

OUT OF DENIAL: AN INTERVIEW WITH DANA FINNEGAN AND EMILY MCNALLY

By Laura Markowitz

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Back in 1987, which was not that long ago, quiet history was made when the definitive book on treating lesbian and gay substance abusers was published *Dual Identities: Counseling Chemically Dependent Gay Men and Lesbians* by psychotherapists Dana Finnegan and Emily McNally, outlined the specific ways that clients' homosexual orientation complicated substance abuse and treatment. While homosexuality had already been depathologized in the mainstream psychiatric and psychological associations for 14 years, clinicians were still trying to assess the special needs of the gay and lesbian community. Researchers and clinicians were studying how the added component of homophobia and heterosexism contributed to any number of conditions, from depression to Post-Traumatic Stress Disorder to addictions. Among LGBT and straight-ally practitioners who worked in the substance abuse field, it was clear that there was a connection between the stress of living in a hostile society as a queer person and substance abuse, but it was another seven years before the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) published Joseph Neisen's monograph on treating LGBT people. It was McNally and Finnegan's work, however, that had convinced many practitioners that they had to look beyond the behavior and help clients understand the ways their identity as lesbians and gays shaped their substance abuse. This year, Finnegan and McNally have published the second, revised edition of *Dual Identities*, with a significant change in the sub-title (and contents) to *Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities*. This change represents an expansion of the book to include two significant groups-bisexual and transgender substance abusers. McNally, a psychologist, and Finnegan, an alcoholism counselor, were in private practice for many years in New York City and New Jersey, and are now retired and living in Southwest Florida. They continue their work as activists and consultants on LGBT substance abuse issues.

Q: I am curious about what first brought you both into the field of LGBT substance abuse. Was it purely professional interest, or was there also a personal component?

A: We both got into the field because of our own personal recoveries from addiction. We both† suffered from destructive experiences earlier in our lives because mental health and health professionals didn't know enough about alcoholism and other drug addictions to help us. In fact, they made it worse! Emily asked her medical doctor if her drinking could cause cirrhosis [cirrhosis], and he told her that as long as she was still eating, she shouldn't worry. Later, when she was drinking a lot and experiencing many late-stage symptoms of alcoholism (e.g., blackouts, daily drinking), she asked her therapist if she might be an alcoholic. He told her no, that at age 25, she was too young.

Dana went to a psychiatrist because she was drinking heavily to combat depression. This therapist assured her that she was not an alcoholic and, in fact, gave her a bottle of Jack Daniels

for her birthday. This same therapist gave her all kinds of prescription drugs (including valium, seconal and thorazine) to "help" Dana's anxiety. Unfortunately, Dana became addicted to the drugs.

With the help of good therapy and a 12-step program, Dana stopped drinking in 1970. A good therapist supported her efforts to get sober and helped her see that she could change. She came off all medications in 1974, with help from Emily and others. In 1971, Emily stopped drinking with the help of a 12-step program. We both feel compelled to use our personal experiences to benefit others.

Q: Was there any organization or out presence of lesbian and gay substance abuse counselors at that time?

A: In the mid 1970s, we were working in the addiction field when the profession of alcoholism counseling was just beginning. It's hard to believe from the vantage point of 30 years later, but at that time, sex was rarely discussed in alcoholism treatment, and sexual orientation was simply never discussed in treatment. Lesbian and gay patients and staff were all in the closet, and no one talked about the elephant in the living room.

All this began to change in 1979. We were still in the closet in our professional lives and were working as alcoholism counselors in an in-patient program. We and our colleagues attended a three-week program in New Jersey, Rutgers Summer School of Alcohol and Drug Studies. During the third day of classes, we attended a workshop on how to help gay and lesbian patients. We were shocked and excited that it was even being offered. It was taught by nonprofessionals--a gay man (Cade W.) and a lesbian (Nancy T.). They told their own recovery stories and described what it was like for other lesbians and gays they knew who were struggling to recover from substance abuse. Just sitting in a room and talking about the conjunction of being gay and being an addict set our hearts thumping.

After the workshop, Nancy told us two things that changed our lives. First, she described meeting a lesbian at this summer program the year before who told Nancy that she had been running back to her room every night to call her lover at home because she felt so alone amidst so many straight people. She thought she was the only gay person there, because all the lesbians and gay men were in the closet. We realized that unless we came out of the closet, we would not be available to others. It was scary! New Jersey was our home state, and many people at the summer program knew us professionally, but did not know we were lesbians. But we felt a strong impulse to push through our own fear--we didn't want others to experience the loneliness the woman had gone through the previous year.

