Transcript: Alcohol is STILL a Drug: An Exploratory Webinar Series (February 1, 2022)

Presenter: De'An Roper
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ANN E SCHENSKY: Good morning, everyone, and welcome.

Hi, everyone and welcome. I'm excited to see so many people this morning. We're going to give it a minute or so, and then we're going to start with the introductions so that Dr. Roper has the entire 30 minutes for her presentation. Good evening from Kenya. We are from everywhere today. All right.

Again, welcome, and good morning or good evening to everyone. We are excited that you're here. This is the fifth of nine sessions for Alcohol is Still a Drug. Our speaker today is De'An Roper.

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All of the TTCs believe that words matter and use affirming, respectful, and recovery-oriented language in all of our activities. We have some housekeeping details for you today. If you're having any technical issues, please message Stephanie Behlman in the chat section, and she'll be happy to help you. Because this is such a short presentation, if you have any questions for the speaker, please put them in the Q&A pod at the bottom of your screen, and the presenter will address them in writing after the session, and they will be posted on our websites.

We will be using automated transcriptions for today's webinar. And this presentation will be recorded and posted on our websites within two weeks, along with any of the questions that people asked. Certificates of attendance will be sent to all who attend the full session, and they could take up to two weeks. And you will be sent a link to your certificate via email. If you'd like to see what else we're doing, please follow us on social media. And we are excited today that our speaker is De'An Roper.

De'An is a licensed clinical social worker and an assistant professor of practice in the School of Social Work at the University of Texas at Arlington. Prior to her academic career, Dr. Roper worked in various systems of care for more than two decades. Her early experience was shaped by working the LGBTQ+ community during the HIV/AIDS epidemic. Later, her direct practice

included working in criminal justice environments, developing treatment programs for people diagnosed with co-occurring disorders.

Dr. Roper's area of practice expertise include program development, LGBTQ+, cultural competence, service team development, and she provides advanced clinical supervision. Her research interests include sexual and gender minority health disparities, health risk behaviors, substance misuse, mental health, and the criminal justice system. So I am excited to turn it over to you.

DE'AN ROPER: Hello, everyone. I'm excited to be here. Thank you, Ann. We will really be talking about an important topic today, and I appreciate everyone being here. We have such a great turnout. Thank you so much. Everybody, I'm assuming, can see my screen. Please let me know if you can't.

So yes, my name is De'An Roper, and my pronouns are she and her. I identify as a lesbian and sometimes queer. I use those terms interchangeably. But I do like to self-identify up front at presentations like this and when I teach classes so that I can act as a role model to help decrease isolation for LGBTQ folks.

So for this presentation today, we will briefly identify and define-- and I mean briefly. We only have 30 minutes-- define general LGBTQ terms and concepts. We will highlight disparities in alcohol use among LGBTQ groups and subgroups. And then we will explain the leading theory for the health and substance use disparities that we find within LGBT groups, subgroups themselves, between each other, and also when compared to non-LGBTQ groups. In other words, heterosexuals. And then we will discuss a few high-level practice ideas.

So let's get started. First we want to talk about that there are terms and concepts that are very different, and that is sexual orientation and gender identity are two different concepts. The main idea is to understand that sexual orientation and gender identity are separate and that this can sometimes be confusing for people.

So as you see, I am using an image here, called the gender unicorn, on the slide. I'm using this partially as a resource for you to access. It's easily found online. There's a lot of information on it. So when you have some time, I really encourage you to look it up, study the codes and the symbols, and read the accompanying information found on the website. Or you could watch the seven-minute YouTube video that's referenced below. It goes into a very thorough explanation.

But I wanted to show you briefly this image and explain that sexual orientation is about who people are romantically attracted to, physically attracted to. And sometimes their behavior will match that, and sometimes it will not. For example, someone could still be attracted to same sex but fearful of acting on those feelings and behaviors. And they still may not identify as lesbian, gay,

bisexual, or queer, or heterosexual. Sometimes people will identify as mostly heterosexual. There's lots of different ways to identify sexual orientation.

