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Date May 30, 1986

TREATING THE CHEMICALLY DEPENDENT LESBIAN--

A SURVEY

A Thesis

Presented for the

Master of Science in Social Work

Degree

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Mary A. Costich-Covey

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Many long hours were spent with the obsession of this project so a special thank you is expressed to my partner, Charlene, and to my daughter, Kathy, who together provided a loving and understanding environment at home.

ABSTRACT

The purpose of the study was to survey workers in the Knoxville, Tennessee, area who provide services to chemically dependent lesbians. A questionnaire was used to obtain information concerning demographic background of the workers, the types of services provided to their clients, the environmental and other factors which influence the type of services provided, and the amount of specialized training received by each worker in the field of chemical dependency in relation to specific issues and concerns of lesbians. The questionnaire was sent to 100 workers in the Knoxville area who treated chemically dependent clients or had a number of lesbian clients in their caseload. Fifty-three responses were obtained and all were utilized for the purpose of this study. The data obtained from the questionnaire were tabulated and analyzed.

Notable differences were found among workers in the use of and provision of tangible and counseling services. Tangible services were used more frequently and with more variety by agency workers when providing services to chemically dependent clients in general than when they were treating chemically dependent lesbians. Tangible services were used almost exclusively by agency workers in combination with counseling services. Private

practitioners utilized counseling services almost exclusively.

No significant demographic factors were found to influence utilization of services. Agency policy and source of revenue did appear to influence both service availability and use of services.

There also appear to be a significant number of workers who have had some specialized training in the areas of chemical dependency and lesbians. However, stereotyped attitudes still prevailed in agency workers and were not seen with those workers who were in private practice.

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CHAPTER I

STATEMENT OF THE PROBLEM

I. INTRODUCTION

Interaction among humans is a normal activity. From birth to death, during most life events and in every life stage, we interact with others. As with most things, there are exceptions to this general principle of human nature. We have heard the stories of children being raised in the wild, or the wealthy isolate we call eccentric. There is the occasional man who goes into the wilderness because he is outraged or disgusted with the human condition. These are the few exceptions and they usually have some choice in their isolation. As humans, we generally seek out and thrive on human interaction. There are others, however, who isolate themselves unwillingly and society does its very best to shun and ignore these people.

Chemically dependent people isolate themselves during the course of their disease process. They slowly kill the feelings of self-worth, burying them ever deeper with each drink, pill, puff, snort, or shot. Slowly they isolate and lose anyone they ever had--themselves, spouses, children, friends, coworkers, peers, extended family, and church. In addition, the rest of society shuns and hides

the chemically dependent person. They may be held up in public ridicule or scorn, but society denies any real responsibility for the person.

The population of chemically dependent people has grown dramatically over the past century. The 1977 HEW Report to Congress, the National Council on Alcoholism, Inc., as well as other research, estimate the prevalence of alcoholism at over 5 percent of the adult population or a total of over 10 million people. To add to this number, over 3.3 million teenagers who drink are showing signs that may lead to alcoholism. Now we can add to this figure an almost equal number of children and adults who are dependent upon other drugs--prescriptions, illegal "recreational" and "hard" drugs.

It becomes easy to see how approximately five or six other persons are directly affected by each chemically dependent person in the United States. This includes spouses/life partners, children, family, friends, employees, and employers. Life conflicts ranging from verbal abuse to physical assault, runaways, or unexplained disappearances of a child or parent, accidental or suicidal death, disabling illness or injury, and an increased divorce rate involve the use and abuse of drugs.

> Of all fatal accidents occurring on the roads today, 50% involve alcohol. Over 80% of fire deaths, 65%

> of drownings, 22% of home accidents, 77% of falls, 36% of pedestrian accidents and 55% of arrests are linked to the use of alcohol. Up to 44% of pilots involved in accidents have been drinking. Violent behavior attributed to alcohol use accounts for approximately 65% of murders, 40% of assaults, 35% of rapes, 30% of other sex crimes, 30% of suicides, 55% of fights or assaults in the home, and 60% of cases of child abuse. Between six and ten percent of employees have alcoholism. The total cost to the nation is nearly 43 billion dollars a year due to absenteeism, health and welfare services, property damage and medical expenses. Lost production alone has been computed at 19.64 billion dollars annually (National Council on Alcoholism, Inc., 1979).

There has been a long standing interest in chemical dependency in our society but it usually focused on social control issues and not treatment issues. In the Virginia Colonies of the early 1600's there was public punishment for drunkenness. In the early 1800's there were the Temperance Societies. On January 16, 1920, Article XVIII of the Bill of Rights went into effect. This is more commonly known as the Liquor Prohibition Amendment. It states:

> After one year from the ratification of this article the manufacture, sale, or transportation of intoxicating liquors within, the importation thereof into, or the exportation thereof from the United States and all territory subject to the jurisdiction thereof for beverage purposes is hereby prohibited (Webster's Dictionary, 1977:139).

Every state in our country has restriction on the sale of alcoholic beverages which are related to age,

quantity, and consumption. Likewise, all states have set restrictions and punishments surrounding the use, sale, and manufacturing of illicit drugs. However, double messages are given to our society members regarding the use of drugs, and then we wonder how the drug problem got so large. We set age limits to help protect our youth so they will arrive at adulthood and be able to make the decision to use, or not use, a drug. Yet rock music and video rock tapes glorify and mystify a drug culture. It is not just what is directly aimed at the youth of today that promotes a double message. Look at the example most adults offer them. Weekend sports events on television are intended for the general public. They exemplify the ideas of individual achievement and team cooperation. Then comes a commercial where the toughest, meanest linebacker asks for a light--light beer that is. Or, perhaps it is a scene where the victors have a celebration bathing in champagne.

We can flip through most popular magazines and see very similar double messages. Not only do we have to be fit, attractive, and economically secure to fit in, we have to drink the right drink. All in complete moderation, of course.

Even the idea of where we are to consume beverages is laden with double messages. It is acceptable to drink

at parties, for celebrations, in church services, or on a deserted island. It is not acceptable to drink in many public places such as state parks and street corners. It is acceptable during business luncheons but not for school noon hours. The consumption of alcohol in moderation is generally acceptable; shooting up with heroin is illegal.

Examples such as these could fill a book of their own. The point to be made is there are numerous biases and standards which we all assimilate into our own belief systems, expectations, and actions. The professionals who work with chemically dependent clients bring into the relationship some of these predetermined attitudes and patterns of relating and reacting to their clients.

This holds true not only for professionals who work with chemically dependent clients. It is true for those who work with any culturally different or minority group of clients. This includes, but is not limited to, women, religious groups, people of color, the differently abled, and sexual preference minorities.

Sherman and colleagues (1978) found that sex biases and sex-role stereotyping are not uncommon in psychotherapeutic practice and are more likely to be found among male than female therapists (Sherman, Koufacos, and Kenworthy, 1978:312).

DeCrescenzo and McGill (1978:60) report 25 percent of the social workers surveyed in their research noted

a total absence of either homosexual men or women in their caseloads, even though evidence indicates approximately 10 percent of the clients in social and mental health agencies are homosexual. Dulaney and Kelly (1982:179) note the above finding as a form of prejudice which is related to the practitioners' difficulty in dealing with this aspect of his or her life.

In summary, Loewenstein (1980:37) notes that "therapists who have a deep conviction that the hetero-sexual, monogamous lifestyle is superior to all others might not be of any help to lesbians."

Just as the number of chemically dependent people have increased over the past century, so has the raw number of homosexuals increased. Berger (1982:236) notes that 8 percent of the adult population is homosexual, and that this group consists of over one and three-quarter million people. This is consistent with the findings of Kinsey and his colleagues. They estimated that 13 percent of the white male population were predominantly homosexual (Kinsey, Pomeroy, and Martin, 1948:650) and 3 to 8 percent of unmarried females and 1 percent of married females were predominantly homosexual (Kinsey, Pomeroy, and Martin, 1953:473).

Counseling chemically dependent people as well as counseling gays and lesbians appears to be an issue for

many practitioners and health care providers. Independently each group has a unique set of problems, concerns, and course of treatment possibilities. Combining chemical dependency with a gay or lesbian identity makes for a whole new area of study, research, and treatment possibilities. In so doing, it is necessary to look at the whole person. This includes the person, the environment, the interaction between person and environment, and the person's perceptions of this interaction. Practitioners provide an array of services, both tangible and counseling, in a variety of settings. A well-balanced program should provide a chemically dependent lesbian with all the resources necessary to maintain a chemically free lifestyle.

II. PURPOSE OF THE STUDY

The purpose of the study was to survey workers in Knoxville, Tennessee, who work in chemical dependency treatment programs and workers in private practice who have a number of lesbians in their caseload. The areas examined in the survey include the demographic background of the workers, the types of services provided to chemically dependent lesbian clients, the environmental and other factors which influence the type of services provided to chemically dependent lesbians, issues of sexuality, length of client's sobriety, the worker's utilization of

outside support groups, and the amount of specialized training in the field of chemical dependency and lesbian specific issues received by each worker.

III. DEFINITION OF TERMS

The following terms are defined for the purpose of this study:

1. Lesbian client--any female client who has identified her sexual/affectual preference towards other females.

2. Chemically dependent--a person who uses a mood changing drug and the use of that drug causes problems in the person's life and they continually use the drug regardless of its consequences.

3. Tangible services--any direct concrete services offered by an agency or therapist to clients to help satisfy their immediate environmental needs. These services include: medical, transportation, recreational, financial, child care, job placement, educational/vocational training, housing or halfway homes, and referral services.

4. Counseling services--any services offered by agencies or therapists dealing with the psychological and social needs of the client in a confidential therapist-client relationship. Included are individual, group, and family treatment.

IV. HYPOTHESES

The hypotheses of this study are stated in a way as to meet the constructs of the null hypothesis.

1. There is no difference among practitioners in the Knoxville area who work with chemically dependent lesbian clients in the frequency of their use of tangible services and counseling services.

2. There is no difference among practitioners in the Knoxville area in the types of demographic and other background factors that influence their work with their chemically dependent lesbian clients (e.g., sex, age, degree of education, specialized training in dealing with chemically dependent lesbian clients, agency policy, educational training, attitudes towards chemically dependent people or lesbians, and the type of policy-making body for the agency).

3. Practitioners in the Knoxville area who work with chemically dependent lesbian clients have had no specialized training in the field of chemically dependent lesbians.

V. LIMITATIONS OF THE STUDY

The study was limited to 53 practitioners in the area of Knoxville, Tennessee, from agencies and private

practitioners with known chemical dependency treatment programs or with known lesbian clientele. No generalizations from this sample to a larger group will be made as the limited sample size may not reflect the preferences of a broader base of practitioners in Tennessee.

