

# CHEMICALLY DEPENDENT LESBIANS AND BISEXUAL WOMEN: RECOVERY FROM MANY TRAUMAS

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## Introduction

Lesbian and bisexual women<sup>i</sup> who are trying to recover from the destructive effects of both chemical dependency and homophobia/heterosexism face formidable problems and tasks. In addition, many such women must struggle with other forces such as the devastating effects of terrible emotional/physical neglect or physical and/or sexual abuse, often inflicted within a chaotic chemically dependent family system.

Unfortunately, long after they begin their recovery from chemical dependency and their process of developing a sense of self, many women are still beset by problems and issues which have neither improved substantially nor been resolved as a result of being clean and sober. Many lesbian and bisexual women with long-term<sup>ii</sup> recovery are still plagued by such major problems as eating disorders, dissociative disorders, depression, Post-Traumatic Stress Disorder (PTSD), compulsive debting/spending, sexual dysfunction, inability to be intimate, relationship problems, internalized homophobia, sexual identity confusion, and self-harming behaviors. Having to struggle with such powerful problems can put these women in danger of relapse and negatively affect the quality of their lives.

Why so many lesbian and bisexual women with long-term recovery must battle with such difficult, complex, and painful circumstances; how they do so; and what life and treatment strategies may help them win this battle constitute the primary focus of this article.

One major source of understanding about this phenomenon of long-term recovery problems is the trauma literature and theory. Not until the last fifteen years has much been written about trauma--what it is, who it happens to, what its effects are, what its treatment is. Especially within the past ten years, more and more has been written. Reasons for this surge in research, the development of theory, and treatment approaches are various. The effects of their war experiences upon Vietnam veterans have become better known and understood; long-term work with and studies of Holocaust survivors have yielded much information about and greater understanding of trauma; there has been more attention to the psychology of being held hostage; and the Women's Movement has had an enormously powerful influence on our awareness and comprehension of the traumas of physical violence, rape, and sexual abuse.

Just what is trauma? Herman (1992) defines psychological trauma as

an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning. (p.33)

McCann and Pearlman (1990)

define psychological trauma as follows: An experience is traumatic if it (1) is sudden, unexpected, or non-normative, (2) exceeds the individual's perceived ability to meet its demands, and (3) disrupts the individual's frame of reference and other central psychological needs and related schemas. (p. 10)

It is possible to take these definitions and apply them to those conditions which are ordinarily not viewed as traumas--alcoholism, sexism, and homophobia. According to Bean (1981), addiction to mood-altering chemicals (including alcohol) often severely traumatizes the addicted person. If the addicted person is a woman, then she is subjected to at least one other kind of trauma, that of the threats of violence and the actual violence inherent in sexism (Herman, 1992). Furthermore, being a woman, her chances of being sexually abused are one in three (Herman, 1992). If this woman is also lesbian or bisexual, then she will experience the traumas inflicted by heterosexism, homophobia, and homo-hatred (Alvarez, 1994; Dillon, 1993; Finnegan & McNally, 1987, 1990; Hall, 1990a; Pharr, 1988). Common and frequent--if not inevitable--responses to these traumas are dissociation, depression, anxiety, shame and guilt, impairment of affect tolerance, psychosomatic conditions, and compulsions which are an acting out of feelings and internal conflicts.

Treating lesbians and bisexual women who are chemically dependent, therefore, is a task of major and complex proportions, made even more complex by such factors as the woman's stage of recovery, especially as it pertains to relapse potential; her stage of development of lesbian or bisexual identity; her family history; her history--if any--of physical, emotional and/or sexual abuse; the strength and nature of her psychological defenses; and the extent of her support systems.