And a second and separate concept is gender identity, gender identity is defined as your inner feelings about your gender. Notice the rainbow and the brain cloud there. It's really about your inner feelings-- other people don't necessarily see that-- about who you are. And sometimes those inner feelings and thoughts don't match what was listed on your original birth certificate in terms of your sex assigned at birth. People who experience this mismatch might label themselves as transgender.

The gender unicorn also helps us illustrate that sometimes people's outward expression, like your clothing and how you walk or talk, et cetera, may not match how you actually feel internally. And sometimes that's intentionally done for safety reasons.

Now, sometimes people don't identify with either gender, not male or female. And they will sometimes refer to themselves as non-binary, sometimes genderqueer, gender nonconforming. Another term you might hear or see more of is gender expansive. It's important to understand that this identity, all of these identities, can really be fluid for some people, depending on how they're feeling or the environments that they're in or the context of the environment.

So before we leave this slide, I just want to mention that the Williams Institute at UCLA Law is one of the leading organizations and research places that really helps us with a lot of data and technical reports for studying LGBTQ folks. And it tells us that about 9.5% of people between the ages of 13 and 17 identify as LGBTQ+. So about 9.5% of youth aged 13 to 17 identify as LGBTQ+. And again, you can find resources about this particular image in these two locations.

So we're here talk about alcohol is a drug. So alcohol is still a drug. Alcohol misuse is the fourth leading cause of death in the United States. And that includes diseases related to addiction and accidents, violence, car crashes, and so forth. We also know that continued use of alcohol will change the brain, and it changes the structure of the brain over time. This is especially true for young people whose brains are still developing.

This lends itself to one of the reasons we really define addiction as a disease. We know that if you're an adolescent and you drink before age 15, you are four times more likely to become-- I mean, to develop an alcohol use disorder later in adulthood. And we know that early age drinking can set up a trajectory into young adulthood, where we see some of the highest rates of alcohol consumption, including binge drinking and heavy episodic drinking, especially among college-age people.

In fact, some research indicates that the first six months of alcohol exposure at college is related to the amount of future college drinking patterns and

consumption. So that first six months really starts to lay that pattern. Recently there's been a trend-- there's a new study-- there's been a trend in college drinking rates where the number of women drinking in the last 30 days is slightly higher than the rates of men drinking in the last 30 days. And that's a new result. It used to be the other way around. But we still see college-age men binge drinking at higher rates and drinking more heavily than women.

So according the CDC, alcohol is still the most commonly used drug among youths. And so let's take a look at some of the alcohol basics and why that might be the case. First of all, it relieves stress. Most times, alcohol will help people relax. And a lot of people depend on it for being what we might consider a social lubricant. If someone's experiencing social anxiety or concerns about being around people, having a drink of course loosens them up and can help them to relax and feel more confident.

It's socially acceptable to drink as well. Some people even push drinking on others when they're drinking, so peer pressure. We all know peer pressure can be really high around alcohol.

And there's really very little stigma to drinking alcohol. There's a lot of social media influence, especially post-COVID, related to drinking alcohol as a way to cope with the pandemic. You see we have these virtual happy hours and so forth as a way to learn to get through the pandemic as we're all sitting at home.

And lastly, it's extremely accessible. Most youth do not have to pay for their own alcohol. They get it from their friends or their family, or their friends have older siblings and had a party and that leftover alcohol, even parents. There's a lot of anecdotal information from providers that I talked to that parents allow their children to drink at home. They actually give them the alcohol. And they say, I would rather provide alcohol to my child and let them drink at home. That way I know where they're going, I know who they're with, I know they're not driving under the influence of alcohol. And they feel like they can keep their kids safer.

And they also say these things because they bought into the social acceptance and this norming of teenagers and young people drinking now. It seems that perhaps the loosening of marijuana laws and legalization of marijuana in certain states might really be influencing this even more. It's sort of like the normalization of drinking among youths seems to correspond with some of that if we take a look at that trend.

