LESBIANS' EXPERIENCES WITH ALCOHOL PROBLEMS: A CRITICAL ETHNOGRAPHIC STUDY OF PROBLEMATIZATION, HELPSEEKING AND RECOVERY PATTERNS

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Joanne M. Hall

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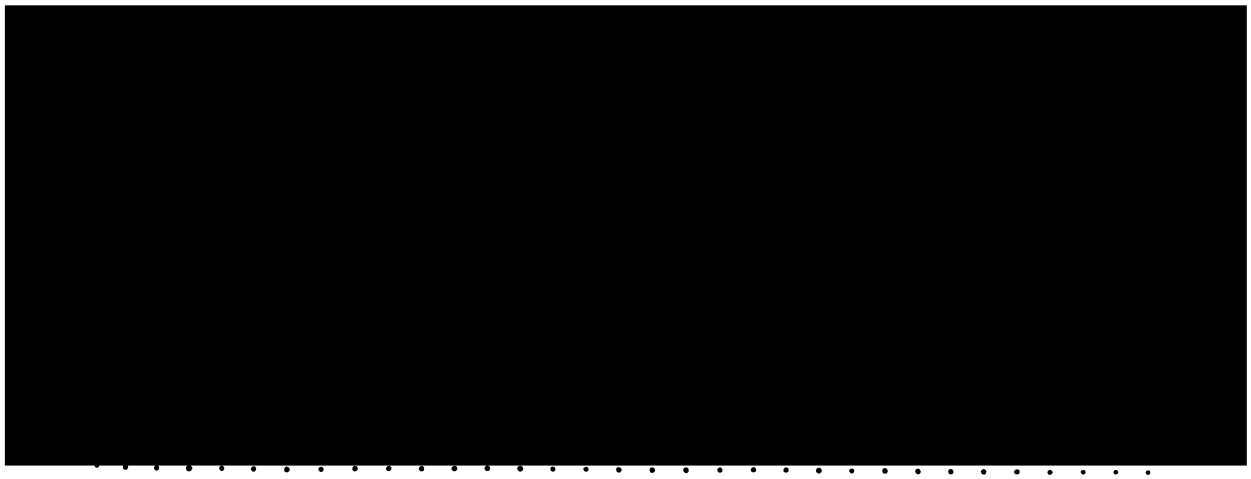

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Abstract

There is evidence that lesbians have greater incidence of alcohol problems, and are collectively moving away from alcohol use. Discrimination based on gender, sexual orientation, class and race complicate recovery for lesbians with alcohol problems. This critical ethnographic study addresses how lesbians identify alcohol problems, seek help and describe health care interactions related to alcohol problems. It also provides descriptions of lesbians' images of recovery and their personal and collective experiences in twelve-step mutual help groups such as Alcoholics Anonymous.

A racially and socioeconomically diverse group of 35 self-identified San Francisco area lesbians recovering from alcohol problems volunteered for participation in indepth interviews. The interview data was examined through narrative analysis, matrix analysis and ethnographic coding. The findings indicate that problematization is ongoing, and includes identification of problems other than alcohol. A conceptual model of the problematization process is developed that emphasizes relationships among alcohol problem construction, interaction, action, validation and reconstruction. Accounts are differentiated on the basis of whether alcohol problems are perceived to be circumscribed or pervasive in the women's lives.

Helpseeking and health care needs are identified, including safety and validation in health care and treatment contexts, and attention to multiple addictive problems, aftereffects of childhood trauma and adolescence as a critical transition for lesbians. Six dimensions of safety in health care interactions are described: client/provider conceptual compatibility, providers' preparedness to interact with lesbians, respect for boundaries, emotional climate, provider persuasiveness strategies and group dynamics. Images used by lesbian participants to describe their recovery experiences include, in order of their prominence, connecting, reclaiming self, empowerment, struggle with compulsivity, personal growth, vocational change, social transition, cycles/celebration, physical transition and conversion. Twelve-step mutual help groups are an important though controversial part of recovery for lesbians; three dialectical tensions are identified: assimilation/differentiation, authority/automony and false consciousness/politicization.

Conclusions and implications for practice and research are guided by the concept of marginalization. Experiences of those living at the periphery of society not only differentiate them from those at the center, but from other marginalized persons, making standardized health care approaches to lesbians and others who are multiply stigmatized inappropriate.

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Alcohol problems among lesbians are said to be more prevalent and more severe than those seen in the general population. The rate of alcohol problem incidence in lesbians has been estimated at 30%, three times higher than the incidence in U.S. women as a whole (Burke, 1982; Cantu, 1985; EMT Associates, 1991; Fifield, Latham & Phillips, 1977; Hastings, 1982; Hepburn & Gutierrez, 1988; Lewis, Saghir & Robins, 1982; McKirnan & Peterson, 1989a; 1989b; McNally, 1989; Morales & Graves, 1983; Nicoloff & Stiglitz, 1987; Raymond, 1988; Saghir & Robins, 1973; Schilit, Clark & Shallenberger, 1988; Weathers, 1980). Lesbians attempt suicide seven times more often than heterosexual comparison groups and often alcohol problems are a factor (Saunders & Valente, 1987). People with alcohol problems have twenty times the suicide incidence seen in the general population (Goodwin, 1973). Rates of suicide completion in alcoholic women are higher than in both nonalcoholic women and alcoholic men (Curlee, 1970; Dahlgren & Myrhed, 1977; Rimmer, Pitts, Reich & Winokur, 1971).

There is evidence that, in addition to being susceptible to alcohol problems, lesbians are especially prone to be critical of their alcohol use (Bradford & Ryan, 1988). Lesbian communities are currently on the cutting edge of a generalized cultural trend away from substance use (Room, 1988). Lesbian communities have been in dialogue about alcohol use and recovery from alcohol problems for the past two decades. Association of substance use with internalized oppression, sexism and ghettoization in the lesbian bar subculture have galvanized lesbian communities to reject alcohol use (Hall, in review). Twelve-step mutual

help programs have become increasingly prevalent within lesbian communities, meeting needs for affiliation, privacy, safety, socialization and spiritual expression (Hall, 1990b; Herman, 1988). The value of these programs remains a source of debate among lesbians, however (Saulnier, 1991). In short, there has been a transition in values within many lesbian communities and a consequent movement away from alcohol-centered socialization to abstinence from alcohol and participation in a recovery subculture. How and why this has occurred has not been fully explored. Understanding community level changes in special populations has implications for understanding health promotion in general and the critical psychosocial mechanisms undergirding it, a priority in nursing research (Hinshaw, Heinrich & Bloch, 1988). Lesbians with alcohol problems comprise one such special population, in view of their health vulnerabilities and the lack of research about the dynamics of alcohol problems in this subcultural group.

The total direct and indirect costs of alcohol abuse in the United States are more than six billion dollars annually (U.S. Department of Health and Human Services, 1983), to say nothing of the toll in terms of human suffering and alienation. In a society perennially engaged in a "war on drugs" (Szasz, 1985), the characteristic patterns of onset and recovery from drug and alcohol problems in specific groups are relatively unknown. Recovery from alcohol problems has a comprehensive, longitudinal quality because addictive behaviors are not discretely separable from persons' views of themselves and the totality of their experience (Naegle, 1988; Saleebey, 1986; Sarbin & Nucci, 1973). Nurse scientists are well suited to develop knowledge about recovery from alcohol problems because of the profession's holistic philosophy, focus

on human responses across the lifespan, and interest in health transitions and longterm care (Chick & Meleis, 1986; Fawcett, 1978), however, relatively little nursing scholarship has been devoted to this field (Murphy, 1988).

Lesbians With Alcohol Problems: A Vulnerable Group

Understanding the health needs of vulnerable groups, such as lesbians, is an investigative priority (American Academy of Nursing, 1992; ANA Cabinet on Nursing Research, 1985; Oberst, 1986; U.S. DHHS, 1990; Woods, 1992). Nurses have recently taken an active role in establishing standards of nursing care in the addictions field (ANA, 1988; Nelson, 1989). They have not, however, reached a consensus about their role relative to the health needs of lesbians with alcohol problems. This study attempts to expand nursing knowledge by focusing specifically on lesbians' alcohol problems, so that eventually culturally competent care (Meleis, 1992) will be accessible for this vulnerable group.

Lesbian identity is a social construction that has evolved to designate women whose primary sexual orientation is toward other women (Kitzinger, 1987). Lesbians share a subculture of collective meanings, traditions and beliefs which are embedded in lesbians' experiences. These experiences are framed in various contexts of lesbian life: (a) arts, such as music, poetry and literature; (b) gathering places, such as lesbian bars and coffeehouses; (c) historical events, such as protests, persecutions, legislative changes; and (d) interactions, such as affectional relationships, friendship networks, celebrations, and collective organizing. Lesbian subculture reflects diversity in members' personal, regional and historical experiences. While lesbian

subcultural practices and beliefs provide a viable basis for defining the lesbian aggregate, there are women who identify themselves as lesbians but are not actively involved in this subculture, who live fairly covertly within the heterosexually-dominated milieu.

Lesbians face excessive demands in their daily lives because of societal prejudices, lack of legal and institutional protections, social isolation and rejection by family members (Bayer, 1987; Hudson & Ricketts, 1980; Millham & Weinberger, 1977; Stevens & Hall, 1991). These pressures are multiplied for lesbians of color, low-income lesbians, lesbian mothers and differently-abled lesbians (Moraga & Anzaldua, 1981; Morgen, 1989; B. Smith, 1983). Moreover, lesbians find it difficult to obtain culturally competent assistance in most current health care contexts (Stevens & Hall, 1988; 1990; Stevens, 1992). The experiential distance between lesbians and health care institutions remains substantial, resulting in continued ignorance and bias on the part of providers, and ever greater health risks to lesbians.

Lesbians face a great deal of societal stigma (Goffman, 1963; Jones, et al., 1984; Stevens & Hall, 1988). Women who have alcohol problems are also highly stigmatized (Ridlon, 1988). Nurses and other health care providers regularly demonstrate negatively stereotyped responses toward clients with alcohol problems (Kilty, 1975; O'Leary, Donovan, Chaney & O'Leary, 1979; Roth, 1986; Sullivan & Hale, 1987; Wallston, Wallston & DeVellis, 1976). Lesbian problem drinkers potentially face compounded stigmatization, that can pose difficulties in recognizing the problem, feeling safe in seeking health care and maintaining a positive self-image in the recovery process (Hall, 1990a; Hall, 1990b; Johnson & Palermo, 1984; Stevens & Hall, 1988; Szasz, 1970;

Ziebold, 1979). Nurses interact with clients at crucial turning points in their lives, including the transition from alcohol problems into recovery. With adequate knowledge and genuine compassion for clients, they can be destigmatizers (Jack, 1989; Volinn, 1983) who communicate to lesbian clients that they are valued and understood. Studies like the one reported here are imperative for the success of such efforts.

Purposes of the Study

The purposes of the study were to understand and describe the processes of identifying alcohol problems, helpseeking, and recovery from the viewpoint of lesbians who are in alcohol recovery. The overall goals were to: (a) provide rich ethnographic descriptions of alcohol problems and recovery from the perspectives of a diverse group of lesbians, (b) describe the specific needs of lesbians with alcohol problems, and (c) suggest changes in policy and practice to more effectively address alcohol problems in the lesbian population. Interpretive and critical perspectives were joined to accomplish this critical ethnographic study.

Health was conceptualized as having emancipatory dimensions (Allen, 1986b; Illich, 1976; Newman, 1986; Stevens & Hall, 1992). Recovery from alcohol problems was conceptualized as associated with greater freedom (Denzin, 1987; Navarro, 1986). The term "alcoholism," which refers to an individualistic, progressive, physiological disease entity characterized by uncontrolled drinking (Brown, 1969; Jellinek, 1960; Keller, 1972), was eschewed as exclusionary and potentially exploitive (Stein, 1990). The term "alcohol problems" was adopted because it is more inclusive, can refer to individual, relational and/or collective phenomena and is relatively free of moralistic overtones

(Cahalan, 1970; Room, 1983; 1984). In this study, alcohol problems were defined as consequences of alcohol use that are disruptive to the self, one's interpersonal relationships, one's chances for health and survival or the health of one's community.

The term "recovery" carries the explicit meaning of a period following illness or trauma. "Recovery" has broader implicit meanings in its use in people's daily lives, however. Aided by the rhetoric of twelve-step mutual help groups and the women's movement's emphasis on self-deterministic and alternative healing methods, the term recovery has developed a lay currency in reference to alcohol problems. Meanings of recovery are constructed by: (a) personal experience; (b) structural factors such as economics, gender and race; (c) cultural images; (d) social networks and (e) organizations invested in the recovery process, such as churches, Alcoholics Anonymous (AA), and treatment facilities.

In this study, recovery from alcohol problems was viewed as including recovery from other concurrent or emergent addictive problems. In this sense, recovery is movement away from compulsive behaviors, such as excessive drinking, overeating, street or prescription drug abuse, eating disorders and overspending. Recovery was also conceptualized as a movement toward personal growth, self-understanding and meaningful relationships. In this broader view, recovery refers to interrelated healing processes and the daily sociocultural experiential impact these processes have on individuals.

Significance of the Study

Lesbian subculture can be a significant source of information about women's health in general, particularly related to self-recognition of, helpseeking for and recovery from alcohol problems.

This study provides knowledge about lesbians' experiences with alcohol problems and recovery, and also offers theoretical development of major nursing concepts including person, health, environment, transition, vulnerability and recovery.

The ways that individuals identify problems in their use of alcohol has not previously been explored qualitatively. This study provides insight about the interactive processes involved in deciding that one's use of alcohol is a problem. Recovery has been described as multidimensional (Tomko, 1988), yet the specific qualities and characteristics of recovery are not well understood. Women's longterm recovery from alcohol problems is virtually an unexplored area. This study fills these gaps. It accesses images persons use to frame their recovery experiences, providing insight about recovery as a reconceptualizing process.

The researcher approached lesbians' experiences with alcohol problems and recovery in their diversity, considering individual, ethnic/racial, economic and historical differences. She contextualized these experiences within the larger historical/cultural environment and articulated collective themes. This critical ethnographic study contributes not only to the knowledge base regarding womens' alcohol problems, but to lesbian communities' efforts to understand their own collective experiences regarding alcohol practices, problems and recovery. The research also contributes to the empowerment of lesbians who have problems with alcohol by giving voice to their struggles and successes.

CHAPTER 2

THEORETICAL BACKGROUND AND REVIEW OF LITERATURE

Theoretical Framework

The theoretical framework for this study joins two compatible but distinct perspectives, interpretive and critical. An interpretive perspective focuses on meanings in interaction. A critical perspective refers to scholarship based on demystification: questioning things as they are, revealing oppressive power relations and analyzing historical processes in order to better understand current problems. Feminism, one of many critical perspectives, focuses on gender as a point of oppression in women's lives. In joining interpretive and critical perspectives in this study, the most inclusive feminist principles are relied upon. That is, social stratification based on gender, race, socioeconomic circumstances and sexual orientation are all reckoned with as potential sources of oppression in women's lives.

The diversity of alcohol-related experiences among lesbians is best appreciated by combining an understanding of individuals' daily interactional experiences with knowledge of relevant historical, cultural and political influences. Stigmatizing experiences based on gender, race, class, sexual orientation and illness represent meaning systems operating at the levels of personal experience, ideology and social structure (Allen & Wolfgram, 1988). The conflicts and discontinuities among these meaning systems are only partially attributable to individual factors, and create tensions which affect individual health behaviors, including alcohol use. Combining interpretive study of meanings of individuals' interactional experiences with critical demystification of oppressive social, economic, and

political environments lends itself to the study of health-related phenomena in multiply-stigmatized subcultural groups of women (Allen, 1985; Anderson, 1990; MacPherson, 1983; Silva & Rothbart, 1986; Stevens & Hall, 1992; West, 1990). Interpretive studies that include the critical elements of history and culture are also consistent with the process-focused, holistic nature of nursing (Benner, 1985).

Interpretive Perspective

The interpretive perspective developed in response to positivism's failure to build an adequate science of human beings (Benner, 1985; Clifford, 1986; Denzin, 1983; Harding, 1987; Holter, 1988; R. Klein, 1983; Reinharz, 1983; Smith, 1979). Interpretive methodologies attend to personal experience, or subjectivity, avoiding the reification, or "objectification," of those under study (Christman, 1988; Oakley, 1981). Rather than assuming that there is a single, scientific "truth," multiple realities are assumed and validated.

Symbolic interactionism is one such interpretive perspective that accounts for the way human beings construct themselves and their realities by their ability to internalize the roles of others, within the processes of face-to-face experiences and socialization processes (Blumer, 1969; Mead, 1934). It is not reducible to a value-free, decontextualized universal model of behavior (Denzin, 1978; Strauss, 1956; Stryker, 1987).

Tenets of interpretive science suggest that reality is socially derived and people in different "worlds" do not share the same views. Methods for studying women, lesbians, and other minorities must reflect how these groups articulate their view of the environments in which they live. Awareness of the history and heritage of lesbians as well as the

research biases against them is essential (Minton, 1986). The standpoint of the external "objective" or "scientific" observer is of little use, because of the need to contextualize descriptions.

The interpretive framework used in this study treats subjectivity and objectivity as dialectically related (Webster, 1983). "Biases" are stated explicitly, rather than ignored or "controlled;" the investigator's stance is reflected in the development of the research plan (Denzin, 1978). Preconceptions or "sensitizing concepts," are not definitive, but suggest directions for the inquiry (Blumer, 1954). Though hypotheses are not tested, prior tentative theoretical premises and knowledge of the group to be studied are articulated as a precondition for interpretive research (Wax, 1971). Not predictability, but intellectual orderliness, is expected of interpretive research (Denzin, 1978).

An interpretive approach is particularly fitting to the field of lesbians' alcohol problems because they are so poorly understood. Simple, scientifically adequate etiological models of alcohol problems, in general, are elusive at best (Miller, 1980). Such ambiguously-structured problems (representing little agreement on the nature of the problem) are poorly suited to the application of statistical measures. Treating alcohol problems as "well-structured" in order to fit experimental methods may lead to solving the wrong problem or solving a problem of little significance (Ratcliffe & Gonzalez-del-Valle, 1988). For example, it is empirically efficient to measure alcohol consumption, but peoples' interpretations of alcohol use are at least as significant in the analysis of alcohol problems. Likewise, when "alcoholism" is used as a dichotomous variable, a false

sense of clarity about the nature of alcohol problems is injected into the inquiry process (Miller, 1976).