The second thing Nancy said that changed our lives was that every time she and Cade presented their stories at this summer program, counselors approached them with questions about how to help their gay and lesbian clients. But not being counselors themselves, the two could not answer those questions. Nancy wanted to know why there were no professionals in the addiction field who were out enough to advise their straight colleagues. What she said resonated with us. We felt called to do something about it.

Q: So what did you do?

A: Well, that night, 25 of us came together as openly lesbian and gay addictions counselors. It was a profound experience. Most of us were terrified of being so out in a professional setting. A gay man from Detroit said that he was married and very closeted. He was attending the summer

school with colleagues from work and was so terrified to be with us that he told us he would not say hello to any of us or acknowledge us the following day or during the subsequent three weeks. And he didn't. A lesbian from Appalachia cried as she showed us a picture of her young children, whom she had lost in a custody battle with her husband. For many of us, it was the first time we had been with others who identified with the intersection of our stories of addiction and recovery and our pain and isolation as gays and lesbians.

After that first meeting, 13 of us formed a group that eventually became the National Association of Lesbian and Gay Addiction Professionals. When we first put the word out that we were forming NALGAP, the response was immediate and strong. We had positive reactions from many straight therapists and organizations, and we heard from countless lesbians and gay men in the alcoholism and drug abuse fields who were doing groups, writing papers and presenting workshops in their local areas. We went to the March on Washington that year (1979) and joined with the other lesbian and gay health groups. We were warmly welcomed by some, but not by all. When we attended an open house for the lesbian and gay health groups, there were no non-alcoholic beverages being served. It was the first of many moments when we encountered ignorance and denial about the problem of substance abuse in our community. Drinking, in particular, had been an integral part of lesbian and gay social life for many years, and we were challenging a deeply entrenched culture.

Q: Did you encounter a lot of misinformation about lesbian and gay substance abuse in the literature?

A: We encountered silence and invisibility. There was not a single book about lesbian and gay substance abuse in 1979. Nancy T. had been collecting unpublished papers that had been written by lesbian and gay addicts during the 1970s and she gave them to NALGAP. We were a clearinghouse for this "fugitive literature." It was the only written information we had that helped lesbians and gays in recovery, and that talked about patterns of LGBT substance abuse. NALGAP distributed a directory of counselors and facilities who were willing to serve as referral sources for lesbian and gay substance abusers. But it was a pitifully small number of sources. There was a therapist in Kansas who ran a group for gay men in a VA hospital alcoholism program, but when she moved to another state, we had to take Kansas out of the Directory. A whole state disappeared! Who says one person can't make a difference?

Q: When did the mainstream substance abuse treatment field start to look at special issues for lesbian and gay addicts?

A: In 1980, the National Council of Alcoholism made it possible for NALGAP members to present a day-and-a-half-long track on lesbian and gay substance abuse issues at their national conference in Seattle. This helped put lesbian and gay treatment issues on the map. The papers from this conference were published by Haworth Press in 1982 (*Alcoholism and Homosexuality*, edited by Tom Ziebold and John Mongeon). This was the first major publication about lesbian and gay substance abuse. While that was a major breakthrough, there still was no book about the wider issue of substance abuse and lesbians and gay men, and we knew from the many questions NALGAP was fielding from practitioners around the country that there was a need for one. We felt "called" to write a book about what we knew and what we thought counselors should know to help their lesbian and gay clients. So *Dual Identities* came into being.

Q: Did the book make a big splash?

A: We had written a few articles before we started on the book, but we were rather inexperienced about publishing. We certainly weren't prepared for the overwhelming response it brought from our straight colleagues and from other lesbian and gay counselors. We received letters and phone calls telling us how our book had helped and asking for even more information. Rehabs and counseling centers used it to educate staff and to support clients, and it became required reading in a number of college and university courses on substance abuse.

But the biggest and most gratifying surprise was the feedback we received from recovering lesbians and gay men, and from those trying to recover. They wrote to us and spoke to us in person about their struggles to get clean and sober in homophobic treatment programs. We also heard about many instances of intolerance and hostility against gay and lesbian people in mainstream Alcoholics Anonymous (AA) meetings.

Q: Was it a problem for queer people to come out in AA?

