

University of Nevada, Reno

**“We deserve to be seen, heard, and included in recovery spaces:” A content analysis  
informing the improvement of treatment for alcohol use for sexually diverse  
individuals**

A dissertation submitted in partial fulfillment of the  
requirements for the degree of Doctor of Philosophy in  
Psychology

by

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THE GRADUATE SCHOOL

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prepared under our supervision by

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## Abstract

**Objectives:** Excessive alcohol use is a public health concern that results in hundreds of billions of dollars in economic costs each year and leads to increased risk for disease, premature death, and other physical and mental health concerns. Sexually diverse individuals (SD; e.g., lesbian, gay, bisexual, queer) represent a community disproportionately impacted by alcohol use disorder (AUD) and alcohol-related problems. Though SD individuals utilize alcohol-related treatment services at a higher rate than the general population, the number of SD individuals with AUDs who seek treatment is low compared to the number of SD individuals with AUDs who do not seek treatment. Thus, current alcohol use treatment programs may not adequately engage or meet the needs of SD individuals. This study seeks to better understand treatment barriers SD individuals face in alcohol-related treatment that may be contributing to low treatment utilization, highlight ways of improving treatment for SD individuals experiencing AUD, and disseminating the findings to provide additional resources and increased knowledge for service providers who work with this community.

**Methods:** A sample of 11 adults 18 years or older who identify as SD (e.g., lesbian, gay, bisexual, queer) and who are currently receiving, or have received (within a one-year timeframe) alcohol use treatment for AUD were recruited for this study. Semi-structured interviews were conducted, transcribed, and a conventional content analysis approach was used to interpret data.

**Results:** Findings from conventional content analysis indicated participants felt their sexuality played a major role in their alcohol use (e.g., identity suppression and exploration, community drinking norms). Additionally, participants emphasized the

importance of creating and maintaining an inclusive and affirming environment, including mind/body/spirit components to treatment (e.g., body work, spirit-based programming), having competent and friendly staff (e.g., trauma-informed staff, increased training on working with community), and including a diverse selection of treatment and recovery models. Finally, all participants shared positive perceptions of incorporating aspects of harm reduction into treatment.

**Conclusions:** These recommendations should be taken into consideration when discussing treatment improvements, program policies, and program structure. It should be a priority to ensure that SD individuals feel safe, understood, validated, and are receiving the most effective treatment possible when entering programs.

## Dedication

I dedicate this dissertation to my family, friends, colleagues, and mentors who supported my dreams and stuck around through the ups and downs of this long journey. My success is a reflection of the village who never gave up on me. Thank you. We did it.

I also dedicate this dissertation to the 11 participants who fearlessly shared their stories.

Thank you.

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“After all, gay liberation  
is the only civil rights movement  
that began in a bar.”

June Thomas, *The Gay Bar. Is it dying?* 2011

**“We deserve to be seen, heard, and included in recovery spaces:” A content analysis  
informing the improvement of treatment for alcohol use for sexually diverse  
individuals**

Sexually diverse<sup>1</sup> individuals (SD; e.g., lesbian, gay, bisexual, queer) represent a community disproportionately impacted by alcohol use disorder (AUD) and alcohol-related problems (e.g., Fish & Exten, 2020). The minority stress model (Meyer, 2003) provides a theoretical framework for explaining these health disparities as being the result of specific stressors that are uniquely experienced by those who are part of the LGBTQ+ community rooted in prejudice and stigma (Frost & Meyer, 2023). Though SD individuals utilize alcohol-related treatment services at a higher rate than the general population, the number of SD individuals with AUDs who seek treatment is low compared to the number of SD individuals with AUDs who do not seek treatment (Allen & Mowbray, 2016). Thus, current alcohol use treatment programs may not adequately

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<sup>1</sup> “Sexually diverse” is a term adapted from the term “Sexual and gender diverse” (SGD).

Sexually diverse (SD) is the chosen term for this dissertation as this study has a primary focus on those who are often referred to as “sexual minorities” in the literature. This includes those who identify as lesbian, gay, bisexual, and queer. We believe that transgender and gender diverse (TGD) individuals may have unique barriers to treatment that deserves its own study.

engage or meet the needs of SD individuals. The purpose of this study is to offer a space for SD individuals with lived experience to share their testimonies through a community-based participatory research model. This study seeks to (1) better understand treatment barriers SD individuals face in alcohol-related treatment that may be contributing to the low treatment utilization, (2) highlight ways of improving treatment for SD individuals experiencing AUD, and (3) disseminate the findings to provide additional resources and increased knowledge for service providers who work with this community.

### **Historical Community Context**

In a *Slate* article titled “The Gay Bar. Is It Dying?” journalist and LGBTQ+ culture writer, June Thomas, describes the historical significance of gay bars for the LGBTQ+ community:

The gay bar has always been a refuge for homosexuals, a place where, as Edmund White once put it, gays "can feed and mate relatively free of predators." Historically, gay bars were a haven from the strictures of the closet, a safe space where patrons could take off the masks they wore while passing for straight. Many lesbians saw them as the one place they could wear the clothes they felt comfortable in rather than the costumes they were forced to wear in the wider world. They were a place to meet, to socialize, to find friends and potential partners. In a way, they were our church, with sermons delivered by disco divas (2011).

In an *Advocate* article titled “Gay Men, We Have a Drinking Problem,” author and activist Tyler Curry explores how gay culture and drinking came to become so interconnected:

The birth of gay culture happened on the corner of "after hours" and "drink until you're comfortable." In a society where being homosexual was taboo, not to mention illegal, those on the LGBT spectrum gathered in small bars across the country where they would drink, let down their exterior defenses, and commiserate with the people who accepted them for who they really were. The music, the style, and the laws against homosexuality have all changed, but that drink is still there (2015).

In 2012, a special issue of the *Journal of LGBT Issues in Counseling* emphasized the important topic of Addiction within the LGBTQ+ community. Editors Chaney and Brubaker (2012) introduce the special issue by exploring the history of bars, nightlife, and drinking as it relates to LGBTQ+ liberation:

On June 28, 1969, lesbian, gay, bisexual, transgender, and queer (LGBTQ) patrons of the Stonewall Inn, a neighborhood bar in Greenwich Village, New York City, decided they were no longer going to tolerate systemic oppression that came in the form of police raids, so they protested, rallied together, and defended themselves. Many consider this historic event the beginning of the LGBTQ civil rights movement. It is ironic that such a monumental action, with the intent to liberate a group of oppressed people, took place at a bar, a place where many LGBTQ individuals satiate addictive urges and are caged within the cycle of addiction (2012).

The historical significance of gay bars as safe spaces for SD individuals may be a driving force in the interconnection between sexual orientation and alcohol use prevalence. The drinking culture within the community paired with minority stressors faced by SD individuals further strengthen this association. For example, Fish and Exten (2020) concluded that not only did sexual minority adults demonstrate higher prevalence rates of AUD, but those who had experienced discrimination in the past year had even greater odds of AUD.

### **Statement of the Problem**

SD individuals are disproportionately impacted by AUD and other alcohol-related disorders yet utilize treatment at low rates. Research is limited with regards to the barriers to treatment that SD individual may face and how these barriers contribute to low engagement and utilization rates within this community. The proposed study aims to examine the current perceptions of SD individuals who are actively or were recently in

treatment for alcohol use, and to identify specific motivations for drinking, useful management strategies, and barriers to alcohol treatment that uniquely impact SD individuals. In doing so, the long-term goal is to improve alcohol use treatment for SD individuals, assist healthcare providers in caring for SD individuals in these treatment programs, reduce harm associated with AUD, and improve quality of life for SD individuals experiencing alcohol-related harm.

## Literature Review

The following chapter will document the current understanding of health disparities among SD individuals, particularly related to AUDs. The review first addresses the prevalence of AUDs among this community. Then, the minority stress model is introduced as a framework to describe the health disparities that are seen within scholarly literature. Specific motivations to drinking that are highlighted in the current literature are then addressed. Finally, this review addresses current literature related to perceptions of AUD treatment among SD individuals and treatment alternatives that have been shown to adequately engaged historically marginalized groups.

AUD and other alcohol-related problems among SD individuals have been documented extensively. The National Survey on Drug Use and Health (NSDUH; 2020) found that, in 2020, approximately 21.8% of SD adults met diagnostic criteria for an AUD in the past year, compared to approximately 11.0% in the overall population. Numerous studies have also shown a higher prevalence of excessive alcohol use and AUD among SD individuals when compared to their heterosexual counterparts (Fish et al., 2018; Hughes et al., 2016; Plöderl & Tremblay, 2015). A recent study that analyzed nationally representative data to examine AUD across the adult lifespan found that gay and bisexual men between the ages of 18 and 45 demonstrated the highest prevalence of AUD, with more than 45% within this age group reporting AUD (Fish & Exten, 2020). Additionally, it was documented that SD women between the ages of 45 and 55 were the most likely to meet criteria for AUD when compared to their heterosexual counterparts (Fish & Exten, 2020).

