Counseling Gay Men and Lesbians with Alcohol Problems

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This paper addresses generic as well as specific alcoholism treatment concerns as related to lesbians and gay men in order to help rehabilitation counselors better understand the issues involved in addiction and treatment with this population.

An accepted notion within the rehabilitation community is that satisfaction with one's sexuality is highly correlated with productivity and social adjustment (Sha'ked, 1981; Trieschmann, 1980). Despite this notion, the topic of sexuality has not received a great deal of attention within the rehabilitation literature. For example, a review of the *Journal of Applied Rehabilitation Counseling*, *Journal of Rehabilitation*, and *Rehabilitation Counseling Bulletin* during the past 10 years reveals that few empirical articles or discussion papers have been published about human sexuality. One theme that emerged in our literature review is that issues concerning homosexuality have been virtually ignored within the rehabilitation field. In fact, to our knowledge, there is only one article that examines the needs of clients with disabilities who are gay. This article by McAllan and Ditillo (1994) outlines myths, terminology, and practical suggestions for rehabilitation practitioners to work more effectively with gay clients. The intent of the present article is to examine specific issues with respect to alcohol treatment of gay men and lesbians.

The "Hidden Minority"

It is estimated that between 10% and 15% of the general population is homosexual (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Despite this statistic, lesbians and gay men have often been referred to as a"hidden minority" (Fassinger, 1991). Such invisibility has been attributed to a variety of factors which include a reluctance on the part of gay men and lesbians to openly acknowledge their homosexuality; lack of awareness, knowledge, and sensitivity of helping professionals who work with homosexuals; and the negative stigma associated with being gay or lesbian (Gonsiorek, 1982). Strong religious doctrine and legal repercussions against same-sex behavior have also contributed to the need for people to remain hidden (Atkinson & Hackett, 1988). In addition, disclosure of one's sexual orientation can lead to isolation, ostracism, and even physical abuse (Herek, 1989).

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Alcoholism is the one disability that affects gay people at a much higher rate than heterosexuals. Kus (1990) stated that between 20% and 33% of the gay and lesbian population has an identified drinking problem. Other researchers believe that between 18% and 38% of gay men and 27% to 35% of lesbians are either alcohol abusers or alcoholics (Doweiko, 1993; Finnegan & McNally, 1987; Hellman, Stanton, Lee, Tytun, & Vachon, 1989; Lewis, Saghir, & Robins, 1982). This percentage exceeds the general population at large which has an estimated alcoholism rate of between 10% to 12% (Gosselin & Nice, 1987; Hollerman & Novak, 1989). In reviewing these statistics about gay men and lesbians, it is important to keep in mind that there are a number of methodological constraints with such research including small sample sizes, non-random groups (Mosbacher, 1988), and lack of a representative sample (Glaus, 1988). Despite these flaws, though, "all of the studies show a remarkable consistency in their findings . . . that 28 to 32 percent of lesbians and gay men are at high risk or are alcoholic" (Finnegan & McNally, 1989, p. 129). Based on these statistics, it is safe to say that alcoholism is the number one health issue for gay men and lesbians (Bickelhaupt, 1990).

Possible Reasons for Increased Alcohol Use Among Gay Men and Lesbians

The difference in alcoholism rates between gay and non-gay populations has been attributed to a number of environmental factors. One factor is that alcohol serves as a method of coping with internal homophobia. Anderson and Henderson (1985) believe that socio-cultural pressure is the most sound explanation as to why alcoholism rates differ between gay and non-gay populations. Overt societal stigmatization of gay men and lesbians can lead to low self-esteem, anxiety, depression, and powerlessness. As such, alcohol may serve as one way to cope with these negative feelings.

A second reason for increased alcohol use/abuse by gay men and lesbians is the fact that legitimate socialization is often limited to bars or parties serving alcohol. Gay bars promote the use of alcohol in much the same way that nongay bars endorse alcohol use in the heterosexual culture (Israelstam & Lambert, 1984). The major difference between the two, however, is that heterosexuals have a greater range of social outlets from which to choose without fear of recrimination (Colcher, 1982; Finnegan & McNally, 1987).