A: More often than not, lesbians and gays felt they had to be in the closet when they shared at these meetings. Some were so afraid of being outed that they didn't get the kind of benefit they needed from meetings because it was not really a "safe" place to open up and reveal themselves to the group. They told us our book spoke to them, and made them realize they were not alone, that there were others like them who shared their reality.

Q: When did the phenomenon of lesbian and gay 12-step meetings start to happen? I know they exist in many cities across the country.

A: Informally, lesbians and gays met in people's homes to support one another's recovery since the 1940s. We were aware of some gay meetings in the metropolitan New York area in the early 1970s. In the early 1980s, the International Advisory Council for Homosexual Men and Women in Alcoholics Anonymous (IAC) came into being. It publishes the *World Directory of Gay/Lesbian Groups of Alcoholics Anonymous*. That makes it a lot easier for lesbians and gays to find safe meetings.

Q: So far, we've only been talking about lesbian and gay people, but I know your new edition of *Dual Identities* includes significant additions to the content that address bisexual and transgender people. Are there significant differences between their issues and lesbians' and gays' issues when it comes to substance abuse and recovery?

A: Learning about bisexuals' and transgender people's special treatment issues stretched our minds, hearts and attitudes tremendously. We didn't know a whole lot about these two groups when we started revising the book. We quickly learned how little research has been done on substance abuse issues in these communities. The deep problem of invisibility and negative attitudes has created a dire situation, leaving bi and trans people the most under-served client populations of substance abusers. In some ways, they are in the place lesbian and gay people were 20 years ago.

We had the good fortune of being invited to join a workgroup of LGBT clinicians, writers and researchers who were contributing to the federal government's Center for Substance Abuse Treatment's proposed manual on treating LGBT substance abusers. We met dynamic people from across the country who opened our eyes to the special issues and problems faced by bisexual and transgender people. We learned that neither group had a voice in the substance

abuse field and that both groups were discriminated against by both the straight world and the gay/lesbian world. Bisexual people are especially invisible and therefore are not identified and served by the treatment field. Transgender people are often the objects of terrible violence. They too are a grossly under-served population and if they do get into treatment, most counselors don't know how to help them. For example, most treatment people don't know how to factor in a transgender person's use of hormones when thinking about recovery from substance abuse. Transgender clients are often viewed with contempt or outright hostility by addiction counselors.

Q: One of the most basic questions we hear from therapists who work in the substance abuse field relates to the relevance of sexual orientation when treating addiction. After all your years of work in the field, what do you think the connection is between being queer and being an addict? Are there cases where the stress of being queer in a hostile world actually "drive people to drink?" And if so, can that turn them into addicts?

A: To answer that, first we need to define queer so that it includes not just sexual orientation, but gender identity too. Ultimately, what we're talking about is being different--"transgressing" the heterosexist norms and rules of "normalcy." Those who transgress by virtue of their very identity, their queerness, are punished by the homo/bi/transphobia of a self-satisfied majority. Struggling against this hostility on a daily basis creates enormous stress for most queer people, and they develop defenses against that stress. Some use alcohol and/or drugs to ease the pain. Some of those users cross over into addiction. The combination of stress, self-hatred, overt hostility and personal jeopardy with alcohol and/or drugs creates a synergy of pain and danger that can, and often does, lead to addiction.

We need to keep in mind, also, the ubiquitous presence of drugs and alcohol in LGBT social life. For decades, the bars have been "safe" and often the only place to meet other queer people. Some drink to "be" queer--to fit in; many drink to not be queer-- to suppress their desire and self-loathing that arises because of that desire. Some segments of gay male culture are centered on drugs and alcohol, including raves, circuit parties, sex with poppers, Ecstasy, GHB and crystal meth. There is a segment of the trans community that, because of the extreme discrimination they face, are forced to earn their living by being sex workers, a scene that's rife with drugs. And for some, getting numb through drug use is the only way to survive. Among the trans community, drug and alcohol abuse have been an accepted method of coping with the enormous stresses of being transgender.

So our answer to what we think the connection is between being queer and being an addict is that being queer is not what puts people at risk. It is a cruel and hostile world, which mistreats those who are different, that puts queer people at risk.

Q: Is there any reliable research out there on the percentage of self-identified substance abusers who are queer versus straight? If so, do those numbers surprise you?

