Drug Use and Increased Risk of HIV Among Lesbians and Other Women Who Have Sex With Women

Marjorie J. Plumb, M.N.A.; Elizabeth J. Rankow, P.A.-C., M.H.S.; and Rebecca M. Young, M.Phil.

INTRODUCTION

Although articles written about lesbian health issues point to a paucity of research on lesbian women, in 1994 the National Center for Lesbian Rights published a bibliography of lesbian health research and articles that included more than 800 citations. Many articles listed in that bibliography had been published in peer-reviewed scientific journals, such as the *New England Journal of Medicine*, *American Journal of Public Health*, *Journal of General and Internal Medicine*, and *Journal of Nursing Scholarship*. In addition, significant research has been conducted that either has been published in non-peer-reviewed journals or other publications or has not been published at all, leaving distribution of the analysis of some local and regional research projects to informal networks. All this research constitutes a growing body of knowledge about lesbian health, including issues related to substance use and the human immunodeficiency virus (HIV).

DIFFICULTIES WITH CURRENT RESEARCH RESULTS

The number of lesbians with alcohol or other drug (AOD) use problems is unknown, partly because of the difficulties researchers face in studying the lesbian population. Studying a marginalized, stigmatized, and fragmented population complicates random sampling (Goffman 1963; Laumann et al. 1994). Thus, many researchers rely on convenience sampling, raising concerns about the systematic bias in sampling as well as the generalizability of results (Young 1993). Because researchers face particular difficulty in accessing the most severely marginalized

of the lesbian population, study samples tend to be composed of predominantly white, middle-class "out" lesbians. Women of color, poor and working class women, and women who have sex with women (WSW) but do not self-identify with the term "lesbian" or participate in mainstream gay culture remain severely undersampled. The demographic and other characteristics of the undersampled women are probably related to both the level of AOD use and likelihood of infection with HIV. Therefore, there are multiple biases associated with convenience sampling of a "general" population of lesbians.

Furthermore, once a sample has been identified, stigmatization of same-sex orientation and behavior makes disclosure particularly problematic. Many women, even as anonymous subjects of research, do not feel safe in disclosing their sexual orientation or the sex of their current or past sexual partners. A study of self-reported sexual behavior in a sample of women in prison compared different assessment techniques and found that same-sex behavior was reported by nearly twice as many women through qualitative assessment with a social worker as was disclosed via structured questionnaires (Magura et al. 1992).

There are extensive data on AOD use among women in the general population, yet researchers until recently have failed to collect or report data on WSW. These general population surveys include women of all sexual orientations but are not analyzed or reported by the variables of sexual behavior or identity.

AOD use has been well documented as a risk factor for HIV infection (Lowry et al. 1994; Trocki and Leigh 1991; Schilling et al. 1994). Reports suggest that WSW who are injection drug users (IDUs) may be at greater risk for HIV transmission through sharing contaminated "works" and through high-risk sexual behaviors than are female IDUs who have sex with men only (Young et al. 1992). No current research explores the mechanisms that can explain the WSW's higher risk. Some individuals knowledgeable about this population of women have suggested that WSW may be more likely to engage in high-risk activities. These activities include sharing needles with high-risk men who have sex with men or sharing needles with other WSW because they assume that lesbians are safe from HIV (Case et al. 1990; Denenberg 1991; Magura et al. 1992).

Although descriptive studies of AOD use and HIV risk among lesbian and bisexual women are available, the literature has been

criticized for several consistent weaknesses (Jazwinski 1991; Young 1993). Many of these studies recruited lesbians at bars, and few samples were matched with appropriate control groups of heterosexual women. Comparisons of AOD use and HIV risk among different studies are also difficult to make because of methodological differences. For example, measures are not comparable among the studies, particularly with regard to timeframes and levels of AOD consumption. This chapter briefly discusses the most frequently cited or most suggestive of these studies. Because of noncomparability, each study is discussed separately. In spite of the studies' lack of comparability, the data on AOD use and HIV risks for lesbian and bisexual women are extremely intriguing, indicating critical areas for future research.

ALCOHOL USE

Both health professionals serving openly lesbian clients and early research on lesbians and alcoholism generally reported that lesbians have a higher rate of alcohol use and alcoholism than that for other women. Some of these early studies suggested that alcoholism affects as many as 30 percent of the lesbian population compared with 10 percent of the general population of women (Lewis et al. 1982; Hastings 1982; Morales and Graves 1983). A needs assessment in San Francisco that included data on AOD use behavior of 318 lesbian and bisexual women, as well as information provided by 140 service providers, suggested that lesbian and bisexual women use alcohol and other drugs, singly and in combination, more often and in greater amounts than women in the general population (San Francisco Department of Public Health 1990).

