Using to Numb the Pain: Substance Use and Abuse Among Lesbian, Gay, and Bisexual Individuals

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The purpose of this study was to examine the relationship between heterosexist events, internalized homophobia, and substance use and abuse among 824 lesbian, gay, and bisexual (LGB) individuals. Participants completed the Schedule for Heterosexist Events (SHE), Internalized Homophobia Scale (IHP), Alcohol Use Disorders Identification Test (AUDIT), and the Drug Abuse Screening Test (DAST). A MANCOVA with age as a covariate and sexual orientation as a cofactor indicated there were significant differences in how lesbians, gay males, and bisexuals experienced heterosexism and internalized homophobia. In particular, gay males and lesbians reported experiencing more heterosexism than bisexuals, and gay males and bisexuals reported experiencing more internalized homophobia than lesbians. Participants who were classified as having at least one alcohol or drug use disorder were significantly more likely to have experienced heterosexism and internalized homophobia than those who were not classified as having a substance use disorder. Implications for mental health counselors, counselor educators, and researchers are noted.

Lesbian, gay, and bisexual (LGB) individuals have faced great societal prohibitions and prejudices based on the expression of their same-gender sexual feelings and behaviors (Stein & Cabaj, 1996). Considered an at-risk group, they are exposed to various forms of discrimination that place them at an increased risk for suicide, dropping out of school, verbal and physical abuse by family or peers, homelessness, HIV/AIDS, psychological distress, and substance use and abuse (Grossman, 1997). These risk factors threaten the well-being and overall quality of life of many LGB persons.

As a result of being sexual minorities in a predominately anti-gay society, LGB individuals experience physical and emotional stress, a phenomenon that DiPlacido (1998) referred to as minority stress. Homophobia and heterosexism are central constructs in the stress experienced by LGB individuals. Homophobia is defined as the anxiety, aversion, and discomfort that some individuals experience in response to being around, or thinking about, LGB behav-
Heterosexism resembles racism or sexism and denies, ignores, and disparages nonheterosexual forms of emotional and sexual expression (Center for Substance Abuse Treatment [CSAT], 2001). Both constructs are found on individual and societal levels, endorsed through the perpetuation of negative myths and stereotypes about people who are LGB, and lead to the discrimination and prejudice of LGB people across the lifespan (Bobbe, 2002; Smiley, 1997). It is important to note that bisexual people may experience additional minority stress complicated by marginality from both the straight and gay communities. This marginalization usually includes same-gender oriented friends urging them to adopt a gay lifestyle and heterosexually oriented friends pressuring them to conform to heterosexual standards (Smiley).

Homophobia and heterosexism have serious implications for LGB individuals as they lead to subtle forms of discrimination (e.g., the exclusion of LGB couples in the media) and blatant acts of alienation and discrimination (e.g., individuals refusing to rent to LGB people; Neisen, 1990). Other examples of heterosexist events include unfair treatment by family, friends, and peers; loss of employment or lack of promotions; and observing/hearing people make heterosexist jokes (Selvidge, 2000). As a result of these experiences, many LGB individuals hide their sexual orientation from others, and feel shame and other negative feelings towards themselves (CSAT, 2001). The phenomenon of internalizing anti-gay attitudes and experiencing negative views of self is referred to as internalized homophobia. Low self-esteem and low self-acceptance, shame, guilt, feelings of inadequacy and rejection, depression, anxiety, and substance use and abuse are some of the common feelings or behaviors that are associated with internalized homophobia (Grossman, 1997; Ross & Rosser, 1996; Stein & Cabaj, 1996).

Because homophobia and heterosexism promote the superiority of heterosexuality, the development of a sexual minority identity has been historically discredited. More recently, however, it has been investigated as a rich form of diversity in sexual orientation. This is evident by the de-classification of same-gender sexual orientation as a psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1973. An increased emphasis on the unique developmental experiences of LGB individuals can be found in the more recent professional literature (Cass, 1979; Herek, 1996; McCarn & Fassinger, 1996; Meyer, 1995).

A major model of sexual minority identity development for lesbians was proposed by McCarn and Fassinger (1996) and later adapted for gay men by Fassinger and Miller (1996). This model informed the present study and provided a framework for understanding the developmental experiences of lesbians and gay men by taking into consideration the complex process of sexual identity exploration and the influences of societal homophobia and heterosexism on the development of a lesbian or gay male identity. This model does not
specifically address bisexual individuals; in fact, the development of a bisexual identity remains under-explored. However, Cabaj (1997) posited that the experiences of bisexual individuals, particularly if they identify strongly with their same-gender attraction, are similar to the experiences of lesbians and gay men. Therefore, bisexual identity development is often explained according to lesbian and gay male identity development (Smiley, 1997).