A: For a long time, starting in 1975, with Lilene Fifield's study, the statistics cited about lesbians and gay men were that a startling 30 to 33 percent were addicted, as opposed to about 10 percent of the straight population. More recent research has shown these alarming statistics to be inaccurate. In fact, the number of LGBTs reporting substance abuse comes to about 10 percent, which is about the same as the straight population.

But what's different and disturbing are the reports showing that, unlike their straight counterparts, lesbians, gay men and bisexuals do not gradually lessen their use/abuse as they get

older. Another disturbing finding of the recent research is the high rates of tobacco use (another form of substance abuse). A 1999 study (Stall, Greenwood, et al.), found that 41.5 percent of gay male adults smoke--a rate far above the national rate of 28.6 percent of the general male population cited by the Center for Disease Control in 1994. This is not just a gay male problem. A study in 1996 found that lesbians smoke more than their gay male counterparts. Transgender people clearly are at the highest risk for all forms of substance abuse. J. M. Xavier's study in 2000, conducted in Washington, D.C., found that 34 percent of the 252 trans participants self-identified as having problems with alcohol and 36 percent as having problems with drugs. Other studies on the trans population have found similarly high percentages of substance abuse among this population. We understand it as an indication of the terrible effects of transphobia on vulnerable people.

Q: In your experience, are there noticeable differences in the kinds of treatments that are most effective for each population?

A: Substance abuse is always the central issue in treatment, because if people aren't clean and sober, they can't possibly deal with their life in any constructive way. The principles and tools of AA have always guided our treatment protocol. These basic principles work for everyone, developing connections with other recovering people, finding hope in the face of despair, having clean and sober role models, and acquiring tools for living life every day (such as learning to structure time and changing life habits built on addiction.)

That said, treatment must be sensitive to the specifics of anyone's situation. Has the lesbian only been able to be sexual while drunk? Has the gay man only found intimacy with other gay men in bars or at raves? Have bis been bombarded with biphobia from both straights and gays and at the same time been bereft of an out bi community in their area? Have trans people used alcohol or drugs to help them deal with the terror of coming out to themselves as well as to others? Bad treatment ignores or is ignorant of each individual's life story and situation.

Q: I have heard some LGBT people describe struggles with the concept of a Higher Power in the 12-step program, having battled the disastrous messages of homophobic religions all their lives. What do you recommend clinicians do to coach their clients through this potential stumbling block?

A: One way is to have a non-homo/bi/transphobic clergy person talk to the LGBT person about religion and spirituality. This is often a powerfully helpful experience. Another way is for counselors first to acknowledge and honor the spiritual pain and loss created by the disastrous messages sent by homo/bi/transphobic religions. Second, they need to help clients distinguish between religion and spirituality, pointing out that a Higher Power is not, in fact, cannot be, defined by narrow religious views. Another helpful approach is for counselors to point out that alcohol and drugs have been substance abusers' "higher power" and that they need to transfer their belief to a positive force or experience.

Q: How do you feel about Gay 12-step meetings? Do you think it's a good thing for queer substance abusers to support one another through the recovery process? Is there a down side to what many call the "triangle clubs"?

A: Both of us got sober in "mainstream" AA and didn't find gay AA until a few years later. When we did, the opportunity for each of us to tell our whole story, including the part about being lesbian, was thrilling. And the support of others who "spoke our language" and understood

our way of life was invaluable. At the same time, it was sometimes distressing to see the amount of cruising that went on (although 13th Stepping-- cruising and dating-- certainly occurred in mainstream 12-Step groups). And sometimes these "triangle clubs" did not seem to have a great number of people with long-term sobriety. At times, these groups have been beset by their own homophobia, but more particularly by their own bi- and transphobia. For example, bi people are sometimes looked down on as "fence-riders" who want the best of both worlds; and trans people are sometimes shunned as being not "real" men or women, or "real" homosexuals. Nevertheless, gay AA and gay Narcotics Anonymous (NA) are invaluable. They provide an atmosphere in which most people who attend can recover in safety. They provide role models who are examples of hope. They provide sponsors whose understanding is based on their own life experiences. In addition, as gay AA and NA have grown, they have fostered large clean-and-sober contingents who march proudly in the Gay Pride parades around the country and who serve as role models for their communities. Gay AA and gay NA create and sponsor Gay Roundups, weekend retreats that provide safe and supportive experiences for recovering LGBTs. Perhaps the most positive aspect of all is that† gay AA and gay NA offer queer people an opportunity to be themselves and feel safe as they struggle to recover.

