ALCOHOLISM AND ADDICTION IN HOMOSEXUALS: ETIOLOGY, PREVALENCE & TREATMENT

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Substance abuse[1] is endemic in the homosexual[2] communities in the United States. Although the etiology of abuse in any given individual can be complex, there are certain themes which are frequently seen in the gay or lesbian addict, and require specialized treatment in recovery. Awareness of these special risk factors is necessary in the successful treatment of a lesbian or gay addict. The author has chosen this topic because he is both homosexual and in long-term recovery from alcoholism.

American Psychiatric Association (1994) (the DSM-IV) lucidly groups all addiction to and abuse of substances into a single chapter: Substance Related Disorders. There is no single theory which accounts for why some people abuse substances and others don't (Straussner, 1993), but the presenting picture is essentially the same regardless of the substance.

In all probability, addiction (like so much mental illness) has a multifactorial etiology. Thus it must be viewed in a biopsychosocial framework. Straussner (1993, p. 11) concludes that,

> It may be best to view substance abuse as a multivariate syndrome in which multiple patterns of dysfunctional substance abuse occur in various types of people with multiple prognoses requiring a variety of interventions.

Some of the predisposing factors are discussed below:

1. The possibility of a **biochemical** or **genetic** factor in intergenerational transmission;

2. **Familial factors** such as early separation from one or both parents early in life; inadequate parenting during childhood; physical or sexual abuse, or growing up in a family with multigenerational abuse of substances;

3. All of the psychological theories posit **psychological factors** in the development of addiction. For all the "insight" provided by these theories, none of them leads to any more effective intervention than the others. In fact, those willing to be straightforward on this subject admit that psychotherapy of any ilk is ineffective in treating active addiction. If the proof of the pudding is in the eating, it is then apparent that the following classic psychoanalytic bromides are wrong and/or irrelevant: the addict uses the substance

- as a substitute for unacceptable sexual or aggressive drives, as a substitute for the primal addiction to masturbation, or as a defense against homosexuality;
- as the result of a fixation in and a regression to the oral stage of development;
- in response to an underlying neurosis based on the conflict between dependence and anger, or
- as slow suicide (Straussner, 1993).[3]

Other more modern theoretical perspectives focus equally ineffectively on poor ego development, pathological narcissism, or a deficiency in the sense of self (Straussner, 1993).

Others theories more useful for treating the individual in later-stage recovery suggested that,

- the addict attempts to medicate emotional problems such as depression, anxiety and anger;
- express dependency needs;
- compensate for feelings of inferiority and powerlessness, or
- relate to such things as low frustration tolerance, high level of impulsivity, or the inability to endure even low-level anxiety (Straussner, 1993).

Learning and behavioral theorists see addiction as a conditioned response; it produces a pleasurable high (perhaps very pleasurable in some, making them more willing to accept the negative consequences of indulgence) or relieves pain (as suggested above). Because children raised by addicted non-biological parents are at a higher risk of alcoholism than children raised by non-addicted non-biological parents, expectancy, modeling, imitation and identification may also predispose to substance abuse (Straussner, 1993).

4. **Environmental and cultural factors** in general can play a role in the etiology of addiction, such as:

- availability of the substance (*e.g.*, many soldiers became addicted to heroin in Vietnam

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1 As used herein unless within quoted material, the terms "substance abuse," "addiction," and "alcoholism" are used interchangeably, and include abuse of and addiction to alcohol and other mood altering drugs. "Substance abuse" includes dependence.

2 "Gay men" and "lesbian women" are sometimes referred to herein as "homosexual," acknowledging that to do so may be less desirable.

3 For a summary and critical evaluation of the equally distorted psychoanalytic view on the etiology of homosexuality, see Nardi (1982) at 14.

because of [1] the high stress of war, and [2] the availability of the substance);

- lack of rewarding alternatives in life (*e.g.,* lack of decent living conditions or opportunity to earn an income, as might be experienced by persons living in a minority ghetto),
- influence of peer groups or mass media, or
- social acceptance of the substance.

Finally, regardless of the theory of addiction or the predisposition of the person to addiction, almost anyone who takes a mood-altering substance in large quantity for a long enough time will experience physical and/or psychological dependence (Straussner, 1993).

Addiction in homosexuals

People with a homosexual orientation are, of course, subject to all of the multiple risk factors for addiction discussed above. They also have some psychosocial predisposing factors common to all hated minorities, and some unique to the homosexual population. There are many different types of alcoholics; there are many different types of homosexuals, and there are even more types of alcoholic homosexuals (Nardi, 1982).

