Opioid Use Disorder in Sexually and Gender Diverse Populations:

Can We Do Better?

To the Editor: A recent JCP article by McDowell and colleagues[1] reported on a study of 1,133 individuals seeking treatment, examining differences in opioid use disorder (OUD) treatment between sexually or gender diverse (SGD) adults and cisgender individuals. All told, rates of OUD were low: just 1% of lesbian/gay patients, compared to 1.5% in heterosexual patients, with no significant difference among gender diverse and cisgender patients. The study also found disparate use of first-line pharmacotherapy with lower rates of buprenorphine in SGD patients.[1]

Previous research has shown that sexual minorities have higher rates of substance use, including prescription opioid misuse, than heterosexuals.[2] This disparity is partly due to stress from discrimination and exclusion. The gender minority stress model highlights challenges for SGD individuals, noting that rejection and exclusion lead to greater psychological distress and health disparities compared to cisgender people. On the other hand, the model also emphasizes resilience—the ability to thrive despite adversity—which can be enhanced by strong relationships, positive self-identity, community support, and affirming care.[3] The high rate of therapy visits among transgender men found in this study is consistent with the theory that increasing gender-affirming care can lead to higher resilience and decreased rates of substance use disorder.[1]

Progress in OUD pharmacotherapy lags behind, with heterosexual patients more likely to receive opioid agonists, while transgender patients are more often prescribed oral naltrexone.[1] Opioid agonists are preferred first-line treatments for OUD due to their effectiveness in reducing cravings, withdrawal symptoms, and improving treatment retention. Conversely, oral naltrexone is less effective, as shown in a Cochrane review of 13 trials that found oral naltrexone no more effective than placebo.[4] The 2020 American Society of Addiction Medicine OUD Treatment Guideline endorses buprenorphine, methadone, and long-acting injectable naltrexone, while specifically recommending against oral naltrexone.[5] The finding that SGD patients have less access to first-line treatment is worrisome.[1]

The authors question if potential drug-drug interactions could explain the relative underuse of first-line medications as HIV medications have complicated interactions with some opioid medications.[1] However, while methadone can have significant interactions with several HIV medications, protease inhibitors are the only HIV medications that require monitoring with buprenorphine.[4]

Finally, long-term opioid use can also cause hypogonadism, complicating hormone treatment. Methadone, a full opioid agonist, can suppress the hypothalamic-pituitary-gonadal axis, leading to decreased production of sex hormones. This suppression can result in symptoms such as reduced libido, fatigue, depression, and decreased muscle mass. Buprenorphine, a partial opioid agonist, appears to have a lower risk of causing hypogonadism; hormone treatment is therefore not a contraindication to buprenorphine therapy.[6]

Providing affirming psychotherapy to SGD individuals can increase resilience to SUD. In addition, educating all parties about the benefits and challenges of FDA-approved treatments can enhance care, improve outcomes, and reduce the burden of OUD in vulnerable populations.

References

1. McDowell MJ, Miller AS, King DS, et al. Opioid use disorder treatment in sexually and gender diverse patients: a retrospective cohort study. *J Clin Psychiatry*. 2024;85(4):23m15185.
2. Fahey KML, Kovacek K, Abramovich A, et al. Substance use prevalence, patterns, and correlates in transgender and gender diverse youth: a scoping review. *Drug Alcohol Depend*. 2023;250:110880.
3. Lee JH, Gamarel KE, Bryant KJ, et al. Discrimination, mental health, and substance use disorders among sexual minority populations. *LGBT Health*. 2016;3(4): 258–265.
4. Substance Abuse and Mental Health Services Administration. *Medications for Substance Use Disorders*. SAMHSA. Accessed December 4, 2024. https://www.samhsa.gov/medications-substance-use-disorders
5. American Society of Addiction Medicine. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update*. American Society of Addiction Medicine; 2020. Accessed December 4, 2024. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline
6. Hallinan R, Byrne A, Agho K, et al. Hypogonadism in men receiving methadone and buprenorphine maintenance treatment. *Int J Androl*. 2009;32(2): 131–139.

Margaret Chaplin, MD
Katie Rogers, PA-S
Vania Modesto-Lowe, MD, MPH

Article Information

Published Online: February 3, 2025.
https://doi.org/10.4088/JCP.24lr15751

J Clin Psychiatry 2025;86(1):24lr15751

To Cite: Chaplin M, Rogers K, Modesto-Lowe V. Opioid use disorder in sexually and gender diverse populations: can we do better? *J Clin Psychiatry.* 2025;86(1):24lr15751.

Author Affiliations: Farrell Treatment Center, New Britain, Connecticut (Chaplin); University of Connecticut-Community Faculty, Farmington, Connecticut (Chaplin); School of Health Sciences, Quinnipiac University, Hamden, Connecticut (Rogers); Hartford Behavioral Health, Hartford, Connecticut (Modesto-Lowe); University of Connecticut Community Faculty, Farmington, Connecticut (Modesto-Lowe).

Corresponding Author: Vania Modesto-Lowe, MD, MPH, Hartford Behavioral Health, 2550 Main St, Hartford, CT 06120 (vmodesto@hbh1.org).

Relevant Financial Relationships: None.

Funding/Support: None.

ORCID: Vania Modesto-Lowe: https://orcid.org/0000-0003-3036-2566