### **Multiple Traumas**

The lesbian or bisexual woman who is a recovering alcoholic has been subjected to at least three traumas. Bean (1981) likens alcoholism to other traumas such as being a concentration camp victim or being a survivor of a natural disaster. She describes the similarities as follows:

In all these other events the painful process is experienced as unavoidable and overwhelming. There seems to be no explanation for it and no help for it. The psychological reactions to these traumas usually include a period of shock, decompensation, and regression. Then the person makes a variety of efforts to control,

master, cope with, and later to bear, understand, and transcend the suffering. That a person faced with the experience of alcoholism would react like other human beings faced with trauma seems obvious [Our italics]. That such a psychology of response to suffering must be understood to work effectively with alcoholics also seems clear. (p. 57)

She notes also that alcoholism is a

catastrophic experience--terrible losses, deprivations, the sense of being at hazard, shame and the certainty one can never atone, the ruin of self-esteem, the utter loss of hope. The alcoholic's circumstances are now wholly traumatic, and he/[she] must make a desperate effort to create a psychology for emotional survival. Denial under these conditions is a primitive defense invoked to stave off psychological collapse. (p. 90)

Thus the person who struggles with alcoholism is traumatized and must deal with the various attendant effects.

One trauma would be more than enough to deal with, but the alcoholic lesbian or bisexual woman must contend with at least two others. As Herman (1992) points out, "violence is a routine part of women's sexual and domestic lives"(p. 28); sexism as manifested by sexual threat and violence harms all women. She further states that "Not until the women's liberation movement of the 1970s was it recognized that the most common post-traumatic disorders are not those of men in war but of women in civilian life" (p. 28). Thus because she is a woman in this culture, the lesbian or bisexual woman is inevitably exposed to the traumatizing effects of sexism.

In addition, because of her sexual orientation, the lesbian or bisexual woman must deal with the trauma inflicted by homophobia and heterosexism. Alvarez (1994) contends that gay people<sup>iii</sup> are very often victims of emotional, and often physical, abuse from our culture and likens them to Holocaust and sexual abuse survivors. Dillon (1993) speaks of "the malevolent influence of homophobia so evident in national life today. . ." (p. 1). We, the authors, agree that homophobia/homo-hatred is enormously destructive and traumatizing. Gay people are the casualties of a vast range of abuses--from "gay-bashing" to vicious name-calling to rejection by family and friends. They are threatened with and subjected to physical violence, emotional abuse, and spiritual rape if they do not conform, keep quiet, stay in the closet and thereby deny their identity, negate their truths, and invalidate their Selves. What is demanded of them is that they collude with their perpetrators. The demoralization created by this action alone is enough to traumatize anyone.

To further compound the problem, many alcoholic lesbian and bisexual women are adult children of alcoholics (ACOAs) who have grown up in dysfunctional alcoholic family systems. In addition, according to Russell (1984), one out of three women has been sexually abused before the age of eighteen, the majority of them in their family. Herman (1992) powerfully describes the kind of childhood resulting from growing up in such dysfunctional circumstances:

Chronic childhood abuse takes place in a familial climate of pervasive terror, in which ordinary caretaking relationships have been profoundly disrupted. Survivors describe a

characteristic pattern of totalitarian control, enforced by means of violence and death threats, capricious enforcement of petty rules, intermittent rewards, and destruction of all competing relationships through isolation, secrecy, betrayal. . . .In addition to the fear of violence, survivors consistently report an overwhelming sense of helplessness. In the abusive family environment, the exercise of parental power is arbitrary, capricious, and absolute. (p. 98)

Such a climate of terror inevitably traumatizes its young victims and leaves them with scars for a lifetime.

### **The Effects of Multiple Traumas**

Herman (1992) has developed a schema which presents the characteristics of a new, more complete diagnostic entity--Complex Post-Traumatic Stress Disorder--to describe the effects, or sequelae, of subjection to totalitarian control, including childhood physical and/or sexual abuse. We will use this schema in conjunction with other writers' views to talk about some of the sequelae of trauma as they apply particularly to people traumatized by alcoholism and homophobia. A caveat is in order here. An examination of the ways various traumas affect people must recognize that there are significant differences between traumas such as, for example, childhood sexual abuse and alcoholism. Nevertheless, we want to present an inclusive view of the devastation wrought by all of these traumas in order to get a clearer look at the factors which affect the long-term recovery process of a lesbian or bisexual woman.

