GRAPPLING WITH SEXUALITY in a Women's Recovery House: My Own and My Agency's Journey

Confronting and working with both same-sex and opposite-sex intimacy issues in a residential women's chemical dependency recovery agency setting can be fraught with difficulty. This article describes my own journey and that of my agency as we explored and improved our capacity for providing respectful recovery services which recognized and worked with women's individual sexuality issues.

by Elizabeth Twining Blue

Elizabeth Twining Blue is Assistant Professor of Social Work, Department of Social Work, University of Wisconsin, Superior, WI

For five years, from 1984 through 1989, I was the director of a halfway house for chemically dependent women, located in a small urban area in northern Minnesota. During this time, in the chemical depend-ency field there was a growing concern about how sexual behavior and sexuality impacted recovery and relapse. Increasingly, chemical dependency professionals had begun to address client sexuality as part of recovery planning and services. However, in our locale this openness did not, as a rule, extend to frankness and sensitivity in treating gay and lesbian issues. As an agency and as a staff, the "hottest," most provocative challenge we faced was how to work with the full range of women's sexuality as part of the overall recovery process.

Sexuality was an issue about which residents were often confused and in pain, about which our staff had varying degrees of comfort, about which many persons in the local sober community had strong opinions, and about which the halfway house was under intense scrutiny. I came into the position as director, with my own set of values and emotional and social blinders. As it turned out, the process of personal and professional growth we all went through at that time was one of the most intense, far-reaching and rewarding ones I have experienced.

During the process, our staff was consumed with "uncovering, discovering, and discarding" those things in our responses to sexuality that were unhelpful and/or harmful to the women and to one another. It was not until I was leaving the agency that I was able to reflect adequately on the entire process.

I was asked in the fall of 1989 to make a presentation at a state-wide women's recovery conference. By agreeing to discuss my own and the agency's experience with this issue, I had to reflect upon those events in a fashion that would allow me to talk about them to people who had not gone through the process with us. When I hung up the phone after agreeing to give the address, I got scared, really scared. I had just volunteered to talk about a process that was not just my story, that had undergone a painful and frightening evolution, about which I still felt some personal vulnerability.

The story was a personal and organizational chronicle of the agency's struggle to respond

to client sexuality issues, especially those related to lesbians. As a staff and an agency, we emerged from a complicated challenge, able to work with sexuality as a recovery issue.

Imagine that you are about to start a new supervisory position in a women's recovery agency. You are excited, full of anticipation and energy. You have feelings of trepidation because there have been serious problems about which you are unclear. On the plus side, you inherited an experienced and dynamic staff, and have support from the executive director and board.

During the first week, you and the experienced staff look over the program, and get to know one another. You begin to get a clearer picture of the problems. An experienced staff person has been singled out by people in the recovering community because she is a lesbian. She feels personally attacked and unappreciated for her considerable contributions to the agency and wonders what working with you will be like. You tell her that you are prepared to deal with public perceptions and concerns about the agency and that your expectation is that she continue to do her job.

During your second week, a board member tells you that you should fire this staff person because she is a lesbian. A community volunteer comes into your office and picks up a picture of you with a male friend and says, "Oh good, you have a boyfriend." Several people go out of their way to tell you about your new agency's "lesbian" image and ask you what you are going to do about it. Another chemical dependency professional complains that the agency sponsors a sexuality group for clients and that "a lesbian is leading the group."

I was angry, threatened and afraid, and imagined all sorts of catastrophes arising from this scenario. This fantasy was my initial reality when taking on the directorship of this women's recovery home.

My first response was to appoint myself the agency heterosexual. In that role, whenever anyone pointed to us and said, "Lesbians!!!!" I essentially said, "No, she just works for me; I'm straight." I put on the heterosexual hat and spoke for us all. Whenever a client reacted homophobically to staff or another resident, I said both behaviorally and verbally, "Follow my lead. You don't have to approve to accept. It'll be all right I'm here to keep the faith." This response, driven by fear, was supported by my own ignorance and lack of awareness. I was saying to the community that my "clean" skirt could cover us all. This reaction gave the impression to a critical community that I was really one of them and was making the best of a bad situation.

My fears were constant. On a daily basis, I was terrified that the house would be shut down by community disapproval. The house had been closed for some months before I came. Community perception was that it was closed because of the lesbians, and this perception was a concern to my supervisor and others. However, a host of dynamics had interacted to produce the closing. One recovering staff person had relapsed; one former staff person had kept this secret, and a current staff member had been kept in the dark about it. Referral sources found that our intake process required too much background material and too much time for pre-placement visits. Thus, they sent fewer prospective clients and the census dropped. Further, of those clients accepted, many were young residents who established a pattern of running away in groups.