In a separate multidimensional study exploring substance abuse and dependence among SD individuals, Goldberg et al. (2013) concluded that SD individuals were 1.5 to 3 times more likely than their heterosexual peers to develop AUD. Within the SD population, it appears that bisexual individuals, and especially bisexual women, endorse a higher prevalence rate of AUDs than gay, lesbian, or heterosexual individuals (e.g., McCabe et al., 2013). Bochicchio et al. (2024), for example, conducted a systematic literature review exploring mental health and substance use among SD women. Their findings provided further evidence of heightened alcohol use among SD women. This review also documented higher rates of reported childhood sexual abuse (CSA) among SD women when compared to heterosexual women and found that reported CSA may mediate the relationship between sexual identity status and negative health outcomes such as excessive drinking and AUDs (Bochicchio et al., 2024).

The minority stress model (Meyer, 2003) provides a theoretical framework for explaining why we might see these health disparities among SD individuals. While all people face general stressors in day-to-day life, there are specific stressors that are uniquely experienced by those who are part of the LGBTQ+ community rooted in prejudice and stigma (Frost & Meyer, 2023). These can include discriminatory policies, being socially rejected or victimized, having internalized homophobia, and concealing one's identity (Frost & Meyer, 2023; Meyer, 2003).

This model attempts to explain at least part of the increased risk of psychological distress and other health outcomes such as AUD among SD individuals (Kalb et al., 2018). While it may be true that these disparities are due in part to discrimination,

stigmatization, and minority stress, there may be other individual or structural motivations to drinking that are unique to SD individuals.

Historically speaking, gay bars have been and continue to be prominent locations for SD people to congregate (McKirnan & Peterson, 1989). They became a place for queer people to openly express themselves outside of the public eye for fear of physical violence, discrimination, and arrest. Because of this cultural importance of bar settings as safe spaces, one might speculate that increased alcohol use among SD people also has a socio-ecological component that should be considered. In their study, McKirnan & Peterson (1989) investigated psychosocial and cultural factors related to alcohol use and abuse among SD individuals and highlighted the importance of bars as a social recourse among SD individuals.

Another study investigated alcohol consumption motivation and management strategies among gay and bisexual men using a socio-ecological framework (Lin et al., 2019). Participants described several specific drinking motivations such as bartender relationships, social expectations, peer influence, and bar settings being the primary setting for socialization among the gay community. It seems that bars are, both historically and currently, an important socio-ecological component for SD individuals to congregate and socialize. While this may be true, it is important to note that this is rooted in the historical treatment of SD individuals throughout history. Gay bars were some of the only spaces for SD individuals to congregate in public spaces and feel comfortable enough to express themselves. Nardi & Schneider (2013) described gay bars as an institution that was needed because change was needed.

A qualitative study that conducted semi-structured interviews to investigate factors that influence alcohol use among SD women identified themes such as drinking to decrease anxiety, to ease social interactions, to increase or enhance enjoyment, and peer pressure (Cogger et al., 2012). The researchers concluded that these findings are crucial in providing culturally competent intervention suggestions that service providers can use to tailor their treatment protocols to better serve SD women (Cogger et al., 2012).

Kalb et al., (2018) administered online questionnaires to get a better understanding of drinking motives among SD individuals. In doing so, they found that many SD individuals used alcohol to cope with negative emotions resulting from minority stress such as homonegative microaggressions, violence based on sexual orientation, and maternal and paternal rejection due to sexual orientation (Kalb et al., 2018). These findings provide evidence for the minority stress model (Meyer, 2003) in that these are all examples of stressors that are specific to SD individuals in addition to the general stressors faced by all people. While some of these motivations to drinking might coincide with drinking motivations of non-SD individuals, there are some potential motivations that are specific to SD individuals that may not be addressed in current treatment programs.

While there are approaches starting to be considered by leaders in the field of alcohol treatment (Hagman et al., 2022), abstinence-based treatments continue to be considered the gold standard for treating AUD (U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2020). Abstinence-based treatments for AUDs include various modalities (e.g., individual, group, and/or family counseling) and settings (e.g., inpatient, outpatients, and/or intensive

outpatient), and all have a common requirement for individuals to avoid substance use entirely.

Though many have benefitted from abstinence-based treatments, studies have shown that these programs sometimes fail to adequately engage people from marginalized backgrounds due to cultural differences that may not be considered (e.g., Collins et al., 2019). These treatments may not take into consideration aspects of one's culture due to the Eurocentric approaches of 12-step programs (Nelson et al., 2022). An example of this comes from research seeking to improve AUD treatment for indigenous people experiencing AUD. Nelson et al., (2022) conducted a qualitative study attempting to inform improvements to alcohol use treatment for American Indian and Alaskan Native people (AI/AN) and found that aspects of culture, such as Talking Circles, were important for AI/ANs that were not included in traditional alcohol use treatment.

Additionally, traditional abstinence-based treatments have been shown to not be engaging or effective with people experiencing homelessness due to highly intense requirements to enter treatment and an emphasis on aspects of treatment that are not as important for this population (Collins et al., 2021). It is well established within the literature that LGBTQ+ people are more likely to experience homelessness than their heterosexual and cisgender counterparts (National Coalition for the Homeless, n.d.) and make up an estimated 20-40% of the homeless population in the United States. LGBTQ+ people experiencing homelessness also have higher rates of alcohol and drug dependence when compared to their heterosexual and cisgender counterparts experiencing homelessness (Ecker et al., 2019). One might speculate that there may be cultural aspects that are important or crucial for SD individuals that are not being emphasized within

traditional abstinence-based treatments. This might explain part of the reason why SD individuals with AUDs are not attending treatment programs at higher rates. Harm reduction may be a solution to this failed engagement.

Harm reduction provides an alternative to treating AUD and other substance use disorders and high-risk activities. Unlike abstinence-based treatment, the primary goal of harm reduction is to meet individuals where they are while incorporating strategies to reduce the harmful consequences of a given behavior (Marlatt & Witkiewitz, 2010). These strategies span across many interventions and behavioral changes that emphasize safer and managed use (Marlatt & Witkiewitz, 2010). For individuals who continue to engage in high-risk behaviors despite experiencing harms associated with these behaviors, harm reduction is an alternative between abstinence and continued harmful use that provides pathways for change, while also reducing negative consequences of high-risk behaviors for both the individual and their community (Collins et al., 2012).

Taking into consideration the significant health disparities within this community and the low engagement in current alcohol use treatment programs, it is important to find a solution to reduce the negative consequences of alcohol use for this population. It is apparent due to the low engagement that there is something that is not effective or not engaging with the current alcohol use treatment programs, and this project aims to understand what that is. Additionally, there is little research related to the current perceived efficacy of alcohol use treatment programs among SD individuals. This project aims to bridge this gap in the literature.

AUD treatment for SD individuals is more needed than the general population (Micale, 2023) simply due to the higher rates of AUDs among this population. This need

is exacerbated by the significantly low treatment utilization rates among SD individuals, likely due to interpersonal and structural barriers to treatment (Micale, 2023). Though it is true that SD individuals utilize alcohol-related treatment services at a higher rate than the general population, the number of SD individuals with AUDs who seek treatment is low compared to the number of SD individuals with AUDs who do not seek treatment (Allen & Mowbray, 2016).

This discrepancy may be due to barriers in pursuing or obtaining proper treatment, or insufficient informed treatment. Alarming, only one in five agencies who indicated providing LGBTQ-specific alcohol-related services on the National Survey of Substance Abuse Treatment Services actually provided such services (Ji & Cochran, 2022). Additionally, individuals who provide these services have indicated minimal training with regards to working with SD individuals (Anhalt et al., 2003; Røndahl, 2011).

The disparities we see in health outcomes for SD individuals highlights the urgency and importance of teaching and implementing affirming healthcare and targeted interventions for this population (Rossman et al., 2017).

### **Purpose of Study**

The current study aims to provide a voice to a community that has historically been underrepresented and to offer an opportunity for SD people to share their experiences in alcohol use treatment. By doing so, this study seeks to highlight ways of improving treatment for SD individuals experiencing AUD and disseminating the findings to provide additional resources and increased knowledge for service providers who work with this community. The long-term goal is to reduce harm associated with

AUD that disproportionately impacts SD individuals by discovering treatment considerations through a community-based participatory research (CBPR) approach.