#### **Totalitarian Control**

Herman's (1992) first criterion is

A history of subjection to totalitarian control over a prolonged period (months to years). Examples include. . .those subjected to totalitarian systems in sexual and domestic life. . . . (p. 121)

We contend that not only childhood physical/sexual abuse but also the abuses of sexism and homophobia constitute totalitarian systems in women's sexual and domestic lives, enforcing their controls via terror, shame, and stigma.

#### **Alterations in Affect Regulation**

The second criterion is "Alterations in affect regulation, including [among others] persistent dysphoria [and] chronic suicidal preoccupation" (p. 121). Such dysphoria and suicidality are frequently evident in the course of people's alcoholism. Furthermore, women in this society often suffer from depression, almost as a matter of course. In addition, Herman (1992) cites "self injury" which can take many forms, one of which is substance abuse. Both she and Krystal (1988) speak also of the disruption of self-care, a phenomenon that Khantzian (1981) and Mack (1981) discuss as central to the devastation of alcoholism. Substance abuse as a means of dealing with the trauma of homophobia has often been cited as a major problem afflicting the gay/lesbian population (Finnegan & McNally, 1987; Hall, 1990a & b; McKirnan &

Peterson, 1989a & b; Ziebold & Mongeon, 1985). And certainly in on-going recovery such behaviors as eating disorders, self-mutilation, impulsive risk-taking, debting, compulsive sexual behavior are both problems and "solutions" because they "serve the function of regulating intolerable feeling states, in the absence of more adaptive self-soothing strategies" (Herman, 1992: p. 166).

Krystal (1988) also writes about the problems of affect regulation experienced by survivors of trauma, among them anhedonia and alexithymia, comprised in part by an "inability for reflective self-awareness (which enables one to identify one's 'feeling' as being an appropriate response to one's self-evaluation)" (p. 244). This inability to self-reflect and self-evaluate can play a significant role in a person's alcoholism, in that she cannot link emotion to act or emotion to meaning. Furthermore, this inability can create serious difficulties and obstacles in a person's attempts to develop a positive lesbian or bisexual identity in the face of severe oppression.

Krystal (1988) goes on to note that trauma survivors suffer from

a posttraumatic impairment of affect tolerance because they experience their own emotions as *heralds of trauma* [Our italics]. Past that, one encounters the problems of alexithymia. The survivors try to block the distress by the use of medication [alcohol and/or drugs in the case of addiction] and keep "proposing a physical illness" (Balint, 1964) instead of utilizing their emotions as signals. (pp. 237-238)

This inability to use one's emotions as signals is an impairment common to alcoholism and can also be observed in lesbians or bisexual women with incompletely formed sexual-affective identities. For example, a woman who is ambivalent or in conflict about her sexual-affective identity may be so frightened of the possibility of being a lesbian that she will deny any emotional and/or sexual responses she experiences and thus be unable to utilize her emotions as signals of whatever her sexual orientation may be.

### **Alterations in Consciousness**

Among the effects of trauma on consciousness listed are those of amnesia, transient dissociative episodes, and depersonalization-derealization (Herman, 1992). The trauma of active alcoholism most certainly produces dissociative episodes in the form of blackouts and brownouts. Recovery from alcoholism is often marked by what appear to be dissociative episodes (e.g., "The last thing I remember, I was walking by the bar and then all of a sudden I was sitting at the bar drinking. I don't know how that happened.") Krystal (1988) talks about "psychic numbing" that trauma survivors experience, in which they "are able to observe and describe the blocking of affective responses" (p. 151) and thus function while not feeling. Gay people who are subjected to the constant, on-going totalitarian system of societal and familial homophobia intensified by their own personal, internalized homophobia learn to survive this emotional battering by "numbing out." They often don't hear (at least not on a conscious level) the homophobic jokes and slurs and innuendoes and whispers. They often don't see the looks, the gestures, the turning away. But to achieve this state, they may dissociate, unconsciously splitting off a part of themselves and keeping it separate and alone.