In hindsight, I have come to believe that some of the low census and negative community press was the result of the our agency being oppressed and "punished" by the larger community for being a staff of assertive women, for daring to respond to female sexuality as a recovery issue, and, most of all, for having a counseling staff of both heterosexual and openly lesbian women. During my tenure as director, frequently there were more lesbians than non-lesbians on staff. Our besetting sin, as I now see it, was that we, especially me , became apologetic and defensive about what we were doing out of fear of the community's response. I operated out of a mixture of my own homophobic fear and a false sense of responsibility for

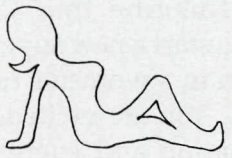
"saving" the house. Much of my energy was spent defending something that wasn't wrong and didn't need defending.

Our agency staff (including me) and the clients spent much "air time" preoccupied with both our own and other people's homophobia. This, in turn, served as an effective diversion that interfered with client exploration of intimacy issues related to recovery. When members of the staff and residents spent serious amounts of time reacting to someone's sexual identity or to someone else's reaction, that interrupted and delayed the healing clients needed to do to support their recovery: facing feelings about being a woman; examining how to establish, conduct and maintain relationships; and addressing needed changes in sexual and intimate behavior. Keeping homophobia stirred up, alive and unsettled, blocked our agency in its efforts to assist all women in all areas of recovery.

Early on, I was told by various lesbians I knew that, if we continued to accept community perceptions and expectations as gospel, we would stay in a defensive mode. I realized this truth later. I remember the sense of em-powerment I experienced when the executive director and I finally agreed to treat this unfounded story like the gossip it was; it was not deserving of our energy and attention. Previously, reacting and over-reacting had had the effect of making rumors and innuendo loom larger. Slowly, I began to see that community perceptions could be corrected, if we responded thoughtfully and openly, and not reacting defensively. When, with the support and encouragement of staff, I refused to treat sexual orientation issues as if they were shameful secrets, something interesting occurred. We experienced more calm as a staff, there was less oppositional noise from the community, and referral sources stayed with us. It became part of my normal practice to share potentially explosive issues with the executive director, he was then able to support our program and to defuse gossip brought to his attention by "well-meaning" folk in the community. Each time community perceptions or expectations became an issue, I had to repeat this process of deciding not to react or defend.

As an agency, we implemented measures to minimize future invectives and to maximize communication with potential referral sources and clients. I asked area treatment centers to let me come to talk about what occurred at a women's halfway house and what the experience was like for the women who lived there. I began to lecture monthly throughout the region. I deliberately exposed myths and misinformation about women's recovery experience in this kind of a setting. I talked about the house being a safe place for lesbians and straight women, and said that both heterosexual and lesbians lived and worked at the house. My talks at local treatment centers increased our visibility as a house; more importantly, it provided the opportunity to give an accurate and positive picture of the halfway house experience.

In residential programs



there is a kind of enforced intimacy because residents go through programs in cohorts, sharing limited space, having only a relatively brief stay that can be counted in weeks or a few short months, and living close to one another's experiences. Sorting out intimacy issues is often a priority for recovering people because intimacy had been so disrupted in the past; and relationship-building is a powerful tool to use for the recovery process. The house became a microcosm of the world outside its door, but the experience was intensified and compressed. Discussion and decision-making about sexuality and sexual identity in this atmosphere required that staff be prepared to interact personally with the women, and assist the women in negotiating their interpersonal relationships with one another. In a house of women, staffed by women, we encountered the sexual issues of when, with whom, and how safe. The discussions and situations involving lesbians generated the greatest heat.

We decided early on that we needed to define and announce boundaries between staff and residents, staff and ex-

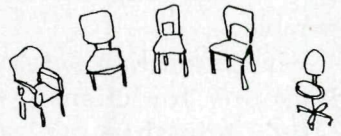
residents, and among residents. Many revised policies and procedures came out of this decision. The first was called the "Staff-Resident/Ex-Resident Boundary Policy;" it laid out the policy that staff would not be buddies, twelve step program sponsors, landlords, or have other such personal relationships wearing confusing "hats." The policy was a starting point for discussions about how the women could best get their needs met by expanding their relationships and learning new self-care skills. While not directly addressing sexuality, it was an important first step. The policy also served to reassure the community that appropriate boundaries were being maintained between staff and residents.