Common to all hated minorities is the narcissistic damage done by the internalization of that hatred. Erikson (1959) asserts that it is impossible for any member of a hated minority to escape that internalized hatred.[4]

Homosexuals are subject to unique stressors, as well. Starting in youth, sometimes as early as school age, sometimes before the homosexual himself[5] is aware of any sexual orientation, he learns some of the dangers of being homosexual:[6] public derision (*e.g.*, "Joey is a fagot!"), discrimination (*e.g.*, "We don't want a queer on the baseball teem"), and physical harm (*e.g.*, "Hit the sissy again!"). The child may be rejected by her family implicitly (*e.g.*, overheard mother: "I'd rather my daughter be dead than be one of those lez-bines.") or explicitly (*e.g.*, Dad: "You are a homo, you are not my son. Get out of my house.") (Savin-Williams, 1994). In later life he will face discrimination in the workplace and the possibility (only today less prevalent) of arrest and imprisonment for "unnatural acts." Rosario, Hunter & Rotheram-Borus (1992) note,

> . . . the experience of being gay or bisexual in our society overwhelms any potential differences in social categories involving age, ethnicity, race, social class or geographical region of the country (p. 19).

The homosexual is often unique in facing hatred and discrimination in that she has no role model, no positive example in her family, no loving parent who has gone through the same experience, to support her in her pain. Those discriminated against because they are (for instance) Catholic, or African-American, or Portuguese, usually have families or communities for which this is a common problem. Gay youth are all too often rejected even by their families (Savin-Williams, 1994) and too seldom have yet found their supportive peers and communities.

Facing this external view of herself, no wonder that the homosexual internalizes this hatred and has difficulty with accepting her identity, building self-esteem, and expressing her sexuality. About 65% of all homosexuals seek therapy and give as a reason depression which is a result of adjusting to their homosexuality; of these, 50% started therapy between the ages of 18-21 (Diamond-Friedman, 1990).

In turn, these difficulties lead some to increase their consumption of alcohol or other drugs to aid in the coming-out process, or to medicate the anxiety or depression associated with concealing their identity or facing rejection from family and friends, discrimination in employment and housing, physical assault, arrest or imprisonment. "The absence of significant subculturally valued alternatives to drinking settings . . . contributes to the dependency on alcohol as an acceptable solution to feelings of anxiety, alienation and low self-esteem" (Nardi, 1982, p. 21).

Colcher (1982) hypothesizes that homosexuals use substances to dull the pain of feeling "different and alone," to reduce "sexual inhibitions" relating to internalized homophobia, and to reduce the stress of the keen competition for good-looking sexual partners. Nardi (1982) hypothesizes that homosexuals are more at risk of drinking to the point of addiction because the gay life style often revolves (or revolved in 1982) around gay bars, which have a history of permissiveness and protectiveness.

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[4] It is the "sad truth that in any system based on suppression, exclusion, and exploitation, the suppressed, excluded and exploited unconsciously believe in the evil image which they are made to represent by those who are dominant" (Erikson, 1959, p. 30).

[5] Unless referring to a person of know gender, the pronouns he and she, and their variations, are used herein randomly and interchangeably.

[6] The following examples are from the author's personal experience or the experience of his close friends.

Historically,[7] various studies indicate that about one-third of all homosexual people will have a problem with substances at some time in their lives (Diamond-Friedman, 1990). In a very large (n=3400) and well-controlled study, McKirnan & Peterson (1989) criticize those studies as being biased for several reasons, not the least of which is that they were made in gay bars of the bar-going population. McKirnan & Peterson (1989, p. 549) found the following percentages of homosexuals reporting alcohol problems:

McKirnan & Peterson Study

	General Population		Homosexual Sample	
Age Group	Men	Women	Men	Women
18-25	29	16	26	24
26-30	25	7	25	23
31-40	16	8	24	25
41-60	7	4.5	19	15
(overall)	(16)	(8)	(23)	(23)

It is interesting that up to age 30, the homosexual men show no higher incidence of alcoholism than men in the general population (although homosexual women show significantly higher levels). But after age 30, the high incidence of alcohol problems does not decline in the homosexual population while it does decline significantly in the general population.

Why are older homosexuals at greater risk of alcoholism? The author has found no insightful explanation in the literature. McKirnan & Peterson (1989) wanly suggest that psychosocial or cultural variables in the homosexual population might be responsible for increased alcoholism in the later years. They hypothesize that homosexual men and women do not typically enter traditional marriages or childbearing roles as they age, are often not in mainstream occupations, and do not typically adhere to traditional sex roles, all of which encourage control of drinking. The author suggests (based on anecdotal evidence) that the functions of childbearing and childrearing may have a significant part in the emotional happiness and stability of the parents, being biologically ego-syntonic which, in turn, could relieve some of the impetus to drink.