A third reason that may explain the higher incidence rate is that alcohol use may help the individual during the "coming out" process (Nardi, 1982). As the individual struggles with the decision to "tell or not to tell", an increasing amount of stress can occur. Using alcohol provides one way to relieve such stress. Alcohol can also be used to help people lower their inhibitions as a way to engage in same-sex sexual activities they may not feel comfortable performing if they are sober (Israelstam & Lambert, 1984). Making the decision to "come out" requires an acknowledgment to oneself, to other gay people, and then to everyone else that you are gay or lesbian (Anderson & Henderson, 1984). As such, "coming out" represents an on-going, gradual process of acknowledging one's sexuality over time. It is important to remember that gay men and lesbians must make a choice about whether to "come out" every time they meet someone new. The process of "coming out" to nongay people may be the most difficult for gay men and lesbians who enter alcoholism treatment. It is important to respect a person's decision if they choose not to "come out" in treatment because of legitimate fears of oppression or possible retaliation (Anderson & Henderson, 1985).

With regard to confidentiality, it is important for counselors not to disclose a client's sexual orientation to anyone without his or her permission. This includes family, friends, and employers. Instead, work with the person to help him or her come to a decision about whether sexual orientation disclosure is desired and with whom.

Counselor Attitudes Toward Gay and Lesbian Clients

Although gay men and lesbians constitute 10% of the general population, it is estimated that between 25% and 65% of gay men and lesbians seek counseling at some point in their life, a rate that is two to four times higher than for nongays (Rudolph, 1988). Consequently, it is highly likely that every counselor will work with gay and lesbian clients during their professional career, even though few mental health or rehabilitation professionals are ever trained to work with gay clients (Graham, Rawlings, Halpern, & Hermes, 1983; Messing, Shoenberg, & Stephens, 1984; Rudolph, 1988; Stein, 1988).

Despite the incidence of alcoholism among gays and lesbians, counselors have received limited training to meet specific needs of this clientele. To the authors' knowledge, there has not been a single study that has specifically examined rehabilitation counselor attitudes toward gays or lesbians. One study (Hellman, Stanton, Lee, Tytun, & Vachon, 1989) found that 40% of substance abuse counselors indicated that they received no formal training in working with gay men and lesbians. A related study conducted by Allen, Peterson, and Keating (1982) examined mental health and rehabilitation counselors' attitudes toward a variety of groups in comparison to alcoholics, of which homosexuality was cited as one of the comparison groups. Although the initial report indicated that attitudes toward alcoholics were the most negative of six client categories, subsequent communication indicated that homosexuals had the highest favorable rating (H. A. Allen, personal communication, April 22, 1992). It is uncertain whether similar results would occur if this study was replicated today.

In order to work effectively with gay clients, counselors need to become aware of their own beliefs, values, feelings, and fantasies regarding gay men and lesbians, and acknowledge how these factors influence the counseling process (Iasenza, 1989; McAllan & Ditillo, 1994; Rudolph, 1988). It is imperative that helping professionals become aware of their own homophobia and heterosexism and learn to rise above the myths and stereotypes if they are to help their clients deal effectively with discrimination and negative forces that gay men and lesbians face (Clark, 1979; Dworkin & Gutierrez, 1989; Iasenza, 1989; Stein, 1988). Accepting the premise that within Western culture it is virtually impossible to grow up without being somewhat homophobic (Israelstam, 1986), rehabilitation counselors must examine their own emotional reactions such as fear, anger, anxiety, and curiosity about homosexuality, no matter how minimal these might seem. Such feelings play a prominent role in contributing to homosexual myths, stereotypes, and assumptions such as, "gay men and lesbians would rather be straight if they could",

"passing as straight is dishonest", "effeminate males are gay or masculine females are lesbians", and "disclosure of one's sexual orientation is necessarily good and appropriate." Further, seemingly innocuous statements such as, "You don't seem gay" or "Maybe you just haven't found the right person to change your thinking" only perpetuate the myth that heterosexuality is the one singular lifestyle that is appropriate. According to House and Holloway (1992), this view is inconsistent with the primary counseling tenets of acceptance, self-worth, and tolerance and results in a devalued status for gay men and lesbians.

