Substance Use in the LGBT Community

And the Persistence of Methamphetamine Use Among Gay and Bisexual men

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23 October 2015
Williamsburg Place Lecture Series
Objectives

• Understand the dynamics of substance use and abuse within the LGBT population.
• Understand the unique treatment needs of the LGBT population.
• Understand the use of methamphetamine and associated behaviors and risks among gay and bisexual men.
• Understand some treatment resources and approaches for working with the LGBT population, and specifically with methamphetamine using gay and bisexual men.
LGBT Substance Use

• As with any population, understanding LGBT substance use requires understanding the contexts in which that use occurs.

• As with any population, understanding LGBT substance use requires understanding the dynamics of the LGBT community and of LGBT individuals.

• As with everyone, working with LGBT substance users requires us to be value clear, to suspend judgment, and to name and resist stigma.
LGBT-wha?

• **Know your terms...**
  – **LGB:** sexual orientation - same-gender loving vs. gay
  – **T:** gender identity - trans vs. cis
  – **Q:** s.o., g.i. & gender or sexual expression
  – **I:** sex or reproductive organs at birth, parts
  – **A:** allies
  – Sexual orientation (sexual identity)
  – Gender identity

• **When in doubt, just ask! (hint: you should ask)**
  – How do you identify in terms of your sexual orientation?
  – Do you tend to partner more with men or women or...?
  – What’s your preferred pronoun?
The Genderbread Person

- **Identity**
  - Woman
  - Genderqueer
  - Man

- **Gender Expression**
  - Feminine
  - Androgynous
  - Masculine

- **Biological Sex**
  - Female
  - Intersex
  - Male

- **Sexual Orientation**
  - Heterosexual
  - Bisexual
  - Homosexual
So...

- Biological sex / sex at birth / sex parts
- Gender identity
- Sexual orientation/sexual identity
- Sexual behavior
  - Can you identify as a straight man who occasionally engages in same-sex behavior?
  - What about a straight guy who only partners with transwomen who have a penis?
- What does it take to be gay? “One drop theory” vs. movement of power and stigma
Dimensions of Sexual Orientation

Identity
Do you consider yourself gay, lesbian, bisexual, straight, queer, trans?

Behavior
Do you have sex with: men? women? both?

Attraction/Desire
What gender(s) are you attracted to physically and emotionally?
Imagine...

• My friend Cael: a male-identified, gay-identified, genderqueer presenting, transperson who likes to use his front sex parts during sexual activity.

• My friend Parker: a female-identified and presenting, lesbian transwoman. She prefers not to use her penis during sexual activities.

• My friend Tony: a masculine presenting gay-identified man who is asexual.

• My friend June: a female-identified, feminine-presenting, bisexual in a long-term relationship with a cisgender man.
Collecting (or not) LGBT Data

- Limited data and data with limitations.
- Routine collection of sexual orientation and gender ID info is (still) not happening.
- Convenience samples vs. population-based data.
- Self-reported data always has limitations.
- Public health data can be better than SUD data, thanks HIV research!
L,G,B Demographics in the U.S.

• Identify as lesbian, gay, or bisexual
  – 1.7 - 5.6% (average 3.5%)
  – Women were more likely than men to say they were bisexual.

• Same-sex sexual contact ever
  – 8.2%

• Same-sex attraction (at least some)
  – 7.5 - 11%

(Laumann et al., 1994; Gates et al., 2011)
Transgender Demographics

- Population-based studies are limited
  - 0.5% of population between ages 18-64
- California LGBT Tobacco Survey
  - 0.1% of adult population
- Estimate in U.S. from the Williams Institute
  - 0.3% of adults
  - Approximately 700,000 people
Dissonance Between Sexual Behavior and Sexual Identity

• 2006 study of 4193 men in NYC (Pathela, 2006)
  – 9.4% of men who identified as “straight” had sex with a man in the prior year
  – These men were more likely to:
    • Belong to minority racial and ethnic groups
    • Be of lower socio-economic status
    • Be foreign born
    • Not use a condom
• 77-91% of lesbians had at least one prior sexual experience with men
  – 8% in the prior year (O’Hanlan, 1997)
Stigma is Key

• **Until 1973**, the American Psychiatric Association considered homosexuality a mental disorder; was removed from DSM II.