SEXUAL MINORITY IDENTITY FORMATION

In their Model of Sexual Minority Identity Formation, McCarn and Fassinger (1996) explored sexual minority identity development at both the individual and group membership level, which occur parallel to each other but not necessarily at the same time. This model included the word phase in place of stage, allowing for more flexibility to move in a “continuous and circular” manner through one’s identity development (McCarn & Fassinger, 1996, p. 522). This notion supports Gonsiorek’s (1995) proposition that the process of identity development is “unpredictable, with stops, starts, and back-tracking” (p. 31). In general, the authors of the model proposed that the sexual minority identity formation process begins when lesbians and gay men feel attraction for the same gender in ways that they do not understand (Awareness), shifts to a time of exploration and curiosity that involve feelings of fear, sadness, or excitement (Exploration), moves to increased personal involvement with the lesbian or gay community and increased awareness of oppression (Deepening/Commitment), and leads to feelings of comfort with and self-acceptance of one’s same-gender sexual orientation (Internalization/Synthesis). Table 1 provides a brief description of McCarn and Fassinger’s four-phase Model of Sexual Minority Identity Formation at both the individual and group membership level.

According to McCarn and Fassinger (1996), the sequence of development of a sexual minority identity and the intensity or difficulty involved is influenced by the degree to which heterosexism and homophobia has affected the individual. This can occur during any of the phases of development as an LGB individual questions sources of learning about sexual orientation (i.e., family, church, school), challenges views that support heterosexuality as a superior sexual orientation, or encounters prejudice and discrimination. These experiences lead to mixed feelings including but not limited to anger, sadness, confusion, and excitement. An LGB individual may experience internalized homophobia and subsequent distress in response to the discrepancy between one’s attraction to the same gender and how society negatively views such same-gender attraction. Several studies have supported this notion.

Rowen and Malcolm (2002), for example, examined internalized homophobia and its relationship to homosexual identity formation, self-esteem, and self-concept among 86 gay men. In the results of their study, the authors indicated
that there was a significant relationship between higher levels of internalized homophobia and less developed gay male identities. A qualitative study by Lock (1998) illustrated the impact of homophobia on the sexual minority identity development of a gay male as he moved through early, middle, and late adolescence. The author identified early sexual experimentation, inadequate same-gender or male-female friendships, depression, social isolation, hopelessness, and despair as significant challenges that one gay male faced as he developed a gay male sexual identity.

**Substance Use and Abuse Among LGB Persons**

The process of forming an LGB identity can be a stressful and challenging process as it involves adopting a nontraditional sexual identity, restructuring one’s self-concept, and changing one’s relationship with society (Reynolds & Hanjorgiris, 2000). As a means of coping with such stress and the emotional pain associated with internalized homophobia, LGB individuals may use or abuse substances (Bux, 1996; Cabaj, 2000; CSAT, 2001). Although alcohol and drug use and abuse provide comfort at times, LGB individuals may experience increased use, abuse, and possible dependency (Cabaj, 2000).

CSAT (2001) suggested that LGB persons are: (a) more likely to use alcohol and drugs than the general population, (b) more likely to have higher rates of substance abuse, (c) less likely to abstain from use, and (d) more likely to continue heavy drinking into later adulthood. There is a small body of research that addresses substance use and abuse by lesbians and gay men, and less research exists on the substance use and abuse patterns for bisexual individuals (Hughes & Eliason, 2002). For example, 20–25% of gay men and lesbians are heavy alcohol users, compared to 3–10% of the heterosexual population (CSAT, 2001). McKirnan and Peterson (1989) reported alcohol problems for lesbians were greater than those for heterosexual women (23% and 8%, respectively), and they found the same for gay men and heterosexual men (23% and 16%, respectively). In terms of drug use, higher numbers of LGB individuals used cannabis (56%) and cocaine (23%) than the general population (20% and 9%, respectively; McKirnan & Peterson, 1989).

The Trilogy Project (Skinner & Otis, 1996) was designed to gather epidemiological data on the lifetime, past year, and past month prevalence rates of alcohol or drug use for gay men and lesbians. In this study, higher rates of marijuana, inhalant, and alcohol use were documented for lesbians and gay men when compared to data from the National Household Survey on Drug Abuse (NHSDA). In particular, 87% of lesbians reported alcohol use compared to 64% of women from the NHSDA study, and 84% of gay men used alcohol compared to 72% of the NHSDA male participants.