### **Alterations in Self-Perception**

Three of the major characteristics Herman (1992) cites in this category are a "sense of helplessness"; "shame, guilt, and self-blame"; and a "sense of defilement or stigma" (p. 121). Certainly people who struggle with alcoholism and with the oppression of homophobia experience a sense of helplessness and concomitant despair. And, unfortunately, some degree of shame, guilt, and self-blame are the inevitable feeling states of those afflicted by alcoholism and/or homophobia. A sense of defilement or stigma is unavoidable in the face of societal disgust and hatred both for those who are alcoholic and for those who are lesbian or gay or bisexual. It should be noted also that people who are ACOAs often suffer from these same sequelae.

A fourth characteristic listed is a "sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)" (Herman, 1992: p.121). The despairing sense of complete and totally unacceptable difference from others captures the utter despair of the alcoholic who feels cast into outer darkness, not fit for human company. And many lesbian, gay, and bisexual people struggle from an early age with powerful feelings of difference and the strong belief (often accurate) that no other person can understand (or accept) their sexual orientation. In the face of vicious homophobia, it is difficult for many gays and bisexuals not to feel that they, too, have been cast into outer darkness.

### **Alterations in Perception of Perpetrator**

Two characteristics in particular speak to the destructive effects of both alcoholism and homophobia--an "unrealistic attribution of total power to [the] perpetrator" and an "acceptance of [the] belief system or rationalizations of [the] perpetrator" (Herman, 1992: p. 121). In regard to the first, Herman (1992) adds a caution: "victim's assessment of power realities may be more realistic than clinician's" (p. 121). Certainly, the *feeling belief* active alcoholics usually hold is that alcohol has total power over them in the sense that they cannot live without it (while, paradoxically, believing at the same time that they can stop any time they choose). The First Step of Alcoholics Anonymous addresses this paradox by teaching alcoholics that while they are powerless over the *chemical effects* of alcohol, they have power (control) over their behavior. Many lesbians and bisexual women ascribe total (or a great deal of) power to society, living in fear of being "found out" and being shamed and rejected.

The second characteristic, accepting the belief system of the perpetrator, applies to alcoholics in a particular way. In and of itself, alcoholism, "the perpetrator," does not have a belief system; yet an internal belief system about the power and importance of alcohol develops within the alcoholic which then acquires the force of immutable reality. For example, many alcoholics are absolutely convinced that they cannot function, socialize, or even live without alcohol. Lesbians and bisexual women are subjected to society's shaming and threatening belief system that they are "unnatural," "sick," "sinful" freaks of nature, that they are failed heterosexuals. They accept these beliefs and/or are affected by them in proportion to how developed their sexual-affectual identity is. But no matter how advanced their identity development is, they are still subjected to the full weight of the cruel and often loudly proclaimed beliefs that society puts forth.

## **Alterations in Relations with Others**

Davies and Frawley (1994) describe survivors' re-enactments in adult relationships of the dynamics of the trauma of sexual abuse and the disruptive effects of those interactions. All of the conditions that Herman (1992) cites in this category are unnervingly familiar to anyone who knows alcoholism: "isolation and withdrawal; disruption in intimate relationships; repeated search for rescuer; persistent distrust; repeated failures of self-protection" (Herman, 1992: p. 121). These occur during a person's active alcoholism, but they continue far into a person's recovery (Bean, 1981; Khantzian, 1981). For the lesbian or bisexual woman, these conditions can mark major problems created by the trauma of homophobia. If women feel threatened because of their sexual-affectual orientation, they may indeed isolate and withdraw. Being lesbian or bisexual presents them with having to choose between keeping their orientation secret--an action which is destructive to close relationships--or coming out to others which puts them at risk of rejection. Either way, keeping secrets or coming out can and frequently does cause disruption in intimate relationships. And, certainly, the battering of homophobia can engender persistent distrust.