• An incredible “This American Life” episode, “81 Words” addresses this history beautifully.
Substance Misuse Among LGBT Persons

• “Studies indicate that, when compared with the general population,
  1. LGBT people are more likely to use alcohol and drugs,
  2. have higher rates of substance abuse,
  3. are less likely to abstain from use,
  4. and are more likely to continue heavy drinking into later life.”

Substance Misuse Among LGBT Persons

- Multiple studies across time have indicated problematic use among LGBT persons to be at least 3 times that of heterosexuals.
- 20%-30% of LGBT report problematic use vs. 10% of straights.
- Gay men/MSM more likely to use some drugs: alcohol, marijuana, psychedelics, hallucinogens, stimulants (cocaine, meth), sedatives, cocaine, ecstasy, GHB, ketamine, poppers, ED meds.
- There is a strong correlation between substance misuse and sexual behavior and risk-taking among MSM/gay men.
- Lesbians & alcohol abuse
Most Commonly Used Drugs in LGBT Community

- Alcohol
- Cigarettes
- Marijuana
- Poppers
- Sexual Enhancement drugs
- Cocaine
- Methamphetamine
- Ecstasy (X, E, Molly)
- GHB (G)
- Ketamine (K, Special K)
- Benzodiazepines

Cultural competence is key: know what to ask
### Recent LGB-specific Substance Use Data

<table>
<thead>
<tr>
<th>Sex/sexual orientation</th>
<th>Past year heavy quantity drinking^1 (percent)</th>
<th>Past year marijuana use (percent)</th>
<th>Past year other illicit drug^2 use (percent)</th>
<th>Past year alcohol dependence^3 (percent)</th>
<th>Past year marijuana dependence^3 (percent)</th>
<th>Past year other illicit drug^2 dependence^3 (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay</td>
<td>18.1</td>
<td>25.2</td>
<td>16.8</td>
<td>16.8</td>
<td>0.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Bisexual</td>
<td>16.4</td>
<td>13.2</td>
<td>17.7</td>
<td>19.5</td>
<td>1.1</td>
<td>5.1</td>
</tr>
<tr>
<td>Not sure</td>
<td>9.4</td>
<td>19.0</td>
<td>5.2</td>
<td>4.8</td>
<td>7.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>13.7</td>
<td>6.2</td>
<td>4.5</td>
<td>6.1</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesbian</td>
<td>20.1</td>
<td>16.7</td>
<td>12.6</td>
<td>13.3</td>
<td>2.8</td>
<td>5.7</td>
</tr>
<tr>
<td>Bisexual</td>
<td>25.0</td>
<td>22.2</td>
<td>14.1</td>
<td>15.6</td>
<td>1.4</td>
<td>3.0</td>
</tr>
<tr>
<td>Not sure</td>
<td>14.0</td>
<td>9.0</td>
<td>8.2</td>
<td>2.1</td>
<td>0.8</td>
<td>0.0</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>8.4</td>
<td>2.6</td>
<td>3.1</td>
<td>2.5</td>
<td>0.2</td>
<td>0.4</td>
</tr>
</tbody>
</table>

## Recent LGB-specific Mental Health Data

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gay (percent)</td>
<td>Bisexual (percent)</td>
</tr>
<tr>
<td>Any mood disorder</td>
<td>42.3</td>
<td>36.9</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>12.3</td>
<td>3.6</td>
</tr>
<tr>
<td>Hypomania</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Major depression</td>
<td>37.8</td>
<td>35.8</td>
</tr>
<tr>
<td>Mania</td>
<td>7.7</td>
<td>14.6</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>41.2</td>
<td>38.7</td>
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<tr>
<td>Generalized anxiety disorder</td>
<td>16.9</td>
<td>11.5</td>
</tr>
<tr>
<td>Panic with agoraphobia</td>
<td>4.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Panic without agoraphobia</td>
<td>13.7</td>
<td>15.5</td>
</tr>
<tr>
<td>Social phobia</td>
<td>12.4</td>
<td>14.2</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>21.8</td>
<td>19.8</td>
</tr>
</tbody>
</table>

Recent Trans-related Data

- 26% misused drugs or alcohol specifically to cope with the discrimination they faced due to their gender identity or expression;
- 41% of respondents reported attempting suicide compared to 1.6% of the general public.
- Four times the national average of HIV infection, 2.64% compared to .6% in the general population, with rates for transgender women at 3.76%, and with those who are unemployed (4.67%) or who have engaged in sex work (15.32%) even higher; AA Transwomen= >24%
Why? Biopsychosocial Context and Dynamics - Not LGBT-specific