Skinner (1994) found that of 190 self-defined lesbians contacted through lesbian and gay organizations in Kentucky, 85.2 percent had consumed alcohol during the preceding year and 65.6 percent within the preceding month. Skinner noted that alcohol consumption by women 25 to 34 years old was higher among lesbians sampled (66.7 percent) than in an age-comparable general population of women (55.2 percent) (as reported in the 1990 National Household Survey on Drug Abuse), but this is clearly not an appropriate control group.

Ryan and Bradford (1988) found in their National Lesbian Health Care Survey (distributed throughout the United States via lesbian and gay organizations, social networks, and other venues such as bookstores

and prisons) that more than four-fifths (84 percent) of 1,925 respondents said they were current consumers of alcohol; 31 percent said they drink "regularly"; 25 percent reported drinking "more than once a week"; and 6 percent said they drink "every day." Daily drinking was most common among women in the $40,000 or higher annual income bracket.

The Health Behaviors Survey of the San Francisco Department of Public Health (1993*a*) developed a method of modified random sampling of women active in the lesbian and bisexual women's communities by randomly choosing venues where large groups of these women congregate, such as street fairs, film festivals, and sex clubs. Surveyors then randomly interviewed patrons (e.g., every fifth woman) as they entered the venue. Of the 483 women surveyed, 82 percent reported that they consume alcoholic beverages at least a few times per year, 20 percent reported drinking about once a week, 22 percent reported drinking two to three times each week, and 4 percent said they drink every day. Among women who drink, 37 percent reported that they typically have one drink at a time, 53 percent have two to three drinks, and 10 percent have four or more drinks on average each time they consume alcohol.

Other studies provide conflicting data about whether lesbian and bisexual women have higher, similar, or lower alcoholism rates than heterosexual women. Bloomfield (1993) in San Francisco and McKirnan and Peterson (1989) in Chicago reported no significant differences in drinking status or rates of heavy consumption between lesbians and other women. However, Bloomfield's (1993) findings indicate that more San Francisco lesbian and bisexual women than heterosexual women reported being recovering alcoholics. In Chicago, findings indicated that lesbians were half as likely to abstain from drinking as the general population (McKirnan and Peterson 1989).

Regardless of rates relative to heterosexual women, alcohol consumption represents a significant health risk in the lesbian and bisexual populations studied. Excessive alcohol consumption by women correlates with higher rates of cirrhosis, accidents, domestic violence, suicide, depression, hypertension, menstrual and reproductive problems, malnutrition, colon and stomach cancers, and gastrointestinal hemorrhage. These health risks must be considered for WSW (Denenberg 1994). Consideration is given below to the specific educational, programmatic, and outreach concerns in targeting WSW.

OTHER DRUG USE

Ryan and Bradford (1988) found that 47 percent of the lesbians they surveyed used marijuana at least occasionally and 20 percent had tried cocaine. Cocaine users were more likely to be black or Latina and young.

In a sample of lesbians 25 to 34 years of age, Skinner (1994) found that 23.5 percent had used marijuana in the past month compared with 9.1 percent of women in the same age range as reported in the 1990 National Household Survey on Drug Abuse (Skinner 1994). Total lifetime use of the following drugs among lesbians in this survey was significantly higher ($p<0.05$) than for Skinner's (1994) age-comparable sample of gay men surveyed: marijuana (87.2 v. 70.8 percent), hallucinogens (38.0 v. 26.2 percent), heroin (5.3 v. 1.5 percent), stimulants (46.0 v. 35.0 percent), tranquilizers (35.3 v. 25.1 percent), and psychotherapeutics (53.2 v. 42.8 percent). Lifetime use for all illicit drugs combined was also significantly higher for lesbians than for gay men (86.8 v. 79.2 percent; $p<0.05$) (Skinner 1994).

The Health Behaviors Study by the San Francisco Department of Public Health (1993*a*) found that 73 percent of lesbians surveyed (n=483) had used at least one illicit substance in the preceding 3 years. The most common substance was marijuana (67 percent), followed by MDA/ecstasy (23 percent), LSD or other psychedelics (22 percent), cocaine (21 percent), depressants (14 percent), and stimulants (14 percent). Of the lesbians surveyed, 2.3 percent had injected drugs in the preceding 3 years.

