stress or trauma related to my sexuality at the time, I might be around people that were. Right now, with Donald Trump as our president, it stresses me out as a queer person, and I feel like I'm smoking more. With the election season and then now with the new presidency—I didn't have self-care as much [as I used to] so I reverted to [that] old crutch. |
| **Sociocultural influences: outsider identities, community norms, and the "gay bar"** | | |
| 8 | Cisgender woman, lesbian, age 34 | I would say a lot of the social activities that are geared toward camaraderie in the gay and lesbian community often surround and involve drinking. The Pride parade is sponsored by tons of alcohol brands. I mean if you [want] to go dancing or to socialize or seek that queer space, it's always in a bar. That's where the events are, so you're always around it. So, if you were somebody who, you know, is inclined to abuse alcohol or you are somebody who is recovering, like you're sort of excluded from those spaces because that's always there. |
| 9 | Cisgender woman, bisexual, age 32 | You can't really cut alcohol out and still go to gay bars. It's not compatible. |
| 10 | Cisgender man, gay, age 30 | If you told me tomorrow the predominant gay activity will not be a gay bar but a hike, I would be overjoyed. My straight friends behave and do things very differently than my gay friends. Those two lives have been separated [for me]. When I've needed help, I've gone and hung out with my straight friends more. But then I don't feel satisfied with my life because I don't have my gay friends. |
| 11 | Cisgender man, gay, age 32 | Within like gay culture [you] use drugs and to party and have fun and be wild, so to fit in or to kind of figure out your own identity, you kind of just play along with that stuff or you go along with whatever, 'cause you see the other people that you identify with are doing it too. |
| **Intersection of sexual- and gender-minority identities and substance use** | | |
| 12 | Transgender man, gay, age 32 | Almost every single time I got heavily into opiates it had something to do with my family. The first time, around 24, was when I first came out to my parents and it went terribly. We didn't speak for 6 months or something like that, and they had been pretty much heavily in my world up until that point. Later, when I transitioned from female to male—that was another whole zoo with my family. [When I] relapsed last year, my mom came out to visit me, and it was the first time she had ever |

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| | | been in my environment where I present as male. It was just really stressful, and I was not prepared for it at all. |
| 13 | Genderqueer, queer, age 23 | My gender and sexuality are so intertwined that, like, it's kind of the same thing. When I was younger, I didn't see how I internally felt [would] ever be able to be a possibility as a lifestyle, especially coming from a [religious] conservative background. My way of handling feelings of rejection and guilt was to self-medicate. And then, it just gets out of hand—and then somehow you're not very in control of it anymore. As I got older, I was able to get a better grasp over my substance use, [but] emotions are brought up by accepting the fact that your gender identity isn't going to change no matter how much you want it to. Because of that, I would fall back into use. |
| **Divergent cases** | | |
| 14 | Cisgender man, bisexual, age 30 | I never really thought about [my sexual orientation and substance use] like that. |
| 15 | Cisgender woman, lesbian, age 27 | No, I've had a very positive experience in life in general. |
| 16 | Cisgender woman, bisexual, age 27 | To 90% of the world, I'm straight—married and boring. Most people don't know to interact with me as anything except a straight woman. But the times that I've been able to interact with someone as not entirely straight, you know, I notice that sort of interaction. |

[a]Identity formation and disclosure and substance use in adolescence.
[b]Interpersonal and structural stressors and substance use in young adulthood.

Box 1. Recommendations for creating LGBTQ-inclusive and -affirming environments and interactions during treatment for substance use disorders

**Create a Welcoming Environment**

Provide resources and materials specifically for LGBTQ people (e.g., referral list of LGBTQ providers).

Display LGBTQ symbols and images (e.g., rainbow flags and posters of LGBTQ people) in the physical treatment space and on Web sites and social media pages.

Display LGBTQ-specific media, brochures, and reading materials in both waiting and treatment rooms.

Create, disseminate, and enforce nondiscrimination policies that include sexual orientation and gender identity.

Acknowledge LGBTQ-related observances (e.g., National Day of Silence, World AIDS Day, and Pride month).

Recruit and retain LGBTQ staff and providers.

Provide a designated gender-neutral restroom in the treatment setting.

Provide ongoing training and capacity building to staff and providers on culturally affirming care for LGBTQ people.

Foster a culture of openness to discuss LGBTQ issues and concerns among office staff and providers.

**Adopt LGBTQ-Inclusive Screening and Evaluation Procedures**

Provide nonstigmatizing opportunities for clients to provide information about their identity or identities on intake and screening forms.

Forms should reflect the diversity of LGBTQ people. Provide opportunities for clients to self-identify sexual orientation, gender identity, relationship status, and share name and gender pronouns.

Inquire about clients' sexual orientation and gender identity (e.g., identification and gender of past sexual partners) during in-person evaluations.

Explain that questions about sexual orientation and gender identity are asked of all clients.

Ask all clients about their gender pronouns, e.g., she/her/her, he/him/his, they/them/theirs. Know that for some clients, especially younger people, pronouns may change over time. Be prepared to honor any changes in pronouns.

Ensure that data collection procedures do not further stigmatize LGBTQ clients or their families.

Gather "relationship status" rather than "marital status."

Inquire about "parents" rather than "mother" or "father."

**Adopt LGBTQ-Inclusive and -Affirming Interactions and Behaviors**

Express empathy, openness, and nonjudgmental attitudes.

Avoid making assumptions about gender identity, sexual orientation, and sexual behaviors (e.g., many lesbians have had sexual contact with men; gender identity and presentation may not be the same).

Understand that LGBTQ people may believe providers either focus too much or too little on their sexual orientation or gender identity.

Be prepared to follow clients' lead about how much to discuss their LGBTQ identity in the context of treatment.

Recognize and leverage the strengths and resilience of the LGBTQ population.

Recognize that "coming out" as LGBTQ is a lifelong experience.

Ensure and emphasize confidentiality.

Recognize and understand implications of diversity within LGBTQ populations.

Use gender-neutral language, such as when assessing for violence exposure and partnership status, to avoid assumptions about the gender of a client's partner or partners. For example, "Are you currently being hurt by someone you are close to or involved with?"

Use the terms clients use to describe themselves. For example, if clients refer to themselves as "gay," do not refer to them as "queer" or "homosexual."

If you make a mistake, such as using the wrong gender pronouns when addressing a client or referring to a partner or spouse, politely apologize and correct the behavior, but avoid overapologizing.

## Highlights

- The authors conducted in-depth qualitative interviews with 59 LGBTQ young adults ages 21–34 with probable substance use disorders from across the United States.
- Participants described substance use as a coping mechanism for dealing with LGBTQ-related stressors in adolescence and young adulthood and as a function of sociocultural influences.
- Transgender and other participants (N=7) with a gender identity not traditionally associated with their birth sex (gender minority) described unique stressors (e.g., coping with two identity disclosure periods) at the intersection of gender identity and sexual orientation, shaping substance use and disorders over time.
- Findings suggest that treatment providers should address clients' substance use vis-à-vis their LGBTQ identities and experiences with related stressors and sociocultural contexts and apply culturally humble and LGBTQ-affirming approaches in their practice.

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