<table>
<thead>
<tr>
<th>Genetics</th>
<th>Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susceptibility/Predisposition</td>
<td>Neglect</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Trauma</td>
</tr>
<tr>
<td>Tolerance</td>
<td>Dysfunctional Families of Origin</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Sexual Abuse</td>
</tr>
<tr>
<td>Sensitization</td>
<td>Intimate Partner Violence</td>
</tr>
<tr>
<td>Brain Changes Due to Substance Use</td>
<td>Pre-existing Mental Health Issues</td>
</tr>
</tbody>
</table>
LGBT Dynamics and Contexts

- Stigmatization
- Isolation
- Harassment
- Discrimination
- Persecution
- Violence

- Self-Hatred
- Internalized Homophobia
- Internalized Heterosexism
- HIV
- Sexual Negativity
LGBT Community Context

- Prevalence of substance use in community
- Norm of sex-linked substance use
- “Pornification” of beliefs about sex and sexuality and sexual performance - internet
- Emphasis of beauty, youth, and appearances
- Lack of experience with valuing ageing in gay male community
- Norm of substance use lessening self-consciousness, stigma, shame, etc.
LGBT Dynamics and Context

- Health risks like HIV, HBV, HCV, HPV, HSV and other STI’s. Long-term trauma/survivors
- Lesbian experience of SA - close community, historical mistrust of systems, especially male-dominated/gay clinics
- Trans experience of SA - unique risks: gender confirmation, disinhibition, sex work and sex exchange/street economy, HIV risk
- IPV, DV
• Resource for working with LGBT Substance Abusers
• CSAT/SAMHSA
• Published 2001, rev up to 2012.
Methamphetamine

- Methamphetamine use is now endemic in gay male community—particularly in larger urban centers. Moved west to east.

- The methamphetamine, poly-substance use, sexual risk behavior, mental health, and HIV/STI syndemic is a challenge to address.

- Treating these requires providers to understand these overlapping issues: HIV prevention, mental health, and substance abuse
What is Methamphetamine?

Crystal Meth

- Synthetic Central Nervous System (CNS) stimulant mostly used as a recreational drug/
- Affects reward system/neurotransmitters
- On the street, generally found as an odorless white or off-white bitter-tasting crystalline powder
Methamphetamine

- Legally prescribed under the brand name Desoxyn
- Prescribed for ADHD, obesity, & narcolepsy
- Other amphetamine and amphetamine-like medications also available
History of Methamphetamine

• 1887 (Germany): Amphetamine first synthesized in a pharmacology laboratory.

• 1919 (Japan): First synthesis of methamphetamine, the most potent amphetamine.

• 1932: Amphetamine first marketed as Benzedrine (sold in nasal inhalers)

• 1940: Methamphetamine first marketed under trade name Methedrine.
History of Methamphetamine

• 1941-45: German and Japanese troops and munitions workers given methamphetamine to alleviate fatigue.


• 1951: U.S. Congress passes a law requiring prescriptions for all oral and injectable amphetamines used commonly to treat obesity, narcolepsy and depression.
History of Methamphetamine

• 1954: Japan speed epidemic - estimated 0.5-1.5 million users (with over 200,000 injectors).

• 1959: First report of IV injection of contents from Benzedrine inhalers

• 1963: Illicit speed production begins when CA Attorney General requests that injectable ampules be removed from the market.

• Late 60s - early 70s: Speed starts to replace LSD as favored street drug in Haight-Ashbury District of S.F.
History of Methamphetamine

- **1970s**: Methamphetamine use primarily located on West Coast.

- **1990s**: Methamphetamine use spreads to Midwest.

- **1996**: U.S. Congress passes Methamphetamine Control Act establishing new controls over key ingredients and strengthening criminal penalties for possession, distribution and manufacturing.

- **2001**: Reports of methamphetamine with increasing frequency on East Coast, beginning a trend.
why is this woman tired?

She may be tired for either of two reasons:

1. Because she is physically overworked. If this is the case, you prescribe rest, because rest is the only cure for this kind of physical tiredness.