In another study (an HIV seroprevalence study), the San Francisco Department of Public Health (1993*b*) found that among 498 lesbians and bisexual women sampled at 24 locations in San Francisco and Berkeley, 10.4 percent reported injection drug use since 1978 and 3.8 percent reported injecting drugs in the preceding 3 years. Of those reporting injecting drugs since 1978, 71 percent had shared needles with other IDUs and 31 percent had shared needles with gay or bisexual men.

All the studies cited above attempted to identify a lesbian or bisexual female population and then survey a specific sample. Another method for assessing differences between lesbian or bisexual women and heterosexual women with regard to drug use and HIV risk is to look at research on female drug users and compare those who report female sex partners

with those who report only male sex partners. Among these studies, within drug-using populations of women, lesbian and bisexual women reported higher rates of unprotected sex and injection drug use than did their heterosexual counterparts. A study conducted by the research program AWARE (Young et al. 1992), of women entering a drug treatment program in California, found that 21 percent of 711 women interviewed had sex with both men and women and 3 percent had sex only with other women. Women who had one or more female sexual partners since 1980 were nearly twice as likely to have injected drugs during the same period as women who had no female sexual partners (76 v. 43 percent).

LESBIAN PERCEPTIONS OF AOD USE

How lesbians perceive AOD use as well as treatment options may play a significant role in the development of effective prevention and treatment programs and modalities for this population. Whether based on fact or fiction, beliefs can be significant barriers to care, and many lesbian and bisexual women may opt out of treatment for AOD dependence because they believe available services will not be supportive of their unique concerns. There is strong documentation of heterosexist discrimination in substance abuse services and a tendency of programs to target sexual orientation for intervention rather than addressing AOD use issues (Hellman et al. 1989; Rudolph 1988; Morales and Graves 1983).

A review of literature on alcohol by Hall (1993) indicates that lesbians believe the consumption of alcohol is greater among lesbians than among nonlesbians. Chief among the reasons cited for alcohol use are the societal oppression and homophobia that lesbians experience, difficulty in accepting the "lesbian identity," and the use of bars to find each other. Some lesbians think that lesbians interact with each other in coalcoholic or codependent ways as a means of protecting each other's sexual identities and that behavior then crosses over to helping each other hide other behaviors such as alcohol use. Some lesbians express a political belief that alcohol and other drugs are tools of a sexist and racist domination used to keep women unaware and exploited. And finally, many believe that severe and prolonged AOD use is a result of lesbians' avoiding treatment for fear of discrimination (Hall 1993).

The fear of discrimination and harassment within treatment facilities also is explored by Hall (1993). Many lesbians believe alcohol treatment programs are sexist and based on male treatment models. They believe that lesbians are not allowed to include their partners in their treatment program and are told by lesbians experienced with treatment not to talk about their sexual orientation or their relationships. Furthermore, some lesbians believe the treatment staff will want to "cure" their sexual orientation rather than address alcohol use problems and will be voyeuristic in asking questions about sexual experiences.

Hall (1994) also describes the cultural issues within "out" lesbian communities regarding alcoholism and recovery, including the rise of lesbian Alcoholics Anonymous groups, large gay pride parade contingents, and the demands for AOD-free space at lesbian events, which are viewed as alienating by some in these communities. In particular, working-class lesbians and lesbians of color may reject this emerging sobriety movement as being "white and middle class."

LESBIANS AND INCREASED RISK FOR HIV/AIDS

HIV transmission risk behaviors for WSW include sharing needles, having unprotected sex with men, having unprotected sex with women, undergoing artificial insemination, receiving blood through transfusion, and being exposed to breast milk (theoretically, a sex partner ingesting breast milk could become infected). Substance use, either as a direct transmission risk or in relation to other risks (such as reducing inhibitions to practice unsafe sex with men or women), is a major cause of HIV infection in lesbians. Lesbians have a strong belief in some level of immunity to HIV after more than a decade of public health messages saying in effect that lesbians are a no-risk or low-risk group (Cole and Cooper 1990/1991; Hollibaugh 1992, pp. 1-3).