## **Alterations in Systems of Meaning**

This category is marked by a "loss of sustaining faith [and a] sense of hopelessness and despair" (Herman, 1992: p. 121). For active alcoholics, these conditions are nearly inevitable. Recovery often involves an active struggle to regain faith and restore hope (Bean, 1981; Kurtz & Ketcham, 1992). In the face of virulent homophobia, it becomes extremely difficult for lesbians and bisexual women to sustain their faith in the societal system which makes up their cultural context. And in the face of society's betrayal of them, many lesbians and bisexual women fall prey to hopelessness and despair.

## **Physiological Effects**

There is one other category which needs to be considered--that of physiological effects. That abuse has physiological effects is not in question. Krystal (1988) notes that when a person is alexithymic and cannot describe or express her affects, she may well express them through somatic symptoms. Van der Kolk (1987), Courtois (1988), and Herman (1992), among others, clearly describe the physiological effects of trauma. As Herman (1992) comments,

Chronically traumatized people no longer have any baseline state of physical calm or comfort. Over time, they perceive their bodies as having turned against them. They begin to complain, not only of insomnia and agitation, but also of numerous types of somatic symptoms. Tension headaches, gastrointestinal disturbances, and abdominal, back, or pelvic pain are extremely common. Survivors may complain of tremors, choking sensations, or rapid heartbeat. (p. 86)

Both Courtois (1988) and Herman (1992) describe the self-harming behaviors which can have long-term somatic consequences, such as "chronic suicidality, self-mutilation, eating disorders, substance abuse, [and] impulsive risk-taking. . ." (p. 166). At least three of these--suicidality, eating disorders, and impulsive risk-taking--are often present in alcoholics' active drinking. And

they frequently continue far into recovery. Although the links between these self-harming behaviors and the traumatic effects of homophobia are not always clear, there certainly has been a great amount of discussion about the amount and effects of substance abuse in the lesbian and gay communities. The most current studies do not support the assertion that "addiction rates are higher among lesbians and gay men, [but] some studies find that lesbians and gay men reported higher rates of AOD-related [alcohol and other drugs] problems" (Proceedings, 1992: p. 13). The contention is that many gay people drink alcoholically to try to soothe their feelings and to not care about the homophobia they constantly encounter and must deal with. Studies by McKirnan and Peterson (1989a & b) and Hall (1990a & b) support that discrimination because of sexual orientation is related to AOD-related problems. In addition, McKirnan and Peterson (1989a & b) found that "bar orientation" (how important the bar setting was to a person) was a very strong predictor of AOD-related problems reported by lesbians and gay men. Given the central social function of bars in many lesbian and gay communities, alcohol especially becomes readily available to those with a strong bar orientation. McKirnan and Peterson (1989a & b) also found that those lesbians and gay men who least likely to report AOD-related problems are those who have a positive lesbian/gay identity.

Certainly the statistics about suicide are chillingly clear in indicating the traumatic effects of homophobia on young people. In his 1989 study, Gibson "concluded that lesbian and gay youth are two to three times more likely than their heterosexual counterparts to attempt suicide" (Cited by D'Augelli, 1994: pp. 16-17). In his 1991-1992 study of 200 lesbian and gay youth, D'Augelli (1994) produced even more terrible statistics:

There was much evidence of suicidality. Only 40% said they had never thought about killing themselves. Many--42%--said they had made a past suicide attempt. (For comparison, high school suicide attempts rate estimates vary from 6% to 13%). (p. 18)