This study documents important first-hand experiences of SD individuals in alcohol use treatment and recovery in a scholarly fashion which can be used to provide recommendations and educate service providers on best practices when working with this community. It will highlight the unique experiences of SD individuals, including barriers to treatment, motivations for drinking, and useful management strategies, that may not be addressed in traditional alcohol use treatment.

Qualitative research amplifies the voices of historically underrepresented and marginalized groups. This project may serve as an important addition to the scholarly literature and aid in increased interest in promoting health equity and resilience within this community.

The primary aims of for the current study are as follows:

1. To determine current perceptions of SD individuals on treatment for alcohol use and their perceived effectiveness of the current treatment.
2. To identify specific motivations for drinking, useful management strategies, and barriers to alcohol use harm reduction that uniquely impact SD individuals.

## **Study Design and Methods**

### **Overview of Research Design**

We conducted semi-structured interviews and used a conventional content analysis to interpret the transcribed data. Grounded theory is a qualitative research approach in which coding categories are obtained directly from text data and is generally used for studies that aim to describe a phenomenon that has limited research literature (Hsieh &

Shannon, 2005). By utilizing this method, researchers avoid preconceived categories, immerse themselves in the data, and allow the data to drive the names for categories and codes (Hsieh & Shannon, 2005). Using this method decreases bias during the analysis stage and reduces the impact of preconceived assumptions about the categories that are identified when interpreting the data (Hsieh & Shannon, 2005). Grounded theory was chosen over other forms of qualitative approaches because there is limited research on this current topic and we wanted to emphasize giving the community a voice and highlighting their words and perspectives.

### **Community-Based Participatory Research**

The current study utilized CBPR to achieve the aims. CBPR is an approach that works to empower the communities that are being researched and to build partnerships at all levels of the study (Larson et al., 2009). CBPR is especially important when working with marginalized populations as it works to bridge several levels of influence that all impact the health and well-being of the community (Larson et al., 2009). We partnered with community health organizations and individuals within the LGBTQ+ community, and these voices are heard throughout all stages of the research project. To create a researcher-community partnership, which is of much importance for CBPR approaches (Green & Thorogood, 2009), we selected a Community Advisory Board (CAB). This CAB consisted of the researcher, representatives from community organizations such as Northern Nevada HOPES, LGBTQ+ community members and community members in treatment programs for alcohol use, as well as other consultants. We used the recommended size of 5-10 members on the CAB (D'Alonzo, 2010). We also participated in operations meetings for medication-assisted treatment (MAT), intensive outpatient

(IOP), and outpatient therapy programs, participated in community outreach, and consulted with the CAB at all steps of the project, including data analysis and recommendations. Using this approach provides important research findings regarding individuals' experience with alcohol use treatment and how we can better serve this population as healthcare professionals.

### **Participants**

A sample of 11 adults 18 years or older who identify as SD (e.g., lesbian, gay, bisexual, queer) and who are currently receiving, or have received (within a one-year timeframe) alcohol use treatment for AUD were recruited for this study. This sample size was chosen as previous research has shown 9-17 interviews is adequate to reach saturation (e.g., Hennick & Kaiser, 2021). Additionally, while sample sizes for qualitative studies are usually determined with saturation, other experts have suggested the concept of "information power" as being a more appropriate determinant (Malterud et al., 2016). Specifically, the researchers suggest that information power is guided by the information density gathered from participants with regards to the aim of the study, sample specificity, use of established theory, quality of dialogue, and analysis strategy (Malterud et al., 2016). Participants were recruited within the state of Nevada using convenience and snowball sampling methods. All genders and ethnicities were included in the study. We recruited from agencies who service vulnerable and underserved communities, such as Northern Nevada HOPES, which is a health center that provides medical care, including IOP and MAT for alcohol use.

## **Data Collection**

An open-ended *qualitative interview* was administered to the participants addressing the following: a) demographic information such as age, ethnicity/race, sexual orientation, gender identity, current treatment status, b) general experiences of current and past alcohol use, c) questions related to if and/or how sexual orientation relates to their alcohol use and alcohol use treatment, d) their general process of finding a treatment program, e) their overall experiences with these treatment programs (i.e., what was effective about their programs, what was ineffective about these programs), f) and how, if at all, they would change these programs to better fit their needs and the needs of other SD individuals (see Appendix A for full semi-structured interview).

## **Procedure**

All procedures were approved by the University of Nevada, Reno IRB. 11 virtual semi-structured interviews were conducted of SD individuals who were currently receiving alcohol use treatment or who received alcohol use treatment in the past year. Interviews were conducted by the PI. The PI attended team meetings of the MAT and IOP programs at Northern Nevada HOPES and shared information about the project. In these team meetings, we also partnered with these community organization leaders to inform study procedures, including the formulation of the semi-structured interview. Prior to finalizing the semi-structured interview, the PI and CAB piloted all interview questions. The project was publicized through flyers and by the coordinators of the MAT and IOP teams at Northern Nevada HOPES. Everyone involved with recruitment abided by guidelines and informed patients that the research study was not required (Wilson et al, 2008). Flyers were placed at other community organizations, such as Our Center,

which is an advocacy organization providing services and resources to the LGBTQ+ community of Northern Nevada, and The Pride Center, which provides free counseling services to LGBTQ+ clients.

We worked with several community organizations, including Northern Nevada HOPES to publicize the project. Participants who were eligible for the study were made aware of the project through IRB-approved flyers and verbal scripts by both the research team and those working at the community organizations. We also contacted student groups and organizations on UNR campus that were relevant to this project for recruitment purposes, such as the Queer Student Union and Gender, Race, and Identity.

Recruited participants were interviewed and recorded by the PI, who conducted a semi-structured interview (see Appendix). In this interview, participants were asked of their overall experiences in alcohol use treatment programs, including aspects that have been affirming to their sexual orientation. Participants were also asked about ways in which alcohol use treatment can be improved for SD individuals. Participants received a \$50 Amazon gift card for their time.

### **Analysis Plan**

Data was analyzed using a constructive grounded theory approach. The sessions were recorded and transcribed using Zoom's transcription feature for qualitative analysis. Three coders then simultaneously listened to interviews and read through transcriptions to fix any errors or discrepancies. All identifying information was taken out of the transcriptions prior to data coding to ensure privacy of participants. Next, grounded theory analysis was used to identify themes. As previously stated, we allowed the data to drive names of categories and codes rather than entering the analysis stage with

preconceived notions of the names or types of categories that were to be uncovered (Charmaz, 2014; Hsieh & Shannon, 2005). The goal of the analysis plan was to identify a dialogue from community members on ways in which medical providers can better support their treatment.

The data was managed in Dedoose (Software, 2014), which is a web application for qualitative data analysis. Dedoose allowed for ongoing monitoring to ensure agreement among coders. Data was independently coded by the coders and a constant comparative process was used (Charmaz, 2014). Initial coding incorporated grounded theory from a constructivist perspective (Charmaz, 2014) by which initial coding was done using a line-by-line technique. During this time, coders narrated what was occurring in the interviews (Charmaz, 2014; Mills et al., 2006). Following initial coding, a codebook was created by the PI and coders. At this time, the redundant codes were removed. Using the codebook, the data was independently double-coded until there was adequate intercoder consistency of 80% (Shek et al., 2005). During this time, coders coded excerpts independently of each other and each transcript was coded 2-3 times. The coders met weekly and resolved any issues with coding or discrepancies that came up. Additionally, the coders met periodically with the CAB to discuss findings. After coding is completed, the PI and coders reviewed the excerpts for each code and summarized them using an analytic memo that described emergent themes. Once this phase was completed, we held a final meeting with the CAB to review the findings to ensure the coders captured the full picture of the research participants' experiences.

## Results

### Sample Description

Participants had a mean age of 36.8 ( $SD = 13.7$ ). 54.6% identified as female ( $n = 6/11$ ), 36.4% identified as male ( $n = 4/11$ ), and 9.1% identified as non-binary ( $n = 1/11$ ). Of the sample, 54.6% identified as White/European American ( $n = 6/11$ ), 27.3% identified as Hispanic or Latino/a/x ( $n = 3/11$ ), and 18.2% identified as Black/African American ( $n = 2/11$ ). See Table 1 for additional demographic sample descriptions. All participants were interviewed via videoconferencing.

**Table 1**  
*Participant Demographics*

Participant	Pseudonym	Age	Ethnicity <sup>a</sup>	Sexual Orientation <sup>b</sup>	Gender <sup>c</sup>	Treatment Type <sup>d</sup>
P1	Jude	30	1	2	2	1, 3, 4
P2	Roan	56	2	2	2	1, 2
P3	Carmen	32	2	4	1	1, 2, 4
P4	Casey	35	1	3	1	2, 3
P5	Dakota	30	2	5	1	1, 2
P6	Sage	27	1	4	1	1, 2, 3
P7	Salem	27	3	3	1	1, 2, 4
P8	Chance	60	1	2	2	1, 2, 4
P9	Hayden	25	3	2	2	2, 3
P10	Sam	57	1	3	1	2, 3
P11	Britton	26	1	1	3	1, 2, 3

*Note.* All participants were given a pseudonym to protect their identities.