Sorenson and Roberts (1997) found similar results with 24% of their lesbian participants stating that they drank two or more drinks per day. In addition, 15%
of lesbians identified as alcoholics and 29% shared that they had attended Alcoholics Anonymous meetings. In a related study, Amadio and Chung (2004) found that 24% of lesbians and bisexual women and 25% of gay and bisexual men had at least a strong possibility of alcoholism. In addition, 15% of lesbians and bisexual women and 11% of gay and bisexual men in the same study met Amadio and Chung’s criteria for drug abuse.

Although the findings of these studies support substance use and abuse in the LGB community, they are beset with methodological limitations such as poor or absent control groups, unrepresentative samples, limited generalizability, and inconsistent sexual orientation terminology (Cabaj, 1996). In addition, authors of many empirical studies either exclude or blend bisexual individuals into their studies; therefore, data specifically related to bisexual individuals is lacking.

**Internalized Homophobia and Substance Abuse**

Reasons for the incidence of substance use and abuse among LGB individuals remain underinvestigated. Cabaj (2000) posited that substance use and abuse disconnects LGB people from feelings of shame and anxiety, provides acceptance, fosters social comfort in bars or unfamiliar social settings, facilitates the acting on feelings long suppressed or denied, and allows for denial and even blackouts about sexual behavior. Cheng (2003) also underscored the internalization of social homophobia as an explanation for the high rates of substance use and abuse among LGB individuals: “Many gay people...feel self-hatred; the use of mood-altering substances temporary relieves but than reinforces this self-loathing in the drug withdrawal period...leading to a worsening of self-esteem” (Cabaj, 1996, p. 786).

Authors of three studies have examined the relationship between internalized homophobia and substance use and abuse (Amadio & Chung, 2004; Jaffe, Clance, Nichols, & Ernshoff, 2000; Kus, 1988), and most reported that substance use and abuse in the LGB community can be attributed to the internalization of anti-gay bias, which “is found in every sector in our society: legal, medical, scientific, religious, political, social, educational, and judicial” (Cabaj, 2000, p. 8). For example, Jaffe et al. (2000) reported a higher prevalence of alcoholism among lesbians than the matched cohort of heterosexual women, and attributed this finding to social oppression and internalized homophobia. After exploring 20 gay males’ retrospective accounts of their experiences with alcoholism, Kus (1988) suggested that participants viewed their gay male sexual orientation negatively while they abused alcohol. A few participants reported that they abused alcohol as an avoidant coping skill when dealing with their sexual orientation.

Contrary to the aforementioned results, Amadio and Chung (2004) found a negative relationship between internalized homophobia and alcohol, marijuana,
In the present study, I explored whether one’s experience with heterosexism and internalized homophobia affects one’s sexual minority development, an aspect of sexual minority development that is receiving increasing attention in the counseling literature. McCarn and Fassinger’s (1996) Theory of Sexual Minority Identity Formation supported the impact of homophobia and heterosexism on one’s sexual minority development, and authors of other conceptual scholarship and empirical research suggested the possibility of a link between internalized homophobia and substance use and abuse (Cabaj, 1996, 2000; Jaffe et al., 2000; Kus, 1988). The hypotheses that informed the presented study were that there would be significant positive relationships between exposure to heterosexist events and substance use and abuse (i.e., alcohol and drug use and cigarette use. Particularly, lesbians and bisexual women with lower levels of internalized homophobia were more likely to use alcohol, marijuana, and cigarettes throughout their lifetime (Amadio & Chung).
abuse), and internalized homophobia and substance use and abuse (i.e., alcohol and drug use and abuse).

METHOD

Participants
Participants in the study included individuals who self-identified as LGB and individuals who are exploring a LGB sexual orientation identity. Study participants ($N = 824$) ranged from 18 to 81 years of age, with a mean age of 32 years, median age of 29 years, and standard deviation of 12 years. Fifty-one percent identified as female, 45% male, 3% transgender, and 1% as “other.” Transgender individuals were included because they self-identified as lesbian, gay, or bisexual, and are therefore able to share related experiences of homophobia and heterosexism based on sexual orientation. It is important to acknowledge, however, that transgender individuals may have unique experiences with bias and discrimination as a result of an intersection between sexual orientation and gender identity. This phenomenon was not explored in the present study but warrants further exploration.