Certainly, not all counselors will be willing to adopt an accepting attitude towards homosexual behavior given their religious, ethnic, family, and cultural background. If the counselor maintains the posture that alcoholism treatment must also involve changing the client to embrace a heterosexual lifestyle then it is better to avoid providing treatment. As Finnegan and Cook (1984) warn, "If counselors are afraid to or do not want to work with gay/lesbian clients, then they should not do so. No treatment is better than inept or hostile treatment" (p. 97). According to some authors (e.g., Lawson & Lawson, 1989), it is better to refer these clients to counselors who are receptive and skilled in working with gays and lesbians. Referring a gay or lesbian client to another professional because that client represents a personal, social, or moral dilemma for the counselor has not received widespread acceptance, however. If a counselor remains homophobic or heterosexist, it may be construed as avoidance behavior. For instance, House and Holloway (1992) ask, "Does the counseling profession tolerate and thus promote the existence of heterosexism and homophobia in the profession?" (pp. 318). Such questions are important for rehabilitation counselors, educators, and supervisors to debate.

Signs of Homophobia and Heterosexism

Unresolved and unchecked homophobia and heterosexism among staff members may manifest itself in several overt and subtle ways such as open hostility, delayed treatment, or sarcastic remarks (Finnegan & Cook, 1984). This nonaccepting attitude may make it unbearable for the client and can result in premature termination. Other examples of institutional homophobia and heterosexism include: (a) telling gay jokes (Tievsky, 1988) or not objecting when people tell anti-gay jokes (DeCrescenzo, 1984); (b) uneasiness, pity, hostility, stereotyping, and/or denial when discussing gay people (Tievsky, 1988); (c) exaggerating the significance of the client's sexual orientation (Tievsky, 1988); (d) an attitude that sexual orientation makes absolutely no difference, which ignores the impact a rejecting society has on a person (Finnegan & Cook, 1984; Tievsky, 1988); (e) having a condescending attitude toward clients by "pointing out the supposed lost life opportunities being homosexual carries (such as children and marriage)" (DeCrescenzo, 1984, p. 121); (f) identifying homosexuality in an agency case conference as one of the client's "problems" (DeCrescenzo, 1984); and (g) discouraging clients from telling family, friends, and co-workers that they are gay or lesbian (DeCrescenzo, 1984).

Attitudes of Gay Men and Lesbians Toward Counseling

Many gay men and lesbians perceive a negative bias against them held by helping professionals (Rochlin, 1982; Rudolph, 1988). This perceived bias may help explain why it is necessary for some clients to avoid discussion of their sexual orientation and to what extent, if any, alcohol plays in coping with social and personal stressors. Avoiding any talk about one's sexuality mirrors the same predicament that many gays and lesbians experience in most social situations, that is, a requirement that they must "pass" as heterosexual in order to avoid discrimination and gain acceptance (Campbell, Hinkle, Sandlin, & Moffic, 1983; Hammersmith, 1987). Many gay and lesbian clients feel alienated by providers who are hostile or unsupportive (Mosbacher, 1988). The perception of gay men and lesbians that helping professionals want to change a client's sexual orientation is one reason gay clients may be hesitant to seek alcoholism treatment.

Alcoholism Assessment and Treatment Concerns

In conducting an alcohol assessment, basic themes concerning frequency, amount, pattern of use, reasons for drinking, and client perception as to how alcohol has impacted personal, physical, social, and vocational areas should be explored. Rehabilitation counselors with limited experience in conducting basic alcohol assessment may wish to review clinical interviews (e.g., Carroll, 1993; Faltz, 1993; Miller & Marlatt, 1984) and/or psychometric instruments such as the Alcohol Dependence Scale (Horn, Skinner, Wanberg, & Foster, 1984), Michigan Alcoholism Screening Test (Mischke & Venneri, 1987), or the MacAndrew Alcoholism Scale (MacAndrew, 1981). Whether clinical interviews, tests, or the combination of the two are used, such assessments should always be conducted in a nonjudgmental manner that communicates a genuine concern for the substance abuser (Faltz, 1992).