CHAPTER II

REVIEW OF THE LITERATURE

I. INTRODUCTION

When one says words like "alcoholic" or "chemically dependent" an immediate picture probably comes to mind. It may be a vision of a skid row bum, a celebrating fool who always has too much to drink at parties, or a parent who gets violent when drinking. Likewise, when one says "lesbian" a picture immediately emerges. Perhaps it is a manly looking female dressed in work boots, jeans, and a tee-shirt with the sleeves rolled up to hold a pack of cigarettes. One may picture faceless women performing some type of "unnatural" sex acts. The picture may be of the two women who have shared the apartment across the hall for the past five years. One always looked a bit odd and they never had any male visitors.

Now, try putting the words "chemically dependent" and "lesbian" together--"chemically dependent lesbian." What new image is created? Odds are, it is not a positive image. It is probably more negative than either image standing alone. The image is negative because we see a female who has failed on many levels. She has failed as a woman because she is an alcoholic and that somehow

makes her weak and unfit. She has failed as a female because she is a woman-identified-woman. She is a lesbian.

Section II reviews the literature which supports the idea that there is a difference in the way chemically dependent men and women are viewed by society. Section III reviews current information about chemical dependency within the homosexual community--especially taking note to deal with the unique problems and concerns of the lesbian population.

II. CHEMICAL DEPENDENCY AMONG WOMEN

Sandmaier (1980) notes that the brutally harsh stigma attached to a female alcoholic shapes the entire experience of an alcoholic woman, and renders it different--in many ways more painful and obliterating--than that of the male alcoholic. A woman is more likely than a man to be driven underground by her drinking problem. In order to protect herself from society's negative sanctions, she is likely to deny or disguise her alcoholism rather than seek the treatment she needs.

Since the beginning of time women have lived with double standards which were created and promoted by a male patriarchal system. A woman's role has been seen as subserviant to man's wishes and needs. Women provided emotional comfort and support; men's roles are task-oriented, problem solving and that of breadwinner.

This double standard renders the female alcoholic totally unacceptable by society and attaches a harsher stigma to her alcoholism. The roles of mother and wife as symbols of her womanhood are tarnished and undermined. The old saying of "motherhood and apple pie" turn into "alcohol and no apple pie"--certainly not a tasty social mix. The female alcoholic feels this stigmatized label and significant others reinforce it continually.

Those close to the alcoholic woman are likely to join her in her desperate denial rather than admitting the problem exists and seeking the needed help. If alcoholism renders a woman repulsive and less valuable in society, how can close friends or relatives acknowledge a drinking problem in a woman they supposedly care for and respect? Not only would such an acknowledgment shatter their entire image of that woman, but it might be seen as a reflection on them as well. Thus, the initial response of those who are close to the alcoholic woman is usually to deny the problem right along with her. Relatives and friends commonly insist that she just likes to drink a little, or that her drinking is a temporary response to short-term stress. Or, they may call it by another, more socially acceptably feminine name like "nerves" or "depression" (Sandmaier, 1980).

Delay in seeking treatment can be attributed to the inability of the family and the professionals to

deal with the stigma imposed on the female alcoholic. Excessive drinking is seen as a greater taboo among women than men. This traditionally defined concept is maintained and perpetuated in clinical settings by staff and patients of both sexes.

Babock and Connor (1982:233) contend that "Men and women do not experience alcoholism in the same way, a fact that is not well understood by those who treat alcoholic women; female alcoholics are largely overlooked in planning treatment and evaluating its outcome, and this neglect is compounded by sexist therapy."

The Kansas Task Force on Women and Alcoholism conducted a survey of recovered women alcoholics who indicated three major obstacles they had to overcome in order to recognize their alcoholism.

> First, thirty-eight percent of the women reported that husbands and families failed to see a problem and discouraged them from seeking treatment. Almost as many women blamed themselves (21%) for their failure to be honest in regard to their alcohol dependency, and third, the reluctance of the professional community to identify the illness, especially in females (Kansas Task Force on Women and Alcoholism, 1979).

In the past, alcohol and drug abuse research has centered primarily on men, but in recent years there has been an increasing awareness that these problems also affect women. One area which is being explored

is the effect of change in female sex-role orientation (expected behavior or interaction style) on the prevalence of alcohol abuse. The role status of housewife and the role of employment emerge as very important issues for most women (Celentano, McQueen, and Chee, 1979:383).

The double standard imposed by society does more than keep the problem of alcoholic women invisible. A woman is more likely than a man to internalize our culture's harsh judgment of her and learn to view herself with pity, hatred, and hopelessness. These negative and degrading feelings often push a woman still deeper into chemical dependency. What else but another drink or pill would deaden her unbearable misery?

Burrow and colleagues note that the addicted female often sees herself as being more sensitive, more dependent, less assertive, and possessing lower self-esteem than her male counterparts (Burrow, Meyers, and Wacker, 1979: 225). Other differences revealed through research and investigation seem to verify that women have higher rates of guilt, anxiety, and depression. Burrow et al. further note that women are more often diagnosed as having an affective disorder while males are viewed as sociopathic (Burrow, Meyers, and Wacker, 1979:225). Problem drinking in women is more closely related to specific life situations such as crisis, divorce, death, or tragedy. Also, role

conflicts seem to be a major causal factor in creating doubts as to role adequacy (Burrow, Meyers, and Wacker, 1979:226).

A woman's mental image of "self" is more negative than that of men and there is a double dose of degradation for the woman. No longer is she viewed as good or normal. She now becomes "sexless" because she is no longer seen as female. She does not fit the expectations of a good woman or as a fit mother. She is totally stripped of her social identity. Curlee (1968) made an important observation concerning the alcoholic woman's self-image. She notes:

> Drinking destroyed the fundamental source of a woman's self-esteem based on the female roles of wife and mother. When these roles were damaged through alcoholism, the source of a woman's prestige and status were seen as crumbling, leading in turn to more excessive drinking and to greater destruction of the basis of her self-confidence (Curlee, 1968: 18).

Alcohol is a tool of masculinity and its abuse is seen as a symptom of moral and emotional weakness regardless of the person's sex, but more so if it is a woman. Women's and men's alcoholism is looked upon as being very different in both cause and effect. Why do we consider it worse for a woman to abuse alcohol than a man; prolonging and intensifying her pain rather than easing it? The double standard which is talked about is grounded in the very

roles of men and women in our culture. It demands and reinforces very different and mutually exclusive sets of behaviors for each sex.

By our current cultural standards, the "unsocialized" behavior often released by alcohol is fundamentally masculine. One of the elements of the male role is the relationship to the instinctual or natural animal self. The man who drinks may live out his virile ideal (even if only in his mind). Hamill describes the masculine fantasies elicited by alcohol.

> Drink was the great loosener, the killer of shyness, the maker of dreams and courage. . . . And everyone around you was witty, interesting, full of morning. They told you all the stories of your life, stories that would fill a hundred books, stories of busted marriages, great disasters, lost heroism, war stories and sea stories and sex stories. There was never any way for the stories to be ruined by the truth (Hamill, 1974).

To whatever extent men affirm their masculinity through drinking, alcohol is used as a tool, a rite, and a symbol. It serves as a test of physical stamina, proof of independence from authority, a reward for a day's work, and an escape from the world of women. A man, when he becomes a victim of "the grape or the grain" is called weak, but, he is inevitably understood and forgiven. Of course, there is a limit to this (Sandmaier, 1980).

Our tolerance for a woman who shares the same pitfalls runs dry. Alcohol enhances and celebrates the male role but it tears down and threatens the female role. A woman loses--her femininity, her goodness, her virginity, her role--her entire sense of "self."

It is not simply the disintegration of the vision of womanhood that accounts for society's bitter and negative response to the chemically dependent woman. What is really at stake is a threat to a major shift in the sexual balance of power. The roles of men and women are not simply opposite sides of a coin, they are fundamentally unequal, and yet, they are interdependent. Men will not keep their dominant place in our culture unless women remain in their subservient and dependent place. Placing women upon a pedestal is a very effective way of ensuring their continued powerlessness (Sandmaier, 1980:12).

If the average woman has trouble meeting the demands of her gender roles, then the chemically dependent woman has no where to go but down. Chemically dependent women pose a greater threat to the sexual status quo. They no longer fit nicely into what our society expects a woman to be. She is breaking the very rules which were imposed on her. By doing this she upsets the delicate balance which is needed for males to remain dominant.

Female alcoholics are much more likely than nonalcoholic females to have parents, especially fathers,

who are alcoholic. Estimates of the prevalence of alcoholism in fathers of women alcoholics generally range from 28 percent (Winoukur and Clayton, 1968) to approximately 50 percent (Wood and Duffy, 1966). Fort and Porterfield (1961) have reported an unusually low 6 percent rate of alcoholism among the fathers of female Alcoholic Anonymous members in Texas. Lisansky's (1957) comparison study of men and women alcoholics from the same treatment facilities showed that alcoholism or problem drinking occurred more often in a parent (particularly the fathers), siblings, or spouses of women. Kinsey (1966, 1968) concluded that women alcoholics have parents who made unrealistic demands on them. Since this research did not use any control groups, it is suggested that the data be interpreted very cautiously. However, Kinsey's work allowed for the whole subject matter to gain popularity and he set a new pace in the "pop literature." Badiet (1976) has appropriately summarized the problem.

> Literature in the addictions field has tended to ignore women in terms of use and misuse of drugs seems evident. . . . . The literature which does exist abounds with myths, sexism, patriarchial notions, and double standards. Women have received great attention mainly when there is concern about the effect on others (husband, children, doctors, etc.) (Badiet, 1976:75).

This negative and constraining outlook reflects traditional roles in our society which have centered

around the familial division of labor. As Mason and colleagues (1976) state, "These roles prescribe behavior regardless of marital status and age, but they are most centrally concerned with gender-based bread-winner versus homemaker specialization" (Mason, Czajka, and Arber, 1976:375). Some researchers have argued that the decrease in the sex ratio of alcoholism may be a result of changing sex-roles and the relative status of women (Gomberg, 1976; Lindbeck, 1972). Bowker (1977) dealt with the sociological aspects of sexual differentiation in substance abuse, and examined drug and alcohol problems among specific groups of women. Wilsnack (1976) reviewed the literature on sex-role orientation and their role in female alcoholism from a psychological perspective. She notes that:

> The liberation movement has been responsible for many sociocultural changes in female behavior, changing behavior in the use of alcohol as well as alterations in "predisposing" factors for the effects of alcohol may be counted amongst these shifts (Wilsnack, 1976:47).

Goodwin et al. research regarding patterns of familial and cultural alcoholism may indicate the importance of cross-sex modeling as a factor in the etiology of alcoholism in women, as well as suggesting that chemical dependency is causally related to some genetically inherited biochemical or metabolic imbalance (Goodwin, Schulsinger,

Hermansen, Guze, and Winokur, 1973). More recent work confirms that there indeed is a biochemical component to chemical dependency and this has contributed to viewing it as a "family disease" in more than just dynamics.