Thirty-six percent of the participants identified as lesbian, 38% as gay males, 16% as bisexual, 2% were currently exploring a lesbian identity, 1% were currently exploring a gay male identity, 4% were currently exploring a bisexual identity, and 3% identified “other.” European Americans (82%) represented most of the participants, along with African Americans/Blacks (4%), Asian Americans/Asians (4%), Latinos/Hispanics (4%), Native Americans (2%), and multi or biracial (4%) individuals. Thirty-two percent of participants had a graduate degree, 29% a bachelor’s degree, 4% an associate’s degree, 30% attended some college, university, or technical school, 4% earned a high school diploma or equivalent, and 1% attended some high school. Household income included 40% above $50,000, 35% between $20,000 and $50,000, and 25% under $20,000. The majority of the participants (75%) indicated that they heard about the study through email listservs, 19% through emails from friends, 2% from an online advertisement or link on the web, 2% from word of mouth, 1% from advertisements in print materials, and 1% from “other” sources.

Procedure
In this study, I used the Internet to recruit LGB participants. In particular, e-mail advertisements to general and multicultural LGB listservs; posters in LGB restaurants, bookstores, and community centers; e-mail advertisements to the directors of LGBT resource centers on college campuses; and personal networks were utilized. Respondents were directed to an Internet survey posted on PsychData, which is a Web-based company that conducts Internet-based research in the social sciences. Appropriate IRB approvals were obtained.
Three hundred dollars was donated to the Rainbow World Fund as an incentive for participants.

Measures

Demographic questionnaire. Participants were asked to report information on their race, age, sexual orientation, gender, educational level, income, geographical location, and relationship status.

Schedule of Heterosexist Events (SHE). The frequency of heterosexist events encountered by LGB individuals in their lifetimes was measured using the Schedule of Heterosexist Events (Selvidge, 2000). This scale was adapted from the Schedule of Sexist Events (SSE) (Klonoff & Landrine, 1995). The SHE includes 17 items that measure frequency of heterosexist events using a 6-point Likert scale that ranges from 1 (this has NEVER happened to you), to 6 (this has happened to you ALMOST ALL OF THE TIME [more than 70% of the time]). For this study, I utilized mean scores for the SHE, which ranged from 1 (representing lowest frequency of lifetime heterosexist events) to 6 (representing highest frequency of lifetime heterosexist events). The SHE demonstrated strong internal consistency when used with a group of lesbians (Cronbach’s alpha = .92; Selvidge, 2000). There are no data on this scale for men that could be located. The Cronbach’s alpha for the SHE in this study was .90. No validity evidence for the SHE could be located; however, validity for the SSE from which the SHE was adapted was established by comparing it to two other measures of stressful events (Klonoff & Landine, 1995). These comparisons resulted in significant positive correlations.

Internalized Homophobia Scale (IHP). The Internalized Homophobia Scale (Martin & Dean, 1987) was used to assess the extent to which same-gender oriented people are “uneasy” about their sexual orientation (Meyer, 1995, p. 43). The IHP is a 9-item measure that utilizes a Likert scale with ratings ranging from 1 (strongly disagree) to 4 (strongly agree). For this study, I utilized mean scores for the IHP, ranging from 1 (representing low to no internalized homophobia) to 4 (representing high internalized homophobia (I. H. Meyer, personal communication, December 20, 2004). In terms of validity, this measure was correlated significantly and negatively with collective self-esteem, importance attached to community involvement, disclosure of sexual orientation to non-LGB friends, and satisfaction with the LGB community (Herek & Glunt, 1995. Higher IHP scores have also been linked to demoralization, guilt, sexual problems, suicide, and AIDS-related stress for gay males (Meyer, 1995). The IHP had acceptable internal consistency (Cronbach’s alpha = .71 for lesbians and .83 for gay men) in a study by Herek et al. (1997). Cronbach’s alpha for the IHP for this study was .87.

Alcohol Use Disorders Identification Test (AUDIT). The AUDIT is a 10-item self report questionnaire that measures alcohol consumption, dependency
symptoms, and personal and social harm as a result of alcohol use occurring during the recent past, rather than one’s lifetime (Allen, Litten, Fertig, & Babor, 1997; Bohn, Babor, & Kranzler, 1995). Individual item scores range from 0 to 4, with total AUDIT scores ranging from 0 to 40. A cutoff score of 8 was used in the current study as its validity against a criterion of alcoholism was found to be generally in the mid .90s and never below the high .80s (Allen et al., 1997). It also demonstrated acceptable validity with regard to other self-report alcohol screening measures such as the MAST, MacAndrew Scale, and the CAGE, and is appropriate for use with males and females, as well as with people from a variety of ethnic groups (Allen et al.). The AUDIT has adequate internal consistency with a Cronbach’s alpha ranging around .80 (Allen et al.; Schmidt, Barry, & Fleming, 1995). The Cronbach’s alpha for the AUDIT in this study was .80.