Alcoholism treatment of gay men and lesbians cannot simply focus on the alcoholism but must also attend to social and psychological aspects between a gay lifestyle and drinking behaviors (Brandsma & Pattison, 1982). To the gay man or lesbian who is alcoholic, sobriety can only be achieved in an atmosphere of acceptance and confronting what it means to be gay or lesbian and alcoholic (Ziebold, 1979). As with any alcoholic client, the first priority is sobriety. Once the client has achieved sobriety, efforts to promote a positive gay or lesbian identity can occur (Faltz, 1993). Attention should be paid to developing a positive identity at this time because internalized homophobia can be a threat to sobriety (Anderson & Henderson, 1985)

In terms of alcoholism treatment, sexual orientation may be used as an excuse to continue drinking. Such rationalizations or denial must be confronted and viewed as a condition that is independent of homosexuality before recovery can begin (Small & Leach, 1977). Denial, which is a defense mechanism used to reduce or eliminate aspects that would cause anxiety, should be examined with respect to the strength and purpose for which it serves. For instance, because Western culture indirectly condones alcohol as a way to induce relaxation or socialization, it is not unusual that people in denial about their true sexuality might also use alcohol to help avoid acknowledging this truth. If the continued use of alcohol develops into alcoholism, the denial system becomes enormously powerful as both alcoholism and sexual orientation must be confronted before sobriety can occur. In order to keep the denial system going, alcoholics will find ways to manipulate and undermine treatment. In addition to

denial, three other defense mechanisms play a critical part in maintaining one's addiction to alcohol -- rationalization, projection, and minimization (Doweiko, 1993). Rationalization is sometimes used to explain behavior that is on one level unacceptable but with the influence of alcohol becomes more acceptable, for example, "I only did it [engaged in same-sex sex] because I was drunk." This explanation can be particularly difficult for persons who are confused about their sexual identity and requires careful exploration (Finnegan & McNally, 1987). Projection, the process by which a person attributes thoughts or feelings that he or she experiences onto others, may manifest itself as blaming others for one's problem. For example, "If my family would accept me for who I am, I wouldn't need to drink." Finally, minimization is used to convince others that the problem is not really as bad as it seems (Doweiko, 1993). These defense mechanisms are often observed during the course of individual treatment and, therefore, it is advisable tohave significant others involved with treatment (Glaus, 1988).

Another important issue is whether people should "come out" in treatment. The choice must be left up to the client (Faltz, 1993; Finnegan & Cook, 1984). Would you ask a non-gay person to "come out" in treatment? (Kus, 1990). Keep in mind that disclosure could also implicate people who are still closeted (especially partners) (Finnegan & McNally, 1989). Finally, it is important to remember that treatment issues for gay men are not the same as treatment issues for lesbians (Kus, 1990; Mosbacher, 1988). For these reasons, it is important to view all clients in terms of their cultural background, race, socioeconomic status, and religious heritage, as well as sexual orientation.

Sobriety Maintenance and Rehabilitation Outcome

One of the most important and successful influences in maintaining abstinence has been the Alcoholics Anonymous (AA) program. Although there has been criticism of outcome studies that examined the effectiveness of AA (e.g., Galanter, Castaneda, & Franco, 1991), it is agreed even by harshest critics that this program is effective for some individuals, especially white males over 40 years old. What is not known is how effective AA is with certain subgroups, like gay men or lesbians. If feeling support and acceptance by others is a critical aspect for recovery, one might question the effectiveness of AA given the stigmas associated with being gay. There is some evidence that gay men and lesbians who participate in AA programs feel ostracism from other recovering alcoholics (Brandsma & Pattison, 1982). In particular, some lesbians resist attending AA meetings because groups tend to be male-dominated and have members who are homophobic and heterosexist (Glaus, 1989). For this reason, gay and lesbian AA groups and treatment programs have been developed. Examples of such groups include Women for Sobriety, Gay Alcoholics Anonymous, Alcoholics Together, and The PRIDE Institute. The development of special AA groups has caused some controversy among recovering alcoholics and treatment professionals because it seems to violate the philosophy and principles of AA. Perhaps the decision of which self-help group one should attend is ultimately dependent upon the client's reaction and interest. Whenever possible, it is best for the client to attend both gay and nongay meetings before making any decision (Glaus, 1989). It is also important to find meetings that are both accessible to and accommodating of people with a variety of disabilities. Unfortunately, self-help groups specifically designed to attract gays and lesbians recovering from alcoholism are not as prevalent in smaller, rural communities so clients need to be able to work within the existing system if they chose to stay involved in AA.