<sup>a</sup>1 – White/European American; 2 – Hispanic or Latino/a/x; 3 – Black/African American

<sup>b</sup>1 – Lesbian; 2 – Gay; 3 – Bisexual; 4 – Pansexual; 5 – Demisexual

<sup>c</sup>1 – Female; 2 – Male; 3 – Non-binary

<sup>d</sup>1 – Inpatient; 2 – Intensive Outpatient; 3 – Residential; 4 – 12 steps

## Primary Analyses

### *Connections between sexuality and alcohol use*

Participants largely expressed a significant connection between their sexuality and alcohol use. The majority of participants felt that being part of the LGBTQ+ community played not only a crucial role in both the onset and maintenance of their alcohol use, but also their recovery. Additionally, some participants endorsed using alcohol as a way of exploring and coming to terms with their sexual identity, but also to suppress and “numb” their sexuality feelings. Some participants cited previous trauma connected to their sexual identity as a primary source of their alcohol use. Finally, a few participants believed there was no connection between their alcohol use and sexuality, and some presented their intersecting identities as playing an even bigger role in the connection between their alcohol use and sex/sexuality. In this section, we will share more specifically the themes that came up in participants’ perceptions of the connection between their sexuality and alcohol use (see Table 2 for themes and their relative representation).

**Table 2**  
*Connections between Sexuality and Alcohol Use*

Theme/topic	<i>N</i>	%	Example
LGBTQ+ community serves as a catalyst for addiction	6	54.5	“Like I said, just the way that the queer community connects in many spaces involves drugs and alcohol” (Britton).
LGBTQ+ community serves as a catalyst for recovery	8	72.7	“We will get dinner together. We’ll sit in all day meetings together. We’ll do, and it’ll just be. These are friendships that I never, ever would have. Everybody in my life is gay and in recovery” (Chance).

Alcohol use played a major role in exploring/coming to terms with, and suppressing sexuality	5	45.5	“For sure, stifling with my sexuality was definitely part of [my alcohol use]. It also helped me explore and have courage to look into that side of me” (Carmen).
Alcohol served as a “numbing” tool to deal with minority stress and other traumatic experiences such as sexual abuse	6	54.5	“I think I also learned in this process that probably my biggest source of desire to numb with alcohol is trauma, both from like being a queer person in [location redacted] and the experiences I had with that and then I had some sexual abuse” (Britton).
There is no connection between alcohol use and sexuality	3	27.3	“You know, I don’t think there is a connection, and I feel kind of guilty admitting that” (Dakota).
Intersecting identities played an even bigger role in the connection between alcohol use and sex/sexuality	2	18.2	“If anything, I think the connections included my sexuality, but also my race and the environment that I grew up in” (Hayden).

*Note.*  $N = 11$ . Denominators for all percentages were 11; however, not all participants provided quotes that were relevant to each category. Additionally, some participants provided quotes that fit with multiple codes within a category (e.g., alcohol played a major role in exploring/coming to terms with sexuality and served as a “numbing” tool to suppress sexuality feelings and previous sexual trauma). Thus, percentages within themes may not total to 100%.

**The LGBTQ+ community serves as a catalyst for addiction.** The prevalence of alcohol use within the queer community and within queer spaces contributed to the onset of alcohol use for many participants. One participant stated:

I think I just like was quickly in [queer] spaces where everyone was drinking too much and so I was drinking too much. And then over time you know now reflecting back on my life and all the drinking and drug

use, I can say that these spaces were kind of the biggest source of my addiction for a while. And I was constantly chasing this energy cycle (Britton).

Another participant highlighted the prevalence of alcohol use among the community and how they believe this contributed to their addiction to alcohol:

I know that [alcohol use] is very prevalent in the LGBTQ+ community as well as drug use. I know that there is a higher percentage of alcohol and drug abuse in LGBTQ+ communities. Looking back, I can see how that may have been a problem for me because I know that a lot of our social life is surrounded around alcohol (Hayden).

One participant noted how they felt the need to drink to be accepted in these queer spaces:

Honestly just the community aspect of going out with your queer friends and just being part of it, I felt like I got better validation and felt seen and heard when I was drunk or like, and the community of just drinking and having a good time like that that's what I needed to be accepted (Jude).

**The LGBTQ+ community serves as a catalyst for recovery.** Although many participants cited the LGBTQ+ community as playing a significant role in their addiction onset, many participants also highlighted the critical importance of community in their recovery journey. Several participants were recommended treatment programs by queer people who had successfully completed the program (e.g., “The person who recommended me was queer so that helped me feel safer about it, like I just trusted her

[Britton]). One participant told a story about the moment he was convinced by a former friend of his to enter treatment:

Well, I was driving my car, drunk as I was, and I pulled into [gay bar] and a friend of mine was playing video poker. He's someone I was sexually active with, but I hadn't seen for years and years, 17 years I guess. And I remember we used to drink really hard together, and I offered to buy him a drink, and he said, "I haven't had anything to drink for 17 years. But I'd be happy to buy you your last drink." And that's when I decided to enter treatment (Chance).

Participants also highlighted the importance of finding LGBTQ+ spaces throughout their recovery journeys (e.g., "Those connections are so important and so healing, like queer people supporting each other in recovery and connecting in recovery" [Britton]) and the need for more queer-specific spaces (e.g., "Having a group of people like connecting with the [queer] community close to you will help you achieve recovery faster" [Sage]).

**Alcohol use played a major role in exploring, coming to terms with, and suppressing their sexuality.** For many participants, alcohol was used as a tool to explore sexuality. For example, one participant noted:

When I was in college I think drinking, a like sort of coming out and figuring out that I was gay and like being part of the gay community. Drinking was such a big part of that. And it let me let go of my fears enough to explore my identity (Britton).

For some, alcohol was a way to push down sexuality feelings:

I was in a marriage with a man I loved but wasn't in love with, and especially had no chemistry with physically. In that time, I was just incredibly unhappy, and I was thoroughly convinced it was because I was into women. And I would drink a lot with the thought of having to, you know, come out as gay. And I had to hide it a push it down and that was a huge point of drinking (Dakota).

Similarly, one participant shared their experience with using alcohol to suppress sexuality feelings to fit a societal mold:

So, I got married at age 19 and was divorced by 21. I married a man because obviously at the time I couldn't have married a woman. But I knew that I had also been attracted to women. So, at that point, I was young and I just kept my mentality towards men for a very long time. I always had this attraction towards women that I thought I had to numb out with alcohol (Sam).

**Alcohol served as a “numbing” tool to deal with minority stress and other traumatic experiences such as sexual abuse.** Many participants shared their experiences with minority stress, victimization, and oversexualization, which all contributed to their use of alcohol. One participant shared her experience of being sexually assaulted during the time in which she was suppressing her sexual identity:

Unfortunately, during this time, I had quite a bit of sexual trauma. I experienced one brutal rape in particular that changed everything. And I know that that's where a lot of my, I think you know just needing to numb everything. I'd always, always had this attraction to women that I thought

I had to numb out that I thought I had to take away. That I wasn't allowed. So, it was something that I really drank away in a sense, because it was something that I felt that others felt that I shouldn't be (Sam).

Other participants shared their experiences of using alcohol to “get through” sexual experiences they did not want to participate in or felt pressured by others to participate in (e.g., “I couldn't be with him when I was sober. And that turned into just I was incapable of being intimate with people sober” [Sage]). Similarly, alcohol was described as a “defense mechanism” by one participant who felt pressured to participate in sex with individuals she did not have a sexual attraction to because of “societal expectations:”

Alcohol is what was my like defense mechanism, right? So because a lot of people could really get their feelings hurt when you don't want to sleep with them, especially if you seem interested in spending time with them. So, I would get drunk and let stuff happen cause it felt like that is what I was supposed to do according to societal expectations. I felt like that is what the way people were supposed to be (Dakota).

One participant described her experience of being oversexualized when she was younger, which contributed to her alcohol use (e.g., “Everyone always sexualized me growing up because of the way I looked. So I just went along with it and it would make it easier if I drank. Alcohol made me grow up faster than I needed” [Salem]).

**There is no connection between alcohol use and sexuality.** Three participants noted they do not feel that their sexuality has any connections with their alcohol use (e.g., “Not that I'm aware of” [Roan]).