**Drug Abuse Screening Test (DAST).** The original DAST (Skinner, 1982) is comprised of 28 self-report items that assess drug misuse over the past 12 months (Cocco & Carey, 1998). The DAST has an internal consistency estimate of .92, and factor analysis suggested it is a unidimensional scale (Skinner, 1982). Staley and El-Guebaly (1990) found the DAST to have acceptable diagnostic validity such that it attained a maximum overall accuracy of 89% in classifying individuals according to the DSM-III Substance Abuse diagnosis. Two shorter forms of the DAST have been developed, a 20-item version and a 10-item version (DAST-20 & DAST-10; Cocco & Carey, 1998), and both demonstrate considerable promise as screening instruments (Bohn et al., 1995; Skinner, 1982). For the present study, the DAST-20 was used with a cutoff score of 5 to identify individuals who are involved with and having problems associated with drug abuse (Cocco & Carey, 1998). Gavin, Ross, and Skinner (1989) suggested a cutoff score of 5 because it has demonstrated the best balance between sensitivity (.96) and specificity (.79). An item analysis for the DAST-20 revealed strong item-scale correlations (.39 to .78) and an alpha coefficient of .92 (Cocco & Carey, 1998). The Cronbach’s alpha for the DAST-20 in this study was .81. Interscale correlations, correlation alphas, means, and standard deviations obtained from the participants for the four scales (SHE, IHP, AUDIT, DAST) used in this study are reported in Table 2.

**Table 2** Correlation Coefficients, Means, and Standard Deviations for the Schedule of Heterosexist Events (SHE), Internalized Homophobia Scale (IHP), Alcohol Use Disorders Identification Test (AUDIT), and the Drug Abuse Screening Test (DAST). Alpha Coefficients are on the Diagonal.

<table>
<thead>
<tr>
<th>Scale</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heterosexist Events</td>
<td>.90</td>
<td>.07</td>
<td>.04</td>
<td>.19*</td>
<td>.121</td>
</tr>
<tr>
<td>2. Internalized Homophobia</td>
<td>.87</td>
<td>.16*</td>
<td>.08**</td>
<td>1.71</td>
<td>.73</td>
</tr>
<tr>
<td>3. Alcohol Use and Abuse</td>
<td>.80</td>
<td>.39*</td>
<td>.430</td>
<td>4.19</td>
<td></td>
</tr>
<tr>
<td>4. Drug Use and Abuse</td>
<td>.81</td>
<td>3.32</td>
<td>2.41</td>
<td></td>
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</tr>
</tbody>
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*p < .01, ** p < .05.
RESULTS

To determine if there were positive relationships between exposure to heterosexual events and substance use and abuse (i.e., alcohol and drug use and abuse), and internalized homophobia and substance use and abuse (i.e., alcohol and drug use and abuse), interscale correlation coefficients were examined. The SHE was significantly correlated with the DAST (r = .19, p < .01). The IHP was significantly correlated with both the AUDIT (r = .16, p < .01) and the DAST (r = .08, p < .05). The AUDIT and DAST were moderately correlated with each other (r = .39, p < .01). Some of these findings supported the hypothesis for the present study; specifically, there are statistically significant positive relationships between exposure to heterosexist events and drug use and abuse, and between internalized homophobia and both alcohol and drug use and abuse. A statistically significant positive relationship between exposure to heterosexist events and alcohol use and abuse was not supported by the data. These findings should be interpreted with caution; although many of them have statistical significance, the correlations were very small and may not have practical or clinical significance.

To determine whether or not there were differences in exposure to heterosexist events and internalized homophobia as a function of sexual orientation and substance abuse, I performed a 3 X 2 multivariate analysis of covariance (MANCOVA). I used age as a covariate, sexual orientation and substance abuse disorder status as the independent variables, and scores on the Schedule of Heterosexist Events (SHE) and Internalized Homophobia Scale (IHP) as dependent variables. The original six categories for the sexual orientation variable were collapsed into three groups by combining lesbians with participants who were exploring a lesbian identity (lesbians), gay males with participants who were exploring a gay male identity (gays), and bisexuals with participants who were exploring a bisexual identity (bisexuals). Two groups were created for the substance abuse disorder status variable: participants who had scores that revealed a disordered status on one or both of the alcohol and drug use disorder scales, and participants who had scores that revealed no disorder. The MANCOVA revealed significant main effects for sexual orientation $F(4,1514) = 6.35, p < .01$ and disordered status $F(2,756) = 5.53, p < .01$ on a combined IHP and SHE variable after covarying out the effects of age, but the interaction effect of sexual orientation and disordered status was not significant $F(4,1514) = 1.24, p > .05$.