Herman (1992) also describes other forms of physiological harm resulting from trauma:

The physiological changes suffered by chronically traumatized people are often extensive. People who have been subjected to repeated abuse in childhood may be prevented from developing normal sleep, eating, or endocrine cycles and may develop extensive somatic symptoms and abnormal pain perception. (p. 183)

There are striking parallels between these changes cited here and the changes observed in alcoholics. Both in their active addiction and in early recovery, alcoholics' sleep and eating patterns are often seriously disturbed and their somatic problems are indeed extensive. Although less is known about the physiological changes brought on by the trauma of homophobia, D'Augelli (1994) provides some insight into this matter:

Coming out. . .at earlier ages, these [gay and lesbian youth] are at higher risk for harassment and violence than more closeted earlier generations. This victimization in turn affects their mental health; and for some. . .the verbal taunts, threats, and punches may induce self-destructive impulses. (p.18)

Furthermore, the following speculation seems well validated by the findings about other traumas: that fear--constant, on-going, unrelenting--fear of discovery, rejection, physical and emotional violence take a tremendous toll on a person's psyche. It seems reasonable to assume that the effects of such fear, over time, would be traumatizing and would result in some of the same sequelae that other traumas produce such as disruptions in self-care, self-harming behaviors, and "a degree of physiological disturbance" (Herman, 1992: p. 187) continuing far into the process of recovery.

### **General Considerations**

Taking into account the traumatizing effects of alcoholism and homophobia (even without regard to any other possible traumas), it is not hard to understand why it could be extremely difficult for an alcoholic lesbian or bisexual woman to develop a solid, integrated recovering self. Unfortunately, some or many of the traumatic sequelae of both alcoholism and homophobia are the unavoidable consequences of being an alcoholic lesbian or bisexual woman.

Treating these women, therefore, is a difficult and complex task, a task made even more complex by such considerations as the woman's stage of recovery, especially in relation to relapse potential; her stage of development of lesbian or bisexual identity; her family history; her history--if any--of physical, emotional and/or sexual abuse; the quality of her psychological defenses; and the strength of her support systems.

### **Treatment Considerations**

The first, the foremost, and the most important consideration in treatment always is where a woman is in her alcohol/drug recovery process. This evaluation has far less to do with the number of years in recovery--although that issue is important--and far more to do with the stability of her life and the strength of her support networks. If, for example, a lesbian or bisexual woman has over five years of recovery, but has had great difficulty holding jobs, has had numerous ruptured relationships, has "run through" three or four (or more) sponsors, and has few, if any, close friends, then her relapse potential may be rather high. Certainly, her profile would strongly caution against delving into past events which may have been traumatic and against focusing on issues other than those which would help her strengthen her support networks and achieve more stability in her work and personal relationships. Another example might be that of the lesbian or bisexual woman who has only three years of sobriety, but has a stable job, has a number of close friends, enjoys an active dating life, and has a good working relationship with her sponsor. Her likelihood for relapse is low, so she is in a safer position to explore other areas such as possible childhood abuse or the development of her lesbian or bisexual identity, areas which might be problematic, difficult, or painful. One other example might be that of a woman who has relapsed because she felt overwhelmed by flashbacks of childhood sexual abuse. The therapist needs to help her focus on the tasks of early sobriety and especially help her to contain her flashbacks, rather than delve into them and thereby exacerbate her PTSD.

A second important consideration in evaluating and planning treatment is just where the woman is in the development of her sexual/affectional identity. For example, a woman may

have been so traumatized by both external and internalized homophobia that she continues to be terrified of coming out to anybody or of attending gay/lesbian AA meetings, even though she may have been in recovery for five or more years. Assisting her to explore both society's and her own homophobia and the traumatic sequelae of it rather than trying to get her to go to gay/lesbian AA would no doubt be the more helpful path. Another example of the stage of identity development might be the woman who is immersed in a long-term relationship, committed to her lesbian relationship, but not involved in any kind of community and thus isolated. She might well need help developing a wider support network of friends and AA peers. As Dillon (1993) points out, she probably also needs help with "the residual effects of hiddenness and duplicity on. . .[her] efforts to form a healthy, esteemed, integrated self" (p. 1).