Throughout recovery, it is important to recognize that relapse is a part of the process. In attempting to anticipate these temporary setbacks, counselors may notice that clients begin reducing the number of AA meetings or other support groups that have been a part of their recovery plan. People who abuse alcohol may also begin to return to bars or parties because they want to socialize with other gay people and do not know of other activities in the community. Should relapse occur, it may present opportunities to examine other counseling issues that had been suppressed by alcohol use. At this point, clients may need to be referred to individual counseling or specialized groups to deal with unresolved issues of abandonment; rejection because of their sexual orientation; low self-esteem; and physical, emotional, and/or sexual abuse. In certain instances, other addictions to food, sex, or work may also serve as a way to keep these uncomfortable issues and feelings suppressed.

Communicating Acceptance to Gay and Lesbian Clients

There have been a number of suggestions made in the literature that may facilitate communicating openness to all sexual orientations. For example, intake forms should request sexual orientation information on the basis of a continuum between 0 (exclusively heterosexual) and 6 (exclusively homosexual). Forms currently used do not ask about sexual orientation, which assumes that everyone is heterosexual. Until a client discloses his or her sexual orientation, counselors cannot tell by the way the person looks, acts, or dresses (Finnegan & Cook, 1984). The use of a continuum is important because sexuality is not two dichotomous groups of heterosexual or homosexual. People who identify themselves as bisexual also need to acknowledge this to treatment personnel. Although bisexuality is not addressed in this paper, counseling issues for bisexuals are similar to those of gay and nongay people with the added stress that bisexuals often feel "caught between two worlds" and belong to neither (Lourea, 1985; Wolf, 1992). With respect to actual practice, Wolf (1992) provides a useful sexual orientation instrument that may be combined as part of other initial intake information. Such forms communicate "permission" to disclose sexual orientation in a non-threatening manner (Gonsiorek, 1982).

Substance abuse professionals need to take a thorough and careful history of the person's alcohol use (Faltz, 1992; Kus, 1990). This is to ensure that the alcoholism is not ignored because of the person's sexual orientation. Include information about significant others, living arrangement, support systems, and detailed sexual history (Finnegan & Cook, 1984). In the initial interview ask the person if he or she is "coupled" rather than "Are you married?". If the response is yes, ask "Do you live with him or her?" (Kus, 1990). Another option is to ask "Are you involved with anyone?", (Dillon, 1986) rather than "Do you have a boyfriend/girlfriend?". It is critical that the counselor assesses how the drinking problem is both affected by and separate from the client's sexual orientation (Anderson & Henderson, 1985).

Helping professionals can also keep books related to sexuality and sexual orientation issues in plain view. By doing so, it provides clients with an unspoken message that it is "safe" to discuss these issues (Finnegan & Cook, 1984). Being aware of community resources for gay and lesbian clients such as support groups, social organizations, and accepting medical and mental health professionals is also important (Fassinger, 1991; Glaus, 1988). It is essential that Counselors read the literature about working effectively with gay men and lesbians. This is no different than reading about working with clients from a different culture or faith. Talking with gay men and lesbians and getting involved in the community is another way to learn about their culture. Receiving supervision from a gay or lesbian therapist or a nongay therapist who knows about working with gay clients is another alternative (Buhrke & Douce, 1991).