**Intersecting identities played an even bigger role in the connection between alcohol use and sex/sexuality.** Two participants shared the impact of their intersecting identities on the onset and maintenance of alcohol addiction. One participant noted how their sexual identity and racial identity together played the most significant role in their alcohol use:

I wouldn't say my sexuality itself impacted my alcohol as much as my sexuality and race did. I kept my sexuality to myself for a very long time. And I think when I was about 20, I finally came out and I told everybody. I think this plus my race and all that comes with it, that is more what impacted my drinking (Salem).

#### ***Important aspects of treatment and recommendations for improvement***

Participants highlighted many important aspects of their treatment experiences that they felt were crucial in their recovery and made many recommendations for how these treatment programs can be improved. Participants emphasized a need for creating and maintaining an inclusive and affirming environment throughout all aspects of treatment. Additionally, participants almost unanimously suggested some form of mind/body/spirit consideration. Some suggestions included grooming, body work such as yoga, and meditation and mindfulness activities. Participants also discussed the importance of having competent, well-informed, and friendly staff. Lastly, there was a great emphasis from participants to ensure that there is diversity in treatment styles and activities that are offered to participants throughout treatment (see Table 3 for themes and their relative representation).

**Table 3**  
*Important Aspects of Treatment and Recommendations for Improvement*

Theme/topic	<i>N</i>	%	Example
Strong emphasis on creating and maintaining an inclusive and affirming environment			
Inclusivity plays an important role in ensuring everyone feels safe and free from judgement	7	63.7	“Inclusivity is important because it made me feel a lot more safe and be able to open up and get the full experience of treatment” (Jude).
LGBTQ-specific groups	3	27.3	“Having space for people to connect with other queer folks like any time that can be an opportunity. Even if you think that only 2 people are going to show up, you make the space” (Britton).
Language/pronouns	5	45.5	“Respect for a person’s identity and pronouns” (Salem).
Understanding LGBTQ+ needs/struggles	4	36.4	“Just have a better understanding of queer people’s experience” (Sage).
Having flags, badges, lanyards, etc. to show support for community	3	27.3	“Use signs and outward facing imagery of LGBTQ people and flags and whatnot is helpful for queer people coming into these spaces” (Britton).
Large interest in incorporating mind/body/spirit elements into treatment			
Spirit-based programming	4	36.4	“I think something spiritual-based is key, at least just for an option as well as equally having medical” (Carmen).
Grooming/self-care	2	18.2	“I think it would be nice to have people come in to do hair, you

			know, something to keep up with grooming and self-care” (Roan).
Body work (e.g., yoga)	7	63.6	“Connecting to the body. You know, things like maybe yoga, or finding different avenues for whatever works for the individual to somatically connect with their body” (Dakota).
Meditation/mindfulness	4	36.4	“We also had a mindfulness aspect to treatment that spoke to me and was important” (Hayden).
Nutrition/Food	10	90.1	“There needs to be good food” (Salem).
Important to have competent, friendly, and informed therapists and staff			
Trauma-informed	5	45.5	“Honestly, I think they should have more trauma counselors that like are well versed in dealing with like unresolved trauma” (Jude).
Better education and/or clinical skills	8	72.7	“Like, way better teachings of how to de-escalate and deal with high-risk situations, you need more training for the staff” (Casey).
Friendliness	6	54.5	“It was nice having wonderful, friendly, and welcoming staff” (Roan).
Person-centered	3	27.3	“I would say target the individual on an individual basis. I don’t care whether it’s 6 or 60 people. They’re not going to all benefit from the same tasks or worksheet” (Casey).

Participants are interested in a diversity of treatment styles and activities to choose from in treatment

Multiple treatment models to choose from	9	81.8	“Well, in an ideal world, there would be all the pathways to like healing would be addressed in the recovery center (Dakota).
Religion/spirituality	4	36.4	“What’s really effective for me is like just helping me get in touch with my spirituality” (Jude).
Physical activity	4	36.4	“Things like horseback riding, trips to a swimming pool, or gardening” (Sage).

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*Note.*  $N = 11$ . Denominators for all percentages were 11; however, not all participants provided quotes that were relevant to each category. Additionally, some participants provided quotes that fit with multiple codes within a category (e.g., a participant may have stated that language/pronouns and understanding LGBTQ+ needs/struggles were important). Thus, percentages within themes may not total to 100%.

**Inclusivity plays an important role in ensuring everyone feels safe and free from judgement.** Participants shared the importance of creating an environment inclusive and affirming to everyone to ensure that individuals feel free to speak openly about their lives without judgment (e.g., “I felt safe talking about my partner and knowing that I was not going to be judged for having a same-gender partner” [Britton]). Other shared that they “never felt any negativity towards their identity or judgment” (Sam) but would have “left without question” (Casey) had there been judgment or feelings of exclusion. One participant shared inclusivity within treatment as playing a crucial role in being able to recover and get the most out of treatment:

It was very important to me, cause it made me feel a lot more safe and be able to open up and get the full experience of treatment, and not have to

like close myself off, or compartmentalize or play a part in hiding myself (Jude).

**LGBTQ-specific groups.** Some participants felt it necessary to provide spaces for LGBTQ+ individuals within treatment programs to come together in the form of groups. One participant shared:

I will say, one thing that comes to mind that I think is very necessary for openness and inclusion is to maybe have like a special group that's specifically for LGBTQ people, where they might feel more comfortable to be open or discuss their history or traumas (Roan).

Another participant explained that their treatment program had specific groups for business professionals and noted, "Having an LGBTQ equivalent group would have been really cool. I'm sure it exists somewhere; I just haven't come across it" (Carmen).

**Language/pronouns.** Participants felt strongly about the use of inclusive language and pronouns within treatment programs. One participant shared that it was "very important" (Roan) to be addressed and to have others be addressed by their preferred name and pronouns. Similarly, other participants had recommendations of ways to create a more inclusive environment by asking individuals to introduce themselves with pronouns if they are comfortable sharing:

I would want to tell treatment programs to ask folks to introduce themselves with pronouns as it is such an easy way to create more inclusive environment and allow people to consider their gender while in treatment and to be respected in that (Britton).

Another participant had similar thoughts, stating “We introduce ourselves like 500 times a day in treatment programs, so it would have been nice to just ask people their proper pronouns to show you care” (Sam). Another participant noted that showing inclusivity can be as simple as “respect for a person’s identity and pronouns” (Salem). Another participant shared their experience of encountering antiquated language in curriculum that they felt was harmful and exclusive:

Everything was so heteronormative in the curriculum and sort of hyper focused on like conventional man marries woman, has children. And there were also some pretty discriminatory remarks in this very antiquated literature that they handed out surrounding HIV+ people. A direct quote from one of the actual physical handouts we were given during our workshop surrounding boundaries was “if you have strong boundaries, you won’t get AIDS.” That was a direct quote. I thought “you guys need to take this out right now” (Dakota).

**Understanding LGBTQ+ needs/struggles.** Some participants felt that having a better understanding of the needs of queer people made for a more inclusive and affirming environment. One participant shared their experience of feeling dismissed in treatment due to providers not understanding the interconnection of their sexual identity and alcohol use:

And another like one thing that I didn’t like was not like on the opposite of that there were these times where they would kind of like dismiss it because they’re like “we’re here for treatment, not for sexuality and stuff.” And I’m just like, it’s not what it’s about, it’s literally just like we need to

be heard. And we just deserve treatment just as much as straight people do (Jude).

Similarly, one participant shared, “Honestly you just need to like recognize that we’re already a marginalized group and that our opinion matters just as much as a straight cis person” (Salem).

**Having flags, badges, lanyards, etc. to show support for community.** Some participants felt it important and necessary for treatment programs to “use signs and outward facing imagery of LGBTQ people and flags and whatnot” (Britton) to show their inclusiveness. Another participant shared that the staff at their treatment program “would wear pride things, like pride bracelets and it felt open, and that people didn’t have to hide themselves” (Sam).

**Grooming/self-care.** Participants were interested in incorporating grooming and self-care into treatment. One participant suggested “having a person to come and give massages because I read somewhere that the body holds onto trauma and I don’t know, maybe a massage can help release that” (Roan). Another participant suggested grooming as part of treatment:

I think it would be nice to have people come in to do hair, you know.

Obviously, I didn’t have that problem (referencing that they are bald). But you know, or manicures or pedicures would have been cool (Salem).

**Body work.** Participants felt that incorporating body work into treatment would help with recovery. One participant broadly suggested, “Maybe some body work. I’m not sure what kind, but I think it important to add some body work if people feel comfortable (Hayden). Another participant suggested “yoga” (Dakota) as a form of body work that

could be included in treatment. Similarly, a participant made a recommendation that prioritized holistic approaches to treatment:

The place where my experience in this model of recovery has been really absent is in terms of that holistic nature, like body work. I would have appreciated more of an emphasis on things like yoga or Pilates or just something to tune into your body and have it be a focal point of recovery (Sage).