Critical Perspective

The theoretical and political perspectives which frame research determine whether or not the target population will truly benefit from the research enterprise (Allen, 1985; Sherwin, 1987). Critical inquiry is rooted in the interests of the group under study, and has as a goal the generation of knowledge that can be used to alleviate oppressive constraints. It attempts to describe the status quo accurately, but also envisions possibilities by viewing the "given" as subject to change (Farganis, 1986; Fraser, 1987).

Feminism, Marxism and critical social theory are critical stances nurses have taken in their studies of women and other vulnerable groups (Allen, 1986a; 1986b; Ashley, 1980; Hedin, 1986; Holter, 1988; MacPherson, 1983; Moccia, 1988; Roberts, 1981; Stevens & Hall, 1992; Thompson, 1987; Webb, 1984; Woods, 1988). All of these stances share the core process of demystification, which involves partisanship, structural analysis, avoidance of dogmatism and the unveiling of options for transformative praxis, that is, emancipation (West, 1990).

Women's lives have never been exclusively shaped by gender, but by a complex of factors including sexual orientation, class, race, ethnicity, educational status, national origin, age, physical abilities (Dye, 1979; Jaggar, 1988). Feminist inquiry reconceptualizes and expands the usual understanding of health, person and environment to include critical awarenesses in each of these areas of influence (Stevens, 1989). Feminism holds that women's experiences, ideas and needs are diverse and considered valid in their own right (Klein, 1983).

There is no specific feminist method. Rather, feminist inquiry applies alternative sources of research problems, hypotheses, evidence and purposes to three basic methods of social inquiry: (a) observing behavior, (b) listening to or questioning informants, and (c) examining historical traces or records (Harding, 1987). Feminist research is distinguished in three ways from other research using these methods. First, feminist research generates its questions for inquiry from the framework of women's experiences, that are described in their diversity, rather than standardized in a universal model of experience. Second, feminist inquiry is done for the purpose of finding answers for women, not primarily for the medical profession, the welfare establishment, commerce, etc., nor to assist anyone in exploiting women. Third, in feminist inquiry, the inquirer's characteristics, motives, interests and history are explicitly included in the process of study. The objectivist stance and the anonymous, invisible voice of authority are avoided in favor of a strongly reflexive approach to inquiry (Harding, 1987).

The critical perspective taken in this study was oriented toward emancipatory structural change in the arena of women's alcohol problems, including the improvement of relevant nursing practice and theory. Lesbians' alcohol problems were considered to have cultural, racial, gender and sexual orientational implications for women's emancipation. The envisioning of a changed future, an improvement in the lives of lesbians with alcohol problems, was an emancipatory commitment on the part of the researcher. The study was directed toward making constraints visible in the context of lesbians' alcohol problems, and

facilitating expansion of lesbians' ideological and interactional strategies regarding alcohol problems.

Integrating Interpretive and Critical Perspectives

An interpretive perspective harmonizes well with a critical perspective (Goff, 1980; Shalin, 1988). Cultural meanings, centered on gender, class, race, or sexual orientation construct contexts in which individuals participate. These meanings, or ideologies, operating at a structural level in interaction, are usually "taken-for-granted" (Allen & Wolfgram, 1988; Denzin, 1983) and can compete with individual experiential meanings (Denzin, 1983). There are multiple realities relative to the contexts in which persons exist; for instance men see a men's world, women see a women's world (Warren, 1988). The issue of reality is epistemological as well as socio-political. Thus knowledge varies according to perspective (Salner, 1985).

To extend understanding of alcohol problems in specific subcultural groups, such as lesbians, definitions and practices of their social contexts should be described (Watts, 1986). The microrelations of power and knowledge which organize everyday practices are then correlated with the description (Denzin, 1983). Critical ethnography is a method fostering comparison of field and historical data sources. It attends to the historical stage on which social actors encounter one another and acknowledges health as socially and organizationally produced and reproduced (Forester, 1983). The history of lesbians as a stigmatized and politically engaged group is relevant to their experiences with alcohol. Historical analysis is thus a legitimate tool for ethnographic research in the proposed study.

Both interpretive and critical science recognize the relevance of everyday life in women's oppression, an historically situated totality (Marshall, 1988). While interpretive ethnography seeks description of everyday worlds (Van Maanen, Dubbs & Faulkner, 1982), critical approaches render the taken-for-granted, everyday world "problematic." Everyday situations are seen with "historical halos" so that the influences of past realities are acknowledged. Research seeks to identify experiential structures, such as reified patterned regularities of thought, action and interaction (Denzin, 1983):

> An individual's location in the life world at any moment in time is phenomenologically and historically constituted into a body of situated, localized practices that provide a...frame of experience (p.131).

Due to the privatization of women's experiences, the meanings of drinking and alcohol problems among women relative to work and leisure may differ sharply from those of men. The personal and particularistic nature of women's experiences and social networks is lost if research focuses on the public sphere and on persons as autonomous public actors (Smith, 1979). Oppression, unnoticed and unquestioned, is obscured until a rupture in the fabric of daily existence fosters a critical change in consciousness (Gilligan, 1982; Mies, 1983; Smith, 1979; Stanley & Wise, 1983b). Emergence of an alcohol problem is a rupturing event for women. Nurses personally attend to many health-related ruptures, and thus are gatekeepers of their consciousness-raising potential for women clients (Volinn, 1983). In the present study, recovery from alcohol problems was viewed as a rupturing process, providing a window to meanings otherwise obscured in the everydayness of lesbians' experiences.

In summary, this study embraced the interpretive perspective and also incorporated the emancipative goals of critical inquiry, specifically feminism. As a study integrating the tenets of these frameworks, critical ethnography is an appropriate term to describe its methods. The processes of critical ethnographic research are described in the next chapter.

Assumptions of the Study

Based on this theoretical framework, the assumptions of the current study are:

1. Persons take action and interpret the actions of others based on the dialectic processes of "taking the roles" of others and reflecting on the self, as described in the symbolic interactionist perspective.
2. Knowledge embodies values and emancipatory interests.
3. Health is a process with emancipatory implications, which can be viewed from multiple perspectives.
4. Lesbians comprise a significant, if unquantified, minority of women.
5. Gender, race, class, and sexual orientation are interrelated in the context of lesbians' experiences.
6. Recovery from alcohol problems is a transition involving person, health and environment and entails multiple realities.

Women and Alcohol

Historical Developments

In colonial America, alcohol use was widespread and accepted, but drunkenness was condemned, especially in women (Lender & Martin, 1982). In the 1800's, successive waves of the temperance movement occurred in

response to: (a) post-civil war urban skid rows, (b) fears of growing immigrant populations, (c) the drinking culture's threat to middle-class youth, (d) "spiritual degeneracy" and (e) the proliferation of saloons (Gusfield, 1963; Lender & Martin, 1982; Winkler, 1972). Though initially promoting moderation, it later demanded abstinence, characterizing alcohol as dangerous in any form (Royce, 1986; Winkler, 1972).

In the later 19th century, temperance consisted of middle class women raiding saloons, destroying liquor supplies and engaging in prayer. They engaged in this public battle to protect themselves and their children from the devastating effects of mens' drinking. Over time, temperance came to have significance for men as drinking and abstinence became symbols of social status and religion. The temperance advocate was typically a white, rural, American-born, Protestant who valued self-control and industriousness. As immigration and industrialization increased with the influx of Catholic "foreigners," temperance provided displaced rural Protestants with a symbolic moral dominance in place of their lost political dominance (Gusfield, 1963).

Middle class women's substance use in this period consisted of their often unwitting domestic use of poorly labeled medicinal compounds containing up to 40% alcohol (Sandmaier, 1980; Stage, 1979). By the last half of the 19th century institutional homes specifically for "inebriate women" and women "opium eaters," often from the working class, were established (Lender & Martin, 1982). The visibly drunken woman symbolized the tragedy of Victorian attitudes. The threat of women's fall from the pedestal through alcohol use was cited in the prohibitionist campaign (Lender & Martin, 1982).

From 1879-1898 and beyond, the Women's Christian Temperance Union (WCTU) combined the temperance agenda with women's concerns, including the liberalization of women's clothing, women's suffrage and the eight hour workday. Women's personal abstinence and freedom from the consequences of male drunkenness came to symbolize empowerment. After the turn of the century, the temperance movement became more coercive as the male dominated Anti-Saloon League overshadowed the WCTU, making divisive, hostile attacks on immigrant "drunkards" who were touted as the root of nearly all evils (Gusfield, 1963). In 1920 the 18th Amendment and the Volstead Act prohibited the sale of alcoholic beverages. It remained in effect until 1934 (Royce, 1986).

The liberating changes in younger women's drinking patterns that occurred in the 1920's increased consumer demands for alcohol in the post-prohibition period. The alcohol industry began targeting women as a new market at this time, resulting in increasing presence of alcohol in "women's environments" (Ettorre, 1986). During World War II, women entered the work force in vast numbers, and socialization in bars became more acceptable for women, though 1950's McCarthyist values reinforced women's place "in the home." Women were again drawn into drug and alcohol-related contexts with the advent of the 1960's drug culture, and 1970's marketing tactics of the liquor industry which encouraged women to drink as an expression of their equality with men. The 1980's were characterized by social "amplification" of alcohol problems in general (Room, 1988). Although the incidence of women's drinking problems has actually been relatively consistent (Knupfer, 1982), U.S. society has alternately understated, maximized or exaggerated the incidence and

severity of alcohol problems in women depending on the political agendas of those in powerful positions.

While women's use of alcohol is now more socially palatable, drunkenness continues to be less socially tolerated in women than in men (Knupfer, 1982). Intoxication has been used as an excuse for men's violence. Simultaneously, consequences of intoxication have been used as rationalizations for limiting women's access to alcohol, in the cause of controlling women's sexual behavior. Therefore, gender-specific interpretations of alcohol's "effects" have empowered men, but have repressed women (Morgan, 1987).

This history is informative for this critical ethnographic study. The politicization of women via the temperance movement is echoed in contemporary lesbian communities' trend away from alcohol and other drug use. In each case, individual decisions about alcohol reflect political and ethical tensions in the context of one's community. Sexism, moral authoritarianism, pathologization of women's bodies, and medicalization of alcohol problems converge in the predominantly negative image of the drunken woman. Lesbians face the stigmatizing effects of this image of drunken women, and the convergence of ideologies linking lesbianism and alcohol abuse.

Ideologies Linking Lesbianism and Alcohol

Basing their arguments on client case studies, psychoanalysts have written throughout this century about interrelationships among women's "homosexuality," alcohol use, alcoholism and mental illness (Hall, in review; Israelstam & Lambert, 1983). There were several competing theories in the psychoanalytic rhetoric. One view saw women's alcoholism and "homosexuality" as co-disorders having the same root

causes, including oral fixation, oedipal conflicts and "incestuous drives" (Clark, 1919; Read, 1920; Karpman, 1948). Another view was that alcohol causes homosexuality, so that if a "homosexual" woman stopped drinking, same-sex sexual behavior would also cease (Nardi, 1982; Stekel, 1933). As late as 1971, medical writers stated that alcoholism, "homosexuality" and mental illness occur more often in the family backgrounds of lesbians (Wolff, 1971).

A breakdown in traditional sex roles, women's adoption of "male behaviors," and the expansion of women's employment opportunities were linked to women's increasing alcohol use as well as to a supposed increase in the prevalence of lesbianism (Clark, 1919; Knight, 1937; Weijl, 1944). Contrarily, Karpman (1948) asserted that "homosexual" women used alcohol in order to have sexual contact with men. In other theories, drinking was associated with "latent (unconscious) homosexuality," in which women's repressed homosexual inclinations are freed by alcohol and overt homosexual gestures are blamed on drinking (Caprio, 1954; Clark, 1919).

In this psychoanalytic literature there were opposing discourses about the relationship between alcohol use and sexuality: (a) alcohol use causes sexual disinhibition (Abraham, 1926; Caprio, 1954; Karpman, 1948; Weijl, 1944), and (b) alcohol use is self-medication to protect against sexual expression (Clark, 1919). Throughout this literature, alcohol and lesbianism were triangulated with malignant jealousy, suicidality, sadomasochism, violence and criminality (Berg & Allen, 1958; Clark, 1919; Karpman, 1948; Read, 1920; Stekel, 1933; 1946). Such theorizing yielded a collection of pathologizing discourses flexible enough to accommodate almost any political need. Ample demonstration of

this fact can be found in the use of psychoanalytic rhetoric by McCarthyists, the U.S. military, the immigration service and other institutional bodies to discriminate against lesbians and gay men (Berube & D'Emilio, 1984; Lewes, 1988). The ideas about lesbians and alcohol promoted by American psychoanalysts in the first half of the century still have an impact on the phenomenon of lesbians' alcohol problems; they persist in caregiver attitudes and lesbians' beliefs about themselves (Hall, in review; Israelstam and Lambert, 1983; Morales & Graves, 1983).

Lesbian Bar Subculture

With the advent of World War II, civilian wartime participation in industry facilitated women's socializing in bars, unaccompanied by men. These general trends in socialization facilitated the emergence of urban lesbian bar subcultures, significantly decreasing the oppressive isolation of lesbian existence (D'Emilio, 1983):

> ...the bars offered an all-gay environment where patrons dropped the pretension of heterosexuality, socializing with friends as well as searching for a sexual partner. When trouble struck, as it often did in the form of a police raid, the crowd suffered as a group, enduring the penalties together. The bars were seedbeds for a collective consciousness that one day might flower politically (p. 33).

Lesbian poet, Judy Grahn (1984), recalled the lesbian bars of the 1950's:

> The bar had considerable dangers.... Sailors lurked in the alleys outside...more than once they beat someone I knew.... In the gay bar I could sit and drink and not be surrounded by men demanding my attention. I could ask someone to dance. I could lead when we danced, or I could find someone who liked to lead and let her do it. I could dance with either men or women. I could sing along with the lyrics and not be embarrassed to be using the "wrong" gender. I could sit with a serious face and not have smiles and pleasantries demanded of me (pp. 31-33).

In the middle decades of the century, bars of any stripe were seen as potential arenas for sexual dynamics, though they clearly served social and organizational functions of the working classes (Powers, 1990). During the period of the 1950's through the 1970's lesbian bars functioned for working class lesbians as places of refuge, self-expression, collective identity and public defiance, as evidenced in life histories of these women (Davis & Kennedy, 1986). Alcohol sales were also a source of fundraising for gay/lesbian causes during this period.

Bars became targets for police harassment of lesbians and gays in the repressive 1950s and the conflicted 1960s (Adam, 1987; Altman, 1982; D'Emilio, 1983; Katz, 1976; Masters, 1962). Massive police crackdowns in Florida and California, with televised court appearances of gay and lesbian bar patrons who had been arrested, caused the closure of many lesbian and gay bars. But they were rapidly reopened by owners, who eventually collectivized against harassment (D'Emilio, 1983; Masters, 1962). In 1961 in San Francisco, Jose Sarria, an openly gay drag queen employed by the Black Cat bar, protested Alcoholic Beverage Control Department (ABC) crackdowns by running for city supervisor, earning 6,000 votes (D'Emilio, 1983).

By the late 1960s, the civil rights, anti-war, and women's movements had created a climate conducive to lesbian and gay liberation. In Greenwich Village in 1969, three days of rioting by gay and lesbian patrons followed the police shutdown of the Stonewall Inn bar. The Stonewall Rebellion politicized younger gays and lesbians, who merged with the older homophile groups, forming national liberation organizations (Adam, 1987; Altman, 1982; D'Emilio, 1983). Lesbian

activists rejected accommodation in favor of total social acceptance of lesbians as their goal (Martin & Lyon, 1972).

In summary, lesbian/gay bars of the postwar era were sites of systematic persecution and collective resistance (Adam, 1987; D'Emilio, 1983). In the 1960s the lesbian/gay bar scene nurtured the seeds of revolution. The centrality of bar subcultures in these processes suggests that alcohol symbolized freedom and self-affirmation for lesbians. In the 1970s, the feminist movement influenced some lesbians to reject the bar subculture as exploitive (Barrett, 1989). Nevertheless, during the 1970s the lesbian bar remained an important sanctuary and source of empowerment for lesbians (Abbott & Love, 1972).

In the 1980s, alcohol emerged as a prism reflecting ideological polarization in lesbian communities. Rhetoric in lesbian communities categorized alcohol as a tool used in the colonization and ghettoization of lesbians and as a precipitant of violence against women in general (Hepburn & Gutierrez, 1988; Jay & Young, 1978; Nicoloff & Stiglitz, 1987; Schilling, 1983; N. Smith, 1983). Lesbians depicted alcohol as a tool of heterosexist oppression at the same time that they critiqued alcohol treatment programs and AA as vehicles for white, male Christian values. Thus, two competing ideologies are the legacy of the historical processes described above: (a) drinking together in lesbian bars is a positive means of self-expression for lesbians, and (b) alcohol use in lesbian bars symbolizes the repression and social confinement of lesbians.

Alcohol Problems

Drinking Practices in the U. S.

The privatization and commoditization of drinking has devalued ethnic heritage and lifeways relative to alcohol (Hinkelammert, 1986; Kovel, 1981; Lukacs, 1971; Saleebey, 1986; Taussig, 1980). Past drinking traditions have been eclipsed, creating a void regarding expectations of drinking behavior (Pattison, 1984), an increase in incidence of alcohol problems (Bales, 1959) and more difficulty in defining them.

Alcohol use has been discussed within the larger framework of addiction, which has been expanded not only to include drug and alcohol abuse, but also the interpersonal burdens incurred by those indirectly impacted by these practices. Addiction has been described as a collective political process, a consumption-oriented pattern of social organization (Wilson-Schaef, 1987). Addiction can be viewed as a common form of consciousness in U.S. culture (Saleebey, 1986). Alcohol/drug use experiences are dialectical processes linking the subjective perceptions of individuals and the psychotropic effects of the drugs, recognizing that drug effects and definitions of normal use are shaped by the culture of the user (Young, 1971). Cultural differences in the definition and perception of individual and collective alcohol-related problems necessitates a perspective which can appreciate both subjective and "objective" reference points. Within dominant U.S. cultural drinking norms, there are still notable ethnic differences in drinking expectations, tolerance of drunkenness, and definitions of drinking problems (Cahalan, 1988). The particular circumstances under which

alcohol use is defined as a problem by lesbians is a focus of this study.

Attribution Models of Alcohol Problems

There is significant diversity in causal attributions of alcohol problems (Ward, 1986), that can be grouped into four major types: (a) moral, (b) medical/disease, (c) enlightenment and (d) compensatory (Marlatt, Baer, Donovan & Kivlahan, 1988). These categories, though not exclusive in their actual manifestations, illustrate the range of notions about who and what is responsible for the development of alcohol problems.