It is understandable then that the chemically dependent lesbian poses an even greater threat to the sexual status quo. The most threatening of her acts is her sheer defiance of men based on her sexual and affectional orientation. This, compounded with her chemical dependency, sets up defiance of men and of her social position. It upsets the patriarchial system of inequality and oppression by upsetting the very scales of social balance.

III. CHEMICAL DEPENDENCY AMONG LESBIANS

There are several problems with obtaining information on chemical dependency and its affects on the gay and lesbian community in general. First, a universally accepted definition of both chemical dependency and homosexuality does not exist. Second, finding a cross section of homosexuals (both gay and lesbians who have come out and those still "in the closet") is most unrealistic. In addition, studying gay and lesbian lifestyles is not a priority for the social sciences and there is generally a lack of research on the topic.

Nardi (1982:9) notes that from 1951 to 1980 there were only forty-two references under the heading of homosexuality (as listed in the index for the Journal of Studies on Alcohol). From this, Nardi concludes that only ten (or 24 percent) of these articles were actual studies of alcoholism or alcohol use among gays. The remainder were broken down in the following manner: 29 percent used references to latent homosexuality and its undocumented causal relationship to alcoholism; 40 percent used homosexuality as one of several pieces of demographic data, but not focusing on it; and 7 percent used homosexuals as a control group to compare with alcoholics, using a psychoanalytic research model. In short, less than one-tenth of 1 percent of all available references in 30 years were on actual alcohol use among gays (Nardi, 1982:10) (see Table I).

Zigrang found that alcoholism appears to have been ignored by many of those working in the field of gay and lesbian counseling and research as well as by general counselors and researchers. During the National Symposium on Homosexuality held in 1980, alcoholism was not mentioned at all in its presentation titled "Homosexuality and Psychological Adjustment," and was mentioned only in passing and without attempting to outline its significance to the gay community in its presentation "Gay Counseling:

TABLE I

NARDI'S BREAKDOWN OF PAST RESEARCH

Year	Psychoanalytic Studies	Homosexuality as a Demographic	Actual Studies of Gay/Lesbians	Total
1951 - 1960	12[a]	5	2[b]	19
1961 - 1970	0	5	1[c]	6
1970 - 1980	0	7	10	17
N = 30	12	17	13	42

Notes: [a]3 of these did not support the psychoanalytic model.

[b]Gays were used as a control group only.

[c]A case study of an alcoholic with homosexual tendencies.

Source: Nardi, 1982:9.

Its Present and Future Directions" (Zigrang, 1982:28). Zigrang also notes that in Bell and Weinber's book Homosexualities there was a complete and extensive study of psychological and social adaptation but it did not have a single reference to alcoholism (Zigrang, 1982:28).

By the apparent lack of interest to those researchers and counselors, one would think that chemical dependency was not a major problem within the gay and lesbian community. Despite this, from what little research has been done, quite the opposite is true.

Martin (1979) contends that the problems of the lesbian alcoholic include those problems intrinsic to all women; however, there are also unique needs which arise from the different conditions that contribute to a lesbian's chemical dependency. Fifield (1975) estimated that approximately 31.4 percent of the gay population in Los Angeles County were showing signs of heavy drinking or alcoholism. In the study of two Kansas cities, Lohrenz and colleagues found that 29 percent of the gays were alcoholic (Lohrenz, Connelly, Coyne, and Spare, 1978). Likewise, Saghir and Robins (1973) research of Chicago and San Francisco found that 35 percent of the lesbians were alcoholic as compared to 5 percent of the heterosexual women who were labeled as excessive or dependent drinkers.

O'Donnell, Leoffler, Pollock, and Saunders (1980) report that alcoholism among the gay population is estimated to be more than three times that in the general population. The research by Ziebold and Mongeon (1982:5) supports this finding. They estimate that alcoholism directly affects some 20 to 30 percent of the homosexual population. Though more accurate and current rates need to be determined, from the research which has been done we can conclude that chemical dependency is a wide spread problem within the gay and lesbian community. For the same reasons that heterosexual chemically dependent women stay "hidden," a double-fold system of hiding is enacted by chemically dependent lesbians.

Finnegan and McNally (1980:1, 2) note that the lesbian who fits into the category of a visible lesbian is at risk--and often pays a great price. She risks the pain of being misunderstood or patronized or feared; she risks the pain of rejection, of contempt, of ostracism. Or perhaps she will be tolerated--or pitied. The risks are high that she will have a very negative experience; and the risk is very high that she may not make it without positive support.

On the other side of the problem, the greater majority of lesbians who are chemically dependent will not willingly take the risk and will remain invisible. They will "pass"

as straight and will not have to risk rejection or ostracism. Instead, they risk their very lives because, by hiding their sexual/affectional identity, they cut themselves off from the help and support that rightfully belongs to them. Thus, they can--and do--remain isolated, alienated, secretive, hidden, feeling unique, guilt-ridden, lonely--and sick. They remain as sick as they are secret--unreached and unreachable (Finnegan and McNally, 1980:2).

It is fairly easy to understand why most chemical dependency treatment facilities deal only superficially with a client's sexual preference. In our culture it is generally too difficult to deal with the whole subject of sexuality, and combining it with the treatment of chemical dependency is almost too much to comprehend. Unfortunately, the way most programs approach the whole subject is with a sort of conspiracy of silence. The underlying assumption is that everyone is heterosexual and/or nonsexual (Finnegan and McNally, 1980:4).

The lesbian in treatment, whether she hides her sexual preference or not, is left feeling very isolated and alone. If "successful recovery" is measured by the stopping of drinking, then she may be a clinical success. But still, she is left with many of the stumbling blocks that most chemically dependent women have. And she is left alone with them (Finnegan and McNally, 1980:4).

The prevailing attitude about chemical dependency is that the person who suffers from it is degenerate, sinful, or at the very least weak willed. These are the very same attitudes most people have about lesbians. Most treatment facilities and support groups work on an implied, if not explicitly stated, assumption that "If the alcoholic only stops drinking she/he will be returned to the 'mainstream of life' as a functioning and useful member of society" (Ziebold and Mongeon, 1982:6). The question which must be asked is, what is the mainstream for the lesbian in recovery and what hope for serenity is offered to the lesbian when her very identity is being denied and limited?

CHAPTER III

TREATMENT MODALITIES

I. INTRODUCTION

This chapter is devoted to a discussion of two specific treatment modalities. The first, and probably the most popular, is a traditional treatment model which is grounded in the medical etiology of illness and which utilizes the philosophy and practices of Alcoholics Anonymous (AA). The second is a feminist model of treatment which utilizes feminist therapy and a woman-oriented support group such as Women for Sobriety. This second model is the most nontraditional and the most controversial of the two models presented.

Colcher (1980:46-47) notes the many similarities between gays and nongays in chemical dependency treatment programs. These issues usually surround: bread and butter problems such as medical attention, housing, employment, and welfare benefits; loneliness and structuring leisure time; and couple or family treatment. There are, however, issues which are different. These issues surround: more fear of being rejected; belonging to two social groups which are not accepted by society; self-oppression; and coming out to AA members (Colcher,

1980:48). It is my contention that chemically dependent lesbians have an additional burden on them by virtue of belonging to another subclass in our society: women.

II. TRADITIONAL TREATMENT

The medical model of chemical dependency follows the disease as a process. It is seen as being primary, chronic, progressive, terminal, and biogenetic. A disease which is primary is one which is the underlying disease and not the result of something else. A chemically dependent person coming into a hospital after an automobile accident may get treatment for the trauma sustained, e.g. a broken arm. However, the broken arm is not the primary disease--the person's chemical dependency is. The broken bone is an acute manifestation of the chemical dependency.

Chemical dependency is chronic, once you have it you will always have it. It cannot be cured but it can be controlled by staying off all mood altering drugs. In this way, chemical dependency resembles diabetes mellitus. There is no cure once you have it, you just learn to regulate it. For the diabetic, food and insulin are used to regulate the disease. For the chemically dependent person, abstinence of mood altering drugs is used to regulate and control the disease.

Chemical dependency is progressive, the longer you have it the worse it gets. The longer one uses and abuses chemicals, the harder it is to stop and the more physical damage is done to the body.

Chemical dependency is terminal. If a chemically dependent person continues to use mood altering drugs, the end result will be death. This may occur by trauma (car accident, falling, etc.) or by a body function or organ failing (heart, liver, brain).

There also seems to be a biogenetic component to chemical dependency. Approximately one out of every five drug users becomes chemically dependent. Of those who do, 95 percent have a family history of chemical dependency (Booher, 1985).

Most people who work in chemical dependency treatment programs agree that this disease is multifaceted and successful treatment relies on treating the whole person. A medically supervised or oriented detoxification deals with one of the physical components of treatment. For alcohol detoxification a patient is often given a drug like Tranxene for four to five days. Oral Alcohol Treatment Supplement (OATS) is also commonly used to help restore the body's metabolic balance. Phenobarbital given over seven days is common for detoxing from barbiturates. Large doses of sedatives for 48 hours are given for narcotic users.

Other physical treatments may include nutritional support and care, and, after treatment, providing antibuse or naltraxone as a preventive measure. Antabuse is some sometimes used for alcoholics as it prevents the alcohol from breaking down into carbon dioxide (which is what gives alcohol a sedative effect). If the person should then ingest any alcohol, they would become nauseated and have a great deal of pain. This often suffices as a good deterrent for many alcoholics. Naltrexone is a narcotic antagonist which blocks the opiate receptors in the brain which then lessens the craving of the narcotic.

Treatment centers usually have some form of emotional assessment and treatment in their program. Psychological and/or psychosocial assessments are done to see if there are any underlying psychiatric disorders. The assessment process also helps the treatment team and the client find assets and ego strengths which can be built upon in the treatment process. This part of a program provides for educational groups so the client can learn about his/her disease and its processes. This is especially helpful in building self-esteem. Chemically dependent people have the same belief systems that non-dependent people have. They have heard and come to believe that they are stupid, crazy, have a lack of willpower, or lack morality. None of these are true of course, but

they do not know it. What they do have is a disease. That disease is tied into the illogical, irrational, irresponsible, uncontrollable, and compulsive use of a drug. The educational component of treatment gives individuals the chance to learn, grow, change, and feel good about themselves.

Group treatment is probably the most important part of treating the emotional aspect of this disease. Through group treatment the denial system of the chemically dependent person is broken down and hence are better able to face their illness and to take responsibility for treatment. Groups also allow for the client to get feedback on a changing self perception and are a place to try out new skills. The group component also helps the dependent person deal with trigger mechanisms, the things that precipitate their drug use. This may focus around issues of unresolved grief, being raised in a chemically dependent home, the result of war, loneliness, etc.

The final major component of treatment has to do with the social, cultural, and spiritual aspects of the dependent person's life. Since many chemically dependent people have successfully isolated themselves from family, friends, church, and employers/employees, it is necessary to rebuild these components.

It has been noted that if an entire family is treated as well as the chemically dependent client, the prognosis doubles for recovery (Booher, 1985). For this reason, most programs have some type of family treatment which is conducted while the client is in treatment.