A third consideration is that of family history. If her family is dysfunctional, especially if one or both parents have been or are active alcoholics, she will probably need much concrete help with the most basic tasks of self-care such as tending to personal hygiene, managing money, managing time, eating properly, getting enough sleep, planning her life. Since growing up in a dysfunctional family system creates problems such as these, therapists need to watch for such self-care deficits in many areas of a person's life far into her recovery. In addition, the history taker needs to explore possibilities of serious neglect and of physical, emotional, and/or sexual abuse. If evidence of these traumas is present, then the therapist must make decisions about when, how much, how intensely (if at all) to work on the neglect or abuse issues in relation especially to the client's recovery status.

Even if the lesbian recovering alcoholic comes from a relatively stable, functional family system, the history taking process must include questions about any possibilities of sexual abuse, employing, of course, a broad, inclusive definition of sexual abuse (both overt and covert forms of abuse). The questioner must listen closely and sensitively, evaluating the answers in light of the traumatic sequelae already known to exist because of the woman's status as a lesbian or bisexual woman who is recovering from alcoholism, and then make treatment decisions.

Another consideration for treatment planning and procedure is that of the strength and nature of the client's defenses. If the client tends to deny and minimize the need for a high degree of personal safety in her life (e.g., she doesn't exercise good judgment about walking alone in dangerous areas; she trusts people who end up harming or exploiting her), then the therapeutic work will need to focus on establishing safety rather than on investigating traumatic material. Another example might be the woman who is obsessive-compulsive and who engages in activities that are harmful to her such as compulsive sexual behavior, spending, overeating. Again, the primary therapeutic task is to help establish safety and to teach other ways to self-soothe. Another consideration is whether a person's defensive system can withstand such stresses as floods of memories or loss of sleep or psychosomatic problems. If the person is overwhelmed by affects and experiences, the therapeutic task would be first of all to teach how to contain feelings. Ultimately, the major evaluation must be about how rigid, how brittle, how flexible, how strong each person's defenses are. The therapeutic work must be adjusted accordingly.

One last issue must be considered--how strong, how extensive is a person's support system. If a woman has no close friends, has no supportive family (or instead has a

dysfunctional, assaultive one), does not belong to a 12 step or other self-help program, then she is at risk for relapse and needs help establishing some kind of support network. She certainly is not in a safe position to do deep, complex, psychodynamic work at that point. The abuses she has suffered, whatever they may be, have isolated and disempowered her. For recovery, she needs support and connections that will empower her.

### **Primary Treatment Responsibilities**

Of the many responsibilities involved in proper treatment, five stand out.

1) Above all else, Herman (1992) stresses, safety must be established and maintained. If a recovering alcoholic lesbian is threatened by homophobic forces--for example, if she will lose her job if her sexual orientation becomes known--she needs to be helped to protect herself and her identity and to feel all right about staying closeted. If an alcoholic bisexual woman with many years' recovery is severely depressed, she needs to receive specific treatment that will help alleviate the depression.

But safety also has to do with the character and training of the treating person. If the therapist knows about and accepts his/her limitations, that alone will offer some safety to the patient. But therapists who work with lesbians or bisexual women who are recovering alcoholics need to know about alcoholism, homophobia, and sexual abuse in order to provide the safest possible treatment. Such knowledge can help therapists focus on clients' alcoholism if there are relapse issues present; can help therapists balance between working on sexual abuse and other issues such as developing a positive sexual-affectual identity; and can help them support clients who are struggling with the dual stigmas of homophobia and alcoholism. If, however, the therapist is ignorant of the signs and symptoms of relapse, or does not know about dissociation, or is homophobic, even subtly so, then his/her recovering alcoholic lesbian or bisexual patients are not likely to be safe.