So let's look at some statistics. Get down to business here. Prior to COVID, just prior to COVID, we had seen a little bit of leveling off or a slight decrease in the general numbers of youth consuming alcohol. But the rates in general identified by SAMHSA's last national study just before COVID-- right before COVID-- indicated about 16.1% of youth used alcohol in the previous 30 days, and 9.2% reported that they had experienced some binge drinking in the

previous 30 days. We also know nationally that adolescents use alcohol more than they use tobacco or marijuana.

Now, that's the national statistic. When we look at the LGBTQIA youth, or the queer youths-- I'm going to use those terms interchangeably-- the statistics, it's really difficult to boil those down into one or two numbers or stats because most of the national larger research studies have not really been collecting data on identifying sexual orientation or gender identity for a long period of time. And we usually like to look at trends in use. And so that requires years of longitudinal kinds of studies.

And as I was explaining earlier, orientation and gender identity is really complex. And there's many ways to measure and identify those variables about how people label themselves and identify in terms of any kind of queer identity. And so it's really difficult for us to compare apples to apples when we start looking at really big studies.

But generally, the accepted number across the literature in general for queer youth-- LGBTQ+ youth-- alcohol use is about two to four times the rate as compared to their heterosexual peers. Now, as I talked about earlier, that post-COVID indicators seem to really indicate of course that queer youth and adults are reporting higher use of alcohol-- alcohol very specifically. Not alcohol and other drugs. Just alcohol. It's probably the same for heterosexual folks, too.

But there are some studies that were specifically looking at queer communities that discuss the implications of the isolation of the pandemic and COVID and the increased use of alcohol to cope in families where they're not necessarily always feeling comfortable, and just the sheer isolation.

Now, there is one other thing that's interesting. There are some newer studies that are looking at the subgroups of sexual and gender identity, so in other words, people who identify as bisexual, or maybe they're unsure, they're questioning, or maybe they identify as mostly heterosexual. This research is comparing those subgroups to each other, what we call within-group rates, rather than strictly collapsing all LGBTQ-identified people into one category and comparing them to heterosexuals.

So for example, a recent study found specifically bisexual and questioning females are at particularly high risk for 30-day alcohol use, as well as lifetime use and heavy episodic use, when compared to their heterosexual females. But females who identified as lesbian are now coming closer to the same rates as their heterosexual female peers. So in other words, females who don't identify as lesbian, and they don't identify as strictly heterosexual, are at higher risk for alcohol misuse. And we also see that in some of the mental health literature, as well.

And it's not necessarily a same for adolescent males, interestingly enough. Although gay males still have a greater disparity of their age of first use of

alcohol when they compared to their heterosexual peers. So in other words, they first drink at earlier ages when compared to straight males.

So a lot of the other research additionally indicates that higher rates of disparities for males and females who do not identify as strictly heterosexual or may identify as bisexual, those folks seem to be at higher risk for lots of issues, including alcohol misuse, mental health, and so forth. So why would this be? Let's talk about the leading theory.

It's actually called minority stress theory, posited by Meyer around 2003. This is the most frequently referenced leading theory in the literature when we start taking a look at trying to explain these disparities. Meyer talks about that where people really experience a very unique, chronic environmental stressors. And these stressors result in internalized and externalizing coping behaviors. And so there's an expectation that because they've been exposed to or experienced so much unique kinds of discrimination and heteronormative kinds of experiences, there's an expectation of rejection or victimization and marginalization.

In other words, they're just expecting it around the corner. Sometimes it's merely reflected in their local or state politics or their school policies. Sometimes it's a perception, and sometimes it's the actual experience.

As a result of some of these experiences and the expectation of discrimination and rejection, they may begin to understand that it's really important for them to conceal their identity. Now, concealment is a really active case. It's hiding. You're actively hiding who you are. And that can really cause significant psychological distress. And as a result, also may limit their disclosure to very few people about who they are, or what they're struggling with, which in turn, of course, decreases their social support systems.