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are two of the most widely used support groups by chemically dependent people. Their introduction to these groups often comes during their treatment program.

AA is a society of kindred spirits which began in 1934 with Dr. Bob S. and Bill W. It has grown from two members to an estimated 1,000,000-plus, with more than 42,000 local groups throughout the world (Alcoholics Anonymous, 1978r:9). The help and power people obtain from an organization like AA or NA cannot be disputed. Literally millions of people are recovering and staying sober and clean because of their involvement with AA or NA and they are successfully utilizing the Twelve Step program (see Appendix A).

Belonging to and working with the AA/NA program helps fill a social function as the recovering person starts to affiliate with other recovering people in a chemically free environment. A new way of acting, reacting, and thinking is exemplified in a social context. This also ties in with filling a cultural component of treatment

by exposing the recovering person to a culture which is drug free. Likewise, a spiritual void is filled by getting the person to accept responsibility for what they can do and control, and letting the rest get taken care of by a higher power.

Most treatment programs utilize some type of aftercare setting for their clients. Again, the function of this is social, cultural, and spiritual. People are required to look deeper into themselves and are encouraged in the growing process. They are taught more about chemical dependency, taught additional life skills, and taught to take care of themselves.

Many treatment facilities have half-way programs which are either directly under their organization or are in the community at large. These programs are good for clients who cannot return to their prior living arrangement for many reasons. For clients who lived in cars or on the streets, this may mean a place to call home. For some it is a place to go where they are allowed to gain additional skills. Or, it may be a stopping place prior to going home. It gives people a chance to work out problems and perhaps work on repairing a failing relationship with their family.

As good as it is, even a program like AA or NA cannot reach every chemically dependent person. One such

group are gay males and lesbians, especially lesbian feminists.

Bittle (1982) notes that AA approaches the solution of personal problems by sharing ideas and experiences. Yet, for the lesbian, being different is central to her identity. The whole experience of being lesbian is not easily understood by even the most liberal person, and the majority of people would prefer to ignore the whole subject matter, if not condemning it first. How then can sharing be helpful for the lesbian who will only be put down, ignored, or humored during a meeting?

Bittle also notes that gays tend to be more alienated from formal religions and--despite our human attempts--God, Him, and Higher Power get translated, however wrongly so, into traditional religion. He explains this further in the following manner:

> Five of AA's Twelve Steps make direct reference to "God" or "Him," and another step refers to a "Power" that is widely interpreted by members of the Fellowship as equivalent to an orthodox "God." The writings of AA's co-founder, Bill W., are liberally sprinkled with references to "God," and his own orientation clearly was strongly religious. Other AA publications leave little doubt that in spite of the emphasized qualification of the Third and Eleventh Steps, "God, as we understood Him," the founders of AA and a major fraction of the membership regard this "power" as a more or less orthodox religious concept (Bittle, 1982:85).

For the lesbian feminist, there are two messages being sent by this thinking: organized religion is the

only way out to a clean and sober life, and only through the patriarchal male system will there be help. Again, being different, having a very unique heritage and culture will doom the chemically dependent lesbian into continued and further destruction.

Chemically dependent lesbians have certain needs which are different from their nonlesbian counterparts, and are drastically different from males. They are in need of support beyond that which is found in the Fellowship of AA. Underhill (1981) suggests some of the essential elements of providing counseling services for the alcoholic lesbian. They include: a supportive and nonjudgmental environment; group therapy; collateral counseling; educational presentations; anger groups; counsciousness raising groups; sexuality groups; vocational/skills training; special groups for lesbian mothers; focus on issues of self-esteem; and individualized services.

Finnegan and McNally (1980:6-9) note additional changes they feel are necessary for treating chemical dependency among lesbians. They include: breaking through denial systems regarding sexuality which are perpetuated by the researchers and staff in the field; there needs to be a new mode for perceiving lesbians; treatment people need to come to terms with their attitudes about lesbians and learn about issues which have bearing on a lesbian's

recovery; there needs to be broader treatment alternatives; there is a need for advocacy groups; there needs to be an increase in the acquisition and dissemination of information about chemically dependent lesbians; and more professionals have to "come out" and be available as healthy role models.

This next section will deal with one of these issues--the need for broader treatment alternatives.

III. FEMINIST THERAPY AS TREATMENT

This chapter was the most difficult for me to write. It was difficult, not because of a lack of well grounded writings, though that certainly is true. Rather, the difficulty came from my familiarity with the subject material. It has taken me well over ten years to achieve my still naive view of radical feminism and at time I forget how it used to be. Integration of a theory into a working model is usually very difficult. For me, taking my feminist actions and beliefs and trying to explain their theory base was the difficult part.

Although feminism has been a common topic in the areas of research and pop literature in the past years, little has been done to incorporate its values and perspectives into a treatment modality. The base for feminist therapy is strong and best understood by looking

at the theoretical constructs of feminism. This is a unique way of viewing the world and it usually does not fit well with how most people view the world. At best, it will challenge the way we perceive our reality. It may anger or confuse you. It is my hope that the anger, confusion, or emptiness will be replaced with new insight and energy. From this view, feminism is philosophical.

Feminism is political. In its most radical and creative form, it destroys the traditional way the world is perceived. It turns a historically patriarchal world on its side. Most of us grow up with fairly traditional beliefs and values. These beliefs and values are man-made constructs which are used for social control. Note, the words "human-made constructs" were not used. they are man made. Historically men have been the record keepers, teachers, and governors of the world. A patriarchal system was created, maintained, and perpetuated by and for a male dominated society. By this I do not mean men purposefully set out to control women--though this has been argued to be true by many radical feminists. Rather, its intent was to set up, protect, and pass on a male culture. In short, it was a form of social control. It has since been legislated, reinforced by religion, and socially accepted by most.

Obtaining a feminist framework for thought is a slow process which involves peeling away the veils of

a very successful patriarchal system. Collins explains the political aspect of feminism in her recent article in the following way:

> Feminism at its most elemental level is a recognition and critique of patriarchy and sexual politics (and their relation to other class oppression--capitalism, imperialism, racism, heterosexism); and a set of beliefs, values, and ideas about the desired direction for change (Collins, 1986:214).

Mander defines feminism in a slightly different way but the tone and end result remain the same. She notes:

> Feminism is not defined as a system, but as an anti-system; one which seems to be continually in the process of evolving and is needing always at its core to remain fluid and changing and growing and moving (Mander, 1974:1).

The idea of an anti-system is the underlying mechanism which allows feminist theory to leave the theoretical arena and move towards application. How then does radical feminism fit in with alternative treatment programs for chemically dependent lesbians? Schults defines this best.

> A Radical Feminist approach challenges the accepted and traditional models of treatment and seeks to gain the right for women to be treated for what they are--not for what male-dominated institutions and professions think they should be (Schults, 1975:484).

The feminist approach to treating chemically dependent lesbians is a non-sexist approach but it goes much further than that. With the assistance of a self-help support group like Women for Sobriety, lesbians--feminists or not--can gain control over their lives and remain chemical free.

Women for Sobriety, Inc. was founded by Jean Kirkpatrick in Quakertown, Pennsylvania. The program existed prior to 1975 in a rough form but it was incorporated in July 1975 (Kirkpatrick, 1981:185). Kirkpatrick is a recovering alcoholic who tried working the AA program but felt she was missing something. Women for Sobriety was born out of a woman's void in a traditionally male oriented program. Ironically, what was born out of Kirkpatrick's void has since filled and saved the lives of thousands of women who were in the deep trenches of chemical dependency. Many of these women are lesbians.

Kirkpatrick felt it was necessary for recovering people to have a program which would systematically allow them to change their lives. She diverges from the AA viewpoint in that, "It is my belief that it is not necessary for alcoholics to be tied to recovery programs for the rest of their lives within the structure of a meeting" (Kirkpatrick, 1981:185). This does not mean a woman

will not have to utilize the thirteen statements of acceptance upon completion of the program. Those statements (see Appendix B) may need reflection and working on for a long time. Unlike AA, however, Women for Sobriety gives women the skills to pattern further development on their own. As Kirkpatrick notes:

> The program of acceptance is a way of thinking that overrides the necessity to drink for it changes the woman . . . it changes you . . . into a confident capable self-assured woman who is ready to take her place in the world to help others who need help. It will provide a view of yourself that will show you how to manage yourself. It will give you a way to grow. It is a pattern for development as a mature woman (Kirkpatrick, Acceptance Program, pamphlet).

In the remaining section of this chapter an example of how a radical feminist theory base can be turned into a treatment model will be put forth. The reader must be reminded of one basic assumption, that a patriarchal model and theory base is no longer a given. Flynn notes that traditional treatment is grounded in a patriarchal system and reinforces stereotypical roles. "Women must learn to accept themselves and must do this in an environment free from men (Flynn, 1981:173).

This new model takes what is usually termed a separatist stand. Research supports the premise that chemically dependent lesbians have a unique set of problems and concerns. It is therefore justified that treatment

for chemically dependent lesbians should be different and separate.

Flynn's (1981:173) methods are adopted for this purpose and include: a combination halfway house and treatment center; a treatment mode that combines drug abuse rehabilitation center, consciousness raising groups, and radical feminist therapy; a creative approach to job placement; a recreational component; a child-care program; and an after-care component.

The purpose of combining a half-way house and a treatment center has several dimensions. First, we must be pragmatic. Very few communities would allow even one all lesbian facility, much less ask them to accept two all lesbian spaces. The second reason relates to the idea of breaking away from a patriarchal system. By having a combined unit/facility, a greater sense of continuity can be obtained, and it allows for a more supportive environment. Newly admitted participants have more access to good role models and have an extra bonus of hope for themselves.

The second method combines drug rehabilitation, consciousness raising groups, and radical feminist therapy. Drug rehabilitation would still provide the detoxification and basic educational component which is provided by most facilities. The main difference is that it would

also break down more of the myths and stereotypes as it pokes and prods at social control issues. The program of Women for Sobriety would replace the traditional AA/NA component. Consciousness raising groups would give the participants another opportunity to explore myths, give alternative interpretations, and provide an environment for growth. Radical feminist therapy would again help to peel away the myths and stereotypes and provide a new perspective for viewing the world and the participants' place in that world. It would also facilitate growth and be a safe place to explore alternatives. It would allow the participants the opportunity to develop a healthy sense of self.

A new approach to job training and placement is another component of this program. This means having the opportunity to really explore and consider jobs outside the range of stereotyped job categories. This traditional way of job choice only serves the purpose of social control and trapping and keeping minorities in an unfulfilling and low paying labor system. This component would mean making connections and contracting with already existing job training programs.

The recreational component would be served by first providing a chemically free environment within a context of socializing. The treatment center would be used for

the lesbian community at large and would remain a chem-free space. This idea already exists in most radical lesbian programs--either partially or wholly. Example: at all large lesbian-oriented music festivals there are designated chem-free spaces which are proportional in size and location to the needs of the participants. There is an understanding that if the two factions collide, it will be resolved in a "sisterly" manner. For whatever reason, this system works. This same principle works at small parties, concerts, and even at some bars. Sobriety and chem-freeness are established and maintained through collective strength.