One participant shared that their treatment program included body work, such as yoga, and that it was very helpful (e.g., “Well, I feel like there was a strong emphasis on like yoga, mindful walks, stuff like that and I thought it was so helpful” (Roan).

**Meditation/Mindfulness.** Participants enjoyed the emphasis on mindfulness and meditation in their treatment programs, and other would have liked more. For example, one participant shared, “I think it would have been nice to have more of an emphasis on mindfulness. You know, I was there for 30 days, some people are there for 45 to 60 days” (Roan). Another participant shared their positive experience with mindfulness being part of the curriculum:

It was such a good experience. You know, some of us can’t afford this kind of stuff or even heard of meditation, so literally just having a 5-minute meditation at the beginning of group did wonders for people (Casey).

**Nutrition/food.** Having healthy food options and nutritional coaching was important for many participants. One participant emphasized the need for food options for all diets:

We need better food. And healthier food options. We need for options for everyone, like I felt like we needed more options for people who were vegans or vegetarians, and like those who had dietary restrictions (Carmen).

One participant shared their experience with nutrition not being a priority at their treatment program and how it impacted their recovery journey:

I would say, this sounds odd, but nutrition would have been a big thing. But once I started having my appetite back, I discovered they just had the wife of one of the staff members cooking, and then would just sort of throw something together. Nobody knew how to cook. I don't know where she got her recipes from, but I lost 15 pounds in 3 weeks. There wasn't any balance (Casey).

Another participant suggested a “nutritional therapist” (Jude) as part of treatment. Others felt “good food” (Salem) and a balanced “three meals a day” (Roan) assisted in their recovery journey.

**Trauma-informed.** Several participants voiced their concern with a lack of trauma-informed therapy within their treatment program. One participant noted their drinking was largely influenced by unresolved trauma:

Honestly, I think they should have more trauma counselors that like are well versed in obviously dealing with unresolved trauma. A lot of my use and drinking came from trying to delay or just get away from trauma that would pop up in my head and just dealing with the different layers of the

human experience. It's more than just drugs and alcohol. The person often has more issues than just substances (Jude).

Similarly, another participant wished for "more trauma counseling" (Sam) in treatment.

One participant shared that they chose their specific treatment program because they advertised their expertise in treating trauma:

The place I actually chose specifically advertised itself as being a dual diagnosis treatment center, and I felt very much that my trauma was like the driving factors to be drink in the excess I was (Dakota).

Another participant stated:

I think being trauma-informed is recognizing that traumatized individuals tend to disconnect, you know, dissociate so hard from their bodies and figuring out ways to get that nervous system regulated is important. And I wish that was present at the place that I've been going to (Sage).

Similarly, one participant shared their concern with treatment centers claiming to be trauma-informed but not offering trauma-informed care:

I think it's important that if you make the umbrella statement that you are trauma-informed that you are actually trauma-informed. That's something my treatment program didn't do very well. You need to stay up to date and be mindful of the genuine impacts and recognize that sometimes if someone presents sarcastic or combative, sometimes you need to take a deeper look and recognize this may be a trauma response (Hayden).

**Better education and/or clinical skills.** Participants largely agreed that clinicians should have proper education and training to handle the complex experiences faced by

those seeking treatment. One participant shared their experience with clinicians not having the proper clinical skills to deescalate situations:

And also, the people at my program needed way, way more training for knowing how to deescalate high risk or violent situations. Because that arises in treatment centers, and the people need to know how to handle it and I felt like that was lacking (Casey).

One participant expressed concern for the qualifications of the staff at their treatment program:

And also, I hate to say this, I was pretty suspicious of the staff and their qualifications to be able to help me care for me in a way that was medically and mentally beneficial to me. Sometimes I just didn't know if they had the proper training (Sage).

Similarly, one participant noted that “all the staff were all recovery addicts and nobody with the exception of one gentleman pursuing a degree had any formal education” (Sam).

On the contrary, some participants shared their positive experiences with having competent therapists (e.g., “The therapists were wonderful, welcoming, and knew what they were doing [Roan]).

**Person-centered focus.** Participants largely felt it necessary to prioritize person-centered care within treatment programs. One participant stated, “People are their own person, I think you need to look deeper and individualize treatment and that's what person-centered really means” (Jude). Another participant noted they would have liked to see staff help people on an individual level especially if they see one person is struggling:

And when you see people struggling, like myself. Personally, I would have like them to take me aside at some point. Because it is very clear when one person, in comparison to maybe the other 5 people, is not functioning at the same level or really struggling (Sage).

**Multiple treatment models to choose from.** The majority of participants agreed that they would have enjoyed being exposed to other treatments styles. For example, some participants voiced their interest in learning about alternative treatment models such as Dharma Recovery and SMART Recovery. One participant said:

Maybe have people come in to talk not just AA, but maybe something like Dharma Recovery and SMART Recovery. It would have been nice to learn about other types of treatment rather than the typical kind (Sam).

Another participant more generally was interested in diverse curriculum so that the treatment didn't seem repetitive:

And it's just like better curriculum that is needed in treatment and more curriculum, so that it doesn't repeat on the same cycle like after, like 2 weeks of treatment. And then, like you, start doing the same work again.

We just need more diverse options and treatment (Dakota).

Some participants voiced their concern with having a single treatment style to choose from (e.g., "It would have been better to have access to a therapeutic situation that didn't involve having AA as the ultimate solution would have been helpful" [Casey] and "What you shouldn't do in treatment is just focus on one specific thing because you need diversity in treatment centers" [Jude]). Some participants had the option of choosing between several treatment styles and felt that this was beneficial for them:

They had different styles of programs there, such as AA, NA, SMART Recovery, and Dharma Recovery. So, we were able to find the ones that spoke to us, and I found that super helpful (Roan).

**Religion and spirituality.** Participants had strong opinions on religion and spirituality. While some believed religion and spirituality played a crucial role in their recovery journey, others felt religion and spirituality interfered with their recovery. For example, one participant shared their experience of identifying as agnostic, but the spiritual journey they had during treatment was what they needed to recover:

And at least for me, I've identified as agnostic for my entire adult life, but having a spiritual experience is what I say got me there. So, I'd say having some kind of spiritual-based program is important and just being open to what it is (Carmen).

While others agreed (e.g., "What really helped me was like helping me get in touch with my spirituality, but I know that doesn't work for everyone [Jude]), others felt uncomfortable with the religion and spirituality component to treatment. One participant voiced her concern with treatment programs having a strong emphasis on religion and spirituality due to their experience with religious trauma:

When I finally got into treatment, they were so like, "Higher Power" doesn't need to be God, but it does for most and they make that very clear. And that made me nervous because all that religious trauma is part of the reason where my drinking came from. I didn't know how to reconcile that in treatment. Even support groups were held in chapels that weren't labeled as religious groups (Sage).

Other participants agreed with this sentiment, and one even shared their experience with searching for other 12-step programs that didn't involve a Higher Power:

Not to sound super edgy or anything, or if you can tell from the aesthetic around me and stuff like that. But I looked into The Satanic Temple, and they have a sober chapter, and they've got their own version of the steps and everything which is very similar but doesn't include the need for a Higher Power. It doesn't have to be all one way (Hayden).

**Physical Activity.** Participants shared their interests in more physical activity while in treatment. One participant noted they were interested in having more options for getting outdoors during tough days in treatment (e.g., “When you're having a really bad day, it could help to be able to go for a walk, go to the park, or just other alternative outdoor activities [Hayden]). Another participant shared the requirement to be active in the treatment program they were in and how they enjoyed it (e.g., “We had to work out, do something active once an hour every day which I felt was good [Sam]). Alternatively, one participant shared their experience of only having the opportunity to participate in physical activity that was too strenuous for them:

I appreciated the attempts, you know, at physical therapy but some of it was too extreme for me. We would be asked to go on 3.5-mile hikes, including some steep and rocky terrain, and they can't leave you alone, so I always felt like I was pokey, and somebody was having to, you know, stay back and babysit me. Which was not a comfortable feeling in the group (Casey).

### *Perceptions of harm reduction as a treatment alternative for alcohol use*

Some participants were not familiar with the term “harm reduction” or “harm reduction treatment” ( $n = 4, 36.4\%$ ). Because of this, “harm reduction treatment” was defined for participants in the following way:

Harm reduction is a set of practical strategies that focus on reducing the harm people experience from substances and meeting people where they are at regardless of if they are ready or able to stop using substances. It is a compassionate stance to minimize substance-related harm and enhance quality of life for people who use substances and their communities.