And we know that social support is a huge benefit to all people. We truly are made to connect with other people. So again, that isolation starts to come up as a factor.

As a result of these experiences, people will tend to internalize the structural stigma that they've experienced. And then they start to struggle with coping, and we start to see emotion dysregulation. This might otherwise be known as internalized homophobia. It's created from these perceived and actual fears and experiences of rejection and marginalization, which in turn creates an increased hypervigilance to the expectation of being victimized or discriminated against, which of course with hypervigilance causes anxiety or increases anxiety. And that can exacerbate mental health coping and also contributes to emotional dysregulation. We can see why people might reach for alcohol.

The other thing we know is that LGBT groups of color not only experience these specific issues, but their experiences are intensified and magnified by racism and the intersectionality of all their different identities. And this can

really compound the complexity of minority stress. Interesting-- we have some more within-group studies where we're finding that different subgroups of LGBTQ folks can experience different kinds of stigmatizing stressors, and then that can manifest in different coping and emotion regulation activities.

So for example, sexual minority females and/or lesbians might experience unwanted sexual advances from heterosexual males who comment, oh, you just need a good man, and so forth. But then young gay males may experience violence from heterosexual males or bashing towards them. So it's a different kind of heteronormative or discriminatory experience. All of these kinds of experiences will in some way serve to influence or mitigate alcohol use and other drug use, and it can look different for each subgroup of the queer youth.

So let's talk about family connections. We know that protective factors for youth for using, misusing alcohol or drugs includes really strong, family bonds, close connections to your family. A strong, close family relationship and parental involvement in what's going on with their children. They know who they're hanging out with, they know where they're going, knowing who their peers are, and so forth, is what the research tells us can help with prevention of substance misuse in youth.

But when you begin to understand minority stress theory, it's most likely that family connections as a protective factor for queer youth probably fall short somewhat. Because what we understand from some really large studies, including a large national study conducted by HRC-- which is The Human Rights Campaign, and there's a link for that study down below on the slide-- they've collected a lot of data that indicates that almost half of LGBTQ youth who are out to their parents report that their families make them feel bad. So the families know. They're out to their families, and they still feel bad in their families. So almost half of kids whose parents know that.

And then those who choose to conceal their identity-- of those who conceal their identity and are not out to their family, 78% of them hear their families make negative comments about queer people. And so therefore those experiences only really serve to reinforce their fears and anxiety and their anticipation of rejection, which then of course fuels emotion dysregulation again and seeking of different kinds of coping skills to feel better. Like, I'm so stressed out. I Can just relax with a drink.

So let's talk about school and social environments for queer youth. Additionally, we have to look at the wider environment for them. And the HRC study that I referenced has identified some emotional and physical safety factors that might surprise you.

77% of queer youth have experienced unwanted comments, jokes, and gestures in the past year related to their sexual orientation or identity. 77%. And that's usually within a school climate, but not always.

85% say that they are at an average number of 5 on a scale of 1 to 10 of stress. 85% say they stay at a 5 on a stress scale. And then 95% of these LGBTQ youths report that they have trouble going to sleep at night. They're worried about fear and safety and rejection. 95% have trouble going to sleep.

So continuing to look at social support, we know this is a critical factor for adolescent identity development. Studies show that social support of queer youth helped facilitate higher positive self-esteem. This social support can look like student school groups or communities with pride events that are very public. In fact, some population-level research shows better mental health and lower S-U-D rates for queer groups that live in states with friendly climates and laws and policies related to LGBTQ+ social issues.

However, there is one study that suggests some of those school GSAs don't really mitigate specifically alcohol use. And they surmise that perhaps that's due to that normative use of social acceptance of teenagers drinking alcohol that we talked about on that earlier slide. But we really do need a lot more research on this.

And social media plays a big role in creating community for LGBTQ youth. Many of you probably have new insights into the role of social media as a result of the COVID pandemic. You may better really now understand how social media does decrease isolation.