Univariate statistics (ANCOVAs) were run as a follow-up to determine which of the two dependent variables (SHE or IHP) were significantly related to sexual orientation and substance abuse disorder status. Results indicated significant effects for sexual orientation on both the SHE $F(2,757) = 6.54, p < .01$, and the IHP $F(2,757) = 5.67, p < .01$. In particular, for the SHE, the mean scores for gays ($M = 1.22, SD = .08$) and lesbians ($M = 1.23, SD = .08$) were signifi-
cantly higher than bisexuals ($M = 1.19, SD = .08$). Although gays and lesbians experienced more heterosexist events than bisexuals, gays and lesbians experienced heterosexist events at similar rates. The effect size for this relationship was small ($\hat{\eta} = .017$). Bisexuals and gays scored significantly higher ($M = 1.83, SD = .76, M = 1.83, SD = .76$, respectively) on the IHP than lesbians ($M = 1.63, SD = .66$). This means that bisexuals and gays had higher levels of internalized homophobia than lesbians. However, the effect size for this relationship was also small ($\eta = .015$).

There were significant main effects for substance abuse disorder status on the SHE $F(1,757) = 10.18, p < .01$ and the IHP $F(1,757) = 4.40, p < .01$. For the SHE, participants whose scores revealed that they were disordered on at least one of the alcohol or drug use scales ($M = 1.22, SD = .09$) scored significantly higher than participants whose scores did not indicate disorders on either scale ($M = 1.20, SD = .08$). The effect size for this relationship was small ($\eta = .013$). For the IHP, participants whose scores revealed that they were disordered on at least one of the alcohol or drug use scales ($M = 1.82, SD = .73$) scored significantly higher than participants whose scores did not indicate disorders on either scale ($M = 1.70, SD = .73$). The effect size for this relationship was very small ($\eta = .006$). Therefore, participants who had an alcohol use disorder, drug use disorder, or both disorders experienced more heterosexist events and internalized homophobia than those who had no disorder, but this finding should be interpreted with caution due to the very small effect sizes.

Finally, there was no significant interaction between sexual orientation and disordered status on the SHE $F(2,757) = .019, p > .05$ or IHP $F(2,757) = 1.19, p > .05$ suggesting there were no differences in SHE or IHP mean responses for gays, lesbians, or bisexuals based on their substance use disorder status.

**DISCUSSION**

Over the past three decades, the fields of counseling and psychology have emphasized the high rates of alcohol and drug use and abuse among LGB individuals. More recently, researchers have sought to find a clearer understanding of how social homophobia and substance use and abuse among people who identify as LGB are related. In their Model of Sexual Minority Identity Formation, McCarn and Fassinger (1996) proposed that homophobia will influence the development of a sexual minority identity such that people who are LGB may feel confused or angry about their sexual orientation, or may avoid “coming out” as LGB to evade negative social consequences. Other studies have supported their claim (see, for example, Lock, 1996; Rowen and Malcolm, 2002). In their model, however, McCarn and Fassinger (1996) do not explicate how LGB individuals cope with the stress of “coming out”, or why substance use and abuse is proportionately higher among LGB individuals than their heterosexual counterparts.
A few researchers have attempted to explain the coping utility of alcohol and drugs through their conceptual and empirical literature (Cabaj, 1996, 2000; Clance, Nichols, & Ernshoff, 2000; Kus, 1988). All have hypothesized that experiences with social homophobia are related to internalized homophobia, subsequent self-rejection, and increased use and abuse of alcohol and drugs as a means of coping.

In the present study, I brought together the literature on sexual minority identity development, the impact of heterosexism and homophobia on such development, and the use and abuse of alcohol and drugs as a way of dealing with minority stress, in order to investigate how they are related. In particular, the relationships between exposure to heterosexist events and substance use and abuse, and internalized homophobia and substance use and abuse were examined. A correlation analysis underscored significant positive relationships between exposure to heterosexist events and drug use and abuse, and internalized homophobia and alcohol and drug use and abuse. The data also suggest that there are differences in how lesbians, gays and bisexuals experience heterosexism and internalized homophobia. Furthermore, participants who are classified as having at least one substance use disorder reported experiencing heterosexism and internalized homophobia more often than those who are not classified as disordered on either the alcohol or drug abuse scale. Although these relationships are significantly significant, their small effect sizes limit my confidence that participants who are classified as having at least one substance use disorder have, in fact, experienced more heterosexism and internalized homophobia. In this case, statistical significance may not necessarily mean that the findings have practical or clinical significance to the field of mental health counseling. To this end, interpret the following discussion points with caution.