Author has found no other research addressing the phenomenon of the prevalence of alcoholism among the older members of gay society, but several explanations other than those given above suggest themselves:

Today's older alcoholics faced a more closeted life in their young years, with a much higher prevalence of the stressors discussed above. Gay liberation had not yet struck. They began drinking heavily earlier and, addiction being a disease most frequently progressing into middle age before being addressed, were addicted by their middle 30's. Thus, the higher rates of alcoholism in those over 30 shown by McKirnan & Peterson (1989) may be caused by an even higher incidence of alcoholism in the pre-liberation group, which is now in its 30's, 40's and 50's. That homosexuals[8] under the age of 30 should show no greater incidence of addiction may be a testament to the positive effects of gay liberation.

Another untested hypothesis which occurs to the author is that many older homosexuals (say, over 35) are faced with the daunting task of competing for lovers, friends, and sexual partners in the unrelentingly youth-oriented, fitness-oriented gay culture. One of the major tasks of middle age for homosexuals is to reach acceptance that they are no longer able to compete on the basis of beauty (of which youth, in the homosexual population, is ordinarily a requisite), and accept that their sex and love lives may be substantially less fulfilling, or fulfilling in different ways, than when they were younger. Many homosexuals as they pass 35 turn increasingly to drugs and alcohol for solace and companionship.

Interventions

Addiction is like a fire; once started it becomes self-sustaining, and the first order of business for the firefighter is to put out the blaze. Only later comes the search for the match. Even psychodynam-

[7] To the extent that literature quoted herein was researched or written before the mid-1980's, it often does not take into account the explosion in drug use in the homosexual population which occurred in the late 1970's and resulted during the 1980's in a greatly increased dual addiction to alcohol, amphetamines and their analogs, designer drugs and cocaine. Author bases this assertion on anecdotal evidence arising from his attendance for a number of years at gay AA, NA and CA meetings.

[8] The author has no theory as to why lesbians under 30 show higher rates of addiction.

ically oriented therapists now agree that focusing on the underlying causes of active addiction in an individual does not work to halt the addictive behavior (Colcher, 1982). Thus *initially* the sexual orientation of an addict is largely irrelevant to his treatment (Colcher, 1982), except (1) as it may causelegitimate concerns as to the treatment he may receive at the hands of an unsympathetic or bigoted treatment staff, or may fuel his alcoholic denial that an open-minded and fair staff could help him, (2) that the homosexual because of his lifestyle may be at special environmental risk,[9] or (3) a contributing and/or sustaining cause of the addiction is serious pathology, as in addicted individuals who also carry another diagnosis of mental illness (*e.g.,* schizophrenia or major depression). In the first two of these cases, an addict can be referred to a gay-sensitive rehabilitation program,[10] or to one of the gay branches of the 12-Step programs.[11] In the case of MICA patients, they should be treated in a duel-diagnosis program. This paper will not discuss the basic interventions common to the treatment of all addicts.

Homosexuals can benefit from some special interventions, however, after early sobriety has been achieved.[12] In the author's experience, addiction is most often initially driven by pain or pulled by pleasure. It is especially important to recovery to reduce pain and stress wherever possible in the recovering addict's life. Twelve-Step programs do this in many ways for straight and homosexual people alike, and these interventions are beyond the scope of this paper. However, for homosexuals, they can learn (perhaps for the first time) to relate to other gay men in non-sexual ways.[13] In particular, gay AA and gay group therapy can assist in this goal, as well as helping the recovering alcoholic build self-esteem by consciously understanding and then rejecting for himself the destructive myths about homosexuality:

> Most of these myths are counterproductive . . . since they are based on assumptions that all gay males are identical, are fixated at regressive levels, and can never achieve a "whole" and satisfactory life. Examples of these myths are: gay males are hysterical and dramatic, especially in dealing with conflict; gay male sex is compulsively driven sex;[14] the treatment objective is a dyadic, long-term relationship; gay males are basically narcissistic; gay sex is basically masturbation; gay males are immature (fixated at pre-Oedipal stages, fixated at adolescence, manifesting the Peter Pan syndrome); gay men are totally sexually liberated; "something" will always be missing, in comparison with heterosexuality; gay intimate relationships cannot last and cannot mature; gays are "sad young men";[15] casual sex is empty sex; gay men are psychotic; gay men cannot obtain relatedness; and so on (Smith, 1982, p. 55).