Child-care programs are desperately needed for chemically dependent lesbians who seek treatment. Often they are separated or alienated from their family of origin so normal helping a family member out does not exist for many. Additionally, many lesbians are mothers and to ignore this only serves to limit the population to be served. Child-care does more than just provide for the children's welfare while the parent is in treatment. It provides treatment opportunities for the children. This adds a preventive component in that children are getting educated and obtaining treatment before they themselves become dysfunctional (either emotionally or physically).

Finally, the after-care component of the program would continue to provide information and additional treatment as do most programs. It would continue to be an involvement with the lesbian community at large and would allow a recovering participant a smoother transition from the protected environment of the facility into the mainstream of society. It would provide the continual opportunity to develop skills and coping behaviors as well as the further exploration and incorporation of self. All of this would involve significant others, children, and family of the chemically dependent lesbian.

The picture I created in earlier chapters was one of doom and self-pity. Here I have presented an alternative to traditional treatment. It is creative. Like traditional forms of treatment, it is not for everyone. This is an alternative, a choice, a chance.

CHAPTER IV

METHODS AND PROCEDURES

I. INTRODUCTION

This chapter is devoted to the discussion of specific methodologies used to conduct this study. Descriptions of the subject selection, the survey questionnaire, and the method used in data collection are included in this chapter.

II. SUBJECTS

The subjects for this project were people who had direct responsibility for treating chemically dependent lesbians. This included those practitioners who work in treatment facilities, mental health facilities, or who were known to have a number of lesbians in their caseload.

For this study, subjects were not randomly sampled. Rather, they were chosen in a deliberate manner. Private practitioners and treatment facilities were chosen on the basis of proximity to Knoxville, specialization, client caseload, or by referrals. The referral aspect lent itself to a snowball-type sampling and was limited to the independent practitioners.

The sample consisted of fifty-three respondents, all of whom had direct responsibility for providing a variety of services to chemically dependent clients or to clients with lesbian identities.

Thirteen treatment agencies, including two mental health centers, and fifteen independent/private practitioners agreed to participate in this study. One agency and two independent practitioners ultimately decided to withdraw from the study and did not return their questionnaires. In all of those cases, the researcher was notified by telephone of this decision.

III. INSTRUMENTATION

The questionnaire used for this study was an adaptation of the questionnaire developed by Tucker (June, 1978). It was used because of its tested reliability and for its easy adaptation for this project. The final version remained a short answer, yes-no, and multiple choice questionnaire. Four basic sections comprised the questionnaire: (1) demographic information (e.g., sex, age, degree, number of clients in caseload); (2) types of tangible and/or counseling services offered to clients; (3) environmental factors which might influence the type of services offered (e.g., funding, time constraints, policy making); and (4) specific training obtained by

each worker in the field of chemically dependent lesbians and/or lesbian related issues.

Clarity of the questionnaire was done by testing the adapted version on two social work students, three medical social workers, and three faculty members. A copy of the questionnaire is included in Appendix C.

IV. DATA COLLECTION

The researcher made an initial telephone call to each of the private practitioners and to each director of the treatment facilities and mental health centers. The purpose of the call was to explain the survey being done and to obtain permission to distribute the questionnaire. One agency contacted declined, another did not return their questionnaire after they had been distributed. All of the independent practitioners contacted agreed to take part in the survey and only two withdrew after receiving the questionnaire.

When permission was obtained, a cover letter and the appropriate number of questionnaires requested were mailed. The cover letter was written to the director or designated person (as requested by the director). In the case of the private practitioners, cover letters were written directly to the practitioner and contained only one questionnaire.

The cover letter was written for two purposes: to briefly explain the survey and to give appropraite contact numbers in case a respondent had a question and/or needed clarification on any part of the questionnaire.

All questionnaires had a self-addressed stamped envelope attached to them for the respondents' use. This was done in an attempt to have a relatively high return rate. One hundred questionnaires were sent out with a 53 percent return rate.

CHAPTER V

ANALYSIS OF DATA

I. RESULTS OF QUESTIONNAIRE

Introduction

The method used for analysis of this project was limited to percentages and range rates. Exact figures may be found in Appendix E. The percentages for each question are listed on the response line in the following manner: A is grouped agency and P indicates private practitioners. This is not a sophisticated form of analysis, but it does allow for qualitative analysis to be backed up by some type of quantitative means.

The summary of the results of this study is divided into four areas which were covered by the questionnaire: demographic information, types of tangible or counseling services offered, environmental factors, and specialized training. Analysis was done between the two groups surveyed (agency workers and independent/private practitioners) as well as looking at combined data. Analysis was done in this way in order to better understand any differences which might be found. Appendixes D and E contain complete results of the survey.

Demographic Information

The demographic questions were asked in order to make some determination of who provides services for chemically dependent lesbian clients. This section of the questionnaire included whether the respondent worked in an agency setting or was an independent/private practitioner, the age and sex of the respondent, the degree of education and year it was obtained, job title, number of chemically dependent clients in each caseload, number of lesbian clients in each caseload, number of social workers with any degree working in the chemical dependency program, number of M.S.S.W.'s working in the program, and the average number of visits or sessions a worker saw clients.

Fifty-three caseworkers responded to the questionnaire. They represented twelve agencies and thirteen independent/ private practitioners. Thirty-seven respondents were female (70 percent), and sixteen were male (30 percent). The questionnaires were answered by two non-degree, two LPN, twelve bachelor's degree, eight master's, nineteen master's degree social workers, nine certified substance abuse counselors, and one Ph.D. (licensed psychologist) respondents.

For purpose of analysis, the level of education responses were broken down into five categories. These

categories represent educational attainment in the following: no degree, licensed pre-bachelor's, bachelor's degree, master's degree, and doctoral degree. Only two respondents (4 percent) had no degree or license. Eleven respondents had received a licensed pre-bachelor's degree (21 percent). The two LPN and nine Certified Substance Abuse Counselors were counted in this category. Twelve respondents had received a bachelor's degree (23 percent). Twenty-seven respondents had a master's degree (51 percent). Only one respondent had a doctoral degree (1 percent) (see Table II).

All of these degrees were obtained between 1964 and 1985. Six respondents obtained their degrees between 1964 and 1969 (12 percent). Twelve respondents received their degrees between 1970 and 1975 (23 percent). Nine degrees were obtained between 1976 and 1980 (18 percent). The balance of 24 respondents obtained their degrees since 1980 (47 percent).

Twelve of the independent/private practitioners (92 percent) and six agency workers had their degrees for over ten years (16 percent). Thirty-two agency respondents (80 percent) and one independent/private practitioner (8 percent) had obtained their degrees in the ten year period since 1975. The two non-degreed respondents were not counted in any of the above analysis.

TABLE II

EDUCATIONAL CHARACTERISTICS OF RESPONDENTS

Educational Level	Number with that Degree	Number in Agency Setting	Number in Private Practice
Non-degree	2	2	0
LPN	2	2	0
CSAC	9	7	2
Bachelor of Science	1	1	0
Bachelor of Art	11	11	0
Master of Science	4	2	2
Master of Art	4	4	0
M.S.S.W.	19	11	8
Ph.D.	1	0	1
N =	53	40	13

The ages of the respondents ranged from twenty-five years of age to fifty-two years of age. The average age of those workers in agency settings was thirty-one years of age, and for independent/private practitioners it was thirty-nine years of age.

All fifty-three respondents had specific caseloads which varied from setting to setting. For the past year, the range for agency workers fell between 20-600 and they averaged 245.4 clients per year. The range for the independent/private practitioners fell between 5-61 and they averaged 48 clients per year.

The number of lesbian clients seen in the past year by agency workers ranged from 0-36 with the average being 7.9 clients per year. Likewise, the number of chemically dependent lesbians seen by these workers ranged from 0-35 with the average being 11.

The number of lesbian clients seen by independent/ private practitioners ranged from 0-15 and they had an average of 14 per year. The number of chemically dependent lesbians seen by these workers ranged from 7-16 and averaged to 10.

Independent/private practitioners saw all of their clients between 4 to 156+ times and averaged 104 sessions or visits. This average was based on their reports of seeing clients once a week for three or more years.

No such comparable data could be extracted for comparison for those workers in agency settings.

Types of Service

Questions 1 through 5 of the questionnaire dealt with client information and how various topics came about during the treatment process.

Question 1 dealt with how the subject of a client's sexual/affectional preference came about. No workers, in either setting, said the subject of their lesbian clients' sexual/affectional preference was the main reason why the client came in for treatment. Workers in agencies indicated 69 percent of their lesbian clients brought the subject up during individual treatment. Independent/ private practitioners indicated 77 percent brought the subject up during individual treatment. Agency workers noted 20 percent brought the subject up in a group session, while 0 percent of the independent/private practitioners reported this. The worker asked the client directly for 9 percent in the case of agency workers, and 15 percent for independent/private practitioners. The "other" category represented 2 percent from agency workers and 8 percent for independent/private practitioners.

Question 2 dealt with how the subject of lesbian chemical dependency came about. This was the main reason the client came in was the response for 99 percent of

the agency workers and for 8 percent of the independent/ private practitioners. The client brought the topic up during individual treatment was the response of 70 percent of the independent/private practitioners. The client brought the topic up during group was the response for 1 percent of the agency workers. Independent/private practitioners asked the client directly in 22 percent of the cases.

Question 3 dealt with the chemically dependent lesbian's drug of choice. Agency workers reported 90 percent used alcohol exclusively, 5 percent used alcohol plus another drug, 1 percent used opiates, and 4 percent used marijuana. Independent/private practitioners reported 87 percent used alcohol and 13 percent used alcohol plus valium and/or marijuana.

Question 4 dealt with whether the worker's client was currently free from drugs. Agency workers said 90 percent were currently drug free (this included those in treatment now), 7 percent were not drug free, and 3 percent unknown. Independent/private practitioners noted 96 percent were drug free currently and 4 percent were not.

The length of sobriety/drug freeness was also asked in this question. The range was 1 day to 3 years for agency workers, and the range was 3 months to 4 years for the independent/private practitioners.

Question 5 dealt with the utilization of support groups. All forty agency workers (100 percent) indicated their chemically dependent lesbian clients utilized AA or NA. In addition, Gay AA is utilized by 8 percent, lesbian rap groups by 3 percent, Women for Sobriety by 3 percent, Metropolitan Community Church by 1 percent, and mental health or private therapists for 13 percent of their cases. Independent/private practitioners report their clients utilize AA or NA 23 percent of the time, Women for Sobriety 31 percent, and independent/private practitioners 54 percent of the time.