When defined, the harm reduction treatment approach was perceived positively by all participants. Some participants felt that harm reduction was a necessary part of the treatment journey to reduce death and the risk of overdose. One participant stated:

I think harm reduction is absolutely necessary for people because if you just preach abstinence, like complete abstinence without cause... there are people that need help quitting and they can't just do it right away. And so with harm reduction, like needle exchanges or carrying around Narcan, like I carry two with me at all times. I live in a big city so there is even more of a risk of overdose. And I think it's really important for there to be clean needles to prevent things like hepatitis C, HIV, and other diseases. And I think it's so important to help people who may want to quit but can't do it because maybe they don't have insurance, or they don't have access to treatment centers so like to help them in that meantime is to make sure they don't die from overdose or disease (Jude).

Similarly, another participant expressed their positive perception of harm reduction as a tool to keep people alive no matter what stage of the recovery journey they are on:

There are so many things that can work in harm reduction. I compare [alcohol use harm reduction] to Planned Parenthood. Like it saves literal lives. I am personally for harm reduction, I am very pro. Right now, I'm working in the music festival event space, and I am very pro drug testing and Narcan training and I know people who are going the Suboxone route. You know? It is a very delicate dance, but I am for anything to keep people alive. That's where I'm at (Carmen).

One participant shared their experience of searching for harm reduction treatment but hearing the term "tossed around" without follow through from providers:

I am so for harm reduction. I love harm reduction. When I was looking... I chose the place I went to because they said they subscribed to a harm reduction approach. But I just feel like... harm reduction can sometimes be thrown around in the same people treatment programs love throwing around "trauma-informed." But like how are you informed? How are you harm reduction? Show me how. They couldn't. We had someone relapse on New Years and their response was to call the cops on her. I don't think that is very trauma-informed or harm reduction (Dakota).

One participant shared their positive perception of harm reduction and a suggestion for treatment facilities:

I think harm reduction is so, so important. It helps so many people. One thing I saw a lot in my time in treatment was... okay, let's say there is

someone and their choice of drug id crack, right? And they're enrolled in treatment. And they would continue marijuana use. And these treatment facilities will kick them out of treatment for that. Really? They are booted from the facility for testing positive for marijuana. But it's like the guy was just smoking crack in the alley and now he is taking edibles to sleep. Do they really think that they need to boot someone for that? Crack or marijuana. (Casey).

Others felt that harm reduction was a “smart move” (Salem), a “great concept” (Britton), and “pretty phenomenal” (Sam). Two participants shared their positive perceptions of harm reduction treatment for many people, but stated they personally needed to choose other routes of treatment (e.g., “I love harm reduction, but I unfortunately, in my own life, needed to find abstinence as it was the best approach for me” [Hayden]).

### **Discussion**

This dissertation documented the lived experiences of 11 SD individuals in alcohol use treatment. In sharing their stories, participants contributed to a largely understudied area of research and provided insight and suggestions that may serve as a foundation for the improvement of alcohol use treatment for SD individuals. This study sought to better understand treatment barriers SD individuals face in alcohol-related treatment that may be contributing to the low treatment utilization, highlight ways of improving treatment for SD individuals experiencing AUD, and disseminate the findings to provide additional resources and increased knowledge for service providers who work with this community. In doing so, there is a long-term goal of increasing treatment utilization and retention for SD individuals in alcohol use treatment and decreasing harm

associated with alcohol use among this disproportionately impacted community. The experiences within treatment programs varied among participants, but all made valuable recommendations about ways of improving treatment to better serve SD individuals.

Most participants shared stories that reflected a connection between their sexuality and their alcohol use. Some participants felt that drinking norms within the LGBTQ+ community served as a catalyst for their alcohol use. Drinking behaviors vary across time and appear to be connected to the drinking norms of a given culture or within a subculture of the larger culture. They are largely dictated by the social structures of an individual's cultural group and the norms among their peers (Hughes et al., 2016). For example, studies have documented perceived drinking norms as being a predictor of drinks per week, binge drinking frequency, and alcohol-related problems (e.g., DiBello et al., 2018; Chen et al., 2022). As previously addressed, gay bars have and continue to be prominent locations for SD individuals to congregate (McKirnan & Peterson, 1989). Settings defined as gay-specific have been associated with greater alcohol consumption quantity with a more permissive drinking culture (Parks & Heller, 2013), and exposure to these drinking contexts and early drinking patterns influence later alcohol use among SD individuals (Parks et al., 2008). Those who identify as SD may have increased exposure to tolerant norms of alcohol use when compared to their heterosexual counterparts (Cochran et al., 2012). It is crucial for treatment providers to be aware of these cultural differences in order to better serve this community.

Participants also indicated the critical importance of the LGBTQ+ community as a catalyst for their alcohol use recovery journey. Participants highlighted their experiences of other community members in recovery showing support in various ways

from pushing them to enter treatment to recommending treatment programs. One participant shared, “Everybody in my life is gay and in recovery” (Chance). Factors such as community and social support have long been associated with improve health and well-being. In the substance use literature, social support has been shown to influence the reduction in risky drinking behaviors (e.g., Humphreys et al., 1997) and enhance recovery motivation (Peirce et al., 2000). Findings from this qualitative study further confirm the importance of social support in alcohol use treatment and recovery.

There were many participants who indicated that their alcohol use served as a means of dealing with the suppression of their sexuality, “numbing” the negative feelings and emotions related to minority stress, and intersecting identities. These findings provide further evidence to support the minority stress model (Meyer, 2003), highlighting the health disparities among SD individuals that may be due to specific stressors that are uniquely experienced by those who are part of the LGBTQ+ community. In order to provide culturally competent treatment, providers should have an awareness of these specific stressors.

Similarly, participants were largely interested in seeing an increase in inclusivity and affirming environments within recovery spaces. One participant shared, “Inclusivity is important because it made me feel a lot more safe and be able to open up and get the full experience of treatment” (Jude). Individuals who enter alcohol use treatment can feel vulnerable, unsafe, and afraid. SD individuals may face additional stressors when entering treatment that does not feel inclusive or affirming to their identities. Participants felt that using proper pronouns, understanding LGBTQ+ needs and struggles, and having

“outward-facing imagery of LGBTQ+ people” (Britton) were critical in ensuring that they were seen, heard, and valued in treatment and recovery spaces.

SD individuals and the larger LGBTQ+ community face barriers when searching for treatment that is free from discrimination, implicit and explicit bias, and respectful of their identities. Many studies have documented discriminatory treatment LGBTQ+ individuals face when seeking treatment that ultimately results in inadequate care (e.g., Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011). Further, service providers have indicated minimal training regarding working with SD individuals (Anhalt et al., 2003; Røndahl, 2011). One participant noted the importance of having “a better understand of queer people’s experience.” (Sage). There is a critical need for improved culturally competent training for service providers to ensure adequate, inclusive, and nondiscriminatory treatment.

### **Limitations**

As with all research, this study carries limitations in the design, data collection, and analysis. First, this qualitative study utilized both convenience and snowball sampling throughout the recruitment process. We partnered with various community health organizations within the State of Nevada with known alcohol use treatment programs in order to recruit participants. Additionally, a few participants were recruited using snowball sampling. That is, some participants were referred to the study through another participant who had already participated in the study. Because both convenience and snowball sampling are both nonprobability and nonrandom forms of sampling (Dörnyei, 2007), this limits the generalizability of these findings and may not be

reflective of the broader SD community. It should be noted, however, that these forms of sampling, and especially snowball sampling, is useful and often preferred when the sample of interest consists of individuals who are marginalized, stigmatized, and who are otherwise not easily accessible (Green & Thorogood, 2009). Additionally, although these findings may not be generalizable to the broader SD population, Korstjens & Moser (2018) suggest that qualitative research may be more beneficial in generating transferable data. Ultimately, it is up to the reader to decide if these findings may correspond with the communities that they work with.

Another limitation is that all interviews were conducted virtually. The PI had initially expected to conduct interviews in-person, but several participants were in different cities, others felt more comfortable speaking of their experiences virtually, and some did not have access to transportation. While some researchers favor face-to-face research interviews (e.g., Parker, 2014), the COVID-19 pandemic has not only increased the trend of virtual interviewing but has also allowed individuals to become more familiar with navigating virtual video conferences spaces and has reduced barriers for researchers and participants alike.

A final limitation that is important to consider when discussing the future directions of this work is that the study included only one individual who identifies as TGD. As discussed, this study may not be generalizable to the broader SD community. This study also may not be generalizable to the broader LGBTQ+ community and more specifically, TGD individuals. While this research may include transferrable data that can be helpful when working with the broader community, TGD individuals may have specific barriers to treatment and suggestions for improvement that may not have been

captured or addressed in this study. In the future, it may be appropriate to include the voices of TGD individuals in a similarly structured study.