Prior to 1940, alcohol problems were regarded as the result of moral failure on the part of the drinker. "Inebriety" was designated a "disease of the will" (Conrad & Schneider, 1980). At mid-century, the medical/disease model was advanced, ostensibly enabling "alcoholics" to seek medical help without incurring moral blame. Disease-oriented theorists defined alcoholism as a "loss of control" over drinking, an individual malfunction (Brown, 1969; Jellinek, 1960; Keller, 1972; Room, 1984). Etiological explanations of this loss of control are conflictive, ambiguous, and not well supported empirically (Shaffer, 1986). The disease model focuses on alcohol, and thus cannot accommodate strategies geared toward moderating other addictive behaviors, such as compulsive gambling, eating, drug use and sexual behavior (Marlatt et al., 1988). Abstinence is considered the single avenue for recovery, and prevention research is geared toward the eventual identification of genetically vulnerable individuals and the recommendation that they abstain from alcohol. Though dual addiction or polydrug abuse is increasingly prevalent (O'Donnell, Voss, Clayton,

Slatin & Room, 1976), especially among women (Mulford, 1977), it is often excluded in operational definitions of alcohol problems in the medical/disease model.

The enlightenment model, advanced by Alcoholics Anonymous (AA) and other twelve-step mutual help groups, stresses the true nature of addiction problems as transcendental or spiritual (Marlatt et al., 1988). The context of these groups provides a discipline and social milieu for restructuring addictive lifestyles. Success in changing behavior is associated with reliance on a spiritual "higher power." The conversion theme prevalent in twelve-step rhetoric implies that elements of the moral model remain embedded in the enlightenment model.

The compensatory model suggests that addictive behavior is learned in the context of personal and environmental factors. This approach recognizes multiple etiologic pathways and discerns common elements across various types of addictive behavior (Marlatt et al., 1988). A synthesis of the compensatory and enlightenment models is reflected in AA, to the extent that the twelve steps of the program (see Appendix A) are a means to learn new coping skills. The compensatory perspective permits a widening of the concept of alcohol problems beyond the disease of "alcoholism" to include prevention, interactional factors, and alcohol control issues.

Defining Alcohol Problems

Considering the array of attribution models, investigation of recovery from alcohol problems in lesbians must concern itself with how alcohol problems are defined by problem drinkers, and how their views are influenced by the views of significant others and potential helpers. The social implications of identifying drinking problems are reinforced

in the notion that a problem can only be a problem to somebody (Cohen, 1971; Scheff, 1984). Inquiry should be reflective of the target group's lived experience in this regard (Peele, 1985). Alcohol problems become manifest according to influences and conflicts in the social milieu (Cahalan, 1970; Room, 1983). In other words, they are culturally situated (Bales, 1959; Peele, 1984; Stivers, 1976; Wolff, 1972). Yet there continues to be considerable resistance to a sociocultural view of alcohol problems in the wider society, as well as in professional and institutional health sectors (Room, 1984).

Alcohol problems are simply defined as those problems closely associated with the drinking of alcohol (Knupfer, 1967). They may include intoxication, dependence symptoms, relational conflicts, memory blackouts, employment or economic strife, legal difficulties and health deficits (Cahalan, 1988). Nursing has traditionally addressed alcohol problems under a variety of labels, such as alcoholism, alcohol abuse, alcohol addiction, polydrug abuse, chemical dependency, substance abuse, habituation (Hughes, 1989), drunk-driving, alcohol-related health problems, and "co-dependency" (Pires, 1989; Tweed, 1989; Zerwekh & Michaels, 1989). The term, alcohol problems, as used in this study includes the above, but contextualizes these problems socially and culturally, individually and collectively.

Women's Alcohol Problems: Empirical Evidence

Large scale reviews of studies about women's alcohol problems conclude that women have lower rates than men do in terms of heavy drinking, incidence of alcohol problems, and lifetime risk for severe alcohol-related difficulties (Armyr, Elmer & Herz, 1982; Bacon, 1976; Hilton, 1988; Schuckit, 1979; Wilsnack, Wilsnack & Klassen, 1986). A

generally accepted incidence figure is that 11% of American woman are substance abusers, and alcohol is their most frequently abused substance (Ferrence & Whitehead, 1980). Subgroups at increased risk include women in their 30s and 40s, those divorced, separated, never married, or unemployed and those who periodically abstain from alcohol (Wilsnack, Wilsnack & Klassen, 1986). Young women are drinking more than in prior decades (Thompson & Wilsnack, 1984) but it remains debatable whether or not drinking styles are converging between the sexes (Ferrence & Whitehead, 1980; Fillmore, 1984). In addition to prevalence rates, studies of women's alcohol problems have focused on genetic influences, female biology, gender role conflict, sexual abuse and power.

Genetic Influences

There are evidences of genetic determination of alcoholism (Cadoret, 1976; Goodwin, 1979), although the major genetic studies have excluded women subjects (Fillmore, 1988). Twin, adoption and sibling etiologic studies of alcoholism suggest that genetic factors are independent of family environmental influences (Bohman, Sigvardsson & Cloninger, 1981; Goodwin, 1981; Goodwin, Schulsinger, Knop, Mednick, & Guze, 1977a). Methods of identifying alcoholism's biologic parameters are actively being explored (Watson, Mohs, Eskelson, Sampliner & Hartmann, 1986).

Alcoholic subtypes that break down according to gender have been proposed, based on the coincidence of personality or affective disorders in alcoholics and their relatives (Winokur, Reich, Rimmer & Pitts, 1970). Women are more likely than men to develop affective disorders, suggesting a genetically determined "broad spectrum illness" manifested

as alcoholism in males and as depression with or without secondary alcoholism in women (Winokur et al., 1970).

Other studies show genetic influences to be less important and support social-environmental determinants of women's depression and drinking (Curlee, 1970; Goodwin, Schulsinger, Knop, Mednick & Guze, 1977b; Lisansky, 1957). For instance, daughters of alcoholics raised in their families of origin have more depression and alcoholism than do daughters of alcoholics raised by nonalcoholic families. Having an alcoholic significant other, whether early or later in life, is consistently related to the development of alcoholism in women (Gomberg & Lisansky, 1984). There are also distinct ethnic differences for women in terms of abstinence rates, alcohol consumption and the physical and social consequences of drinking (Leland, 1984).

The question remains whether a complex behavioral phenomenon, such as an alcohol problem, could result from one biologic process (Peele, 1985). Many researchers attest that genetic factors account for only a proportion of clinical alcoholism incidence (Cahalan, 1988) and do not account for ethnic, gender or social class differences in problem drinking (Cahalan & Room, 1974). If genetic factors were solely responsible for alcohol problems, their distribution over per capita consumption would be bimodal, rather than the smooth, near log-normal distribution which actually occurs (Hyman, 1979; Room, 1984; Vaillant, 1983). Genetic factors are at best modestly predictive in general (Naegle, 1988; Peele, 1986; Vaillant, 1983). Because women are underrepresented in genetic studies, conclusions about genetic factors in female alcohol problems are inappropriate (Fillmore, 1988).

Female Biology

Another common focus in research about women and alcohol is female biological vulnerability to alcohol problems. Women's alcoholism has been linked to the menstrual cycle, childbirth, menopause, abortion and gynecologic surgeries. Methodological flaws and equivocal data undermine these associations, however (Schuckit & Duby, 1976).

In comparison to men, women have a later onset of problem drinking but a more rapid physiological course of illness, which leads them to treatment faster (Hill, 1984), suggesting greater "pathology" in women (Levi & Chalmers, 1978; Lisansky, 1958; Spain, 1945; Wanberg & Horn, 1970). In advanced alcohol problems, symptoms become increasingly similar for men and women (Knupfer, 1982). Women entering treatment have a less severe overall clinical presentation than men (Armor, Polich & Stambul, 1976). This may be because women are more responsive to negative feedback about their drinking, which facilitates problem recognition (Mulford, 1977). Men tend to identify occupational, legal or financial problems related to alcohol use, while women report more depression, distrust and emotional upset (Robbins, 1989). These differences may reflect sampling biases of household surveys or gender-related cultural expectations about how problems are articulated.

Female alcoholics are more likely than male alcoholics to be divorced, to have had a psychiatric hospitalization (Curlee, 1970) and to have been prescribed psychoactive drugs (Russo, 1985; Tamerin, Tolor & Harrington, 1976). This may indicate that women's alcohol problems are related to psychiatric illness, or may reflect health care providers' tendency to pathologize women's behaviors more often than they do men's. Alcohol research on all-women populations has reflected

the preoccupation of the decade, such as the "empty nest" syndrome in the 1960s, and the fetal alcohol syndrome in the 1970s (Clemmons, 1986). Overall, research on women and alcohol ignores individual genetic factors in favor of gender-related biological factors, including childbirth, sexual dysfunction and menopause. This approach paints women as susceptible to alcohol problems, not as individuals, but as members of a "vulnerable gender," which reinforces the idea that women need the structure of rigid social roles to protect them from the scourge of alcohol problems.

Sex Role Conflict

Women have been purported to be socially "protected" from alcoholism by the constrictive female role (Gomberg & Lisansky, 1984). Role changes are cited in the etiology of women's alcoholism across the life span (Wilsnack & Cheloha, 1987). Longitudinal research (Fillmore, 1987; 1988) comparing women and men in the general population has suggested that: (a) women have higher rates of problem remission throughout the life course, (b) men and women's incidence rates of alcohol problems converge during ages 30-40, (c) incidence of women's problem drinking peaks in the 30s and 40s and sharply declines with older age and, (d) compared to men, women's alcohol problems occupy less temporal life space. These age-related variations in incidence refute the notion that women's roles "insulate" them from alcohol problems.

Women's alcohol problems have also been hypothetically associated with particular sexual behaviors. Early studies of women alcoholics characterized them as either sexually "frigid" (Levine, 1955) or "promiscuous" (Karpman, 1948), labels that were never applied to male alcoholics. In an interview study, Beckman (1979) found that women

alcoholics, more than nonalcoholics, reported enjoying heterosexual intercourse after drinking. These findings indicate that some women may use alcohol to overcome sexual inhibitions or misogynist sexual dynamics, or may use sexual enhancement as a rationale for increased drinking. These retrospective studies cannot establish that specific sexual behaviors cause problem drinking, but they epitomize the persistent interest in a sex role-alcohol problem link in women.

Many studies have focused on sex roles and women's alcohol problems (Beckman, 1978; Keil, 1978; Lundy, 1987; Scida & Vanicelli, 1979). Sex role conflicts, such as "lack of femininity," "unconscious masculinity" and "conscious hyperfemininity" were more prevalent among alcoholic women than among matched nonalcoholic controls, as measured by masculinity/femininity scales and projective tests in Wilsnack's (1973) oft-cited study. Femininity, as operationalized by Wilsnack, is concern for appearance, (e.g., use of makeup, maternal identification, and non-assertiveness). This definition is obviously culturally biased. Women who are unmarried or childless invariably appear "unfeminine" by these standards. Moreover, this definition of femininity is a two-edged sword; women who embrace the maternal role may be deemed "hyperfeminine," also considered a deviation. Instruments that have been used to determine sex role appropriateness are of questionable validity and tend to stereotype women with alcohol problems. The interpretation of gender differences in sex role conflict scores is also crucial. "Unconscious masculinity" has been critically re-interpreted by feminists as signalling women's increasing autonomy, which some women "manage" through alcohol or other drug use (Ettorre, 1986).

Some research indicates that sex role conflict is not a factor in alcoholism (Kroft & Leichner, 1987). A replication of Wilsnack's measures on 30 female alcoholics and their nonalcoholic sister controls yielded no significant differences (Anderson, 1980), suggesting that within-group variation accounted for earlier findings. If sex role conflict is significantly involved in the etiology of alcoholism, more overt evidence of sex role confusion should be seen than is presently observed (Schuckit & Duby, 1976).

Jones (1971) studied drinking problems in urban middle class women who had extensive psychological assessments completed during adolescence. Results indicated that women with alcohol problems in adulthood were more likely to have been described by significant others as moody, sensitive to criticism, pessimistic, vulnerable, withdrawn, self-defeating and "hyperfeminine" when they were adolescents. A retrospective study of alcoholic women and their non-alcoholic sisters yielded similar findings (Anderson, 1981). In another study, many women who had temporarily stopped drinking reported that they did so in response to same-sex sexual feelings that they had experienced during drinking episodes. Heavy drinkers were especially likely to report sexual "disinhibition" associated with their drinking (Klassen & Wilsnack, 1986). Abstinence from alcohol is thus seen as a means of maintaining the heterosexual "norm" for some women. Though none of these studies focused on sexual orientation per se, the findings raise questions: Could significant others' evaluations about "feminine" behavior during adolescence be associated with negative self-evaluations and eventual alcohol problems? Are negative self-evaluations and social isolation in adolescence and increased alcohol use in adulthood

associated with nonconformity to sex role expectations? Because these studies failed to describe the meanings of alcohol use associated with "hyperfemininity," disinhibition and same-sex sexual feelings from the women's perspectives, relationships among these variables remain ambiguous.

Sexual Abuse and Power

Rape and sexual abuse histories have been demonstrated in many women who have alcohol problems (Covington, 1982; Sandmaier, 1980), suggesting that women may drink excessively in response to discomfort associated with sexual trauma. For example, of 118 women AA members, 29 had experienced incest as children, and about 40% of these met criteria for post-traumatic stress disorder (Kovach, 1986). Evans and Schaefer (1987) summarized the research linking childhood sexual abuse and chemical dependency as follows: (a) female incest survivors begin chemical use earlier than do other women and have generalized discomfort with sex, (b) 40% of chemically dependent women have a history of incest and, (c) half of male incest perpetrators are alcoholic. They hypothesized that childhood sexual abuse alters family power dynamics and blurs generational boundaries, causing dysfunction in the meeting of intimacy needs. This dysfunction presumably increases the potential for addiction in survivors of incest.

Powerlessness, defined as a low sense of control over one's options, is related to alcohol consumption and the incidence of drinking problems, mediated by the degree of work alienation and the availability of social network support (Seeman, Seeman & Budros, 1988). Women alcoholics report more powerlessness and low self-esteem associated with their drinking than men do (Beckman, 1980). Such findings, along with

the reality of the intense stigmatization of women alcoholics, reflect actual power imbalances between the sexes rather than imbalances within the woman's psyche (Ettorre, 1986). These studies suggest that women's alcohol problems arise from structural conditions of gender oppression and repression.

Methodological Problems in the Research

There are significant methodological problems that compromise the reliability and validity of research generating empirical knowledge about women's alcohol problems. These problems include small sample sizes (Belfer & Shader, 1971; Covington & Kohen, 1984; Diamond & Wilsnack, 1978; Driscoll, 1982; Oberstone & Sukoneck, 1976; Schilit, Clark & Shallenberger, 1988), overrepresentation of hospitalized subjects (Curlee, 1969; Kinsey, 1966; Lemere & Smith, 1973; Levine, 1955; Schaefer & Evans, 1982; Tamerin, 1978; Wall, 1937), omission or failure to specify minority subjects (Beckman, 1980; Covington, 1982; James, 1975; Noel & Lisman, 1980; Parker, 1972; Saxon, Kuncel & Kaufman, 1978; Wood & Duffy, 1966), and retrospective design (Lisansky, 1957; Schuckit, Pitts, Reich, King & Winokur, 1969; Tamerin, 1978; Wilsnack, 1973). Hence, generalizability is limited, and purported antecedents of women's alcohol problems may actually be consequences or reflect reciprocal processes (Gomberg & Lisansky, 1984). For example, sexual dysfunction has been cited as both a cause and a consequence of alcohol abuse in women.

Lesbians' Alcohol Problems

A summary of studies relevant to alcohol problems in lesbians is available in Appendix B.

Incidence Studies

General population surveys on alcohol consumption have traditionally excluded sexual orientation as a demographic variable. Limited survey research indicates that compared to heterosexual women, the incidence of alcohol problems among lesbians is significantly higher, affecting an estimated 30% of lesbians as compared to 11% of women in the general population (Fifield, 1975; Fifield & Latham & Phillips, 1977; Lewis, Saghir & Robins, 1982; Saghir & Robins, 1973; Schilit, Clark, & Shallenberger, 1982; Weathers, 1980). In a study of 40 lesbians and matched heterosexual controls from an outpatient clinic, lesbians were four times as likely to be habituated to alcohol, amphetamines, or barbiturates (Swanson, Loomis, Lukesh, Cronin & Smith, 1972). Younger lesbians in particular tend to report using other drugs, such as cocaine and marijuana (McKirnan & Peterson, 1989a). A national lesbian health survey (N=1917) revealed that 25% of lesbians reported drinking several times a week, 6% reported drinking daily and 14% reported being worried about their substance use (Raymond, 1988).

In the Chicago area, 3400 gay men and lesbians were surveyed about alcohol practices through gay/lesbian organizations and newspapers (McKirnan & Peterson, 1989a). The sample was predominantly white and college educated with relatively low incomes; 22% (748) were female, (mean age=32). The proportion of lesbian abstainers was higher than that of gay men (19% vs. 8%), but the total number of abstainers (gay and lesbian) was lower as compared to the general population (14% vs. 29%). Most of the lesbian drinkers consumed moderately, however, 23% of lesbian participants reported alcohol problems, compared to 12% of general population survey respondents. This study supports the idea

that lesbians may be more sensitive to the negative consequences of alcohol use, even at moderate levels of consumption, but does not explain why this sensitivity exists.

The San Francisco Lesbian and Gay Substance Abuse Planning Group commissioned a study of alcohol and other drug use in gay men and lesbians (EMT Associates, 1991). The survey study included a sample of 416 gay and bisexual men and 318 lesbian and bisexual women. The average age of respondents was 32 years, 80% were Euro-American, 20% were people of color. Forty-five percent had incomes under $20,000 per year; their low incomes were not reflective of their advanced educational levels. This research sampled lesbians in considerably larger numbers than previous research about combined lesbian/gay populations. Of the women in the study, 74% identified as lesbian and 26% identified as bisexual. Findings suggested that lesbians use alcohol and other drugs more often and in greater amounts than women in the general population. Using a matrix of criteria to establish risk levels for substance use, this study found that 33% of the lesbians surveyed were either chemically dependent or had problematic substance use patterns. Another 26% of the lesbian respondents reported being in recovery from alcohol and/or other drug use.

In contrast to findings from multiple studies that suggest higher rates of drinking problems in lesbian communities, one study involving a convenience sample of 117 midwestern lesbians found that only 10% reported ever having any problem with alcohol (Johnson, Guenther, Laube & Keettel, 1981). Ten percent incidence of alcohol-related problems might be expected in the general population of drinkers, given the age of this sample (mean=29, range=19-52) (Cahalan, 1988; Fillmore, 1984).