Questions 6 through 9 asked questions about tangible (direct) services. Question 6 asked if the workers provided tangible (direct) services. All forty (100 percent) of the agency workers replied they did provide these types of services for their chemically dependent clients. Only one independent/private practitioner (a minister) provided these services. Agency workers provided the following tangible services: transportation (20 percent); meidcal (18 percent); recreational (15 percent); educational/vocational (20 percent); housing/halfway programs (50 percent); child/daycare (5 percent); financial (30 percent); group support (100 percent); others--individual therapy or other support groups--(8 percent).

Question 7 asked if the above services were provided directly by the worker and all forty reported they were.

Question 8 dealt with how many times per week a service was provided to chemically dependent clients. Agency workers broke down in the following manner: transportation (3 percent); medical (3 percent); recreational (13 percent); educational/vocational (13 percent); housing/ halfway programs (13 percent); job placement (10 percent); child/daycare (8 percent); financial (13 percent); referral (25 percent); support group (50 percent); other--individual therapy or other support group--(13 percent).

Question 9 dealt with how many chemically dependent lesbians were provided with these services in a typical week. Agency workers said: housing/halfway programs (3 percent); financial (3 percent); support groups (13 percent); others--private therapist--(13 percent).

Questions 10 through 13 dealt with providing counseling services to chemically dependent clients. All fifty-three respondents (100 percent) said they provided counseling services for their chemically dependent clients.

Question 11 asked what types of counseling services they provided to their chemically dependent lesbian clients. Agency workers reported providing individual, group, and family/significant other treatment/therapy as 80 percent for each form of treatment and 30 percent for couples or AA/NA therapy. Independent/private practitioners said they provided individual treatment/therapy 100 percent

of the time, and family/significant other therapy 77 percent of the time.

Question 12 asked how many times a week these counseling services were provided to each of the chemically dependent lesbian clients. Agency workers reported providing: individual therapy 0 to 6 times a week; group treatment 0 to 15 times a week; family/significant other therapy 0 to 6 times a week; and other--AA/NA--0 to 6 times a week. Independent/private practitioners reported using individual and/or family/significant other therapy 1 time per week for each client.

Question 13 asked how many chemically dependent lesbians were being provided with these same services. Agency respondents provided individual, group, and family therapy at a range of 0 to 6 times a week, with the average being 4. Independent/private practitioners ranged from 1 to 15 times a week with the average being 14.

Question 14 asked respondents which type of service, direct or counseling, was more beneficial to their clients as a whole. All fifty-three respondents (100 percent) said they felt counseling services were the most beneficial for their clients. Two respondents, both agency workers, report feeling equally comfortable doing both types of services.

Question 15 asked the respondents which type of service, direct or counseling, they prefer providing

to their chemically dependent lesbian clients. Again, all fifty-three (100 percent) reported a preference for providing counseling services. Likewise, two agency respondents report feeling equally comfortable with either type of service.

Questions 16 through 18 asked about specific topics and issues which could be explored or worked on in individual, group, and family counseling. Within each of these the following areas were listed: sexual counseling, family issues, AA/NA, brief therapy to increase self-esteem and ego strength, crisis counseling, work issues, support groups, legal issues, discrimination, and other. Due to the complexity of these answers, a table displaying this information can be found in Table III.

Question 19 asked if other workers in the agency or practice provided services to chemically dependent lesbians other than the services the respondents were providing. For agency workers, 88 percent responded no and 13 percent yes. For independent/private practitioners, 92 percent reported no and 8 percent yes.

Question 20 asked if there were any other tangible or counseling services which could be provided for the respondent's chemically dependent clients. In the agency setting, 18 percent said yes, other groups were needed; 83 percent said no other services were needed.

TABLE III

SUMMARY OF INFORMATION FROM QUESTIONS 16, 17, AND 18 OF SURVEY QUESTIONNAIRE*

Services	Agency Workers			Independent Practitioners		
	Individual	Group	Family	Individual	Group	Family
Sexual counseling	15	95	10	100	23	23
Family issues	95	100	100	100	62	77
AA/NA	100	100	100	8	8	8
Brief therapy	80	100	100	31	0	0
Crisis counseling	95	100	100	23	54	46
Work issues	24	100	100	100	15	0
Support groups	100	100	100	100	8	8
Legal issues	10	100	68	100	8	0
Discrimination	23	0	3	100	8	0
Other	8	0	0	100	0	0

*Shown in percent.

Independent/private practitioners all said (100 percent) no other services were needed to be provided by them.

Factors Influencing Service

Questions 21 through 27 dealt with factors which influenced the types of services provided to chemically dependent lesbians. Factors looked at included agency policy, primary source of revenue, how long the agency or practice had existed, decision making body, and willingness to change policies.

Question 21 asked what factors limited the services provided to chemically dependent lesbian clients. All thirteen independent practitioners (100 percent) said the client's inability to pay was the main factor. Most of the agency workers said this question did not apply to them and did not answer the question.

Question 22 again asked which type of service is easier for the provider, tangible or counseling services. All fifty-three respondents (100 percent) said counseling services were easier to provide for their chemically dependent lesbian clients.

Question 23 dealt with the primary source of revenue for the agency/practice. For the agency workers, 23 percent were self-pay, 50 percent insurance, 8 percent grant, and 8 percent Tennessee Department of Health and

Mental Retardation. For independent/private practitioners, 92 percent were insurance and 8 percent from a church.

Question 24 reflected how long the agency/practice had been providing services for chemically dependent clients. The agency workers responded their agencies had existed in this capacity for: 18 percent less than a year, 15 percent for 1 to 3 years, 60 percent for 4 to 10 years, and 8 percent for over 10 years. Independent/ private practitioners had been serving this group for: 15 percent for 1 to 3 years, 38 percent for 4 to 10 years, and 46 percent for over 10 years.

Question 25 reflected who determined policy in both settings. Agencies reported: 48 percent Board of Directors, 78 percent executive directors, 43 percent administrative staff, 3 percent partnership decision, and 5 percent a corporation of medical staff. Thirteen of the independent/private practitioners reported this being an individual decision (100 percent), with one of those people also noting that their congregation also had some say.

Question 26 dealt with the receptiveness of the agency or individual for change in policy. All fifty-three respondents (100 percent) say they and/or their agencies or practices were receptive to changes in policy regarding chemically dependent lesbians. To follow with this,

question 27 asked if these changes were ever incorporated into treatment programs. Again, all respondents (100 percent) said yes.

Specialized Training

The remaining questions, 28 through 35, dealt with various facets of specialized training the respondents may have had in the areas of working with lesbian clients and/or working with chemically dependent lesbian clients.

Question 28 asked if the respondents knew of any lesbian oriented resources available in the Knoxville community. Agency workers (8 percent) knew of minimum resources available, while private practitioners (92 percent) knew of multiple resources.

Questions 29, 30, and 31 asked specifically about where and what type of training the respondents had surrounding lesbian clients. Private practitioners (70 percent) had specific training in working with lesbian clients and received their training in college, in workshops or conferences, and inservices. All 70 percent of the private practitioners had utilized each of these forms of training. Almost equal division was found for agency workers. Forty-eight percent had received some specialized training and fifty-eight percent had received no special training. For those who did receive special training, workshops or conferences and inservices were

the methods utilized for the training. Additionally, only 16 percent was obtained through college or university courses. All respondents reported course content contained at least an overview of the special needs and concerens of gay males and lesbians.

Question 32 dealt with whether this training was helpful for the respondents. All respondents said yes (100 percent).

Question 33 dealt with whether the respondents would like additional training. Again, all said yes (100 percent).

Question 34 dealt with whether the respondents changed their approach in dealing with lesbian clients since their training. Sixty-seven percent of private practitioners did not feel they changed their approach. Of the agency workers, 89 percent felt they had changed their approach.

Question 35 dealt with those people who had no special training in the area of chemical dependency within the lesbian community. All of the private practitioners (100 percent) said this training would be beneficial for them. Twenty-one agency respondents (95 percent) said this training would be beneficial for them.

II. SUMMARY OF RESULTS

The summary of results is based on the hypotheses of this study. The first hypothesis states there is

no difference among practitioners in the Knoxville area who work with chemically dependent lesbian clients in the frequency of their use of tangible services and counseling services.

This study yielded several findings related to the first hypothesis. The most obvious was the difference found between the two groups of respondents. All forty (100 percent) of the agency workers were found to provide tangible services for their chemically dependent lesbian clients. The services provided were equally split among the choices offered. Only one (8 percent) of the private practitioners provided any tangible services and they were limited, but equally split between transportation, recreation, and support groups.

The second finding was the increased use of tangible services provided to chemically dependent clients in general compared to those tangible services provided to chemically dependent lesbian clients. There was also a greater variety in the services provided to chemically dependent clients in general than to chemically dependent lesbians.

In the area of counseling services, all fifty-three respondents (100 percent) reported provided counseling services to their chemically dependent lesbian clients. There was no difference between the groups on this level.

There does appear to be a qualitative difference in the types of counseling offered. Agency workers utilize all four types of counseling services: individual, group, family, and other. The private practitioners did not utilize group treatment or the other category.

Implied in these findings is a difference in the rate of providing tangible and counseling services to chemically dependent lesbian clients. There also is a difference between the two groups of respondents in their provision of these two services. Therefore, the first hypothesis is rejected.

Hypothesis 2 states there is no difference among practitioners in the Knoxville area in the types of demographic and other background factors that influence their work with chemically dependent lesbian clients. No significant difference in demographic factors was found which would influence the services provided by the practitioners to their chemically dependent lesbian clients.

It was found that some demographic factors did influence the types of services utilized by practitioners when looking between respondent groups. The group of private practitioners had achieved a slightly higher level of education, had their degrees longer, were slightly older, and appeared to have more autonomy in their work.

Despite the between-group findings, the first part of hypothesis 2 is accepted on the basis that, overall, demographic factors influencing services were not found.

It appears that some nondemographic factors did influence the type of services provided by the respondents. More tangible services and more varied services were provided by agency workers and this is reflected in the source of revenue and policy determining factors. Agencies had a more varied source of revenue: 23 percent self-pay, 50 percent insurance, 8 percent grant, and 20 percent funded by Tennessee Department of Health and Mental Retardation. Private practitioners obtained payment in the following ways: 92 percent insurance and 8 percent church.

Policy was determined by individual decision (100 percent) for private practitioners. Agency workers had their policy determined by: 78 percent executive directors, 48 percent Board of Directors, and 43 percent by administrative staff.

This second portion of hypothesis 2 pertained to other factors influencing services. These findings do not support this hypothesis. Therefore, the second portion of hypothesis 2 is rejected.

Hypothesis 3 states that practitioners in the Knoxville area who work with chemically dependent lesbian clients

have had no specialized training in the field of chemically dependent lesbians.