2. Because she is mentally "done in." Many of your patients—particularly housewives—are pushed under a load of dull, routine duties that leave them in a state of mental and emotional fatigue. For these patients, you may find Desadrine an ideal prescription. Desadrine will give them a feeling of energy and well-being, renewing their interest in life and living.

Desadrine* (dextro-amphetamine sulfate, S.K.F*) is available as tablets, clinic, and Spiradra* capsules (sustained release capsules, S.K.F*) and is manufactured by Smith, Kline & French Laboratories, Philadelphia.


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APPETROL-S.R.

meprobamate 300 mg. + dextro-amphetamine sulfate 15 mg. sustained release

TO HELP BRING WEIGHT DOWN... AND KEEP IT DOWN

DAILY FOR WEIGHT REDUCTION

"Appetrol-S.R." as part of the weight control program can curb appetite, usually with a single capsule dose per day—helps bring weight down to the normal range you establish.

INTERMITTENTLY FOR WEIGHT CONTROL

Then, whenever weight rises above the acceptable maximum, the patient, at your direction, can again take "Appetrol-S.R." daily with an appropriate diet until weight returns to the normal range. Thus, recurring overweight crises and the need for extended, severe dieting may be avoided.

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is available to
High Altitude Flying Personnel!

Benzedrine Inhaler is now an official item of issue in the Army Air Forces.

It is available to Flight Surgeons for distribution to high altitude flying personnel, for relief of nasal congestion.

**Benzedrine Inhaler**

A Volatile Vasoconstrictor ... Outstandingly Convenient,
But, First and Foremost, A Highly Effective Therapeutic Agent.

Each Benzedrine Inhaler contains stramonium, S.K.F., 250 mg., oil of lavender, 75 mg., and menthol, 14.5 mg.

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To physicians in the Armed Forces...

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In accordance with your offer to physicians in the Armed Forces, please send me one of your new plastic BENZEDRINE INHALERS.

Name
Address
Slang for Methamphetamine

- Crystal
- Meth
- Crystal Meth
- Speed
- Tweak/Tweek
- Crank
- T

- Tina
- Crissy/Christy
- Glass
- Ice
- Uppers
- Yaba
- Shabu shabu
Methamphetamine 101 Lite

• Effect on the body is similar to most other stimulants except that the high lasts hours or days. Long runs are common, frequently paired with sex.

• Psychosis, and auditory and visual hallucinations are common with longer-term use, although possible with limited use.

• Affect on dopamine release and re-uptake is significant as compared to other stimulants and “pleasure behaviors”.

• Strictly speaking, medically-monitored withdrawal management is not indicated, but brain changes: memory, concentration, word recall, can persist.
Natural Rewards Elevate Dopamine Levels

**FOOD**

- NAc shell
- Empty Box Feeding

![Graph showing dopamine concentration in the NAc shell over time with data from Di Chiara et al.]

**SEX**

![Graph showing copulation frequency and dopamine concentration over time with data from Fiorino and Phillips]

Source: Di Chiara et al.

Source: Fiorino and Phillips
Effects of Drugs on Dopamine Levels

**AMPHETAMINE**

- DA
- DOPAC
- HVA

**COCAINE**

- DA
- DOPAC
- HVA

**NICOTINE**

- Accumbens
- Caudate

**MORPHINE**

- Dose (mg/kg): 0.5, 1.0, 2.5, 10

- Accumbens

Graphs show the percentage of basal release over time after administration of different drugs (amphetamine, cocaine, morphine, nicotine) with different axes for each category.
Routes of Administration

- **Oral**: 20-30 min. - contaminants
- **Snorting**: 3-5 min. - damage to nasal membranes & structure. Risk for HCV.
- **Smoking**: 7-10 sec. - Bronchial damage.
- **Hot Rail**: 7-10 sec.
- **Injecting (intrav.)**: 15-30 sec. - Risk of HCV, HIV, abscesses (no muscle or skin pop)
- **Rectal/Booty Bump**: 3-5 min. damage anal cavity tissue, blood, infection
- **Others?**
“But I don’t slam...”

- Social networks of users often divide along route of administration.
- Snorters/smokers tend to regard their crystal use as less serious and more in control.
- Snorters/smokers tend to view injectors as renegade or on the social margins.
- Injector sub-groups are, to some degree, bonded by shared social stigma.
- Most, but not all injectors started out snorting or smoking.
- Subculture - a “gay drug” - paired with sex - slamming as penetration
Why Gay Men and Meth?