The new policies said that there would be: a) no using of mind-altering drugs, b) no violence, and c) no sexual involvement with other women in the house while living at the house. While a number of potential residents were taken aback by this frankness, and some decided not to enter the house, many residents let us know that these limits increased their sense of safety. We outlined grievance procedures and clients' rights and stated boundaries and expectations about sexual and other behaviors. For example, if a resident hid a weapon in her room or on her person, she was discharged. While non-sexual physical expressions of affection were encouraged, sexual fondling was grounds for referral or discharge.

The first severe test of the campaign for openness came when I received a call from a referral source intimating that we had a staff person sexually involved with a resident. After conducting an investigation, the executive director and I dismissed the staff person for modeling and maintaining inappropriate boundaries with a client. Residents were kept informed as to what was alleged, what our response had been, and what actually transpired. Even though a few residents left, we followed through with agency standards while leaving a positive impression. I responded to questions from the referral source without discussing specific staff or resident information. At inservice training sessions delivered to programs in the immediate area, I also announced we had a staff change. I told them what had been alleged and what our response had been. This served to inform them of our process, and to halt gossip before it had expanded exponentially.

Our staff had differences of opinion about intimacy issues. We defined intimacy differently based on our personal histories and cultures. In response, during the first year, we initiated staff development groups to clarify our thinking. We brought in an outside therapist to facilitate our groups. It became the norm that whenever there was an internal staff crisis, we would bring in a therapist — women from a local mental health clinic, with strong feminist ideals, and group process experience. We used the group to confront intimacy issues, to express personal and professional concerns, and to open communication. As a result, we created the expectation that crises would not be avoided and differences would not be buried.

As the organization grew more complex, we met monthly.



Any staff behavior which might impact or interfere with client recovery or staff boundaries, was discussed and resolved through compromise and negotiation. Using these facilitated groups and practicing direct communication in regular staff meetings allowed staff members to confront a misguided sense of responsibility for one another's and clients' behaviors; we celebrated the coming out of a lesbian staff person and shared her evolution through that experience. We established when and under what circumstances we shared our personal experiences about sexuality, with one another and with the women in the house. We confronted one another on heterosexist thinking and on overreacting and feeding homo-phobic reactions in clients.

Facing the challenge of acknowledging clients as sexual beings, we developed a house philosophy about how to respond to sexual concerns and behaviors. Sexual attraction and feelings were normal elements of the recovery process, so the fact of sexual attraction was to be

treated with calm and honesty, regardless of whether it involved same-sex or opposite-sex relationships. Getting the staff to do this was not the problem; my own commitment and follow-through had been the biggest obstacle. Stepping out from behind my role and into that group arena was frightening. I felt exposed and vulnerable.

In counseling sessions and groups for clients, we selected non-shaming approaches to address intimacy issues and sexual acting out. Exercises and approaches were designed to help the women establish positive personal identities and focused on teaching them how to be intimate in healthy ways with other women. Many of the women entered the house mistrusting and competing with other women. Quite often we learned that the women had grown up in alcoholic and/or drug abusing families where appropriate gender and sexual role modeling was missing. Large numbers of the women had experienced sexual violation at the hands of family members, long-term partners, and casual sexual partners. Some had been abusive themselves to the men, women, or children in their lives during their drinking or drug using periods. We wanted them to learn how to deal with intimacy in its myriad forms, for example, to learn that genital intimacy, albeit important, was only one of many intimacies. Our goal was to make it possible for them to discover non-sexual intimacy with other women in jointly completing tasks, expressing feelings, enjoying activities together, and sharing confidences.

One approach the therapist used with staff groups was art, such as mask-making. Each woman helped another to make a plaster strip mask of her own face and decorate them. Women were invited but not required to participate. It was a means for sharing non-sexual intimate activity and non-sexual loving touch. Another such activity was the bag exercise: women cut out pictures and sayings from various printed media or drew something of their own and placed them inside the bag; some were made into a collage on the outside of the bag. This activity fostered self-clarification about how they saw themselves inside, which was only shared with the group if they wished. The outside represented how they presented themselves to others; explaining the outside collage opened avenues of mutual questioning and communication. They examined their own congruence by comparing the insides and outsides; the exercise also aided them in surfacing hidden issues with others when they were ready to do so.

In groups counselors employed non-verbal exercises like "sculpting power" and other relationship dynamics. Exercises in mutual problem-solving and role rehearsal prepared the women to resolve situations they might encounter in and out of the house. The women were also encouraged to identify and express what they observed about relationships with one another. In doing this, they learned to trust their own perceptions.