Language is used by members of a culture to help define who is and who is not a member, therefore awareness of use of language is also important. By using certain words and idioms, people are "able to expose their identity to others they believe might be . . . [gay or lesbian] or accepting of them in a heterosexual context" (Lukes & Land, 1990, p. 159). Be careful to use the words "sexual orientation" rather than "sexual preference." Being gay, lesbian, or bisexual is no more a choice for people than being heterosexual. Also, use the words gay or lesbian, rather than homosexual because it has many negative connotations attached to the history of homosexuality as a mental illness (Kus, 1990). Using the word "gay men and lesbians" is more inclusive than using the word "gay" all the time. Also be aware of client language. Oftentimes clients will not use the pronouns "he" or "she" but instead will refer to people as "they" (Finnegan & Cook, 1984). Listen to what is said as well as what is not said.

It is also important for organizations to promote the hiring and acceptance of gay and lesbian staff. This is not to say that only gay people should counsel gay people. Only that acceptance of gay male and lesbian workers as well as clients is important in sending a positive image. In addition, agencies should not tolerate homophobic or heterosexist comments or behaviors in others (Finnegan & Cook, 1984).

Final Comments

If one considers that 10-15% of the general population is gay or lesbian, then this percentage should be approximately the same for people with disabilities. This estimate, however, does not include the number of people who are HIV-infected or have AIDS. While demographics are changing, at this time gay men still represent the largest number of people with AIDS (Centers for Disease Control, 1992). Based on the numbers alone, every rehabilitation professional will work with gay clients, so it is important that they be trained to provide appropriate services. Otherwise, they may further alienate gay and lesbian clients, who are in need of services, and not even know it. Rehabilitation counselors need to be tolerant of all kinds of people, regardless of their sexual orientation, disability status, race, or gender. Counselors have a responsibility to advocate for all clients, particularly people who are oppressed by society. By learning about gay and lesbian clients, rehabilitation counselors can be a part of the solution, rather than a part of the problem.

References

Allen, H. A., Peterson, J.S., & Keating, G. (1982). Attitudes of counselors toward the alcoholic. *Rehabilitation Counseling Bulletin, 25*, 162-164.

Anderson, S.C., & Henderson, D. C. (1985). Working with lesbian alcoholics. *Social Work, 5*, 518-525.

Atkinson, D.R., & Hackett, C. (1988). *Counseling non-ethnic American minorities*. Springfield, IL: Charles C. Thomas.

Bickelhaupt, E. (1990). The health history: What to look for and how to ask. In R.J. Kus (Ed.) *Keys to caring: Assisting your gay and lesbian clients* (pp. 12-18). Boston: Alyson Publications, Inc.

Brandsma, J.M., & Pattison, E.M. (1982). Homosexuality and alcoholism. In E. M. Pattison & E. Kaufman (Eds.) *Encyclopedic handbook of alcoholism* (pp. 736-741). New York: Gardner Press.

Buhrke, R.A., & Douce, L.A. (1991). Training issues for counseling psychologists in working with lesbian women and gay men. *The Counseling Psychologist, 19*, 216-234.

Campbell, H.D., Hinkle, D.O., Sandlin, P., & Moffic, H.S. (1983). A sexual minority: Homosexuality and mental health care. *American Journal of Social Psychiatry, 3*, 26-35.

Carroll, J.F.X. (1984). Substance abuse checklist: A new clinical aid for drug and/or alcohol treatment dependency. *Journal of Substance Abuse Treatment, 1*, 31-36.

Centers for Disease Control. (1992, October). *HIV/AIDS Surveillance*. Atlanta, GA: Author.

Clark, D. (1987). *The new loving someone gay: Revised and updated*. Berkley: Celestial Arts.

Colcher, R.W. (1982). Counseling the homosexual alcoholic. *Journal of Homosexuality ,7* (4), 43-51.

DeCrescenzo, T.A. (1984). Homophobia: A study of the attitudes of mental health professionals toward homosexuality. *Journal of Social Work & Human Sexuality, 2*, 115-136.