Broad Appeal With Diverse Benefits

• Increases energy and productivity - work/home
• Erases self-doubts, including body image, stigma
• Lifts depressed mood, medicates ADHD
• Relieves boredom
• Decreases anxiety about: sexual performance, HIV, disclosure, and internalized homophobia
• Facilitates uninhibited sexual expression
The Meth-Sex Connection

- Feeling less inhibited.
- Feeling “sexier”, more attractive and virile.
- Having more vivid sexual fantasies.
- Facilitating particular sexual behaviors.
- Prolonging sexual play.
- Delaying orgasm.
- Having more intense orgasms.
- Meth use combined with other drugs: GHB, sexual enhancement drugs, benzo’s, poppers.
Meth and Sex - Longer Term

- Meth is sex, sex is meth: sex-meth fusion
- Paranoia/psychosis
- Increasing difficulty getting an erection and increasing difficulty achieving orgasm
- Disconnected sex - lack of intimacy/induced intimacy - total sexual objectification
- Never having sober sex
- Increasing feelings of social isolation and alienation - sexual behavior may become solitary
- HIV and STI transmission risk
Frequency of Meth Use & HIV Prevalence

Methamphetamine and HIV

• CM use facilitates increased (impulsive/compulsive) sexual activity.
  • Long sexual sessions lasting hours to days; multiple partners

• Associated with increased risk-taking during sex
  • 2004 CDPH/CDC study of Chicago MSM
    » Meth users reported 2x more sex partners in past year
    » Meth users reported 3x more unprotected receptive anal sex

• Increases risk of HIV infection
  • 2005 UCSF/CDC study of San Francisco MSM
    » Meth users 3x more likely to have recent HIV infection
    » Meth users during sex 4x more likely to recent HIV infection

STD/HIV/AIDS Chicago, Chicago Department of Public Health, Summer 2005
LGBT Treatment Needs

- Treatment and prevention of substance misuse must address: co-occurring mental health disorders, HIV/STI, and sex fusion/sexual compulsion.

- Treatment environments must be sex-affirming and safe for clients to be out about sexuality, HIV, sexual behavior, body image, homophobia, and shame.

- Effective treatment must address sexual behaviors and sex-linked substance misuse in order to adequately address relapse and to assist clients in re-establishing sexual life and health without substance use. Very few programs do this.
LGBT Treatment Needs

• Treatment of LGBT persons (and frankly all persons) must acknowledge the variety and types of relationships and behavior: primary relationships, open relationships, hook-ups, polyamory, kink.

• Treatment of LGBT persons must acknowledge the significance of the internet, online engagement, and apps in connecting with other LGBT persons both for socializing and for sex. Good and bad.

• Treating substance misuse among LGBT persons must acknowledge the context and drivers of use: stigma, homophobia, discrimination, family of origin, religion, HIV, etc...
LGBT Treatment Needs

- Treatment of LGBT persons must understand the history of HIV and its effects and aftermath. If you are working with a gay identified man in his 40's or up, especially one from an urban area, you must understand the experience of living with the specter of debilitating illness, premature death, and unfathomable community loss that was nearly invisible to or ignored by most other people during the 1980’s and 1990’s.

- HIV+ long-term survivors, “AIDS Survivor Syndrome”
  - Living always on the death horizon
  - Delayed planning, lack of sense of purpose
This means taking a sex-positive, harm reduction approach

Harm reduction is a set of practical strategies whose goal is to meet drug users “where they’re at” to help them reduce any harms associated with their drug use.

Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.
Abstinence $\leftrightarrow$ Harm Reduction

- Harm Reduction focus for sexual health, even in an environment of drug and alcohol abstinence.
- 12-step programs can be prescriptive about sexual behavior—contradictory, arbitrary, and not necessarily culturally tailored (and not in the Big Book).
Framework for Working with LGBT Substance Misusers

- Know your role, know your stuff
- Be in touch with your own values/beliefs
- Meet person where they are
- Assess sexual health and potential for AOD relapse.
- Know your stuff, or where to find out, and be transparent about this.
- Explore options to support sexual health while reducing sex-related harm
Sexual Health and Substance Misuse