In a review of HIV research specifically on WSW, Stevens (1993) reported that lesbians are presumed by health providers, researchers, and the Centers for Disease Control and Prevention (CDC) to be at lowest risk in the HIV epidemic. Cole and Cooper (1990/1991), Young and colleagues (1992), and others point to several weaknesses in an early report by CDC suggesting that WSW represented less than 2 percent of all reported AIDS cases. Because the CDC analysis was based on

reports gathered from medical providers, many of whom undoubtedly share the perception that women with AIDS are either drug users or heterosexually active, the data as reported on same-sex sexual activity may be inaccurate. In the database used by the CDC staff for this analysis, sexuality data were missing for 13 percent of the population studied. This information gap may reflect a reluctance on the part of medical providers to request or include this information about their women patients.

Most studies of HIV risk behaviors and seroprevalence in women fail to collect or report data on WSW. In a review article of several published and unpublished studies, Young and colleagues (1992) report that data in the studies that do make such reports suggest that certain subsets of WSW may be at greater HIV risk than women who have sex only with men. Among lesbian and bisexual women surveyed in San Francisco and Berkeley (San Francisco Department of Public Health 1993*b*), HIV seroprevalence rates were threefold the rates for all adult and adolescent women in the region (1.2 v. 0.4 percent). Other studies also suggest an association between same-sex sexual behavior and other risk behaviors. A study of drug-using women in San Francisco found that lesbian and bisexual women were more likely to report having male sexual partners who were gay or bisexual and to practice higher rates of anal sex than did their heterosexual counterparts.

No published study has documented the mechanisms that explain why same-sex sexual behavior may increase risk in ways that are apparently unrelated to having female sex partners, such as injection and other drug use behaviors, homelessness, and sexual behaviors with male partners. Although female-to-female sexual transmission of HIV is not currently implicated as a significant risk factor among WSW, increasing numbers of HIV-seropositive women indicate that female-to-female transmission may become an increasingly important risk in this population.

Stevens (1993) discusses possible reasons that lesbian IDUs may be at greater risk for HIV infection than heterosexual female IDUs. Chief among the reasons is the "invisibility" of lesbians with HIV because of both the lack of acknowledgment from the medical community and the need to hide one's status from a lesbian community often hostile to drug users and to WSW who have sex with men. This invisibility has caused a dearth of specific HIV prevention information targeting at-risk WSW.

Lesbian-identified IDUs may feel protected from HIV by their lesbian identity and then may place themselves at risk by such activities as sharing needles with other lesbians or gay men. In addition, because it causes people to avoid or leave treatment early, discrimination in AOD treatment programs may prolong the use of illicit substances, thereby increasing risk. Discrimination in the lesbian community against AOD users and those most at risk for AOD use (lesbians of color, sex workers, lesbians in prison, working-class lesbians, butch/femme lesbian couples, S/M lesbians, etc.) marginalizes members of those communities. Young and colleagues (1992) suggest that WSW IDUs are multiply marginalized and may therefore be the subset of female IDUs who are most likely to take risks, are least likely to be reached by education and health programs, have the least access to services, and are the least receptive to the programs that do reach them.

AREAS NEEDING FURTHER RESEARCH

1. What is the prevalence of AOD use among lesbians and bisexual women compared with prevalence among heterosexual women?
2. Is the incidence of AOD use rising or falling among lesbians?
3. What are the qualitatively distinct characteristics of AOD use by lesbians?
4. How do subgroups of WSW, particularly those who identify as lesbians v. those who do not, differ in level and type of AOD use?
5. What are the differences in treatment outcomes among lesbian, bisexual, and heterosexual clients?
6. What is the contemporary attitude in treatment programs toward lesbian and bisexual women AOD users, and how effectively do these programs serve them?
7. What are the current barriers encountered by lesbians who seek assistance for AOD use?
8. What are the distinctive characteristics of successful AOD prevention and treatment programs for lesbians?
9. What are the HIV risk behaviors of lesbians, especially lesbian IDUs?
10. What are appropriate HIV prevention strategies and messages for lesbians?

11. How can research be conducted in a manner that is culturally competent and reaches the full diversity of WSW?

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AUTHORS

Marjorie J. Plumb, M.N.A.
Director of Public Policy
Gay and Lesbian Medical Association
459 Fulton Street, Suite 107
San Francisco, CA 94102
(415) 255-4547, ext. 306 (Tel)
(415) 255-4784 (Fax)
mplumb@glma.org (E-mail)

Elizabeth J. Rankow, P.A.-C., M.H.S.
Researcher
Office of Cancer Prevention, Detection,
and Control Research
Box 2949
Duke University Medical Center
Durham, NC 27710
rankow@aol.com (E-mail)

Rebecca M. Young, M.Phil.
Division of Sociomedical Sciences
Columbia University
57 Turner Place
Brooklyn, NY 11218

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