Question 29 in the questionnaire indicated 48 percent of the agency workers and 69 percent of the private practitioners had received specialized training in working with lesbian clients. All fifty-three respondents indicated experience in working with chemically dependent lesbians. Question 30 further confirmed this finding. Therefore, hypothesis 3 is rejected.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND DISCUSSION

I. SUMMARY

This study was a survey of fifty-three workers in Knoxville, Tennessee, who provide services to chemically dependent lesbians. A questionnaire was used to obtain information concerning demographic background of the workers, the types of services provided to chemically dependent lesbian clients, the environmental and other factors which influence the type of services provided, and the amount of specialized training received by each worker in the field of chemical dependency and lesbian specific issues. Fifty-three workers from twelve agencies with chemical dependency treatment programs, and thirteen private practitioners who had a number of lesbian clients in their caseload, were used as subjects for the investigation.

A multiple choice, short answer questionnaire was adopted from Tucker (1978) and mailed to workers in order to examine the programs and services provided by treatment facilities and private practitioners for their chemically dependent lesbian clients. The data obtained from the questionnaires were tabulated and analyzed. The overall

results are reported in the following section of this chapter.

II. CONCLUSIONS

From the analysis of the data on the preceding pages, the following conclusions are drawn:

First, there appears to be a notable difference among workers in Knoxville who provide tangible and counseling services to chemically dependent lesbian clients. Tangible services were used more frequently and with more variety by agency workers when treating chemically dependent clients in general than when they were treating chemically dependent lesbian clients. Tangible services were utilized almost exclusively by agency workers and were combined with counseling services. Private practitioners utilized counseling services almost exclusively.

Second, no significant demographic factors were found which would influence the workers' ability to utilize services for chemically dependent lesbians.

When looking between groups of respondents, it was noted that private practitioners achieved a slightly higher level of education, had their degrees longer, were slightly older, and had more autonomy in their work than did their agency-employed counterparts. Agency policy and source of revenue appear to influence service availability and use.

Finally, there are a significant number of workers in Knoxville who have had some specialized training in the areas of working with chemically dependent clients and lesbians. However, the majority of respondents felt they needed more training or insight into the problems specifically related to chemical dependency among lesbians.

III. DISCUSSION

After careful consideration and analysis of the data, it can be stated that workers in the Knoxville area who work with chemically dependent lesbians are providing both tangible and counseling services for their clients. Private practitioners are providing counseling services more than tangible services. They also provide counseling for longer periods of time but also deal with many more issues related specifically to their clients. In addition, they utilize individual and family therapy as their treatment of choice. Further, they have more educational training and have been in the field longer than agency workers.

On the other hand, agency workers provide counseling services and almost all of the tangible services available for chemically dependent lesbians. They are providing services for a shorter period of time, due to the length of traditional treatment programs, but they are seeing a larger number of clients overall.

Both groups of practitioners have explored additional training in the area of special needs and concerns of chemically dependent lesbians. Unfortunately, a number of agency workers noted in the comment section of the questionnaire that they saw no real difference between chemically dependent lesbians and other chemically dependent people. This reflects the common attitude most people have about lesbians as well as it reflects the general gap between research and practice. There is still a need for further education in this area.

Successful treatment of chemical dependency relies on treating the whole individual. Tangible and counseling services are both needed. Lesbian clients have a unique set of problems and concerns, and all of those must be treated if chemically dependent lesbians are expected to recover from their illness.

There is strength in sisterhood. Let each of our successes be taken note of and let us stand up to be counted. Let our lives shine--chemically free at last.

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APPENDIXES

APPENDIX A

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1 -- We admitted we were powerless over alcohol--that our lives had become unmanageable.

2 -- Came to believe that a Power greater than ourselves could restore us to sanity.

3 -- Made a decision to turn our will and our lives over to the care of God as we understood Him.

4 -- Made a searching and fearless moral inventory of ourselves.

5 -- Admit to God, to ourselves and to another human being the exact nature of our wrongs.

6 -- Were entirely ready to have God remove all these defects of character.

7 -- Humbly asked Him to remove our shortcomings.

8 -- Made alist of all persons we had harmed, and became willing to make amends to them all.

9 -- Made direct amends to such people wherever possible, except when to do so would injure them or others.

10 -- Continued to take personal inventory and when we were wrong promptly admitted it.

11 -- Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for the knowledge of His will for us and the power to carry that out.

12 -- Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

APPENDIX B

WOMEN FOR SOBRIETY ACCEPTANCE PROGRAM

1 -- I have a drinking problem that once had me.

2 -- Negative emotions destroy only myself.

3 -- Happiness is a habit I will develop.

4 -- Problems bother me only to the degree I permit them to.

5 -- I am what I think.

6 -- Life can be ordinary or it can be great.

7 -- Love can change the course of my world.

8 -- The fundamental object of life is emotional and spiritual growth.

9 -- The past is gone forever.

10 -- All love given returns twofold.

11 -- Enthusiasm is my daily exercise.

12 -- I am a competent women and have much to give to others.

13 -- I am responsible for myself and my sisters.

APPENDIX C

QUESTIONNAIRE

Do you work in an agency setting? _____ Yes _____ No

Are you an Independent or Private Practitioner? _____ Yes _____ No

_____ Sex _____ Age _____ Job Title

_____ Degree _____ Year Obtained

_____ Number of chemically dependent clients

_____ Number of lesbian clients

_____ Number of social workers in your agency's chemical dependency program with MSW degree?

_____ Total number of social workers with any degree in your agency's chemical dependency treatment program.

_____ Number of clients seen in the past 12 months

_____ Number of chemically dependent lesbians seen in the past 12 months

_____ Number of lesbians seen in the past 12 months

_____ What is the average number of visits or sessions that you see a client

1. For the clients you know are lesbian, how did the topic of their sexual/affectional preference come about?

_____ It was the main reason client came in.
_____ The client brought the topic up during individual treatment.
_____ The client brought the topic up during a group session.
_____ I asked the client directly.
_____ Other (specify)

2. For the clients you know are chemically dependent lesbians, how did the topic of their dependency come about?

_____ It was the main reason client came in.
_____ The client brought the topic up during individual treatment.
_____ The client brought the topic up during a group session.
_____ I asked the client directly.
_____ Other (specify)

3. What has been the chemically dependent lesbian's drug of choice?

_____

4. Is your client sober/drug free now _____ Yes _____ No
If yes,

_____ What has been the length of sobriety or drug freeness for your chemically dependent lesbian client?

5. If your client utilizes a support group, which is utilized? Check all which apply.

_____ AA or NA
_____ Gay AA
_____ Lesbian rap group
_____ Women for Sobriety Group
_____ Women Inc. Group
_____ Metropolitan Community Church
_____ Other (specify)

6. Do you provide any tangible (direct) services to your chemically dependent clients? _____ Yes _____ No

7. What tangible services do you provide directly (in person) or indirectly (you set up) to the chemically dependent clients you work with? (Check all that apply)

_____ Transportation
_____ Medical
_____ Recreational
_____ Educational/Voc Rehab
_____ Housing/Halfway Program
_____ Job Placement
_____ Child/Daycare
_____ Financial
_____ Support Group
_____ Other (specify)

8. How many times a week do you provide these services, either by telephone or by personal interview?

_____ Transportation
_____ Medical
_____ Recreational
_____ Educational/Voc Rehab
_____ Housing/Halfway Program
_____ Job Placement
_____ Child/Daycare
_____ Financial
_____ Referral
_____ Support Group
_____ Other (specify)

9. How many chemically dependent lesbian clients do you provide with your services in each category during a typical week?

_____ Transportation
_____ Medical
_____ Recreational
_____ Educational/Voc Rehab
_____ Housing/Halfway Program
_____ Job Placement
_____ Child/Daycare
_____ Financial
_____ Referral
_____ Support Group
_____ Other (specify)

10. Do you provide any counseling service to your chemically dependent clients?

_____ Yes
_____ No

11. What counseling services do you provide to the chemically dependent lesbian clients you work with?

_____ Individual treatment/therapy
_____ Group treatment/therapy
_____ Family/Significant others treatment/therapy
_____ Other (specify)

12. How many times a week do you provide these services to each of your chemically dependent lesbian clients?

_____ Individual treatment/therapy
_____ Group treatment/therapy
_____ Family/Significant other treatment/therapy
_____ Other (specify)

13. How many chemically dependent lesbian clients do you provide with your services in each category in a typical week?

_____ Individual treatment/therapy
_____ Group treatment/therapy
_____ Family/Significant other treatment/therapy
_____ Other (specify)

14. Which services do you feel are more beneficial to your clients?

_____ Tangible services
_____ Counseling services

15. Which type of services do you prefer to provide to your chemically dependent lesbian clients?

_____ Tangible services
_____ Counseling services

16. Do you engage in individual counseling in these areas?

_____ Sexual counseling
_____ Family issues
_____ AA/NA
_____ Brief therapy to increase self-esteem and ego strength
_____ Crisis counseling
_____ Work issues
_____ Support groups
_____ Legal issues
_____ Discrimination
_____ Other (specify)

17. Do you engage in group counseling in these areas?

_____ Sexual counseling
_____ Family issues
_____ AA/NA
_____ Brief therapy to increase self-esteem and ego strength
_____ Crisis counseling
_____ Work issues
_____ Support groups
_____ Legal issues
_____ Discrimination
_____ Other (specify)

18. Do you engage in family counseling in these areas?

_____ Sexual counseling
_____ Family issues
_____ AA/NA
_____ Brief therapy to increase self-esteem and ego strength
_____ Crisis counseling
_____ Work issues
_____ Support groups
_____ Legal issues
_____ Discrimination
_____ Other (specify)

19. Do other workers in your agency/practice provide services to chemically dependent lesbians other than the ones you provide?

_____ Yes (specify)
_____ No

20. Are there any other tangible or counseling services you could provide to your chemically dependent lesbian clients?

_____ Yes (specify)
_____ No

21. What factors limit your being able to provide services for chemically dependent lesbian clients?

_____ Agency policy
_____ Client's inability to pay
_____ Educational training
_____ Your attitude towards lesbian clients
_____ Other (specify)

22. Which type of service is easier for you to provide for chemically dependent lesbian clients?

_____ Tangible services
_____ Counseling services

23. What is the primary source of financial support for your agency/practice?

_____ Self-pay
_____ Insurance
_____ Private group (e.g., church or benefactor)
_____ Grant
_____ Other (specify)

24. How long has your agency/practice provided services for chemically dependent clients?

_____ Less than a year
_____ 1-3 years
_____ 4-10 years
_____ Over 10 years

25. Who determines policy pertaining to treatment programs in your agency/practice?

_____ Board of directors
_____ Executive directors
_____ Administrative staff
_____ Partnership decision
_____ Individual decision
_____ Other (specify)

26. Is your agency receptive to the recommendations regarding the needs of the chemically dependent lesbian made by the social workers in your agency/practice?