Both in and out of client groups, when there was sexual energy and attraction between clients, it was acknowledged and solutions were tried. We did not give the women permission to behave in an overtly sexual way with one another. Women who tried to establish exclusive relationships were required to spend time separately from one another, learning to include other people in their lives. If they persisted in unhealthy exclusivity or in pursuing one another sexually, we discharged and/or referred them elsewhere. When two women in the house had sexual energy between them, it was not treated as if it were a "secret" to be stuffed away or ignored. Rather, we supported each woman in finding appropriate ways to work out how she felt, without acting it out. We learned that, we had to discharge and/or refer women who did become sexually active with one another while living in the house. We found that once that leap had been made in a relationship, it indelibly affected the entire group. Its effects on the women involved and the others with whom they lived could not be undone.

The women in the house reacted when two women fell in love or became sexually involved. Reactions usually ran the gamut from disgust to extreme anxiety. The house was supposed to offer a safe place; safety was a big issue because of the abuse, neglect, and

abandonment many had experienced before they entered recovery. In addition, a good many of these women had acted out sexually as part of their drug using careers, for example: prostitution for money or drugs or acceptance; multiple sexual partners; and group sexual activity. Many women looked at their recoveries as a second chance, a sexual time out, a once-in-a-lifetime opportunity to explore, disclose, and be vulnerable. For some women, the falling-in-love situation caught at their own uncertainties about sexual identity, safety, and lack of personal boundaries. If a woman had been victimized during her drinking or drug using career, it called up the fear of being re-victimized, only this time by women.

Some women that had sexual experiences with other women when they were drinking or using drugs had unsettled thoughts and feelings about this previous behavior. Did this mean they were lesbians-in-waiting? For some women, this concern was exacerbated by their homophobia, confirming stereotypes they held about lesbians and lesbian relationships. Would this make them vulnerable to being "preyed upon" by other women in the house, they worried. Other women were jealous of the exclusivity of the intimate relationship between two peers. They felt shut out and, sometimes angry because they could not "compete" fairly if unwilling to be sexual themselves. The disgust reaction was attributed by many of them to the values instilled in them during their childhoods. This was a very religious part of the country. Same-sex behavior went against everything they had been taught by their families and churches.

When there was sexual or romantic energy between a client and staff person, that, too, was acknowledged and diffused. Sometimes it was as simple as

calling the energy by its proper name and by having the staff person clarify with the resident what the actual relationship and boundaries were. Sometimes a resident was reassigned to another staff person. On one occasion, when the energy was mutual and obvious, it was acknowledged, and boundaries and expectations were clearly defined and followed by all parties.

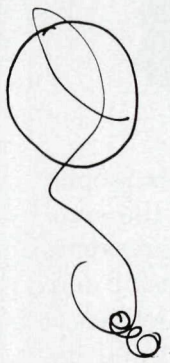
Not all of this openness was conducted easily and with sweetness and light. We were very concerned with how sexual matters were perceived and at times twisted by the women; for many of them, having a safe opportunity to identify and work on a sexuality issue was necessary to achieve and maintain recovery. I think that people who work with recovering addicts and alcoholics delude themselves if they think that sexual thinking and behavior somehow take a sabbatical while clients are in residence in a facility. More often than not, whatever the dynamic in the house, the women and their grapevine had possession of it long before the staff; it had usually been chewed over and distorted by the time we came into the equation. In addition, every woman came into the house with her own world view, experiences, and values regarding sexuality. As candid and genuine as we tried to be, some women probably did not believe or trust us. I also believe that, however disturbing and frightening it was for staff to be forthright and authentic in matters sexual within the house milieu, it was many times more difficult for residents. As staff, we were open with them because not doing so created worse difficulties. At one point, I underwent a confrontation that was a personal milestone for me. A lesbian resident told me how my assumptions about her sexuality had affected her. She took the risk of telling me how she experienced my hetero-sexism and homophobia while living in the house. It was difficult for me to understand and hear her. I operated from a "self-centric" perspective where, if I didn't "get" it, then it was not a genuine problem. I screened other people's reality through my assumptions and defenses, or not at all. This was especially true if I were struggle to come out and be true to

herself. She did not feel safe to be real with me.