Whatever the etiology of an individual's addiction, successful long-term recovery requires the individual to come to terms with himself and to learn to cope with life. In the treatment of the gay alcoholic, the therapist must not only keep perspective on the client as an addict, but also as a homosexual, with all that may mean to that person in his biopsychoso-

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[9] For instance, (1) the gay bar is often a place to meet friends, potential sexual partners, and a lover, and (2) casual "back-room" or bathhouse sex is a widely accepted sexual release for many homosexuals. Both present a risk that the recovering alcoholic will be tempted by the ready availability of alcohol, ecstasy, special-k, cocaine, and poppers. In addition, because of the wide use of poppers for sexual disinhibition and pleasure, some recovering addicts are not able to have satisfying sex without them for some time into sobriety. Newly recovering addicts need cautioning, instruction, and assistance in finding alternatives to these outlets or in learning to use these outlets with minimum risk of relapse.

[10] Such as Pride Institute in Minnesota.

[11] Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, etc.

[12] Six months to a year of sobriety.

[13] The author is not suggesting that relating in sexual ways is bad, but only that it can be limiting. Unless sex leads to love, sexual interest most often wanes (at least in men), and will not by itself support a continued friendship. A series of one-night stands does not usually lead to having a group of friends for support or companionship, which is a vital resource in recovery.

[14] It is important that the therapist (gay or straight) not bring into treatment his own preferences or prejudices as to what constitutes "appropriate" or "healthy" sex any more than it would be appropriate for the therapist to bring into treatment her own preference for the gender of her sexual partner. If the client's sexual practices are (1) dangerous, such as unsafe sex, (2) ego dystonic to the client himself, or (3) run a risk of triggering a relapse, then the therapist may encourage the client to question the practice or question his own (perhaps unreasonable) feelings about the practice which make it both seductive for him and yet at the same time ego dystonic. Smith (1982) lucidly encourages therapists and clients to adopt a non-judgmental stance towards a wide variety of sexual practices, noting that "sexual compulsiveness is not the same as high frequency or so-called 'casual sex" and that, "The value system of the client must be given importance since casual sexual relationships are unjustly discriminated against through cultural notions" (p. 60).

[15] Or "bitter old queens."

cial setting. This includes being aware of the special challenges discussed above of low self-esteem and the special problems of aging in the homosexual community.

The therapist must be sensitive to the gay subculture and to subcultural changes. The therapist must also be aware of the developmental tasks, as described by Erik Erikson, that gay men face throughout their lives. For instance, the stage of generativity is more than just parenting. Older gay men need information and encouragement to find the joys which can be contained in the second half of life (Smith, 1982). Self-help groups give ample opportunity, through 12th step work[16] for mentoring and nurturing others, and for utilizing that most noble of the ego defenses: altruism.

References

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders *(4th ed.). Washington, DC: American Psychiatric Association.*

Colcher, R.W. (1982). Counseling the homosexual alcoholic. *Journal of Homosexuality, 7*(4). 43.

Diamond-Friedman, C. (1990). A multivariant model of alcoholism specific to gay-lesbian populations. *Alcoholism Treatment Quarterly, 7*(2). 111.

Erikson, E. (1959). Identity and the Life Cycle. *New York: Norton. 30. Quoted from Greene, R. & Ephross, P. (1991).* Human Behavior Theory and Social Work Practice. *New York: Aldine de Gruyter. 97.*

McKirnan, D.J. and Peterson, P.L. (1989). Alcohol and drug use among homosexual men and women: epidemiology and population characteristics. *Addictive Behaviors, 14*. 545.

Nardi, P.N. (1982). Alcoholism and homosexuality: a theoretical perspective. *Journal of Homosexuality, 7*(4). 9.

Rosario, M., Hunter, J., & Rotheram-Borus, M.J. (1992). *HIV risk acts of lesbian adolescents.* Unpublished manuscript, Columbia University. Quoted from Savin-Williams, R.C. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: associations with school problems, running away, substance abuse, prostitution and suicide. *Journal of Consulting and Clinical Psychology, 62*(2). 261.

Savin-Williams, R.C. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance abuse, prostitution and suicide. *Journal of Consulting and Clinical Psychology, 62*(2).261.

Smith, T.M. (1982). Specific approaches and techniques in the treatment of gay male alcohol abusers. *Journal of Homosexuality, 7*(4). 53.

Straussner, S.L.A. (1993). Clinical Work with Substance-Abusing Clients. New York: The Guilford Press.

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[16] Helping someone newer in the program to achieve and maintain sobriety.