Nevertheless, general empirical conclusions indicate a significantly higher rate of alcohol problems among lesbians as compared to other women. Reliable epidemiological estimates of alcohol problems in lesbians, requiring random samples or structured comparison groups, have not been available due to the fact that lesbians comprise a hidden, stigmatized subculture. There remains a need for systematic epidemiological study of drinking patterns in this population (Nardi, 1982).

Lesbians' Increasing Awareness

Alcohol problems have been purported to be more tolerated in lesbian communities than in straight society. Some have said that non-drinkers have low visibility in lesbian communities, which leaves the impression among lesbians that "everyone drinks" (The Way Back, 1982). Others have suggested that lesbians are more sensitive to the signs of problem drinking (McKirnan & Peterson, 1989a; N. Smith, 1983). In the present era of decreasing alcohol consumption in the U.S., there is increasing sensitivity about alcohol problems, sometimes referred to as "problem inflation" (Room, 1988). Lesbian communities may be reflecting this general heightened awareness about alcohol problems (Hall, in review), though the actual extent of those problems is not fully known.

In the early 1980s, Hastings (1982) predicted a decline in alcohol use among lesbians because of alternative social opportunities created by the women's movement, development of treatment and mutual help efforts specializing in lesbians' alcohol problems and sociocultural changes enabling lesbians to live more openly. Although ten years later it appears that lesbians are more aware of alcohol

problems, and many are in recovery, there are few treatment efforts targeting the alcohol problems of lesbians and societal discrimination against lesbians remains quite palpable. Hastings' explanation of the trend away from alcohol in lesbian communities is incomplete and depends heavily on changes in the larger society. Additional explanatory factors must be found within lesbian communities themselves.

Saulnier's (1991) contention is that lesbian communities have collectively taken on a preoccupation with alcohol problems that has been generated in institutions in the mainstream culture. The increasing number and interconnectedness of twelve-step programs that address alcohol problems, codependency, compulsive sex, overspending and eating disorders within lesbian communities increases the probability that lesbians will problematize their alcohol use. This movement toward increased awareness of alcohol problems has not occurred without tremendous debate among lesbians about the role of alcohol use, the efficacy and "safety" of twelve-step programs, the equation of recovery with "powerlessness," and the effects of the recovery movement on the social and political dynamics in lesbian communities.

Lesbians' Vulnerabilities

Lesbians are believed to be especially susceptible to alcohol problems for one or more of the following reasons: (a) they use alcohol to compensate for societal oppression (Glaus, 1988), (b) they socialize in lesbian/gay bars (Glaus, 1988; Johnson & Palermo, 1984; Nardi, 1982; Nicoloff & Stiglitz, 1987; Weathers, 1976), (c) they have minimal awareness of the consequences of their drinking due to their excessive use of denial and secrecy as coping patterns (McNally, 1989), (d) they drink because isolation and alienation are prevalent in lesbian life

patterns (Glaus, 1988; Johnson & Palermo, 1984), (e) they are unable to accept being a lesbian as a positive identity (Colcher, 1982; McNally, 1989; Rofes, 1983; Schilit, Clark & Shallenberger, 1988), (f) they associate with "codependent" peers in the lesbian community (Glaus, 1988; Hepburn & Gutierrez, 1988), (g) they have histories of being raised in "dysfunctional families," and (g) they avoid mental health and substance abuse treatment because these programs are not lesbian-sensitive (Johnson & Palermo, 1984; Sandmaier, 1980).

Related to ideas about the role of oppression, some scholars posit that lesbians who develop rigid defenses against societal stigmatization may unknowingly let these defenses reinforce a "budding alcohol dependency" (Ziebold, 1979). The lesbian who incorporates drinking as a symbol of rebellion toward the straight world resists defining it as a problem just as she resists being pathologized as "homosexual." In a qualitative study by Clark and O'Connell (1985) lesbians associated their addiction with avoidance of painful psychic experiences and a need for power. These findings point not only to personal stressors, but to political needs, as relevant to lesbians' interpretation of their alcohol problems. Research and clinical efforts to help women with alcohol problems need to incorporate a comprehensive view of stigmatization on both individual and social levels. Lesbians may not acknowledge drinking problems if "recovery" requires acceptance of the medicalizing label of "alcoholic" and/or separation from the social support of the lesbian bar scene (Hall, 1990a).

There is equivocal evidence about the reliability of the socialization in lesbian bars explanation. When the frequency of "bar-going" was held constant, lesbians displayed higher rates of heavy

drinking and alcoholism than did heterosexual controls (Lewis, Saghir & Robins, 1982). It could be that lesbians speak more openly about their drinking practices, feeling less bound to traditional female sex role expectations than do heterosexual women. Another study found no differences in psychological adjustment, alcohol consumption or bar-frequenting habits between lesbians and matched heterosexual controls (Oberstone & Sukoneck, 1976). In a comparison of nonalcoholic and alcoholic lesbians both groups visited bars with equal frequency, though nonalcoholic lesbians did not stay as long or drink as much (Woods, 1981). This suggests that bar-going itself is only one aspect of lesbian alcohol practices to be considered in examining the development of alcohol problems.

In spite of widespread acceptance of the "bar etiology" of gay mens' alcoholism, gay men recovering from alcoholism in AA overwhelmingly reported that their drinking was already problematic before they ever entered a gay bar (Clark & O'Connell, 1985; Kus, 1988a; 1988b). The phenomenon of reinterpreting one's past, commonly seen in the AA recovery process, could explain these individual retrospective perceptions (Maxwell, 1984; Robinson, 1979; Rudy, 1986; Taylor, 1979; Thune, 1977). The meanings of drinking-related interaction in lesbian bars and in other contexts of lesbian drinking have not been sufficiently investigated to clarify and contextualize the significance of the "bar etiology" of alcohol problems in this subcultural group.

Vulnerability related to non-acceptance of lesbian identity is supported by sparse evidence. In an ethnographic study of primarily gay men and a few lesbians, Kus (1988a) identified a pattern of non-acceptance of gay identity linked with the development of

alcoholism. He noted that acceptance of gay identity did not occur until after abstinence began and recovery from alcoholism was well underway. The researcher's conclusion that alcoholism represents a tragic detour in the process of accepting gay identity is limited by the fact that the acceptance phase of the coming out process is not clearly defined. Its application to lesbians' alcohol problems is tenuous given the small number of lesbians in the sample. McNally's (1989) descriptive study of eight lesbians recovering in AA revealed that some lesbians reported using alcohol either to "cope with" or to deny lesbian identity. She suggested that women who have not acknowledged or accepted being lesbians are at a therapeutic disadvantage in heterosexually-oriented alcohol treatment programs. Self-acceptance of lesbianism was reported to be non-contributory to alcohol problems in 29 of 30 alcoholic lesbians interviewed in Los Angeles (Hawkins, 1976).

Related to "dysfunctional family" explanations, the San Francisco survey (EMT Associates, 1991) had lesbian respondents identify reasons for their alcohol use. Forty-eight percent of those surveyed reported having been sexually assaulted as children. They said they drank to avoid emotional pain, reduce social discomfort and avoid thinking about problems. In a qualitative comparison of 15 alcoholic and 15 nonalcoholic lesbians, alcoholic lesbians experienced feelings of being unwanted, had greater religious involvement, fewer support persons, less popularity, and more "distance" from fathers during childhood, as compared to nonalcoholic lesbians (Schilit, Clark & Shallenberger, 1988). The sample was too small to clarify the significance of these differences; other factors may be operative, such as number of siblings, ethnicity or class. In another study using an outpatient sample, twice

as many lesbians as heterosexual women (16% vs. 7%) had alcoholic or abusive fathers (Swanson, et al., 1972). Diamond and Wilsnack (1978) concluded that the lesbian alcohol abusers they interviewed drank due to low self-esteem and dependency conflicts, a finding which fails to distinguish them from women with alcohol problems in general (Beckman, 1981).

Lesbians' problems with alcohol occur in diverse individual experiences and social contexts because lesbians are a group of marginalized persons. No single etiological explanation can be made to account for these problems, and the search for such an explanation is a misguided task (Nardi, 1982). The challenge is to identify patterns and name concepts which clarify without homogenizing the experiences of marginalized persons.

Seeking Help for Alcohol Problems

General Patterns of Helpseeking

An individual's belief that health assistance can be effective and the impact of his or her social network combine to foster helpseeking, with the balance in favor of individual beliefs (Berkanovic & Telesky, 1982). Nevertheless, even these "individual" beliefs are ultimately attributable to sociocultural processes. Analysis of personal histories of helpseeking trajectories are needed to illuminate this process (Chrisman, 1985).

Severity of symptoms does not necessarily lead to helpseeking. Rather, it is a triggering event (Gortmaker & Eckenrode, 1982), such as a "breakdown" in the social context or interpersonal crisis (Zola, 1964; 1973). People usually consult with family and friends before seeking professional assistance for health concerns (McKinlay, 1973). Social

networks mediate between stressful events and helpseeking and are a source of lay solutions (Gourash, 1978). If the lay network is extensive and dissimilar from the dominant culture, it is less likely that formal professional help will be sought (Freidson, 1960).

Generally women seek and use health services more often than men do (Dohrenwend & Dohrenwend, 1976; Gurin, Veroff & Field, 1960; Kadushin, 1958-59; Lempert, 1986; Lin, 1967; Woods, 1985), and younger people seek help more often than older people do (Gourash, 1978). Euro-Americans are more likely to seek professional care than are members of other ethnic groups who tend to use informal support networks (Gourash, 1978; Neighbors, Jackson, Bowman & Gurin, 1983). It is not clear, however, whether ethnic disparity in helpseeking is due to cultural preference, lack of finances, or fear of racial discrimination in health care.

Helpseeking for Alcohol Problems

There are "condition-specific helpseeking careers" (McKinlay, 1981). The process of helpseeking for alcohol problems depends on cultural norms as well as individual factors (Pattison, 1984). Particular structural factors are pertinent to the alcohol helpseeking process. For example, clinical observation suggests that clients' rates of agreement to enter into treatment for alcohol problems can be predicted by the length of the waiting period before initial consultation and the availability of "treatment slots;" the longer the wait, the less chance that potential clients will enter alcohol treatment (Wanberg & Jones, 1973).

Characteristics of the immediate social environment are more influential than are demographic factors in the patterns of helpseeking

among problem drinkers (Cahalan & Room, 1974). Individuals' lack of awareness of "the problem" is often supported by significant others such as family members who are defending their own drinking or hold stigmatizing views of alcohol problems (Cermak, 1986; Wegscheider-Cruse, 1984). Social networks thus contribute to a pattern of repeated relapse and helpseeking, or to successful recovery (Eells, 1986).

Individuals usually seek help when they have reached a state of "demoralization," that is, unable to meet environmental demands yet unable to extricate themselves (Frank, 1974). This is sometimes referred to as "hitting bottom" (Alcoholics Anonymous, 1976; Brown, 1985; Taylor, 1979). From a critical point of view, this might be reframed as a liberating "moment of perception" in which one's constraints are made visible (Freire, 1970). The perceived meanings of "hitting bottom" influence the types and sources of help that are sought. For instance, if societal oppression is blamed for the demoralizing crisis, help may be sought in the form of political activism rather than conventional alcohol treatment.

Women's Helpseeking

Role of Significant Others

More than half of married women alcoholics have husbands with alcohol problems (Knupfer, 1982). Women are more likely than men to seek help for physical, marital or family problems without mentioning alcohol use, and to attribute drinking-related symptoms to the stresses of everyday life (Curlee, 1970; Johnson, 1965). Women are overrepresented in mental health treatment populations, yet are underserved for problems incongruent with traditional sex role stereotypes (Russo & Sobel, 1981). Women with depression, a

stereotypically "female disease," are more likely to seek help and be correctly diagnosed and treated. But women with alcohol problems, a "male disease," are more likely to be misdiagnosed or left untreated (Ettorre, 1986).

Significant others of white, middle-class, heterosexual women often ignore or deny their alcohol problems as a way of protecting women from negative labeling (Ridlon, 1988). Half of the 89 women in James' (1975) study tried to discuss their drinking with someone, but were told that they could not possibly be alcoholic, leading half of these women to consider suicide as a way out. Such "protective" actions by family and friends permit heavier alcohol-related damage to be incurred as these women continue to drink while others "turn their heads" (Ridlon, 1988). It is not known whether similar pseudo-protectiveness operates in lesbian communities.

Women tend to enter treatment when their social networks are exhausted (Mulford, 1977). Criticism of drinking by one's children is an especially motivating influence for women. Family and friends urging treatment, available child care options, and ability to pay are salient factors in women's helpseeking for alcohol problems (Beckman & Amaro, 1986; Muchowski-Conley, 1982). These considerations are also crucial for lesbians, particularly lesbian mothers (EMT Associates, 1991).

The literature does not clarify whether women enter treatment after a shorter drinking history because of more severe symptomatology or because their social networks refuse to compensate for them, as they might for problem drinking men. The perceived costs of entering treatment are greater for women than for men. Women experience more family opposition, financial pressure and friendship conflicts when

entering treatment for alcohol problems (Beckman & Amaro, 1986; Robinson, 1984). Husbands of alcoholic women typically don't suggest treatment, choosing instead to abandon their wives or conceal their problems (Hornik, 1977). A survey in San Francisco (EMT Associates, 1991) revealed that lesbians are likely to report relationship problems related to alcohol use, but do not end relationships for these reasons. Researchers concluded that lesbians tend to stay in troubled relationships. An alternate more positive view of the finding is that lesbians tend to remain committed to their partners and weather the troubles of alcohol problems, making lesbian partnerships an important source of social support and motivation to seek treatment.

Role of Health Care Providers

Medical specialties each offer a distinctly different interpretation of the same symptoms. When the presenting complaint is well within the domain of the specialty, underlying alcohol problems are not explored, especially if symptoms can be construed as unrelated to drinking. Specialists may defer to the ambiguous "primary care provider" whose supposed role is to address "lifestyle" difficulties such as alcohol problems. Nurses in specialized settings are pressured by the excessiveness of role demands to overlook difficulties, such as alcohol problems, which they consider to be tangential to the immediate health condition.

Physicians and clients may have incongruent role expectations of each other. Obstetrician-gynecologists are specialists, but are considered by many women to be their primary health care providers. Because specialists are likely to overlook signs of addiction, nurses have been encouraged to take up the slack by questioning

obstetrical-gynecological patients about substance use (Busch, McBride & Bonaventura, 1986). Despite a historical emphasis on the concept of holism in nursing, only recently has nursing begun to define intervention for alcohol problems in women as an appropriate concern for nurses working outside mental health areas (Hall, 1991).

There is virtually an "unspoken agreement" between physicians and female clients not to discuss alcohol use (Clark, 1981; Sandmaier, 1980). Rather, medical stereotypes of women and self-deprecation on the part of women themselves combine in the physician-client interaction to foster the prescription of psychoactive drugs (Ogur, 1986). Women are more likely than men to be perceived as pill takers by physicians (Hirsch, 1981). Physicians prescribe mood altering drugs more often for female than for male substance abusers (Celantano & McQueen, 1984; Robinson, 1984; Sandmaier, 1980; Schuckit & Morrissey, 1979), often fostering secondary addiction.

Incidence rates of women's alcohol problems, relative to the numbers of women entering treatment, suggest that physicians and other gatekeepers are reluctant to label problems as alcohol-related (Hanna, 1978). Health care providers tend to deny evidence of "unseemly" problems, such as alcohol abuse in female clients, focusing instead on physical, mental or sexual dysfunctions (Clark, 1981). Understandably, they are loathe to assign a label they view as negative (Critchlow, 1986; Johnson, 1965; Ridlon, 1988; Robinson, 1984), reflecting a malady they view as intractable (Wechsler & Rohman, 1982).

Jellinek's (1952) model of alcoholism progression, derived from an all male sample, drives current clinical assessment of alcohol problems. The stages posited by Jellinek are not applicable to women, which

results in their diagnosis at later stages of illness. For instance, covert drinking and remorseful feelings typically occur in early stages for men, but in the final stages for women. Early indicators of alcohol problems for women include: personality changes when drinking, memory blackouts, feelings of "supersensitivity" in response to others (James, 1975), behavioral excesses, unsafe sexual behavior, difficulties with children, lethargy, and changes in the appearance of skin or hair (Schmidt, Klee & Ames, 1989). Researchers in the area of alcohol problem indicators in women argue that the norms of women's daily existence are not known, which decreases clinicians' ability to identify breaks in usual patterns that might signal the onset of alcohol problems. Lesbians' daily patterns are even less known, making culturally sensitive, contextualized descriptions of lesbians' alcohol problems a research priority.

Coercion and Confrontation

Alcohol problems are among the few health conditions society has responded to by coercing the "sufferer" into treatment. Families, nurses, therapists, physicians, employers, law enforcement agencies and courts "arrange" confrontations, creating crises to convince individuals that their alcohol problems warrant treatment (Atkinson, 1985; Eells, 1986; Freedberg & Johnston, 1978; Luks, 1982; Nir & Cutler, 1978; Twerski, 1983).

Non-legal coercion usually takes the form of a group confrontation, often organized by a therapist or other health care provider. It involves the matter-of-fact, concerned, non-judgmental communication by significant others of specific drinking-related behaviors which have caused them harm and enumeration of consequences

should problem drinkers decide not to seek treatment (Tweed, 1989; Williams, 1989). Occupational health nurses, among others, may coordinate such interventions and/or use negative incentive policies to facilitate treatment referrals for problem drinking workers who are being threatened with termination (Lewis & Messner, 1986).

The results of confrontation are either described as "unpredictable" (Lewis & Messner, 1986) or "overwhelmingly successful" (Williams, 1989). Confrontation may initiate an emancipating recovery, or it may be experienced by the problem drinker as a dehumanizing and alienating interaction. It has been suggested that successful intervention is contingent upon having chosen the "reachable moment" for each problem drinker (Pires, 1989). Research on confrontation ordinarily omits female subjects, so its effectiveness for women has not been established. In one study that did include women, families of women problem drinkers acted as barriers to recovery (Robinson, 1984). Social networks of women are more likely to be protective, to oppose treatment, and to conceal alcohol problems than are those of men (Beckman & Amaro, 1984; Fewell & Bissell, 1978; Wood & Duffy, 1966).