These online safe spaces for these queer youth are sometimes the only escape where they can feel that they have other people that feel the same way, and they're not alone in their struggles, and they feel less isolated. These are people who can mirror their experiences and validate their struggles and their identities without the threat of rejection or marginalization. Many times, social media is where queer learn cultural norms and dating norms.

The flip side of this positive community connection is that it also increases one's exposure to alcohol messaging, too. In fact, a study on college-age women during COVID indicates that these sexual minority women have higher rates of drinking than their gay male peers. And one factor that they relate it to is their frequency of exposure to social media, like checking their Instagram and Snapchat. Some of these participants in the study admitted that they actually go online specifically looking for alcohol-related messaging.

So some quick suggestions for clinical practice. First, we have to remember identity development during adolescence can be fluid and changing very quickly, in fact. They're learning who they are through their reflections from the environment, their relationships with their peers and their family and family connections. And you as a provider need to remain open to their expressions of fluidity.

Go with the flow. Try to keep up. Be respectful when they request change. Sometimes it can make us feel uncomfortable. But your own transparency

and appropriate level of honesty will go a long way in developing rapport and building trust. Remember, the chances of them perceiving or anticipating rejection is going to be high just based on their previous experiences with their family and their peers.

And remember also, sexual behavior does not mean identity. It is always inappropriate for a clinician to suggest how someone should identify. Let it be their own process. Accompany them on this journey of curiosity. They need a trusted adult who can mirror them no matter who they are. They Are acceptable and they're OK and that they will be OK. It's part of our job to instill hope, one of those SAMHSA recovery principles.

Remember words have power. Ask, how do you identify? But make sure you ask it in a private setting for sure, not necessarily in front of other staff. Read the contextual cues of the environment that you're in. Be transparent. Be authentic. If you misgender someone and call them by the wrong pronoun, catch yourself, apologize, and move on.

Respect diversity. Understand that the LGBTQ community is very diverse, and not only in just terms of race and ethnicity, but immigration status and disabilities and so forth. Get trained in trauma-informed care. Now that you understand minority stress theory and you can see how it relates to trauma and traumatic experiences for queer youth, make sure your organization is not recreating some of that trauma by practicing non-affirming LGBTQ practices.

Use harm reduction model. This approach is one of the most respectful of all approaches in that it really is meeting the client where they are. Abstinence is not always going to be the desired outcome.

Recognize that young men who have sex with men and transgender women of color are at higher risk for HIV infection, especially those who are misusing alcohol and other drugs. And again, using that harm reduction model, strategize with clients on how to reduce their risk.

Understand minority stress theory and help the youth understand their reactions in the context of that reaction. And help mirroring connection and emotional safety for them in that moment. Help them identify safe and supportive systems.

Make sure that you understand your job is not to help youth come out or find a label. They must decide for themselves. Although sometimes you may have to point out whether it's safe for them to come out and help them problem solve with all of that.

Make sure that you employ peer role models in your organization. This helps to decrease their sense of isolation. Polish up those motivational interviewing skills. Start where a client is. I see it a lot where clinicians want to go faster than where the client's ready to go. And finally, advocate for organizational

community and systems changes that embrace and empower queer youth and communities.

It really has been a pleasure. I appreciate your time and attention. There are resources here in the slides. Here's all the references. You can certainly type in some of your questions, and I'll be happy to answer those via email. Thank you very much.

ANN E SCHENSKY: Thank you, Dr. Roper. This was amazing. So much really good information. And just to remind everyone that we will post the recording and the amazing list of resources at the end, as well as any questions that people may have had, on our websites. So feel free to look for them.

If you have any other questions, you can let us know. Otherwise, again, thank you all for your time. And especially you, Dr. Roper, for your time and an incredible presentation.

DE'AN ROPER: Absolutely.

ANN E SCHENSKY: All right, everyone. Have a fantastic day, and we will-- OK. We have one question that we will send to Dr. Roper. And everyone have a great day.

DE'AN ROPER: Thank you so much.