I was very ashamed because I was raised cross-culturally and knew something of being defined as "other." Thus, I had prided myself on my acceptance of others. However, my version of acceptance in this instance was bounded by my ignorance, my unintended and unconscious judgments, and my lack of bona fide openness to dialog. My mind, rooted in heterosexist thinking, did not change rapidly. However, once I could see the negative effect on someone else I valued, I changed. As the director and supervisor, my attitudes and assumptions bled through to the house population to which they reacted. Discovering that I could be so righteously blind appalled me and provided me with a powerful impetus to change. Every step of the way, I had to break down my own defenses, develop new understandings of situations, learn new behavior, and rehearse it until it became mine.

The decision our agency made to quit being defensive and ultra careful not to offend the sensibilities of homophobic residents and community people was a wise one. No matter how "nice" or "careful" or "sensitive" we were, we and the women we served were the ones who had continued to pay a price. However, our decision was more easily made than actually accomplished. Lesbian staff people continued at times to feel attacked and unsafe. As a house, we had spent a lot of time giving people the opportunity to air their homophobia and their attendant feelings, and in the process, the homophobic fears had somehow been given more expression, and thus, more validity.

Rather than forbidding dating, we eventually decided that the women needed encouragement to talk honestly about relationships and we no longer pretended that they didn't enter them. We allowed women to date people who were not members of the household after an initial orientation period. When restrictions were placed on relationships, they were made in terms of the woman's individual history and vulnerability around issues like sexual abuse and being male- or female-de-pendent. Permission to date, for example, was not necessarily an issue of longevity in the house; it was an issue of personal choice, fit, and priorities. We expected them to take re-sponsibility for the conse- quences of their sexual and intimate behaviors. We taught them that it wasn't a matter of us telling them what they could and couldn't do, so much as it was about them learning to live with the consequences if they did harmful things to themselves in pursuing relationships. We reflected their patterns and our concerns back to them. We were clear when we did not support a behavior, but did not attempt to control or restrict unless we saw the situation as life-threatening.



In our interviews of prospective staff, we asked tough questions about intimacy and attitudes on promiscuity and sexual orientation. We encouraged staff to take inservice training on intimacy issues of all kinds.

As an organization, we had to work from the inside out to find some of these solutions. We were aided in this by several factors. We had a supportive executive director. As a supervisor, I was a team player. While the overall agency had a hierarchical structure, the women's program was a team, working from a collegial model. Our team had a coherent, agreed-upon treatment philosophy to center our efforts.

As an organization, we had to work from the inside out in order to find some of these solutions. We were aided in this by several factors: We had a supportive executive director, and I was a team player. While the overall agency operated in a hierarchical structure, the women's program was a team working from a collegial model, with a coherent, agreed-upon treatment philosophy to center our efforts. We utilized the principles of Alcoholics Anonymous and a philosophy related to the unique aspects of women's intepersonal and growth processes. We had balance in age and sexual orientation and almost all staff had long-term sobriety and a commitment to our process. Each staff person, in the final analysis, was willing to do her own personal, self-reflective work as she went through this process. This meant

anything from self-inventorying to seeking out additional support in therapy.

Stability was another supporting factor. Because we were also a long-term residential setting (women were in residence six to nine months), we had the time and opportunity to work on deeply rooted issues. Throughout this five-year period, we had relatively little staff turnover. Finally, we had fine local women's resources available, and created a budget to support the process.

As I looked back on this five year experience, I did some serious personal soul-searching around dealing with sexuality within the agency. To my surprise, I discovered new feelings related to the entire experience which I had buried at a deeper level, new feelings. I felt exposed, vulnerable, and resentful that I had to learn and practice sensitivity about other people's sexuality; I felt resentful that I had been put in a position where I had to examine my intimacy issues, which I believed were no one's business but my own; I felt resentful because I seemed to be the token non-lesbian in certain situations; I felt resentful because I sometimes felt outnumbered and scapegoated; I felt resentful that I couldn't "belong" and was, at some level, always on the outside; I felt resentful that I had to check myself to see if I was being "correct;" I felt resentful at living in a recovering community fishbowl and being vulnerable to others' opinions.

When this pain about my resentment sank in, I had a powerful insight — lesbian women and women of color in this society have to contend on a daily basis with this type of pain, fear, and resentment from being marginalized.

In retrospect, I am grateful for having had to deal with sexuality as an agency issue. I appreciate the diversity in my life, and see what an asset being "different" can be. I was and am grateful to the lesbians who took the time to invest, teach, and bear with me. Out of their risking, I gained tremendous experience in exploring and establishing my professional limits and boundaries. I now know that I am able to stand behind and for something I believe in, not just give it lip service.

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