- Client/participant defined - their goals
- Always balance harm with benefit
- Increasing sexual health and well-being often minimizes harm
- Acknowledge the impact of sexism, racism, classism, homophobia on sexuality
- Identify what person gets out of experience (and reduce any shame)
- Validation and respect for choices “don’t yuk someone else’s yum”
Risk/Harm and Strength/Asset Assessment

• Explore reasons for using
• Explore pros/cons of using
• Explore method of meth administration
• Explore patterns of use - especially relationship between use and sex
• Explore interpersonal relationship dynamics
• Identify previous success and attempts at reducing harm, quitting
• Identify support network and needs
Some Assessment Questions

• How do you identify in terms of your sexual orientation? How about your gender identity?
• What pronoun do you prefer?
• Describe your first same-sex sexual experience... (age, who, consensual, what was this like?...)
• Describe your first opposite-sex sexual experience... (age, who, consensual, what was this like?...)
• Nowadays, do you typically partner or hook up with people of the same gender or opposite gender?
• Are you in a primary relationship? Do you have agreements about openness vs. closedness?
Some Assessment Questions

• If lgbt-identified: tell me your coming out story.
  – To whom/when/in what context (online, HIV)/was it within your control/is it ongoing/are there key people who don’t know?

• Do you masturbate? What was the messaging (if any) you received about masturbation? How does it fit into your life now? How does it fit in the context of your primary relationship?

• Tell me about your relationship to and consumption of sexual media (porn). Age of first exposure? Who was there? Positive or negative? Relationship now?
Some More Questions

- How do you understand your LGBT identity to connect to substance use?
- Do you spend a lot of social time at bars and clubs?
- Do you use apps or internet hook-up sites to meet sexual partners? How’s this been for you?
- Do you typically use methamphetamine in conjunction with other drugs?
- Do you typically use methamphetamine in conjunction with sexual behavior?
- Describe the last time you used methamphetamine: who was there, where were you, what happened, etc...
Even More Questions: HIV

• When was the last time you were tested for HIV?
• Do you know your HIV status?
• If negative: How often do you partner or hook up with someone with an unknown HIV status or a known positive HIV status?
• What sort of prevention strategies do you use to stay negative or to minimize transmission risks?
• If HIV+: Do you have a primary care provider? How often do you see them? What are your numbers like? Have you ever had an opportunistic infection?
• How much would you say your substance use affects your HIV treatment adherence?
• What sort of prevention strategies do you use to minimize transmission risks?
Exploring Sex and Meth

- What is the difference between sex with meth and without it?
- What fantasies and behaviors does meth give “permission” for? What purpose does it serve?
- What is worst case scenario of having sex without meth? Best scenario?
- How does meth affect sex both physically and psychologically?
- How do you feel before, during, and after sex?
- How does body image play in? Is this a relapse risk?
- How does your substance use fit with your sexual and relationship ideals?
Harm Reduction Strategies Beyond the Physical

- Explore self and body image
- Values clarification about sex
- Enhance negotiation skills
- Empowerment with decision making
- Separate identity from behavior
- Identify where self-esteem is held
- Explore sexual likes and dislikes
- Sexual anatomy and physiology of pleasure
- Explore and deconstruct sexual roles
Harm Reduction Strategies for Meth Users

- Lube, lube lube!
- PrEP, PEP, understanding TasP and risk
- Check for trauma, openings, abrasions
- Viral hepatitis, STD and HIV checks - doc
- Method of meth administration
- Communication and safe words
- Adaptive positioning/sero-sorting
- Barrier use - condoms
Treatment & Support Options

• Treatment
  – CBT, harm reduction, MI
  – Sensitivity about 12-step engagement/reluctance
  – Culturally-tailored gay-specific treatment “Getting Off”

• Support & Information
  – Crystal Meth Anonymous (CMA)
  – Other 12-step self-help groups (AA, NA, etc.)
  – SMART Recovery
Definition of Sexual Health

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; *it is not merely the absence of disease, dysfunction or infirmity*. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

–World Health Organization
Approximately 40%-60% of clients identify CM as their drug of choice. Consistent for the past 6+ years.

Past 2 years, 70%-90% of CM users are HIV+

Continued integration of CM-specific information and material in treatment including emphasis on HIV and sexual behavior. Sex in recovery group.
Q&A and Contact Info

• Questions?

• Thanks!

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