**Heterosexism and Sexual Orientation**

The findings of the present study indicated that lesbians and gay men were more likely to experience heterosexist events than bisexuals. According to Reynolds and Hanjorgiris (2000), the formation of a lesbian or gay identity involves a period of negotiating one’s relationship with self, family and society as one embraces a new minority sexual identity. During this process, lesbians and gay men become aware of heterosexism and homophobia in their environments, and likely feel angry as a result of being ostracized by the majority heterosexual population. These experiences characterize lesbians and gay men as being in the Exploration phase of McCarn and Fassinger’s (1996) Model of Sexual Minority Identity Development. Bisexual identity development, however, is underexplored (Reynolds & Hanjorgiris, 2001), and although it is often explained according to lesbian and gay male sexual minority identity development (Smiley, 1997), one should not assume that bisexuals’ experiences with homophobia and heterosexism are the same. Cabaj (1997) posited the experi-
ences of bisexual individuals will be similar to the experiences of lesbians and gay men, particularly if they identify strongly with their same-gender attraction. Accordingly, bisexual individuals would be aware of heterosexism in their environments, and likely experience the phases of McCarn and Fassinger’s model. Conversely, bisexual individuals who identify strongly with their opposite-gender attraction may not be aware of heterosexism in their environments and, therefore, might not report it as often as their same-gender oriented counterparts. The identity development of bisexual individuals and their experiences with homophobia and heterosexism warrant further exploration.

**Internalized Homophobia and Sexual Orientation**

The overall higher scores on the IHP for gay men and bisexuals in the present study suggest that they experienced more internalized homophobia than lesbians. In their research, Rowen and Malcolm (2002) and Lock (1996) indicated that gay men with less developed gay male identities experienced higher levels of internalized homophobia, which was often associated with significant challenges, including but not limited to, depression. This finding is important to consider since the degree of internalized homophobia, according to McCarn and Fassinger (1996), will likely determine the difficulty of moving through the phases of sexual minority identity development towards dedication and self-love as LGB individuals and away from rage, anxiety, and insecurity. As gay males in this study reported experiencing higher internalized homophobia, variables in need of exploration to help clarify this finding include their level of gay male identity, their presence in a phase early sexual experimentation, inadequate same-gender or male-female friendships, depression, social isolation, hopelessness, or despair. (Lock, 1996; Cabaj, 1996, 2000). Although bisexual identity development is underexplored at this time, some scholars suggest that bisexual individuals may experience a phenomenon called *internalized biphobia*, which results from marginalization that usually includes pressure from same-gender oriented friends to adopt a gay lifestyle and opposite-gender oriented friends to conform to heterosexual standards (CSAT, 2001; Smiley, 1997). Internalized biphobia may cause bisexuals to struggle to answer questions such as “Who am I?” and “Where do I fit in?” that prevent them from experiencing pride associated with their bisexual identity (Smiley, 1997, p. 377). Therefore, it is possible that bisexuals in this study who reported experiencing internalized homophobia were, in fact, experiencing an intersection between internalized homophobia and internalized biphobia. Further research is warranted on the intersection of internalized homophobia and internalized biphobia, and how it affects sexual minority identity development.

**Heterosexism, Internalized Homophobia, and Substance Use and Abuse**

Participants who were classified as having at least one alcohol or drug use
disorder reported that they experienced more heterosexism than those who were not classified as having an alcohol or drug use disorder. This finding is intriguing when considering the widely hypothesized association between heterosexism, homophobia, and substance use and abuse (Cabaj, 1996, 2000). DiPlacido (1998) proposed that LGB individuals experience physical and emotional stress as a result of encounters with discrimination, anti-gay violence, and the fact that heterosexuality is an “unspoken identity…from which deviation is abnormal” (Flowers & Buston, 2001, p. 24). Experiences with the stress described above places LGB individuals at high-risk for adverse mental health outcomes, including but not limited to the use and abuse of alcohol and drugs (Cabaj, 1996, 2000; Flowers & Buston, 2001).