Dillon, C. (1986). Preparing college health professionals to deliver gay-affirmative services. *Journal of American College Health, 35*, 36-40.

Doweiko, H. (1993). *Concepts of chemical dependency* (2nd Ed.). Pacific Grove, CA: Brooks/Cole.

Dworkin, S.H., & Gutierrez, F.J. (1989). Introduction to special issues. Counselor be aware: Clients come in every size, shape, color, and sexual orientation. *Journal of Counseling & Development, 68*, 6-8.

Dworkin, S.H., & Gutierrez, F.J. (Eds.). (1992). *Counseling gay men and lesbians: Journey to the end of the rainbow*. Alexandria, VA: American Association for Counseling and Development.

Faltz, B.G. (1992). Counseling chemically dependent lesbians and gay men. In S.H. Dworkin & F.J. Gutierrez (Eds.) *Counseling gay men and lesbians: Journey to the end of the rainbow* (pp. 245-258). Alexandria, VA: American Association for Counseling and Development.

Fassinger, R. E. (IWI). The hidden minority: Issues and challenges in working with lesbian women and gay men. *The Counseling Psychologist, 19*, 157-176.

Finnegan, D.G., & Cook, D. (1984). Special issues affecting the treatment of gay male and lesbian alcoholics. *Alcoholism Treatment Quarterly, 1*, (3), 85-98.

Finnegan, D.G., & McNally, E. (1987). *Dual identities: Counseling chemically dependent gay men and lesbians.* Center City: Hazelden.

Finnegan, D.G., & McNally, E.B. (1989). The lonely journey: Lesbians and gay men who are co-dependent. *Alcoholism Treatment Quarterly, 6,* 121-134.

Frances, R.J., & Miller , S.I. (Eds.). (1991). *Clinical textbook of addictive disorders.* New York: Guilford Press.

Galanter, M., Castaneda, R., & Franco, H. (1991). Group therapy and self-help groups. In R.J. Frances, & S.I. Miller (Eds.), *Clinical textbook of addictive disorders.* New York: Guilford Press.

Glaus, K.O. (1988). Alcoholism, chemical dependency, and the lesbian client. *Women & Therapy, 8,* 131-144.

Gonsiorek, J. C. (1982b). An introduction to mental health issues and homosexuality. *American Behavioral Scientist, 25,* 367-384.

Gosselin, R., & Nice, S. (1987). *Lesbian and gay issues in early recovery.* Center City: Hazelden.

Graham, D.L.R., Rawlings, E.I., Halpern, H.S., & Hermes, J. (1983). Therapists' needs for training in counseling lesbians and gay men. *Professional Psychology, 15,* 482-496.

Hammersmith, S. K. (1987). A sociological approach to counseling homosexual clients and their families. *Journal of Homosexuality, 14,* 173-190.

Hellman, R.E., Stanton, M., Lee, J., Tytun, A., & Vachon, R. (1989). Treatment of homosexual alcoholics in government-funded agencies: Provider training and attitudes. *Hospital and Community Psychiatry, 40,* 1163-1168.

Herek, G.M. (1989). Hate crimes against lesbians and gay men. *American Psychologist, 44,* 948-955.

Hollerman, P.R., & Novak, A. H. (1989). Support choices and abstinence in gay/lesbian and heterosexual alcoholics. *Alcoholism Treatment Quarterly, 4,* 71-83.

Horn, J.L., Skinner, H.A., Wanberg, K., & Foster, F. M. (1984). *Alcohol dependence scale.* Toronto: Alcohol Research Foundation of Ontario

House, R. M., & Holloway, E. L. (1992). Empowering the counseling professional. In S.H. Dworkin & F. J. Gutierrez (Eds.) *Counseling gay men and lesbians: Journey to the end of the rainbow* (pp.307-323). Alexandria, VA: American Association for Counseling and Development.

Iasenza, S. (1989). Some challenges of integrating sexual orientations into counselor training and research. *Journal of Counseling & Development, 68,* 73-76.

Israelstam, S. (1986). Alcohol and drug problems of gay males and lesbians: Therapy, counseling, and prevention issues. *Journal of Drug Issues, 16,* 443-461.