In her study of lesbians with chronic illness and hidden disabilities, Browne (1985) found that lesbians perceived friends to be more supportive than family of origin, yet one third of their friends were unsupportive of their chronic illness identity. Browne and others (Kurdek & Schmitt, 1987) have found that lesbians' social networks have more non-kin members and a greater proportion of female members than those of heterosexual counterparts. Therefore, interventions for lesbians with alcohol problems seem contingent on the involvement of significant non-kin members of social networks. Research is needed to

establish (a) whether confrontation is a culturally appropriate intervention with lesbians with alcohol problems, (b) which members of lesbians' social networks would be most effective and (c) whether most lesbians have the required number of concerned others who identify their alcohol use as problematic.

Legal coercion takes the form of arrest, court mandated treatment, and imprisonment. Compared to alcoholic men, alcoholic women are less likely to get arrested and if convicted of an alcohol-related crime are less likely to earn a jail term or be referred for alcohol treatment (Blumenthal and Ross, 1978). These findings indicate a reluctance on the part of the legal system to label women's alcohol problems, and a general reluctance to incarcerate women in penal institutions. Resistance by gatekeepers to label women alcoholic has been thought to impede early intervention (Beckman & Amaro, 1984), but labeling of alcohol problems does not necessarily assure access to treatment in current judicial and health care arenas. Legal coercive measures tend to be counterproductive after the first phase of treatment, and frequently interfere with patients' rights to information and appeal (Freedberg & Johnston, 1978; Luks, 1982).

"Codependency" as a Factor in Helpseeking

"Codependency" is a term for certain maladaptive behavior patterns including denial, compulsivity, excessive self-sacrifice, hypervigilance, anxiety, depression, emotional constriction, stress-related illness, that may also be accompanied by substance abuse (Black, Bucky & Widder-Padilla, 1986; Cermak, 1986; Coleman, 1983; Deren, 1986; Woititz, 1983; Zerwekh & Michaels, 1989). Codependency has also been referred to as "relationship addiction," or a loss of self in

relationship. Women who are partnered to alcoholics or who are children of alcoholics often identify as codependent and join mutual help groups such as Alanon or Adult Children of Alcoholics (ACA). After a period of self-assessment in Alanon or ACA, some codependent individuals problematize their own alcohol use and seek treatment and/or join AA (Cermak, 1986). Likewise, those recovering from alcohol problems may at some point identify codependency as an additional problem. While the concept of codependency is not part of traditional AA ideology, it has become increasingly meaningful, especially for people who are influenced by several twelve-step programs. The subcultures of recovery are thus increasingly interwoven under the widening conceptual umbrella of "addiction."

There have been efforts made to adopt codependency as a psychiatric diagnostic category (Cermak, 1986). But the notion of codependency is so non-specific that designating it a disease could pathologize much culturally-relevant caring behaviors. Mutual help groups organized around the ambiguous label of codependency, such as Alanon, have legitimized womens' needs for social support. A "diagnosis," even a self-diagnosis, seems to be a prerequisite to personal change in U.S. culture (Young, 1971). Unfortunately, the logic of codependency may overly individualize responsibility for social problems and pathologize natural support systems in exchange for mutual support group benefits. Ergo, in this study, the term codependency is used when referred to by others, but codependency is not recognized in this theoretical framework as a clinical entity.

Recovery from Alcohol Problems

Recovery from alcohol problems is a change process initiated in the helpseeking and treatment phases that continues over a lifetime. One view of recovery suggests that, in response to a personal crisis, the whole life pattern is reconstructed by the self within the context of other recovering persons (Brown, 1985). For many individuals the success of recovery depends upon their participation in AA, a relatively effective mutual help program for many chemically dependent persons (Emrick, 1987; Zimberg, 1985).

Culturally it appears that drinking alcoholics live in "a world apart" created by prolonged distortion of thought and isolation. They have a markedly different relationship to drinking and live in different "social worlds" than do nonalcoholics or recovering alcoholics (Biernacki, 1986; Maxwell, 1984). Recovery, therefore, means leaving this "world apart" and discovering a whole new world. AA is a subculture in which the alcoholic is assisted to make this transition by those who know the symbols and language of the problem drinking experience (Maxwell, 1984).

Recovery in the Context of Professional Treatment

Professional treatment includes any number of modalities: detoxification, individual and group therapy, medications (e.g., disulfiram, known as Antabuse), education, family therapy, cognitive therapy, mutual help group (AA) activities, occupational therapy, employment counseling, biofeedback, aversion therapies and assertiveness training (Bennett & Woolf, 1983). Typical programs combine detoxification, individual counseling, group therapy and family

involvement, while some clients are referred for long term residency in halfway or 3/4 way houses (Cahalan, 1988).

The choice of controlled drinking versus abstinence as a recovery goal, and who gets to make that decision, are critical issues for all clients. At the current time, abstinence is so widely promoted that opting for controlled drinking virtually places a client outside of the conventions of most treatment programs and AA's mutual support.

Effectiveness of Treatment

Empirical evaluation of alcohol treatment programs is complicated by the variety of definitions of alcohol problems used, a lack of clear outcome variables and the variety of treatment strategies used in practice. Cross-sectional, retrospective and short term repeated-measures studies show that treatment programs are generally more effective than no treatment (Emrick, 1974; McLellan, Luborsky, O'Brien, Woody & Druley, 1982). Any treatment seems to "work" to some extent, however, some individuals find their way out of drinking problems without professional treatment (Cahalan, 1988).

Treatment effectiveness appears to be unrelated to the goal of treatment or the specific interventions used. Whether moderation of alcohol consumption or abstinence was the treatment goal, client outcomes were similar. Psychotherapy, group therapy, hypnosis, covert sensitization, disulfiram, aversion, cognitive restructuring, blood alcohol level (BAL) discrimination training, behavior modification, operant learning and mutual support groups were each found to be moderately effective (Miller & Hester, 1980).

The length of followup in longitudinal studies of treatment and non-treatment effectiveness determines overall impressions of the

prevalence and severity of alcohol problems and the definitions of recovery and relapse. In a review of empirical studies of treatment effectiveness (Miller & Hester, 1980), the general conclusion was that at one year follow-up, approximately 26% of treated alcoholics were abstinent or "improved," which means a reduction in the frequency and severity of drinking and its negative consequences. This figure was compared to the rate of abstinent or improved controls. At one year follow-up, approximately 19% of untreated alcoholic controls were abstinent or improved.

By the end of a three year study of persons with untreated alcohol problems, some were no longer experiencing problems associated with alcohol, whereas others were (Cahalan, 1978). Problem drinkers who did not exhibit alcohol problems after three years, even though they did not receive any treatment, were called "spontaneous remissions." Such an outcome would be considered impossible from the standpoint of the permanent "loss of control" posited in the disease model (Keller, 1972). Remissions of alcohol problems without treatment are usually not completely "spontaneous" but are linked with transitions, such as marriage, job change, physical illness, financial crisis (Saunders & Kershaw, 1979), or with maturation and "settling down" (Cahalan, Cisin & Crossley, 1969; Vaillant, 1983).

Most longitudinal studies do not cover a long enough period of time to detect a return to problem drinking occurring in long term recovery. Vaillant's (1983) study is the exception, but it was limited exclusively to male subjects. In his 40 year longitudinal study of 600 men, the majority of recoveries, defined as prolonged periods of abstinence, occurred outside of clinical intervention. These results

must be interpreted in light of the fact that few treatments were available during much of the time period covered by the study. Vaillant's major conclusion was that recovery is not "spontaneous," rather it is always attained through the help of others.

Most evidence suggests a self-limiting quality to addictive problems which may precipitate improvement or remission unrelated to interventions. Any treatment, no matter the type, may be effective because it functions as a source of attention and support. More and better designed research is needed to clarify which treatments are most effective for specific kinds of problems and clients (Miller & Caddy, 1977; Miller & Hester, 1980). The "drunk-abstinent" dichotomy needs to be replaced by outcome evaluation which includes a pre-treatment baseline, defined criterion variables and multiple follow-up assessments utilizing collateral sources of data (Sobel, 1978). A serious lack of methodological progress in the treatment arena itself reflects fears of external criticism, and the belief that evaluation is too costly and intrusive. Moreover, moral and punitive themes historically associated with treatment for alcohol problems (Tournier, 1986) draw attention away from the need for systematic evaluation of therapeutic effectiveness.

Relapse

Changing a habit pattern such as problem drinking has been described as a process occurring in three stages: (a) readiness to change, (b) implementation (treatment of the problem) and (c) maintenance (Marlatt & Gordon, 1985). Relapse refers to a failure to maintain the intentional change in a behavior pattern. In terms of alcohol problems, relapse usually refers to a return to drinking after a period of abstinence. Two thirds of empirically recorded relapses occur

within 90 days post-treatment (Marlatt & Gordon, 1985), however, research studies and treatment programs ordinarily follow individuals for only six months or a year. Relapses can occur after one, five, or even 20 years (Vaillant, 1983).

How relapse is responded to often reveals the attributional orientations of health care providers and clients. For instance, in the disease model a single lapse in abstinence constitutes a full relapse, because it is believed to lead inevitably to a complete loss of control over drinking. As a result, an "abstinence violation effect" occurs wherein guilt and self-condemnation accelerate the progress from a single lapse to full relapse (Marlatt & Gordon, 1985).

Relapse prevention is a strategy that prepares an individual for what to expect when a lapse occurs, and how to prevent its escalation into a full relapse, regardless of whether the treatment goal is controlled drinking or abstinence (Marlatt & Gordon, 1985). This promising direction in research and intervention represents an attempt to identify treatment strategies that do not depend on the disease model and the abstinence goal, but could be implemented in a variety of treatment programs, including those with controlled use orientations. The relative effectiveness of this approach in women, or lesbians, in particular, has not been explored.

Women and Alcohol Treatment

Controlling for gender differences in prevalence of alcohol problems, men have been found to enter alcohol treatment more than twice as often as women, contrasting sharply with womens' utilization of other health resources (Furst, Beckman, Nakamura & Weiss, 1981). It is unclear, however, whether this trend has persisted into the present. In

a survey of gay men and lesbians, twice as many men as women reported receiving services from alcohol/drug treatment facilities in San Francisco (EMT Associates, 1991). Women's lower socioeconomic status accounts for much of their underutilization of alcohol services (Beckman & Amaro, 1984). Employers are less likely to confront female employees about their problem drinking and mandate treatment (Beckman & Kocel, 1982; Beyer & Trice, 1981). They are more likely to simply fire women with alcohol problems, especially since, compared to men, they are more often in expendable positions such as clerical, retail and service work.

Treatment for alcohol problems can be psychologically traumatic for women. More often than men, women are inappropriately routed through psychiatric wards. In mixed-gender alcohol treatment programs, personnel commonly have rigid, traditional sex role behavioral expectations regarding female clients, labeling women problem drinkers as "unfeminine," "insensitive," "seductive" or "sleazy" (Sandmaier, 1980). Alcohol/drug treatment personnel in general have more absolutist views than do caregivers in other fields (Young, 1971). All-women treatment programs are rare. By 1980 the National Institute of Alcohol and Alcoholism (NIAAA) had funded only 29 women's programs among a total of 500 treatment facilities in the U.S. (Sandmaier, 1980), even though women's programs have demonstrated above average success rates (Sandmaier, 1977). All-women treatment programs have not been empirically substantiated as more effective for women than mixed-gender treatment programs (Duckert, 1987; Vanicelli, 1984), but certain subgroups of women may benefit more from these programs. Qualitative data indicates that lesbians prefer female providers of care (Cantu, 1985; Clark & O'Connell, 1985; Stevens & Hall, 1988).

Women demonstrate variability in their treatment-related preferences regarding such issues as significant other involvement (Muchowski-Conley, 1982), individual versus group therapy (Annis, 1980; Curlee, 1971) and acceptance of aftercare (Corrigan, 1980; Gary & Gary, 1985-86). Variability by race, class and ethnicity accounts for many of the differences. The number of life stressors that women clients bring to treatment correlates with recovery rates; the more problems women face in addition to their difficulties with alcohol, the poorer their prognosis (MacDonald, 1987). Typical stressors are emotional, marital, sexual, medical, financial, parental or job-related. For instance, women identify lack of job training as a major factor in their alcohol problems, whereas their caregivers do not prioritize this as a problem for their clients (Levy & Doyle, 1974). Social support is another key factor; the greater the number of personal relationships a woman has on entering treatment, the better the abstinence rate (MacDonald, 1987).

Relapse risk is increased for women who are non-assertive and have great anxiety about facing alcohol-related situations post treatment (Rist & Watzl, 1983). Assertiveness training has therefore been useful in women's alcohol treatment, especially if geared to women's alcohol-related social dilemmas. Other topics about which women clients desire education are: effects of prescription drugs, general nutrition (Fredericks, 1976), blood sugar problems, exercise, shame, depression, guilt, sexual issues, spirituality, lesbianism and bisexuality (Schaefer & Evans, 1987).

Reviews of the literature on treatment of women's alcohol problems point to myriad gaps in knowledge due to methodological difficulties, inappropriate research questions, inadequate sampling, inconsistent

outcome measures, and misconstrual of results (Beckman & Amaro, 1984; Braiker, 1984; Duckert, 1987; Russo & Sobel, 1981; Vanicelli, 1984). Characteristics of providers, interactional dynamics among providers, clients and significant others, as well as modes of intervention are not well-assessed in alcohol treatment studies (Miller, 1985). Many general studies fail to report gender ratios. Women in general, and lesbians in particular, are statistically invisible (Morales & Graves, 1983; Vanicelli, 1984).

Lesbians and Alcohol Treatment

The National Directory of Facilities and Services for Lesbian and Gay Alcoholics (Vachon, 1987) lists 297 agencies or persons in 37 states who offer some type of alcohol-related services geared toward gay men and lesbians. Fifty-two of these listings are private psychotherapists. The range of services offered includes volunteer hotlines, support groups, literature, legal advice, individual therapy, as well as outpatient and inpatient treatment. Of the 188 treatment programs listed, 60 are inpatient and 156 are outpatient. Only 24% provide any free services to indigent clients. While 20% have an all gay/lesbian staff, 18% report having no openly gay/lesbian staff members. Only 8% of these services are offered in a women-only format; most are primarily oriented toward the treatment of gay men's alcohol problems. An apparent assumption is that lesbians' problems with alcohol are the same as gay men's. Lesbian-oriented formalized treatment is not widely available. The effectiveness of these gay/lesbian services in terms of lesbians' recovery from alcohol problems has not been studied. Especially difficult to document is the success and cost-effectiveness

of private psychotherapy in fostering recovery for lesbians with alcohol problems.

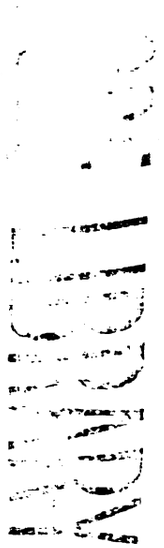
A survey of providers, lesbians, and gay men in San Francisco (EMT Associates, 1991) indicated that lesbians' access to substance abuse services is limited by: (a) lack of services specifically for lesbians, (b) lack of sensitivity toward lesbians in general programs and (c) burdensome costs and long waiting lists. Alcohol treatment staff have more authoritarian and "homophobic" responses toward lesbian clients than do drug treatment staff. Perhaps drug treatment staff are less judgmental because they are accustomed to dealing with the stigma of criminality attached to illicit drug use (Morales & Graves, 1983). Even in San Francisco, a city known for its liberal views about gays and lesbians, alcohol treatment services are not adequately developed nor well enough funded to meet the lesbian community's needs.

Lesbians often find formalized treatment programs unresponsive to their needs because providers tend to: (a) assume heterosexuality, (b) underestimate the daily impact of stressors lesbians face, (c) disregard lesbian partnerships, (d) focus on lesbianism as the "problem" instead of adequately addressing alcohol issues and (e) refuse services to known lesbians (Anderson & Henderson, 1985; Cecconi, 1983; Colcher, 1982; Johnson & Palermo, 1984; Morales & Graves, 1983). Needs lesbian clients might have regarding acceptance and affirmation of themselves as lesbians are usually overridden by the clinical view that when these needs coexist with alcohol problems, the alcohol problems must be prioritized (Colcher, 1982; Glaus, 1988). This reflects the influence the alcoholism movement's disease concept has had on clinical practice. Currently, the majority of alcohol treatment programs avoid focusing on

"underlying issues" construed as driving the problem drinking in favor of defining addiction itself as "the problem" (Peele, 1984). Questions persist about the efficacy of this singular approach. For instance, lesbians who wish to stop drinking but have not developed other means of easing the pain, alienation and low self-esteem that results from living in a culture that ignores, vilifies and pathologizes them may find that these "underlying issues" are not addressed in clinical settings.

Recovery in the Context of Mutual Help Groups

Alcoholics Anonymous: The Prototype Mutual Help Group



AA, the prototype mutual help program in the U.S., is deeply rooted in the pragmatist and populist traditions. AA was profoundly influential in changing the negative stereotypes of alcohol problems. From 1935-1955 its membership grew from 2 to 133,000. Historically, the influences on which AA was based were the Oxford movement, Carl Jung's views of spirituality and recovery, William James' descriptions of conversion, and the personal recovery experiences of a New York stockbroker and an Ohio proctologist in the 1930's (Kurtz, 1988). Its philosophy complements American tendencies to join, to seek group identification. It advocates optimism and empiricism and opposes scientific elitism (Dumont, 1974; Hall, 1991). Though spiritually oriented, AA has tried to appeal to the non-religious while not offending the religious. AA culture is relatively unstructured, compared to modern bureaucratic institutions. AA members tend to value personal experience and face-to-face interaction over scientific objectivity, egalitarian cooperation over hierarchical relations and group consciousness over legal authority (Kurtz & Kurtz, 1986).

How do people find and join AA? A 1980 AA survey showed that 38% of AA members credited professional help with getting them into AA. Even more members affiliated through contact with other AA members (Maxwell, 1984). Another study found the following entities to be instrumental in leading individuals to join AA: (a) another AA member, (b) family, (c) physician and (d) the media (Norris, 1976). AA members appear to have a keen sense of timing in how new members are approached and assisted (Robinson, 1979). Further study is needed to document how gender, class and sexual orientation affect this sense of timing in the interaction between group members and newcomers in AA.

It has been suggested that AA appeals to lesbians because of its democratic, somewhat decentralized, structure (Herman, 1988). Another attraction lies in the current organization of AA, which allows subgroups, such as lesbians, to form meetings of their own under the auspices of the larger organization. A stumbling block for lesbians and others who do not conform to group custom comes in the form of dogmatism and inflexibility in general AA groups (Hall, 1990b). For example, the question of political activism is a point of conflict between mainstream AA members who avoid discussion of "outside issues" and minority AA members who face social discrimination within AA as well as in the outside society. There is much variability in the way AA's tenets are interpreted by individual members (Bean, 1975a; 1975b), but AA clearly has social reinforcement functions (Cahalan, 1988).