Q: What do you think is the most important advice you give LGBT and straight clinicians in the new edition of *Dual Identities*?

A: Just because people are LGB or T doesn't mean they're not homo/bi/transphobic. We recommend that therapists learn about their own beliefs and feelings. What are your reactions to LGBTs? Do you look down on masculine women? Effeminate men? Do you believe bisexuality is a viable, normal orientation? Do you see transsexuals (whatever their stage of transformation) as fake men or women? Do you see anyone who doesn't fit the heterosexual stereotype as queer? What makes you feel uncomfortable? Deal with, work through, your beliefs and feelings so that you are not visiting your prejudices upon clients. If you can't deal, then refer. Do not join with society's homo/bi/transphobia and heap more shame and negativity on clients. Then, go the next step. Become culturally competent. Learn about the different cultures from which your LGBT clients come. By different† cultures, we mean the many and various environments and communities people inhabit. For example, does your lesbian patient live in an all-women's community or does she live in a rural area which has only one gay bar in a 100-mile radius? Is your gay male patient an African-American who is ostracized by his racial group and dealing with racism in the LGBT community? Is your patient an older man, living alone, or a younger man whose circle of friends has been decimated by AIDS? Is your patient a bisexual woman who isn't sure which world-lesbian or straight-she belongs in? Is your patient a bisexual man who is married and has relationships with men outside his marriage? Is your patient a transgender person who gets hormones on the street and does sex work to stay alive? Is your patient a transgender person who is deeply closeted and presents as the gender he/she was born with although knowing he/she is really the opposite gender? In this way, you can appreciate what your clients deal with and will go back to, what has shaped them and what their extended families and their support systems are contributing to their addiction and sobriety.

Q: What do you think is the number-one thing straight therapists today might miss when they work with LGBT substance abusers?

A: The number-one thing straight therapists might miss is the non-stereotypical LGBT,†the very feminine and married lesbian, the very masculine and married gay man, the bisexual who

fits the stereotype of a lesbian, gay, or straight person, and the trans person who is assumed to be gay or straight (rather than trans) or who has successfully transformed his/her gender identity.

Q: I have always wondered about inpatient programs. Are there many that are specifically queer-friendly? Would that make a big difference to a client?

A: Not to be dramatic, but it could make the difference between life and death to a client. We can't know how many LGBT people have been subjected to unfriendly or hostile treatment during their most vulnerable time and have left or been thrown out of treatment because of it and have subsequently died from their addiction. Substance abuse is a chronic, progressive, fatal disease.

There are not enough queer-friendly inpatient programs. And the only queer-affirming programs we know about are Pride and Alternatives. We know of no specific inpatient programs for bisexuals or transgender people. This lack is a serious matter because LGBT-friendly inpatient programs would make it possible for more LGBTs to get treatment. Many LGBTs can't get non-discriminatory treatment from mainstream programs and can't deal with staying closeted in treatment in order to protect themselves. Thus they may not get treatment at all.

Q: The world has changed dramatically since the 1980s, when your first edition of *Dual Identities* was published. Is the mainstream of the substance abuse treatment community mostly aware now of the special needs LGBT people have?

A: Yes and no. Fortunately, yes, in that many more counselors are better trained and more aware. We just did a training in August for the Florida Alcohol and Drug Abuse Counselors' conference and were pleased by the response. About 80 people attended, whereas in days gone by we felt lucky if 10 showed up. More importantly, the people who came seemed to be both knowledgeable and less burdened by homo/bi/transphobia and were clearly interested in learning more so they could help their LGBT clients. And the majority seemed to consist of straight allies, so we didn't feel we were "preaching to the choir." Even with such a positive experience, we know that funding for treatment and training has been cut back, so many of the counselors who need training aren't getting it.

There are still too many counselors whose homo/bi/transphobia taints their attitudes toward LGBT clients. These days, the climate of conservatism and heterosexism in the country is a dangerous and menacing one for LGBTs. This is a climate created not only by the fundamentalists, the conservative Christian right, but also by the federal, state and local governments. The whole issue of faith-based treatment programs threatens the well-being of LGBTs who need treatment. The government is cutting AIDS programs and threatening AIDS activists. And state, local and the federal governments oppose anti-discrimination laws that would protect LGBT's rights. This unholy alliance between government and religion generates, encourages and validates homo/bi/transphobia. It makes the world unsafe for LGBTs.