Israelstam, S., & Lambert, S. (1984). Gay bars. *Journal of Drug Issues, 14,* 637-653.

Kinsey, A., Pomeroy, W., & Martin, C. (1948). *Sexual behavior of the human male.* Philadelphia: W. B. Saunders.

Kinsey, A., Pomeroy, W., Martin, C., & Gebhard, P. (1953). *Sexual behavior of the human female.* Philadelphia: W. B. Saunders.

Kus, R.J. (Ed.). (1990). *Keys to caring: Assisting your gay and lesbian clients.* Boston: Alyson, Publications, Inc.

Lawson, G.W., & Lawson, A. W. (1989). *Alcoholism and substance abuse in special populations.* Rockville: Aspen Publishers, Inc.

Lewis, C.E., Saghir, M. T., & Robins, E. (1982). Drinking patterns in homosexual and heterosexual women. *Journal of Clinical Psychiatry, 43,* 277-279.

Lourea, D. N. (1985). Psycho-social issues related to counseling bisexuals. *Journal of Homosexuality, 11,* 51-62.

Lukes, C. A., & Land, H. (1990). Biculturality and homosexuality. *Social Work, 35,* 155-161.

MacAndrew, C. (1981). What the MAC scale tells us about men alcoholics: An interpretive review. *Journal of Studies on Alcohol, 42,* 604-625.

McAllan, L.C., & Ditillo, D. (1994). *Journal of Applied Rehabilitation Counseling, 25,* 26-35.

Messing, A.E., Shoenberg, R., & Stephens, R.K. (1984). Confronting homophobia in health care settings: Guidelines for social work practice. *Journal of Social Work & Human Sexuality, 2,* 65-74.

Miller, W.R., & Marlatt, G.A. (1984). *Manual for the comprehensive drinker profile.* Odessa, FL: Psychological Assessment Resources.

Mischke, H.D., & Venneri, R.L. (1987). Reliability and validity of the MAST, Mortimer-Filkins questionnaire and CAGE in DWI assessment. *Journal of Studies in Alcohol, 48,* 492-501.

Mosbacher, D. (1988). Lesbian alcohol and substance abuse. *Psychiatric Annals, 18,* 47-50.

Nardi, P.M. (1982). Alcoholism and homosexuality: A theoretical perspective. *Journal of Homosexuality, 7,* 9-25.

Pattison, E.M., & Kaufman, E. (Eds.). (1982). *Encyclopedic handbook of alcoholism.* New York: Gardner Press.

Rochlin, M. (1982). Sexual orientation of the therapist and therapeutic effectiveness with gay clients. *Journal of Homosexuality, 8,* 21-29.

Rudolph, J. (1988). Counselors' attitudes toward homosexuality: A selective review of the literature. *Journal of Counseling & Development, 67,* 165-168.

Sha'ked, A. (1981). *Human sexuality and rehabilitation medicine: Sexual functioning following spinal cord injury.* Baltimore: Williams & Wilkins.

Small, J., & Leach, B. (1977). Counseling homosexual alcoholics. *Journal of Studies on Alcohol, 38,* 2077-2086.

Stein, T.S. (1988). Theoretical considerations in psychotherapy with gay men and lesbians. *Journal of Homosexuality, 15,* 75-95.

Tievsky, D.L. (1988). Homosexual clients and homophobic social workers. *Journal of Independent Social Work, 2,* 51-62.

Trieschmann, R.B. (1980). *Spinal cord injury: Psychological, social, and vocational adjustment.* New York: Pergamon Press, Inc.

Wolf, T.J. (1992). Bisexuality: A counseling perspective. In S.H. Dworkin & F.J. Gutierrez (Eds.), *Counseling gay men and lesbians: Journey to the end of the rainbow* (pp.175-187). Alexandria, VA: American Association for Counseling and Development.

Ziebold, T.0. (1979). *Alcoholism and the gay community.* Washington DC: Blade Communications, Inc.

Received: April 1993
Revised: June 1993
Accepted: July 1993