_____ Yes
_____ No

27. Are these recommendations ever incorporated into treatment programs?

_____ Yes
_____ No

28. Do you know of any lesbian oriented resources which are available in the Knoxville Area?

_____ Yes (specify)
_____ No

29. Have you had any specific training in working with lesbian clients?

_____ Yes (If yes, answer questions 30-34)
_____ No (If no, please skip to question 35)

30. If yes, where did you receive the training? (Check all which apply)

_____ College/University course
_____ Workshop or conference
_____ Inservice training
_____ Other (specify)

31. What area (s) was covered during the training session you attended?

_____ An overall introduction/review of the special needs and concerns of gay males and/or lesbians.
_____ Tangible services helpful in dealing with gay males and/or lesbians.
_____ Counseling services and techniques helpful in dealing with gay males and/or lesbians.
_____ Working in a gay male and/or lesbian community setting.
_____ Consultation work with agencies or support groups who work with gay males and/or lesbians.
_____ Other (specify)

32. Do you feel this training was helpful to you in dealing with your lesbian clients?

_____ Yes
_____ No

33. Would you like to have more training in the area of gay male and/or lesbian chemical dependency?

_____ Yes
_____ No

34. Have you changed your approach in dealing with the lesbian client since your training?

_____ Yes (Please feel free to elaborate on back page.)
_____ No

35. If you have not had any training in the area of chemical dependency within the lesbian community, do you feel it would be beneficial for you to have this training?

_____ Yes
_____ No

Any comments or suggestions regarding this questionnaire or this research may be written here.

APPENDIX D

TABLE IV

DEMOGRAPHIC AND CASELOAD INFORMATION

Variable	Range		Average	
	Agency	Private	Agency	Private
Age	27-50	25-52	31	39
Sex				
Female	28	9	---	---
Male	12	4	---	---
Year degree obtained	1964-85	1969-85	---	---
No. workers with M.S.S.W.	0-5	NA	2	NA
No. workers with any degree	1-10	NA	5.4	NA
No. CD clients	1-800	8-19	262	12
No. lesbian clients	0-36	0-17	22	15
No. clients seen in past 12 months	20-600	5-61	2454	48
No. CD lesbians seen in past 12 months	0-35	7-16	11.1	10
No. lesbians seen	0-36	0-15	7.9	14
No. visits/sessions seen	---	4-156+	---	104

APPENDIX E

RESULTS OF QUESTIONNAIRE

1. For the clients you know are lesbian, how did the topic of their sexual/affectional preference come about?

A	P	
0	0	It was the main reason client came in.
69	77	The client brought the topic up during individual treatment.
20	0	The client brought the topic up during a group session.
9	15	I asked the client directly.
2	8	Other (specify)

2. For the clients you know are chemically dependent lesbians, how did the topic of their dependency come about?

A	P	
99	8	It was the main reason client came in.
0	70	The client brought the topic up during individual treatment.
1	0	The client brought the topic up during a group session.
0	22	I asked the client directly.
0	0	Other (specify)

3. What has been the chemically dependent lesbian's drug of choice?
A 90% alcohol, 5% alcohol plus other, 1% opiates, 4% marijuana.
P 87% alcohol, 13% alcohol plus another drug, usually marijuana and valium.

4. Is your client sober/drug free now A 90% Yes A 7% No 3% Unknown
P 96% P 4%
If yes,

_____ What has been the length of sobriety or drug freeness for your chemically dependent lesbian client? A 1 day to 3 years.
P 3 months to 4 years.

5. If your client utilizes a support group, which is utilized? Check all which apply.

A	P	
100	23	AA or NA
8	0	Gay AA
3	0	Lesbian rap group
3	31	Women for Sobriety Group
0	0	Women Inc. Group
3	0	Metropolitan Community Church
13	54	Other (specify)

6. Do you provide any tangible (direct) services to your chemically dependent clients? A 100% Yes A 0% No
P 8% P 92%

7. What tangible services do you provide directly (in person) or indirectly (you set up) to the chemically dependent clients you work with? (Check all that apply)

A	P		A	P	
20	100	Transportation	0	0	Job Placement
45	0	Medical	5	0	Child/Daycare
15	100	Recreational	30	0	Financial
20	0	Educational/Voc Rehab	100	100	Support Group
50	0	Housing/Halfway Program	8	0	Other (specify)

8. How many times a week do you provide these services, either by telephone or by personal interview?

A	P		A	P	
3	8	Transportation	10	0	Job Placement
3	0	Medical	8	0	Child/Daycare
13	23	Recreational	13	0	Financial
13	0	Educational/Voc Rehab	25	8	Referral
13	0	Housing/Halfway Program	50	8	Support Group
			13	0	Other (specify)

9. How many chemically dependent lesbian clients do you provide with your services in each category during a typical week?

A	P		A	P	
0	8	Transportation	0	0	Job Placement
0	0	Medical	0	0	Child/Daycare
0	0	Recreational	3	0	Financial
0	0	Educational/Voc Rehab	0	8	Referral
3	0	Housing/Halfway Program	13	0	Support Group
			13	0	Other (specify)

10. Do you provide any counseling service to your chemically dependent clients?

A	P	
100	100	Yes
0	0	No

11. What counseling services do you provide to the chemically dependent lesbian clients you work with?

A	P	
80	100	Individual treatment/therapy
80	0	Group treatment/therapy
80	77	Family/Significant others treatment/therapy
30	0	Other (specify)

12. How many times a week do you provide these services to each of your chemically dependent lesbian clients?

A	P		A
3	1	Individual treatment/therapy	Range = 0-6
5	0	Group treatment/therapy	Range = 0-15
1	1	Family/Significant other treatment/therapy	Range = 0-6
1	0	Other (specify)	Range = 0-6

13. How many chemically dependent lesbian clients do you provide with your services in each category in a typical week?

A	P	
4	14	Individual treatment/therapy
3	0	Group treatment/therapy
4	0	Family/Significant other treatment/therapy
0	0	Other (specify)

14. Which services do you feel are more beneficial to your clients?

A	P	
2	0	Tangible services
40	0	Counseling services

15. Which type of services do you prefer to provide to your chemically dependent lesbian clients?

A	P	
5	0	Tangible services
100	100	Counseling services

16. Do you engage in individual counseling in these areas?

A	P		A	P	
15	100	Sexual counseling	95	23	Crisis counseling
95	100	Family issues	24	100	Work issues
100	8	AA/NA	100	100	Support groups
80	31	Brief therapy to increase self-esteem and ego strength	10	100	Legal issues
			23	100	Discrimination
			8	100	Other (specify)

17. Do you engage in group counseling in these areas?

A	P		A	P	
95	23	Sexual counseling	100	54	Crisis counseling
100	62	Family issues	100	15	Work issues
100	8	AA/NA	100	8	Support groups
100	0	Brief therapy to increase self-esteem and ego strength	100	8	Legal issues
			0	8	Discrimination
			0	0	Other (specify)

18. Do you engage in family counseling in these areas?

A	P		A	P	
10	23	Sexual counseling	100	46	Crisis counseling
100	77	Family issues	100	0	Work issues
100	8	AA/NA	100	8	Support groups
100	0	Brief therapy to increase self-esteem and ego strength	68	0	Legal issues
			3	0	Discrimination
			0	0	Other (specify)

19. Do other workers in your agency/practice provide services to chemically dependent lesbians other than the ones you provide?

A	P	
13	8	Yes (specify)
88	92	No

20. Are there any other tangible or counseling services you could provide to your chemically dependent lesbian clients?

A	P	
18	0	Yes (specify)
83	100	No

21. What factors limit your being able to provide services for chemically dependent lesbian clients?

A	P	
0	0	Agency policy
8	100	Client's inability to pay
0	0	Educational training
0	0	Your attitude towards lesbian clients
5	0	Other (specify)

22. Which type of service is easier for you to provide for chemically dependent lesbian clients?

A	P	
5	0	Tangible services
100	100	Counseling services

23. What is the primary source of financial support for your agency/practice?

A	P	
23	0	Self-pay
5	92	Insurance
0	8	Private group (e.g., church or benefactor)
8	0	Grant
20	0	Other (specify)

24. How long has your agency/practice provided services for chemically dependent clients?

A	P		A	P	
18	0	Less than a year	60	38	4-10 years
15	15	1-3 years	8	46	Over 10 years

25. Who determines policy pertaining to treatment programs in your agency/practice?

A	P	
48	0	Board of directors
78	0	Executive directors
43	0	Administrative staff
3	0	Partnership decision
0	100	Individual decision
5	0	Other (specify)

26. Is your agency receptive to the recommendations regarding the needs of the chemically dependent lesbian made by the social workers in your agency/practice?

A	P	
100	100	Yes
0	0	No

27. Are these recommendations ever incorporated into treatment programs?

A	P	
100	100	Yes
0	0	No

28. Do you know of any lesbian oriented resources which are available in the Knoxville Area?

A	P	
8	92	Yes (specify)
92	8	No

29. Have you had any specific training in working with lesbian clients?

A	P	
48	69	Yes (If yes, answer questions 30-34)
52	31	No (If no, please skip to question 35)

30. If yes, where did you receive the training? (Check all which apply)

A	P	
16	100	College/University course
100	100	Workshop or conference
100	100	Inservice training
11	78	Other (specify)

31. What area (s) was covered during the training session you attended?

A	P	
100	100	An overall introduction/review of the special needs and concerns of gay males and/or lesbians.
0	33	Tangible services helpful in dealing with gay males and/or lesbians.
32	100	Counseling services and techniques helpful in dealing with gay males and/or lesbians.
0	56	Working in a gay male and/or lesbian community setting.
90	89	Consultation work with agencies or support groups who work with gay males and/or lesbians.
0	0	Other (specify)

32. Do you feel this training was helpful to you in dealing with your lesbian clients?

A	P	
100	100	Yes
0	0	No

33. Would you like to have more training in the area of gay male and/or lesbian chemical dependency?

A	P	
100	100	Yes
0	0	No

34. Have you changed your approach in dealing with the lesbian client since your training?

A	P	
89	33	Yes (Please feel free to elaborate on back page.)
11	67	No

35. If you have not had any training in the area of chemical dependency within the lesbian community, do you feel it would be beneficial for you to have this training?

A	P	
95	100	Yes
5	0	No

VITA

Mary Alice Costich-Covey was born on January 15, 1952, in Rochester, New York. She was the first of four children born to Richard F. Costich and Beverly S. Costich LeBoo.

In 1970, Mary graduated from R. L. Thomas High School. She also attended Webster Jr. High School and Ridgecrest Elementary School, all in Webster, New York. From June 1970 through January 1980, she worked at Eastman Kodak Company in Rochester. In 1977, Mary entered the University of Rochester (Rochester, New York) and in 1981 she received the Bachelor of Science degree with a major in General Studies. In September of 1981, Mary entered The University of Tennessee, Knoxville to begin work on a Master's in sociology. After one year in that program she entered the College of Social Work. She left that program in February of 1983 to seek help for her chemical dependency. In September of 1984, Mary returned to the College of Social Work and received her Master of Science in Social Work in June 1986.

Ms. Covey has a fourteen-year-old daughter, Kathy. She currently resides in Knoxville, Tennessee, with her daughter and her partner. She remains chemically free.