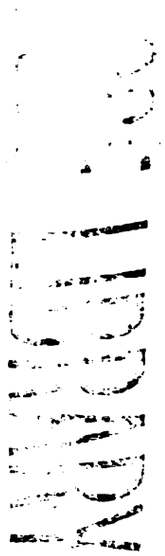
As for the interactional workings of AA, a number of authors have suggested that the negative stigma of "alcoholism" is reversed through a relabeling process in AA (Trice, 1970). The change process is not merely a transition from drinking to abstinence. Rather, admitting one

is "alcoholic" in AA includes a commitment to change one's entire lifestyle (Robinson, 1979). Coming to AA and admitting one is alcoholic signifies identification with the group and commitment to a new future. Recovery for the "alcoholic self" has been described as a group interactional phenomenon, wherein individuals take on the identity of a recoverer, deconstructing and rebuilding their self-concepts in the context of AA (Denzin, 1987). Individuals in AA extend themselves toward others, yet paradoxically, the helper is believed to be helped more than the receiver (Caplan & Killilea, 1976).

James (1902) used the concept of conversion to frame a negotiation of identities. AA adheres to this image of recovery; the alcoholic leaves an old self behind and becomes a new person. In AA recovery, telling one's story of conversion from drunkenness to sobriety acts as a model for interpreting the past and a basis for "recreating" the self (Thune, 1977). Crucial disclosure dilemmas emerge for individuals whose life experiences include non-alcohol related stigmatizing features. In mainstream AA groups, predominantly white, heterosexual and middle class, lesbians may not attain the degree of affiliation needed for successful recovery because they cannot safely disclose their life stories.

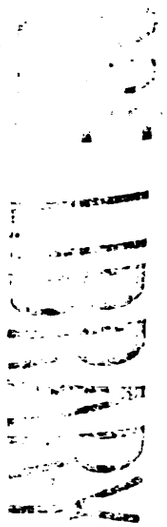
Researchers have been fascinated by the process of recovery in AA. Taylor's (1979) model of recovery in AA has five stages: (a) "hitting bottom," (b) simplification, (c) "honeymoon," (d) re-emergence of life problems, and (e) perpetual recovery. A crisis event (hitting bottom) usually precipitates helpseeking, which leads to professional treatment, AA involvement or both. Recovery, in this stage process, is viewed as beginning in the drinking period via a "drive toward surrender" (Zweben,

1986) in which the individual seems to be subconsciously preparing to "hit bottom" (Taylor, 1979; Trice, 1959). In the simplification phase, other AA members assist the novice to focus all of his/her energy on the task of not drinking, no matter what (Taylor, 1979). For example, the bodily and behavioral changes of early recovery, including appetite swings, grief, depression, irritability, and sleep disturbances (Hoffman & Estes, 1987) are addressed in the AA slogan "H-A-L-T," meaning "Never get too hungry, angry, lonely or tired." With the establishment of a new life pattern free of alcohol use, there is elation, a type of honeymoon. At some point in this honeymoon phase, life problems that were temporarily overshadowed by the alcohol crisis re-emerge. Then, according to the model, long term efforts toward recovery begin. In the phase of perpetual recovery one becomes "sober" rather than merely "dry." The "new person" works intensely to deal with daily struggles, while developing the ability to handle problems which contributed to past drinking (Taylor, 1979).



As for the effectiveness of AA, the anonymity, ambiguity and fluidity of AA's membership make consistent estimates of the program's success virtually unobtainable (Leach & Norris, 1977). Longer term AA members have been observed to attend fewer meetings (Leach, 1973). Nevertheless, AA is largely a "way of life" internalized by its adherents. Therefore, meeting attendance alone is not an accurate criterion of its success (Kus, 1988b). Many alcoholics do not find a way of life in AA and return to drinking (Vaillant, 1983). But of those introduced to AA who subsequently resume drinking, some return to AA at a later point. They often report that exposure to AA changed their perceptions about alcohol, e.g., "AA spoiled my drinking" (Brown, 1985).

AA appears to be a positive influence in maintaining recovery for those who are well affiliated into its ranks. Problem drinkers' identifications with the images presented by other AA members seem to be crucial to their successful recovery in AA. Accordingly, those at either end of the spectrum, problem drinkers who avoid AA altogether and problem drinkers who are well affiliated in AA seem to have fewer difficulties in recovering from alcohol problems than those who "misaffiliate" or respond ambivalently toward AA (Robinson, 1979). Those (gender unspecified) who have irregular or infrequent AA contact have a poorer outcome (measured by aftercare attendance and time abstinent) than either those who make no AA contact or those who are regular AA attenders (McLatchie & Lomp, 1988). This indicates that AA affiliation may be easier for certain subgroups, who probably differ socially and psychologically from subgroups who do not affiliate (Ogborne & Glaser, 1981; Trice & Roman, 1970). More research is needed to determine the conditions of AA affiliation for specific subgroups, regions, and historical periods. The effectiveness of AA for lesbians, as for other subcultural groups, has not been established.

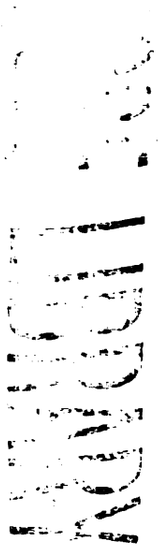


Women and Mutual Help Groups

Historically, women have struggled to gain peer status in AA (Vourakis, 1989). The development and proliferation of women-only and other "special interest" AA groups (e.g., atheist, African-American, dually addicted, Latino, lesbian, gay) suggests that AA still retains a white, Christian, middle class male aura (Kurtz, 1988; Leland, 1984; Vourakis, 1989). Lesbians, for instance, report difficulty in affiliating with predominantly white male AA groups (McNally, 1989). Women's AA meetings or all-lesbian AA groups often provide a safer, more

comfortable environment for lesbians to discuss discriminatory interactions and to normalize multiple stigmas (Hall, 1990b).

In her grounded theory study, Vourakis (1989) documented the process of AA group selection by recovering women. Group selection is not a once-and-for-all decision based on compatible demographic characteristics of joiner and group, but a complex ongoing process guided by a calculus of personal, group and structural factors. Early group selection is rather hit-and-miss; later it is more specifically articulated with personal growth needs. Based on these findings, the calculus of group selection by lesbians in AA may be expected to change over time and depend on factors other than sexual orientation, such as group size, drinking styles, gender and social class. This is an area for further research.

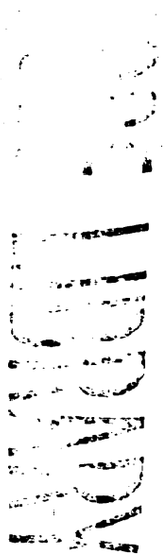


Women for Sobriety (WFS) is another mutual help group for women with alcohol problems. WFS was founded by Jean Kirkpatrick, a sociologist who herself had difficulty affiliating with AA (Kirkpatrick, 1977). Both AA and WFS describe alcoholism as a "disease," but WFS's thirteen principles differ from AA's twelve steps. They stress "control" instead of "powerlessness" and define personal growth and positive thinking more broadly. Compared to AA meetings, there seems to be a less competitive atmosphere in WFS meetings. For instance, women appear more open in discussing relapses in abstinence from alcohol (Kaskutas, 1989). WFS is often attended by women AA members who supplement their recovery by adding the WFS perspective. Other WFS members prefer to attend WFS meetings exclusively. It should be noted that in comparison to AA, WFS is far less accessible to women because it

is a relatively new organization and has been established only in limited regions, usually in urban areas.

Lesbians and AA

Lesbians have joined AA and other twelve-step programs in appreciable numbers, as evidenced by the increasing numbers of gay and lesbian "special interest" meetings. These meetings have been launched in response to ideological and social barriers in AA, such as sexist language in AA literature, Christian imagery, homophobic interactions and anti-gay/lesbian "jokes" (Anderson & Henderson, 1985; Bittle, 1982). The first all-lesbian/gay AA conference was attended by 178 people in San Francisco in 1976. Many major metropolitan areas have since hosted similar annual conferences. In 1989, attendance at San Francisco's "Living Sober," the world's largest lesbian-gay AA conference, reached 5200 (Heins, 1989).



Bloomfield (1990) found that as lesbians remain in AA over a period of years, their friendship networks increasingly incorporate lesbians who are also AA members. Retention of AA friends provides a high level of social support that bolsters continuing participation in AA. This suggests that social support may be a key aspect of AA for lesbians who use this form of mutual support. The friends one makes in AA, rather than other facets, such as AA philosophy and literature, may be most important to long term recovery.

It may be that twelve-step groups provide a sense of family, acceptance and spirituality for lesbians who are rejected by churches, families of origin and other socially supportive institutions because of their sexual orientation. But some lesbians object to what they see as an uncritical acceptance of the "twelve-step worldview" by so many of

their sisters recovering from a variety of self-diagnosed addictive problems (Hall, in review). The danger in affiliating with AA, as they see it, is that lesbian political activism may be replaced by individualism and spiritualism (Herman, 1988; Johnson, 1989). A contrasting view is that recovery programs and mutual help groups are potentially as liberating or oppressive as participants make them (McDaniels, 1989). As one lesbian activist put it:

> The lesbians I see going in to twelve-step programs are basically trying to stay alive. They aren't the people I would see at political meetings. Without recovery they would probably be dead. Dead women don't have any politics (Hall, in review).

Questions about liberation relative to lesbians' participation in mutual help groups such as AA need to be examined with more focus on context, available options, choice of groups and long range collective outcomes in lesbian communities where the trend toward recovery has been well established.

Summary

The stigma against women with alcohol problems and the stigma against lesbians share common negative elements, including sexualization, imputation of "homosexual desires," immaturity, rejection of marriage and motherhood, unattractiveness, masculinity, self-hatred, suicidality, jealousy, aggressiveness and criminality. The mutually reinforcing qualities of these shared elements make it likely that stigmatization will be severe for lesbians with alcohol problems (Hall, 1990a).

The epidemiological study of alcohol problems has not adequately included women, let alone lesbians. The incidence of alcohol problems cannot be reliably discerned in stigmatized, hidden communities (Morin,

1977), but is believed to be significantly higher in lesbians than in heterosexual women. The focus on genetic etiology has not produced a viable intervention for preventing or treating alcohol problems to date. The etiological focus on female biology and sex roles has discriminated against women, and may be more directed at controlling women than controlling alcohol problems. This preoccupation has undoubtedly precluded investigation of other aspects of women's alcohol problems. Because of a pattern of disproportionate scholarly attention to white males, little progress has been made in developing a knowledge base that addresses the prevention and control of alcohol problems in women.

Research on helpseeking indicates that women's helpseeking patterns are different from men's, but clarification of these differences necessitates interpretive study of women's helpseeking experiences in response to alcohol problems. As the etiology of alcohol problems remains enigmatic, a single causative variable and the possibility of a universal treatment are equally unlikely. There is much variability in terms of treatment strategies, numbers of interventions in each program, outcome measures and empirical design which mitigates against standardization, consensus and reliability of findings. Current treatment strategies are not correlated with etiological factors nor with patterns of helpseeking. The research on treatment demonstrates clinical and theoretical attempts to "cover the bases" by combining strategies from biological, psychological and social models of alcohol problems. Treatment effectiveness data indicates that only a minimum of empirical control has been achieved in tempering the impact of alcohol problems. Qualitative methods are more feasible and

flexible in the process of identifying approaches to treatment that are deemed effective and useful by various client groups.

Debate persists as to the efficacy of abstinence or moderation as recovery goals. Long term recovery remains largely unexplored, though relapse prevention provides a strategic basis for moving beyond initial recovery issues to anticipate long term recovery patterns. AA's effectiveness among selected populations is not known because quantitative research schemes have sampling difficulties and employ clinically biased outcome measures.

There is a great need for information on the subjective experiences of recovery from alcohol problems, helpseeking, treatment, and mutual help from a lesbian perspective. How do lesbians define alcohol problems? What actions do they take in their recovery? Do lesbians have access to treatment for alcohol problems? How are they perceived and treated by health care providers? Are most lesbians who are recovering from alcohol problems involved in AA? How is AA viewed by lesbians? What are lesbians' recovery experiences outside of AA? How are the experiences of codependency and addiction related for lesbians? In what other terms might these experiences be expressed? How are perceptions changing regarding alcohol problems in lesbian communities? How do lesbians interpret the role of recovery in their personal and collective lives?

This literature review suggests several areas of concern about recovery from alcohol problems in lesbians which have emancipatory implications, including (a) the political implications of theoretical conflicts in the alcohol field about treatment and recovery processes; (b) the array of social and political influences on women's drinking,

sbians' drinking; (c) the dynamics of race, gender, class
ientation in alcohol problems and recovery; (d) sexist and
assumptions in research; (e) the implications of coercion
in treating persons with alcohol problems; (f) the
and effectiveness of treatment for women's alcohol
lesbians' perceptions of caregivers and (h) benefits and
alternatives to, twelve-step groups. These issues are
n viewing alcohol problems from a critical feminist
If explicated, they could provide contextual information
ndividual experiences in alcohol recovery.
these issues for further inquiry are embedded in the
which lesbians identify their drinking as problematic and
response to such problems. The nature of the relationship
ery from alcohol problems and the process of emancipation
importance in building theory to guide nursing practice in
nities. A clearer picture of this relationship is a
ctive of this study.

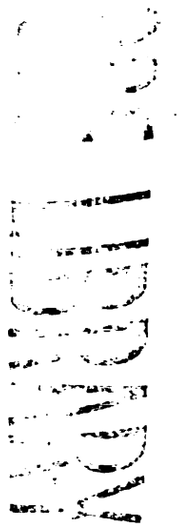
Research Questions

poses of the current study were to investigate the
problem definition, helpseeking and recovery in lesbians
tify as having alcohol problems. The research questions

lesbians identify their use of alcohol as a problem?
e lesbians' helpseeking experiences regarding alcohol
s?
lesbians describe and interpret their health care
tions regarding alcohol problems?

4. How do lesbians describe their experiences in recovery from alcohol problems?

5. What are lesbians' experiences in mutual help groups associated with recovery from alcohol problems?

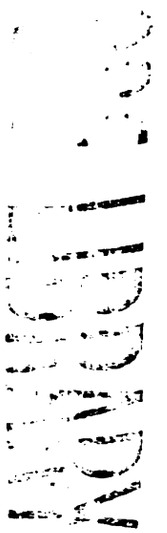


CHAPTER 3

METHODOLOGY

Study Design

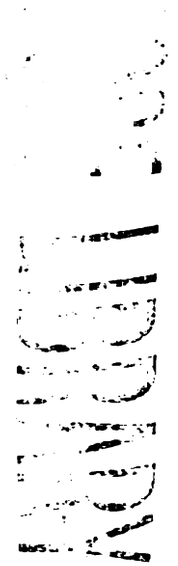
This critical ethnographic study of lesbians' experiences in recovering from alcohol problems incorporated ethnographic-style interviewing and critical analysis in the generation of knowledge. Conceptual and operational definitions of central terms used in the study can be found in Appendix C. Because of the need for flexibility and reflexivity in critical ethnographic studies, various strategies for accessing participants, interviewing, data analysis and dissemination of findings were explored throughout the research process. Those strategies that were actually used are discussed here. As the components of the methodological design are outlined in the following pages, issues concerning rationale, ethics, the population of interest, the researcher, and rigor in ethnographic studies are examined.



Ethnography is a tool for understanding a given area of human experience, including the environment that surrounds it, the history that precedes it, the intent of the persons who create it and the pattern that gives it form (Agar, 1980; 1986). Ethnography is a description of a subculture from member's point of view (Cohen & Tripp-Reimer, 1988; Werner & Schoepfle, 1987). Examining descriptions of real-world situations in terms of motives, goals and values, and envisioning a more emancipated future are definitive elements of critical ethnography (Clifford, 1986; Cohen, 1985). Critical ethnography validates and interprets descriptive data through comparison to broader social, economic and political environments. In order to address emancipatory issues in field research, investigators improvise

with situational demands. Innovative methods, gathered from a variety of sources and tailored to the particular needs of the research situation, are employed (Reinharz, 1983).

This study design required some innovation in terms of making the research process acceptable and credible for lesbians, who have historically suffered from the process and conclusions of pathologizing research. For example, the demographic questions were finely edited to avoid heterosexual assumption, using words such as "partner" and "significant other" rather than "spouse" or "husband." Flyers were placed in specific locations which would let potential participants know that the researcher was familiar with lesbian social contexts. The investigator used self-disclosure selectively to meet participants' needs to know what memberships and identities were shared by investigator and participant.



Setting and Sample

The setting of the study was the lesbian communities of the San Francisco and Berkeley-Oakland areas. Recruitment was from a community-based population. No recruitment of patients from mainstream bio-medical health services was done. Inclusion criteria for volunteers indicated that they be: (a) at least 21 years of age, (b) self-identified as lesbians, (c) self-identified as having problems with alcohol, and (d) at least one year into their recovery from alcohol problems. The last criterion was based on an assumption that women who have been in recovery for at least a year are able to be reflective about their own recovery process. Their perceptions and interpretations about their use of alcohol and strategies for recovery, therefore, contain a self-analysis beyond the mere reporting of past events.

Volunteers for participation needed to identify themselves as having an alcohol problem, but there was no requirement that they label themselves as "alcoholic" or "addicted," nor did they have to be members of AA. A total of 35 women recruited through purposive sampling participated in interviews during several months of 1990 and 1991.

Recruitment of Participants

Initial participants were recruited through research notices posted in selected contexts in local lesbian communities (e.g., women's book stores, The Women's Building, women's cafes and coffeehouses, lesbian owned businesses) and research notices mailed to lesbian organizations (see Appendix D). The flyers described the study and particularly invited the participation of low-income lesbians, lesbians of color and older lesbians. It was made clear that involvement in AA or any other mutual help group was not required of participants; non-AA members were sought to provide a basis of comparison, and to more accurately represent the diversity of experience within the study population. Those interested in participating contacted the investigator by phone and received more information. At that time, interviews were scheduled with those who agreed to participate.

A second wave of participants was generated by word-of-mouth referral by initial participants in a snowball fashion (Becker, 1978; Biernacki & Waldorf, 1981; Burgess, 1984). Eleven women, 31% of the total sample, responded by telephone after seeing the posted flyers. Nine women (26%) responded to flyers that were mailed to lesbian organizations and had been passed along by co-workers and organization members. Fifteen women (43%) were recruited through snowball sampling. Recruitment was facilitated by the personal efforts of many individuals

in the lesbian community, several of whom were never in direct contact with the investigator. The study was apparently perceived as valuable and appropriate by many women and word of it was passed along.