Herman (1992) talks about the issue of safety in working with childhood sexual abuse victims, an issue that has far-reaching implications. As she says,

probably the second most common [therapeutic] error is premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance (p. 172).

She then gives an example of a person in early recovery who would not go to AA and who was suddenly flooded with memories of abuse. The therapist, at the urging of the client, began doing intensive abuse work. As Herman (1992) points out, the therapist "failed to recognize that exploring traumatic memories in depth was likely to stimulate more intrusive symptoms of post-traumatic stress and therefore to jeopardize the patient's fragile sobriety" (p. 173). She goes on to note that thorough evaluation of the patient's current status is essential to ensuring safety and thereby protecting the patient. This caveat applies to all alcoholics in recovery, no matter what stage of recovery they may be in. Bean (1981) also stresses that safety must underly everything else.

2) As Herman (1992) notes, in survivors of chronic childhood abuse, "Self-care is almost always severely disrupted" (p. 166). Bean (1981), Mack (1981), and Khantzian (1981) also describe the disruption or lack of self-care stemming from the traumatic effects of alcoholism. And those who work with recovering alcoholic gay and lesbian clients (Finnegan & McNally, 1987; Kus, 1988; McNally, 1989) discuss the deficits in self-care that have developed in part as a result of responses to homophobia and alcoholism.

Thus teaching self-care becomes a primary treatment responsibility. It is important to teach clients how to perform what are described as all the tasks of early sobriety. They are actually the tasks that a traumatized person does not know to do and does not know how to do. They may include such matters as dealing with obsessions to drink and/or drug, managing one's time, handling one's money, and protecting oneself (e.g., handling assaultive or intrusive others; taking proper self-defensive precautions).

In addition, therapy must help clients deal with whatever self-harming behaviors they may be engaging in--from eating disorders to self-mutilation to impulsive risk-taking. Since these behaviors serve to help people soothe their intolerable feelings, therapy needs to address and teach other ways to regulate feeling states.

3) Clients need to be helped to recognize, name, and express their feelings and to learn how to cope with those feelings. They need to learn how to regulate feeling states, how to contain feelings, how to safely express them. They also need to learn how to respond to others' feelings in ways appropriate to and supportive of their own well-being.

4) Another treatment responsibility is to encourage and assist clients to engage in mourning their losses which may range from a childhood lost to abuse to all the losses incurred in active alcoholism to the losses produced by homophobia (e.g., loss of status, loss of friends/family/job).

5) Primary also to effective treatment is the task of helping to de-shame and de-stigmatize the client. Shame and stigma are the results of abuse, whether it be sexual abuse, physical violence, alcoholism, or homophobia. The sufferer blames herself, "reasoning" that she must have been bad, that otherwise this evil would not have happened to her. If sexually abused, children are often told that they liked it, that they asked for it. If physically abused, the person is often blamed for "provoking" the perpetrator. If the person falls prey to alcoholism, she "brought it on herself," she "asked for it"; no matter how much public information is presented, many people still see alcoholism as "self-inflicted." If a person is attacked from without and within by homophobia, she must hear that she is "sick," "sinful," "perverted," "unnatural," "immoral," and/or "insane." To be attacked by any one of these, much less all of them, is to be subjected to powerful shaming forces. And to "own" any of these states of being is to take on a stigmatized identity.

Clients need to be able to work through the shame they experience from being traumatized. They need to transform their stigmatized identity into a positive one in order to heal. It is the task and the privilege of the therapist to accompany them and assist them on their healing journey.

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### ENDNOTES

1. This population includes many women who do not know what their sexual orientation is and whose search for such knowledge may take many years.
2. We define "long-term" as five or more years of continuous recovery.
3. The term "gay people" is to be understood as inclusive of bisexual women and men