Participants who were classified as having at least one alcohol or drug use disorder also reported that they experienced more internalized homophobia than those who were not classified as having an alcohol or drug use disorder. This finding supports the notion that internalized homophobia is related to alcohol and drug use and abuse (Cabaj, 1996, 2000; Clance, Nichols, & Ernshoff, 2000; Kus, 1988). Alcohol and drugs serve as a temporary relief from depression and other negative feelings caused by internalized homophobia (Bobbe, 2002). Although McCarn and Fassinger’s (1996) model does not directly address the relationship between substance use and abuse and sexual minority identity development, it does underscore the emotional intensity and difficulty of the process of developing an LGB sexual identity in the context of societal oppression. Combined with Cabaj’s research on the relationship between internalized homophobia and substance use and abuse, and the results of the present study, a person who is experiencing heterosexism or internalized homophobia and using or abusing substances to “overcome the internal fear, denial, anxiety, or even revulsion about gay sex” and a gay lifestyle (Cabaj, 1996, p.786) would likely be characterized as being early in their development of a sexual minority identity. As aforementioned, this suggests that participants’ level of LGB identity development is a critical variable to assess in future research in this area.

**Implications for Counseling Practice**

This study has implications for mental health counselors who provide services to LGB individuals who use or abuse substances, either in a general counseling practice or a substance abuse program. According to Cabaj (1997), there are special treatment concerns for LGB people in addition to recovery from substance abuse such as recovery from the consequences of homophobia. To achieve recovery from substance abuse and homophobia, an LGB client needs to address his/her own acceptance of self with the support of a gay-affirmative counselor. It is important for a counselor to identify that internalized homophobia is the result of living in an anti-gay culture, and to encourage the use of counseling and Alcoholics Anonymous as a means of expressing negative feel-
ings like shame (Bobbe, 2002). Treatment plans should address the degree and impact of internalized homophobia and how it is related with the sexual minority identity development of the client (Cabaj, 1997). A model of sexual minority identity development such as McCarn and Fassinger (1996) should be utilized as a theoretical guide to help explore the experiences of clients and where they may be in terms of their “coming out” at both the individual and group membership. Issues related to sexual orientation should be discussed in individual, partner, and group counseling, when appropriate. Affirmative counseling groups specific to LGB people are useful in that they create a safe environment where clients can freely discuss their experiences as LGB individuals, and how these experiences have affected their substance abuse behaviors. Although the issues discussed in such groups may have little or nothing to do with sexual orientation, the groups still provide a sense of acceptance and support that may provide a new experience for LGB clients (Hicks, 2000). Gender-specific groups where lesbians/bisexual women and gay/bisexual males can share counseling concerns relevant to their gender identity, that may otherwise not occur in gender-mixed groups, can also be helpful.

This study also has implications for counselor educators who teach and supervise mental health counselors. In particular, counselor educators need to increase the awareness of students on the impact of homophobia, heterosexism, and internalized homophobia on the lives of LGB people, and how LGB individuals might cope with minority stress. By educating counselors-in-training on sexual minority identity development (i.e., McCarn and Fassinger’s Model of Sexual Minority Identity Formation) and other important sexual orientation constructs, counselors will be better prepared to work with LGB clients. Counselor educators can integrate case studies using LGB clients, videos that introduce important historical LGB events and key figures, and invite LGB guest speakers to help students learn about the LGB community.

Limitations and Future Research

Caution should be taken when generalizing the results from this study to the LGB community at large, as the Internet was used to recruit participants and to complete the survey. LGB persons without access to the Internet, who did not frequent the type of places where calls for participation were placed, were not represented in my sample. Investigators should incorporate a diversity of methods to recruit LGB individuals who may not be integrated into the LGB community, or individuals who do not have access to the Internet.

The use of self-report measures is a second limitation; it is possible that participant responses were influenced by social desirability, that may have led to an underreporting of substance use and abuse. In addition, the IHP has been criticized in the literature because it “taps rather extreme internalized homophobia associated with the desire to change a homosexual orientation” (Shidlo,
Therefore, this measure may be more appropriately used with very homophobic LGB individuals, and may miss more subtle to moderate internalized homophobia. More research on the scoring procedures, psychometrics, and the appropriateness of this scale for lesbians, gay men, and bisexuals is warranted.

Finally, the incorporation of measures that assess sexual minority identity development is necessary as the literature suggest that this variable may be an important moderator of my study’s results.

In conclusion, the results of this study indicated significant differences in how lesbians, gay men, and bisexuals experience heterosexism and internalized homophobia. In addition, participants who were classified as having at least one alcohol or drug use disorder reported experiencing more heterosexist events and internalized homophobia than those who were not classified as having either substance use disorder. This linkage may provide an important foundation from which counselors and clients can explore clients’ experiences with homophobia, heterosexism, and internalized homophobia, and how these constructs influence their presenting problems. There is much that remains unknown about the etiology of alcohol and drug use and abuse among LGB people. To this end, mental health counselors, counselor educators, and researchers must continue efforts to investigate factors that enable LGB individuals to celebrate their sexual minority identities and avoid drug and alcohol abuse that arises as a function of minority stress.

REFERENCES


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