Several members of the lesbian community were enlisted as informants to: (a) help recruit participants, especially those from ethnic/racial minority groups, (b) provide feedback in response to selected analyses of the data in terms of its validity and (c) assist in decisionmaking regarding political, ethical and theoretical dilemmas in the research process. Informants are generally those persons who share a narrative understanding of the research situation with the investigator (Bruner, 1986) and report information about the communities to which they belong, rather than about themselves (Zelditch, 1962).

Study Participants

Demographic Profile

A demographic profile of the sample of 35 lesbian participants is provided in Table 1. Twenty-four (68%) identified themselves as Euro-American, six (17%) as African-American, three (9%) as Latina, one (3%) as Asian-American and one (3%) as Native American. Ages of participants ranged from 24 to 54; the mean was 37. The mean length of time in recovery from alcohol problems was 5.7 years, with a range of 1 to 25 years. Number of years of education varied from 12 to 22, with a mean of 16.3. All participants had graduated from high school or had completed equivalency requirements. Twelve (34%) had attended some college. Twenty-one (60%) had college degrees; among these, 11 had masters degrees and 2 had doctorates.

Table 1
Demographic Profile

Demographic variable	Mean [a](SD)	Range	Frequency	%
Race				
Euro-American			24	68
African-American			6	17
Latina			3	9
Native American			1	3
Asian-Pacific			1	3
Age	37 (7.2)	24-54		
Years of education	16 (2.4)	12-22		
Annual Income ($000)	27 (12)	9-50		
Years in recovery	5.7 (5)	1-25		
Occupation				
Business			9	26
Counselor			5	15
Clerical			4	11
Nurse			4	11
Social Worker			3	8
Laborer/Service			3	8
Community Organizer			2	6
Student			2	6
Homemaker			1	3
Teacher			1	3
Performer			1	3

Note. N = 35.
[a]SD = Standard deviation.
[b]Three subjects were unemployed at the time of the interview.

Participants' incomes were remarkably low relative to their educational levels. In terms of yearly income, 12 (34%) of the participants reported less than $20,000, 11 (31%) reported incomes of between $20,000 and $29,000, 6(17%) reported incomes of between $30,000 and $39,000, and 6 (17%) had incomes between $40,000 and $50,000. The range of yearly income was $9000 to $50,000; the mean was $27,000. As a matter of comparison, the average annual pay for 1990 in the San

Francisco metropolitan area was $30,325 (U.S. Department of Labor, 1991).

Class backgrounds were determined by participants' self-definitions: 8 (23%) impoverished, 16 (46%) working-class, 10 (28%) middle-class, and 1 (3%) affluent. By comparing current incomes to participants' self-descriptions of economic circumstances in the households of their youths, 12 (34%) were downwardly mobile, that is, living at a lower economic standard now than at the time they were growing up. Eleven (32%) had approximately the same standard of living when compared to their family of origin and 12 (34%) were categorized as upwardly mobile.

Figure 1 illustrates the occupational profile of participants. Thirty-four percent were employed in health occupations, many of them in HIV services or substance abuse fields. The subject matter of the research was obviously a factor in this occupational distribution; in addition: (a) women are more often employed in help-related fields, (b) lesbians choose HIV-related work in solidarity with women and gay men living with HIV, and (c) entering the substance abuse counseling field

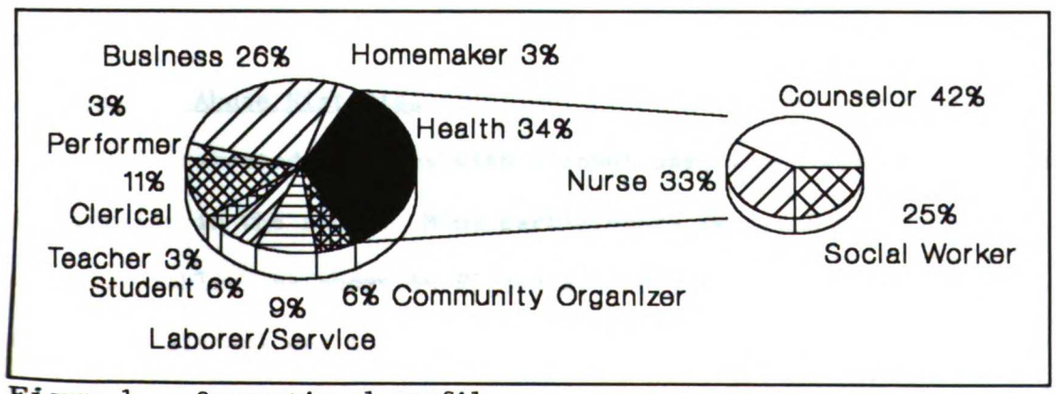
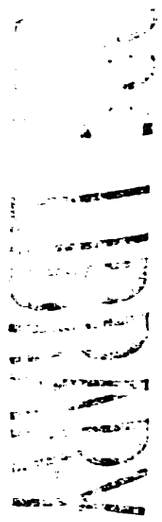


Figure 1 Occupational profile

in recovery may solidify one's commitment to growth or provide a change from work one considers incongruous with recovery.

Of the 35 participants, 16 (46%) reported being in a partnered relationship with another woman at the time of the interview. Since these women did not have access to their partner's income or benefits, and in only about half of the cases did they share a residence, categorization of yearly income reflects the participant's income alone. Eight (23%) of the total had borne one or more children, five of whom had one or more dependent children living at home at the time of the interview. All of the women who were parenting dependent children had yearly incomes below the average annual pay for San Francisco. Eleven (31%) of the participants had been married or had long term male partners at some time in the past; all of these women were between 36 and 47 years of age. None were in marriages or partnered to men at the time of the interviews.



Twenty-two (63%) of the participants reported that they had no current religious affiliation. The 13 (37%) who identified current religious affiliation stated them as follows: 3 Catholic, 2 Jewish, 2 Unitarian, 2 Wicca, 1 Protestant, 1 Zen Buddhist, 1 Metaphysical and 1 New Age.

Addiction and Abuse Histories

All 35 reported problems with alcohol use, which was a criterion for inclusion in the study. Many participants reported more than one addictive problem, as shown in Figure 2. Only three participants (9%) stated that alcohol was their only addictive problem. The other 32 (91%) were polydrug abusers, consistent with current trends among problem drinkers in general. Drugs used other than alcohol included

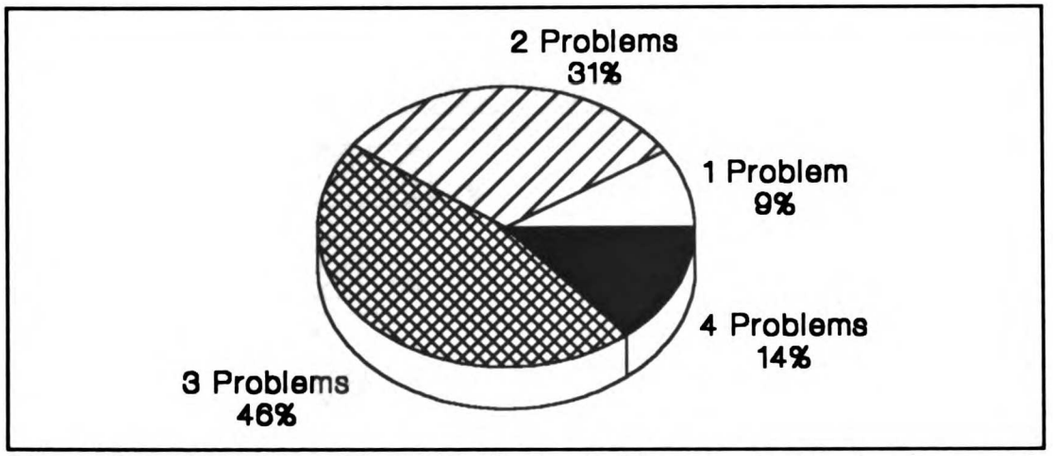


Figure 2 Number of addictive problems reported by each participant (N=35)

cocaine, marijuana, amphetamines, LSD, heroin, and laxatives. Twelve (34%) of the total reported difficulties with food, eight (23%) with "codependency," four (11%) with sexual compulsivity, and two (6%) with compulsive spending.

Twenty-one (60%) participants reported that their primary addictive problem was alcohol. Figure 3 depicts the other addictive problems participants prioritized as the most problematic for them.

Twenty-six (74%) reported being children of at least one problem drinking parent, commonly referred to in twelve-step vernacular as Adult Children of Alcoholics (ACA). Twenty-two (63%) reported that as children they experienced some form of abuse including physical, mental and/or sexual. Sixteen (46%) reported a specific history of childhood sexual abuse (CSA). Only five women (12%) in the sample had neither a problem drinking parent nor a history of childhood abuse. Remarkably, all participants reporting three or more addictive problems also reported histories of ACA, childhood abuse or both. Of the 16 participants reporting childhood sexual abuse (CSA), 14 reported at least three addictive problems.

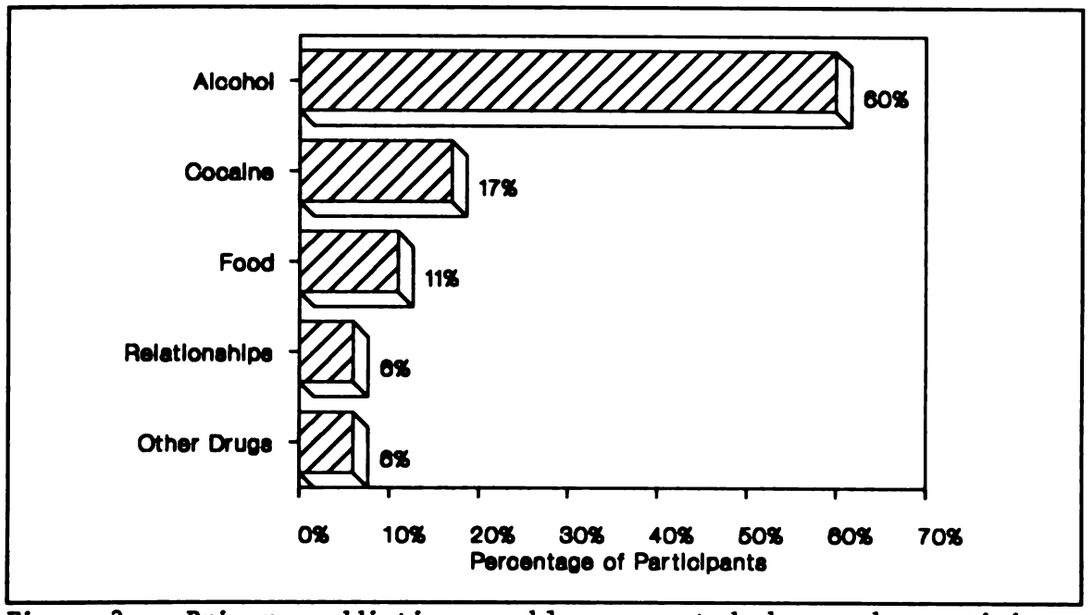


Figure 3 Primary addictive problem reported by each participant (N=35)

The figures on abuse histories represent only those cases in which disclosure of such abuse was volunteered in the midst of the interviews, since this information was not directly solicited in the demographic or interview questions. These figures may be underestimates of actual incidence in this group. Dissociation is a common defense mechanism in those who suffer childhood abuse, therefore it is possible that some participants who did not report abuse may not have been aware of having experienced such abuse at the time of the interview. Among those who were aware, some may have been unwilling or unable to initiate conversation about it in a research interview.

Drinking Patterns

Standard alcohol use questions were used to ascertain the degree of heavy drinking, drunkenness and related problems that occurred during the last 12 months of participants' alcohol use (see Appendix E). These items were adapted with permission from general population surveys of

drinking practices and alcohol problems used by the Medical Research Institute, Alcohol Research Group at University of California, Berkeley. Because of a perception in the lesbian community that psychometric research may be used to reinforce pathologizing theories about lesbians (Hawkins, 1976), the number of forced-choice items was kept to a minimum in this study.

For some women the last year of their drinking had occurred only one year prior to the interview, while for some others it was 10, 15 or even 25 years earlier. Variability in memory for these events diminishes the reliability of their estimates. Thirty-three informants answered these questions; two participants declined because they believed the questions were irrelevant to their experience.

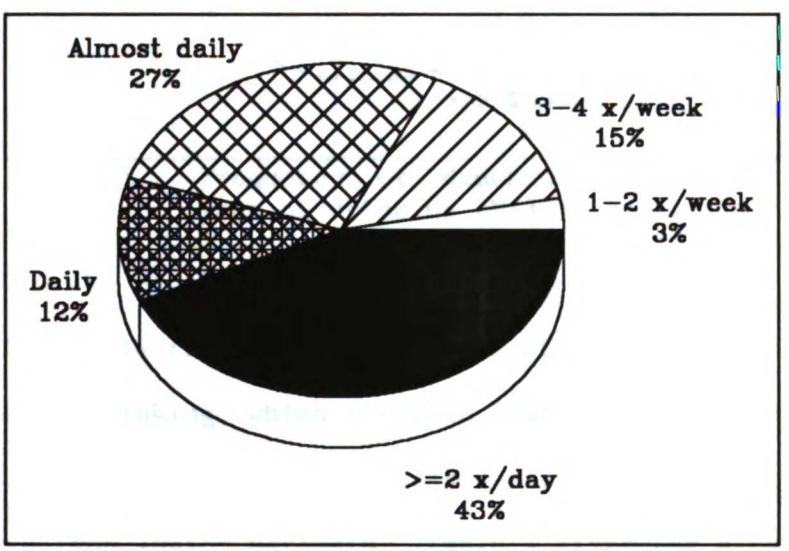


Figure 4 Frequency of alcohol use in last year of drinking (N=33)

In describing their frequency of alcohol use in the last year of drinking, all participants drank at least a few times a week and half drank at least daily (see Figure 4).

Frequency of drunkenness (self-defined) in the last year of drinking is illustrated in Figure 5. Seventy-two percent reported drunkenness at least 3 times per week. Cross referencing reported frequency of drinking with frequency of drunkenness, 21 (64%) of these 33 participants would be termed heavy drinkers with frequent drunkenness in their last year of drinking. No participants could be categorized as light drinkers. Clearly, the amount of drinking reported reflects patterns seen among problem drinkers rather than social drinkers.

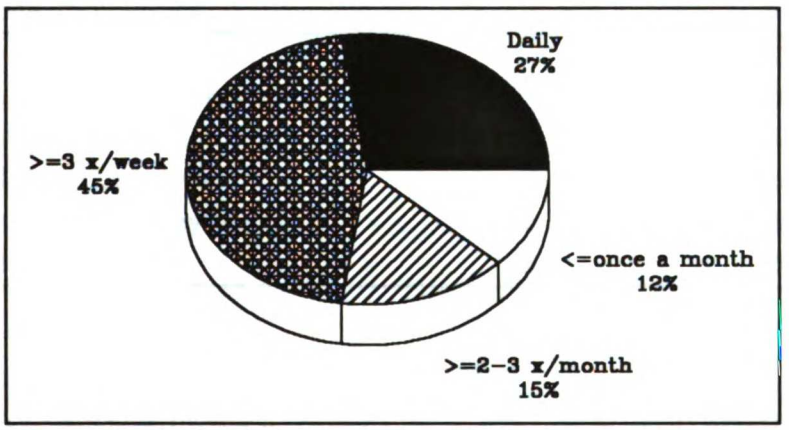


Figure 5 Frequency of drunkenness in last year of drinking (N=33)

Table 2 details reported consequences of alcohol problems during the last year of drinking, which included families or friends expressing concern, losing friends, missing work, receiving warnings from health care providers, and losing partners. Table 3 lists the alcohol problem-related resources contacted during the last year of drinking including health care personnel and services as well as law enforcement.

Table 2
Consequences of Alcohol Problems During Last Year of Drinking (N=35)

Consequences	Frequency	%
Family/friends concerns	25	76
Loss of friends	16	48
Illness resulting in work absenteeism	13	39
Warnings from health care providers	9	30
Loss of partner	6	18

Table 3
Contact With Resources in Last Year of Drinking (N=35)

Resource	Frequency	%
Therapist	17	48
Alcohol treatment program	13	36
Police	8	24
Mental health center	7	21
Hospital/emergency room	6	18
Judicial system	5	15

Data Collection

Interview Process

The task of ethnographic research is to gain an understanding of insiders' views, and to identify problematic features of the social world in question (Denzin, 1978; Wiseman, 1970). Meanings members derive from their experiences are the bases for their actions, thus they are analysts of their own perceptions (Schwartz & Jacobs, 1979). Furthermore, there are natural means for transmitting insiders' knowledge to outsiders; by role-taking researchers merely tap into these processes (Lofland, 1971). This requires immediacy and intimacy in a face-to-face situation, like in the interviews for this study. In

addition to being a data gathering technique, interviewing is a social act in which interviewer and interviewer coparticipate (Briggs, 1986).

All interviews were conducted by the investigator between April 1990 and February 1991. An interview guide was used in interviews, which lasted on the average about 2 hours (see Appendix F). Generally, participants were invited to talk about self-recognition of alcohol problems, patterns of helpseeking, pathways to sobriety, strategies for recovery, avoidance of relapse, barriers to recovery, and perceptions of professional treatment and twelve-step groups.

A goal in interviewing was to elicit narratives, which are stories having a temporal structure of beginning, middle and end. Even where answers to interview questions appeared to be unrelated, the participant was allowed to continue with a minimum of interruption (Mishler, 1986). Interview questions were relatively non-standardized, that is, fixed in meaning but not in wording. Broad questions were preferred over specific ones (Gorden, 1980). Defensiveness in stigmatized groups was minimized by the use of "how" rather than "why" questions (Becker, 1978). The investigator attempted to avoid questions that suggested a specific "party line" answer (Agar, 1980).

The interview is one of the major means of data collection in nursing practice and research. Too often, however, the interview remains an unexamined aspect of qualitative research. Usually errors in interview research involve the imposition of one set of communication norms on a community that organizes talk differently from the researcher's community. The interview must be seen as a communicative event, not a neutral vehicle for observation (Briggs, 1986; Mishler, 1986). Attention to the unseen context, the shared idiosyncratic

knowledge on which the interaction is based, is needed in order to interpret interview data. The structure of a story or episode may be as revealing as its content (Agar, 1980). The construction of a standard format for interview assessment in a given study is a means of systematically analyzing context (Briggs, 1983).