### **Recommendations**

The findings of this study have implications for program structure, policy, and service provider competency that may promote more compassionate, effective, and culturally competent treatment and recovery for SD individuals. Many recommendations align with the compassionate and pragmatic principles of harm reduction. An overarching recommendation is to consider how programs and providers at all levels can incorporate aspects of harm reduction principles into their programs and practices. The following are recommendations for alcohol use treatment programs and providers:

#### ***Program structure***

Many participants shared their recommendations about how to better structure alcohol use treatment programs to engage SD individuals. For example, the inclusion of LGBTQ+ groups may not only create a more inclusive and affirming environment but may also provide a space for SD individuals and the larger LGBTQ+ community to engage with fellow community members, share their experiences in a safe environment, and learn strategies that incorporates an understanding of minority stress. Although not specific to alcohol use, studies have found that group therapies that include components of anti-oppression principles and sessions on coming out and internalized homophobia had positive treatment outcomes and symptom reductions among LGBTQ+ group members (e.g., Ross et al., 2008).

Programs may consider including complimentary pathways to recovery alongside their treatment model. For example, participants voiced interest in the inclusion of yoga,

meditation, mindfulness, and nutrition training. One participant shared, “I would have appreciated more of an emphasis on things like yoga or Pilates or just something to tune into your body and have it be a focal point of recovery” (Sage). Participants largely agreed that the preferred treatment and recovery route includes a more holistic approach. Research suggests treatment efficacy for programs such as Mindfulness-Based Relapse Prevention (MBRP; Witkiewitz & Bowen, 2010) and Mindfulness Oriented Recovery Enhancement (MORE; Garland et al., 2014) as complementary therapies for addiction.

Treatment programs should be understanding of how traditional treatment models may be triggering or harmful to some individuals and be willing to tailor or adjust treatment. For example, many participants shared their feelings about religion within the treatment and recovery space. For some SD individuals, religion is triggering. One participant stated:

When I finally got into treatment, they were so like, “Higher Power” doesn’t need to be God, but it does for most and they make that very clear. And that made me nervous because all that religious trauma is part of the reason where my drinking came from. I didn’t know how to reconcile that in treatment. Even support groups were held in chapels that weren’t labeled as religious groups (Sage).

On the contrary, some participants felt that religion and spirituality was the key component to their recovery journey. It is important to understand the needs of each client and to be willing to adjust language and have alternative ways of approaching spirituality and religion within treatment programs.

Tailoring treatment seemed to be an overarching theme for many participants. It can be important to meet each client where they are at on their treatment journey, understand their wants and needs, and assess the client's progress based on what their goals of treatment are.

### ***Program policy***

SD individuals should be supported and respected throughout their treatment. Treatment programs should strive for creating and maintaining an inclusive and affirming environment for all clients. Policies should be in place to ensure that clients are addressed by their preferred names and pronouns. Additionally, programs should remain committed to using inclusive language. This includes all materials that may be presented to clients.

Participants expressed a need for increased training for service providers. Policies should be in place to ensure that service providers are receiving training on ways of being more inclusive and affirming toward SD individuals. Additionally, many participants shared their interest in having providers who were trauma-informed and understanding of minority stressors. Ideally, treatment programs should prioritize hiring at least one person on staff who specializes in LGBTQ+ care. Additionally, all providers should be willing to engage in additional training and be willing to check their biases when working with SD individuals. It is important for all individuals to feel comfortable and welcome within treatment and recovery spaces, and providers may need to go to additional lengths to prioritize the safety and inclusion of SD individuals.

### ***Service provider recommendations***

Service providers should become familiar with their competencies and areas of growth. By understanding areas of growth, service providers can seek further training on

their own to ensure they are providing the best care for SD individuals as well as the larger LGBTQ+ community. This can be in the form of continuing education, manuals and workbooks addressing LGBTQ+ concerns, consulting with other providers, attending diversity trainings, etc.

Participants also stressed the importance of trauma-informed care within the treatment setting. As previously noted, members of marginalized groups face unique traumagenic stressors and experiences (Meyer, 2003), and LGBTQ+ individuals are at an increased risk for violence, discrimination, harassment, discriminatory policies, and being socially rejected or victimized (Elze, 2019; Meyer, 2023). Not only does evidence suggest that SD individuals and the larger LGBTQ+ community experience higher levels of trauma, including historical childhood trauma, compared to the general population (Carig et al., 2020; Elze, 2019; Anderson & Blosnich, 2013), but there is also evidence to support that these repeated stressors associated with minority stress lead to symptoms highly associated with posttraumatic stress disorder (PTSD; Friedman, 2013). These higher rates increase the risk for substance dependence as well as other psychosocial problems LGBTQ+ individuals face such as homelessness, suicidality, and disease (Andersen & Blosnich, 2013). Additionally, many participants in this study endorsed prior trauma as being a catalyst for their substance use. For example,

A lot of my use and drinking came from trying to delay or just get away from trauma that would pop up in my head and just dealing with the different layers of the human experience. It's more than just drugs and alcohol. The person often has more issues than just substances (Jude).

It is imperative for service providers to understand the unique vulnerabilities of this community as it related to trauma exposure (Levenson et al., 2021). Authors of an article exploring the application of trauma-informed care for LGBTQ+ individuals made suggestions for service providers that included helping clients find safe, validating spaces, understanding the minority stress model as it related to trauma for LGBTQ+ individuals, pushing back against oppression and stigma, and assisting clients in redefining self that both validates their identities and promotes post-traumatic growth (Levenson et al., 2021).

### **Concluding Remarks**

This study addresses a gap in the literature and is only a piece of the larger discussion that seeks to better understand how we as researchers, practitioners, service providers, etc. can offer the best care for SD individuals seeking alcohol use treatment. The ideas shared by these 11 participants creates a platform to inform more effective care for SD individuals. These recommendations should be taken into consideration when discussing treatment improvements, program policies, and program structure. It should be a priority to ensure that SD individuals feel safe, understood, validated, and are receiving the most effective treatment possible when entering programs.

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## Appendix

### Semi-structured interview

Thank you for agreeing to participate in this research project. We would like to learn more about the experiences of lesbian, gay, bisexual, and queer individuals in treatment programs for alcohol use in an attempt to make these programs more inclusive and effective for the community. We hope to publish a study based on our findings from these interviews, present the study at professional conferences, and provide recommendations for best practices when working with sexually diverse individuals in alcohol treatment programs. Do you have any questions?

- For this interview and during data analysis, we will not be using your real name in order to protect your privacy. Would you like to pick the fake name that we will use to refer to you?
- What is your sexual orientation? What is your gender identity?
- Are you currently in an alcohol use treatment program or have you previously been in a treatment program in the last year?
  - If current, which treatment program are you currently in?
  - If previous, which treatment program were you in?

We are hoping to gather as much information as possible about your experiences in alcohol use treatment programs. Please answer the following questions in as much detail as possible. Much of what you say is likely to be helpful.

*\*For all the following questions, follow-up on any key ideas, phrases, or words that are not elaborated upon by the interviewee (e.g., “you mentioned you experienced X... can you tell me more about that?”)\**

- Please tell me a little bit about your experience with alcohol. Try to start from when you first started drinking alcohol up until now.
  - If not clarified, do you remember a moment when you feel that you knew you needed to seek treatment? Tell me about that.
- Are there aspects of your sexual orientation that are related to your use of alcohol?
  - If yes, can you describe?
- When you were searching for an alcohol use treatment program, what were some important things you were looking for in the program?
  - How important was it for you to find a treatment program that provides LGBTQ+ care?
- In as much detail as possible, please describe your process of finding an alcohol use treatment program.
  - If not answered, were there other programs you tried but did not like?  
What were some reasons why you did not like these programs?
- In as much detail as possible, please describe the aspects of your current [most recent] program that you enjoy[ed].
  - If unclear, what are some things you like about the facility? Therapist(s)?  
Case manager(s)?

- Are [were] there any negative aspects of your treatment program? What are some aspects of your treatment program that you do[did] not enjoy?
- Were there any aspects of treatment that you feel were effective? Ineffective?
  - If unclear, what are some things you like about the facility? What are some things you liked ab
- What aspects of your treatment experience have been affirming of your sexual orientation, and what aspects have not been?
- What advice would you give to treatment providers to make this process more affirming and effective?
- Imagine you are able to design the ideal treatment program. What are aspects that you would include in this treatment program? What are some aspects you would not include in this program?
- Is there anything else you would like to add? Anything we didn't cover that you think would be relevant?
- Do you currently have a diagnosis related to alcohol use?
  - If so, what is that diagnosis? Ask for estimate of how much/often, etc.
- Do you currently use substances? If so, which substances?
  - For each, ask estimate of how much/often, etc.