This study used three means of assessing the interview process itself. First, at the conclusion of every interview, participants were asked to give feedback about the relevance and inclusivity of interview questions, their general perceptions of the interview, and their ideas about how it might be improved. Their suggestions and comments were used to guide subsequent interviews. Second, the investigator devised and used a systematic interview assessment guide to record fieldnotes about each interview (see Appendix G). The systematic interview assessment guide prompted the investigator to record nonverbal communication in the form of gesture, posture, and body language (Mehrabian, 1981). Power dynamics, redefinition of questions by participants, hesitation, resistance, and interruptions were also noted. Special emphasis was given to determining motivations of participants and researcher, and the consequent definitions they gave to the interview situations. For example, in some cases it was apparent from the inquisitiveness of participants that understanding the research process itself and ensuring the accurate preservation of their stories in that process was a salient motivation. The interview assessments were helpful in corroborating the presence of ideological tension by pinpointing areas of anxiety and ambivalence. For example, when asked about negative aspects of AA, some participants became hesitant or resistive because as AA members they believed the AA program should not

be questioned or criticized. Field notes about interview processes were helpful in data analysis. For instance, in the case of accounts that were relatively abbreviated, providing a minimum of information, field notes provided information about setting and emotional interaction, ruling out possible environmental conditions that could have affected disclosure in these interviews. Third, a research diary was kept throughout the period of the study in which the investigator documented her reflections, emotional reactions, and theoretical insights on an ongoing basis. Impressions of interview processes made in the research diary were used later to identify commonalities and differences among the interviews during data analysis activities.

Interview Procedure

Potential participants contacted the investigator by telephone or were contacted via telephone by the investigator after referral by key informants or other participants. The investigator described the study briefly, answered questions and negotiated an interview time. Interviews were scheduled for a time and place of the participant's choosing that was adequately private. Most interviews were conducted in participants' homes. A few were done in women's coffeehouses. Upon meeting informed consent was obtained. An information sheet was provided to all participants as well as a verbal explanation of the procedure and purposes of the study (see Appendix H). Volunteering by verbal agreement constituted consent to participate; no written records containing names or signatures were kept. It was clarified in plain language that participants could choose to answer all, some, or none of the questions asked in the interview. They were told that they could terminate participation at any point they so desired, without any

repercussions. The information sheet also informed participants of the risks of their involvement, primarily the effects of emotional vulnerability experienced in talking about alcohol-related problems and in recalling painful episodes.

The information sheet bore the investigator's name and telephone number in case of: (a) questions or concerns that might arise after the interview, (b) desires to share additional insights not discussed in the interview and (c) referrals of study volunteers. Participants were offered the option of filling out a small card with name and address in order to receive a summary of the study results. These cards were added to a general mailing list and kept separate from other study materials.

Each interview meeting began with a series of demographic questions (see Appendix I). Then the alcohol use assessment was done (Appendix E) followed by the ethnographic interview. At the end of the interview the investigator spent 10-15 minutes with each participant in order to: (a) address questions or concerns arising from the interview process, (b) observe that participants were not emotionally distraught or exhausted as a result of their participation and (c) reinforce the investigator's availability by telephone should any concerns about the interview arise later. A few times participants declined to answer an interview question or to provide a piece of demographic information. No participant terminated her interview. On several occasions participants became emotionally distressed and tearful in response to material they were disclosing, but in none of these instances did the distress exceed an understandable expression of feeling, nor was an intervention needed other than active listening on the part of the investigator. The interviews were taped via a standard audiocassette recorder; no

participants objected to this recording. Field notes of the content and process of the interview were handwritten by the investigator immediately after the interview and typewritten within the subsequent two weeks.

Data Analysis

Analysis of the interview data was oriented toward moving beyond mere description to integrate participants' accounts within the larger historico-political framework (Bruner, 1986; Denzin, 1978; Mishler, 1986). Ethnography can be seen as a narrative with a particular kind of structure. Contemporary narratives often depict the past as "exploitation" and the future as "emancipation." Temporally, ethnographic data represents the present in that narrative story (Bruner, 1986; Mishler, 1986). Hence, the personal becomes historical (Geertz, 1973). The narratives from individual accounts in this study were considered to also be communicating a collective story (Richardson, 1988). Critically reflexive ethnography reaches its conclusions within historical contexts, thereby facilitating unity between theory and practice (Webster, 1983).

Initial data analysis began simultaneously with initial interviews, thus subsequent data provided theoretical comparisons (Agar, 1980; Hammersley & Atkinson, 1983; Schwartz & Jacobs, 1979). The investigator discussed emergent themes with colleagues in women's health and with informants representing various segments of lesbian communities throughout the period of the research. Repeated auditing of interview tapes was a key basis for the analysis (Mishler, 1986). The investigator listened to the interview audiotapes multiple times in the early analysis period. Later in the analysis the audiotapes were

consulted selectively for clarification purposes. The audiotapes remained the primary data record. Written texts of the interviews were also generated for constant comparative coding and narrative analysis through verbatim transcription accomplished by the investigator.

General Analytic Strategies

Three general analytic strategies were used in dealing with the data as a whole: constant comparison, narrative analysis, and matrix analysis. Their use is described in the following sections.

Constant Comparison

The data were coded, using constant comparison (Glaser, 1965; Glaser & Strauss, 1967) to explore antecedents, conditions, consequences and characteristics, organizing these data according to a code book. Initial coding served to organize topics, and focused codes were used to define categories. Codes were constructed to represent participants' in vivo categorization schemes and assumptions as well as to make note of ideas that were missing in the data (Charmaz, 1983). For example, it was noted that returning to social drinking was not a topic referred to by participants. Coding schemes were arranged to accommodate diversity within the participant group, rather than to "homogenize" the data and obscure intragroup differences. For example, rather than assuming that "hitting bottom" was a fairly standard experience for those having alcohol problems, in the analysis this phenomenon was broken down into more specific concrete behaviors and thought processes about which there were variable experiences and opinions.

Narrative Analysis

Narrative analysis includes consideration of the temporal order of events, individual and group differences, story structures,

discontinuities in discourses, and coherence within stories (Agar & Hobbs, 1982; Bruner, 1986; Mishler, 1986). The following questions informed narrative analysis in this study: What kinds of stories were told? What ideologies are embedded in these stories about lesbians and alcohol? Who are significant characters in these stories? What contradictions exist within and between the various accounts?

The initial narrative analysis depended heavily on ways of representing each woman's interview as a whole. This was accomplished by constructing visual and written synopses of each account that could be compared and contrasted for common themes, differences and patterns. Pictures and diagrams were drawn to assist in this process. Adequate paraphrases (Polanyi, 1985; Stevens, Hall, & Meleis, 1992) were also constructed. This narrative technique allows one to write a shortened version of the interview that contains the main plots and contexts in which actions occurred, the characters involved, and participants' evaluations of story events.

Time lines were constructed, representing each participant's history of coming out, alcohol and other drug use, transition to recovery, significant recovery events, health problems, health care for alcohol problems, use of mutual help groups, individual and group psychotherapy and substance abuse treatment. These time lines served to place the events and processes articulated in each interview into chronological order. They were used as a referential means of contextualizing other findings.

Following these activities, all interviews were reviewed and each narrative was delineated and tagged by a cursory phrase indicating its content. Narrative was defined either as: (a) a story, having a

beginning, middle and end, or (b) an expository verbalization expressing beliefs, opinions or meanings about a specific experience, separated from other narratives in the account by cues of topic change. In other words, where the subject or form of the account shifted, a division was made, and a new label was applied to each new narrative. Some of these shifts were related to content and pacing of the interviewer's questions, while others occurred within a participant's response to a question. Next, the narratives in each interview were organized according to basic content areas related to the research questions: identifying alcohol problems, helpseeking, health care interactions, recovery experiences and mutual help group experiences.

Matrix Analysis

Matrix analysis is a qualitative method in which data is systematically entered into matrices according to decision rules which are constructed to answer emergent questions in the data analysis process. Matrices may be (a) descriptive, examining a single concept across subjects; (b) outcome oriented, focusing on results and changes in a dependent variable; or (c) process oriented, illustrating the dynamics of change (Marsh, 1990). Making a matrix is an exercise in logic that cross-classifies categories to discover new insights about how the data can be organized (Patton, 1980). By working back and forth between the actual instances found in the data and a graph created by crossing two categories, matrices were filled in. An example of a matrix format used in this analysis is contained in Figure 6. The researcher's creativity and the nature of the data itself determined the dozens of matrices that were constructed for this study. For example, matrix analysis was used to compare participants' narrative accounts of

Major Recovery Images	Problematization Accounts: Circumscribed	Pervasive	Abbreviated
Connecting			
Empowerment			
Reclaiming Self			
Personal Growth			

Figure 6 Matrix format

recovery images, according to factors such as ethnicity/race, views of problems in the account, age, and length of recovery. Matrix analysis was useful in organizing large volumes of narrative data by means of themes and facilitated exploration of numerous provisional theoretical patterns in the interview data.

Analytic Procedures Specific to Research Topic Areas

The basic analytic techniques described above were used throughout the process. More specific analytic procedures were applied according to the research topic area being explored. Substantive details about the analytic tasks accomplished in two areas, identifying alcohol problems and recovery images, are shared in the next sections to demonstrate more precisely how results were derived. Results of the analysis of alcohol problem identification are in Chapter 4. Results of the analysis of recovery images are in Chapter 6.

Identifying Alcohol Problems

Through examining narrative linkages and areas of relative emphasis within each interview account, it became clear that the identification of alcohol problems was also connected to the identification of other life problems. In other words, alcohol use was only one among a number of problems similarly focused upon either prior to, simultaneous with or subsequent to the transition to recovery. Typically these were emotional, relational or addictive problems other than alcohol. The process of identifying and responding to alcohol-related problems, termed "problematization" as a result of the analysis, appeared to occur over a period of years in pre-recovery, and usually extended as an ongoing sequence into the recovery period. For example, a participant might initially identify anger and relationship conflict as a problem and seek help. After a health care provider refers her to AA, she might concur that alcohol and drug use is the underlying focal problem. A year into alcohol recovery she may decide she is also a compulsive overeater, for which she seeks additional help and joins Overeaters Anonymous (OA). Three years later she may experience a crisis in her family which activates memories of childhood trauma for which she seeks individual therapy.

Therefore, I decided to analyze problematization more broadly, as an ongoing phenomenon, including problems other than alcohol. The analysis focused on problem constructions, or the set of linked concerns which were being "problematized" by participants at a given point in time. Typical constructions might be "anger/friend concerned about drinking/blackouts" or "can't stop crying/isolated."

Based on this rationale, each account was specifically reviewed for its problematization content. A summary of the chronological series of problematization shifts in each account was written. Each written summary was condensed into diagrammatic form abbreviating the account to a sequence of problem constructions. The summaries included information about factors influencing the content and form of each problem construction. Where information was available, changes in self-understandings were noted, such as when individuals identified as lesbian or "alcoholic," or realized the impact of their ethnicity/race. Such changes in self-image were designated as problems only when they were described as such by participants.

Participants' responses to each problem construction were also recorded, including involvement in informal interactions, health care, substance abuse treatment, individual or group psychotherapy and 12-step programs. Temporal cues were used in the diagrams to indicate the length of time between shifts from one problem to the next. Abstinent periods relative to addictive problems including alcohol, other drugs, food, sex, money or relationships were also recorded.

The self-defined transition to recovery was indicated in the summary and diagram. By considering problematization, abstinent periods and recovery separately in these summaries, the transition to recovery was not simply reduced to an addiction/recovery dichotomy or continuum.

Contextual cues in women's stories were used to temporally locate problems in the summary, according to the individual's recollection of perceptions occurring at the time of these problematizations. For example, if an individual who had a history of being abused as a child was unaware or unconcerned about this until five years into recovery,

then this problem, child abuse, wouldn't appear chronologically in the summary until the fifth year of recovery, the point at which it was consciously identified. In other words, a concerted effort was made to have the summaries reflect the participant's description of prior states of awareness and definitions of problems, separate from her retrospective interpretation of problems at the time of the interview. In a few instances, it was not possible to distinguish the two perspectives.

Another consideration was that even where participants had distinguished their perceptions over time, the description of these differences was also reflective of an interpretation made at the time of the interview. Therefore, the summaries were not equated with longitudinal documentation of contemporaneous events. The summaries were most useful as depictions of how conceptualization, focus, awareness and significance of problems varies at certain points in the course of alcohol problems and recovery.

The problematization summaries and diagrams constructed for each interview account were compared for common elements in the transition to recovery, which constitutes a particular instance of problematization. Lists of examples of each separate part of the transition process were generated from the data. Coding and categorization procedures were used to isolate the components of this transition. Each component was then conceptually defined and a provisional model of transition to recovery was developed including the following concepts: constituents, perceptual constraints, environmental constraints, construction, interaction, action, validation, reconstruction and revision. Each account of transition to recovery was then examined to verify that each of the

components of problematization was evident, and that the sequential arrangement of these components in the account was consistent with the proposed model.

Viewing each as a whole, accounts were examined for narrative patterns in problem perception. Choice of language, feeling tone, kinds and numbers of stories, semantic linkages, evidences of untold stories, and non-verbal communication recorded in field notes were evaluated for each account. The accounts were placed in three groups based on similarities in problematization content. Then another review was done to define more specifically what themes characterized accounts in each category.

Two dimensions formed the basis for differentiating the three groups: (a) the degree of disclosure and detail in the account and (b) how pervasive the problems were in the lives of participants. The three types of problematization accounts were then articulated conceptually and the categorized accounts served as a basis for comparisons in the analyses.

Recovery Images

The interviews were audited for themes reflecting participants' interpretations of recovery, and how they strategized to maintain it. Images indicating conceptualizations of recovery were verbalized through characteristic word choices or implied in stories. Considering all of the interviews as pooled data, these images were identified and differentiated.

Accounts were then reviewed separately for the variety of recovery images illustrated. The number of recovery images described in each account varied; usually two to three were identified, occasionally there

were four or five. All of the images in each account were then ranked according to their relative dominance, determined by the centrality of each image in the account as a whole. Relative dominance of the images in each account were used to determine the overall dominance of each theme across all the accounts, with the help of matrix analysis.

Accounts were collectively analyzed for possible relationships between participants' preferred recovery images and age, ethnicity/race, length of recovery, type of problematization account, patterns of identifying as a lesbian, and use of twelve-step groups. These analyses used a matrix analytic framework of the characteristic or group by dominant recovery image. In most of these comparisons frequencies of the dominant first and second recovery images from each account were used. When there were equivocal results by this means, the analysis was repeated, including the third-ranked image from each account. These frequencies were used to rank the collective recovery images, identifying the most dominant themes in the context of meaningful contrasts which the data permitted. It should be noted that in these contrasts the actual frequencies are not meaningful in statistical terms, but rather they indicate the relative salience of a particular theme across accounts. Therefore, the images are presented in rank order of their dominance, rather than with numerical frequencies, in order to underscore the qualitative rather than quantitative nature of the contrasts.

Rigor in Critical Ethnographic Research

Issues of reliability and validity discussed in conventional, empirical research reflect the reductionistic, objectivist assumptions of that perspective. Critical ethnographic methods are not well

evaluated by conventional reliability and validity criteria. The rigor of this critical ethnographic interview research was established by using criteria of reflexivity, rapport, coherence, consensus, credibility, honesty, mutuality, empowerment, complexity, conscious partiality, naming, insider/outsider issues and ethical concerns for the rights of participants (Hall & Stevens, 1991).

Whether or not the study lived up to its assumptions was greatly dependent on the skill and sensitivity of the researcher. Colleagues, domain scholars, members of the group from which the sample was recruited and participants themselves also contributed to the reliability and validity of this qualitative investigation. Concern about reliability and validity in both the content and process of the study extended from the generation of the research questions through the phases of data collection, analysis, and continues in the dissemination of findings.

Reflexivity and Rapport

Research entails a series of decisions made by the researcher, requiring reflexivity at each step of the process (Ratcliffe & Gonzalez-del-Valle, 1988). Inadequate, invalid representations of participants' reality usually reflect the investigator's preconceptions of participants' experiences (Sandelowski, 1986). A reflexive approach to research fosters integrative thinking, appreciation of the relativity of truth, awareness of theory as ideology, and willingness to make values explicit. Reflexivity is an essential feature of critical qualitative research (Bruner, 1986; Olesen & Whittaker, 1968). The reasoning process is not linear, but dialectical, alternating between sources of information.

Reflexivity was fostered in this study by means of a chronological research diary, detailed enough that an outsider to the process could audit the decisionmaking process relevant to sampling, interviewing, data analysis and validation. In the course of keeping this diary, key questions were answered throughout the data collection and analysis process, such as: What biases am I holding in the ways I have interviewed and analyzed the data? Are there counter viewpoints expressed by participants? Does listening to the audiotape versus reading the written transcript of the interview create a different impression of the data?

Rapport is a criterion reflecting how well the participants' reality is accessed (Agar, 1980; Bruyn, 1966). Elements of rapport, such as the length and frequency of contact, intimacy of the setting, and researcher sensitivity to language and connotation indicate the processual validity of qualitative data (Becker, 1978; Briggs, 1986; Denzin, 1978; Mishler, 1986; Sandelowski, 1986). To enhance rapport, the interviews were held in as private a setting as possible while still allowing the participant a choice. Jargon, clinical terms and stigmatizing labels such as "alcoholic" were avoided. Rapport was evaluated in field notes of participants' verbal and non-verbal behaviors, in their willingness to recruit other participants and in the depth and specificity of their disclosures. A limitation to rapport was the single interview design, which did not allow a great deal of time for participants to form a relationship with the investigator.

Coherence

Coherence reflects the unity of an account. Coherence is evidenced in the consistency of the whole with its constituent parts

(Benner, 1985). Informants were used in this analysis process; they reviewed summarized findings and provided their impressions about any inconsistencies in the whole. Notes, memos and comments were systematically recorded in the research diary were periodically reviewed during data collection and analysis for evidence that the insights formed a whole picture. The research diary also represented the coherence of the researcher's "decision trail" throughout the study (Sandelowski, 1986).

Consensus

Reliability in qualitative research is reflected in the degree of consensus among participants, that is, the presence of recurring themes. While inconsistency among participant accounts does not "invalidate" their perceptions, agreement among behavioral, verbal and affective elements of particular episodes or interviews supports the presence of consensus (Bruyn, 1966). Individual vs. group and spontaneous vs. elicited data were means of checking consensus across accounts (Bruyn, 1966; McCall & Simmons, 1969). The investigator also considered the social position of each participant within the lesbian social network, and in the general society, in order to gain a perspective on similarities and differences among viewpoints (Sandelowski, 1986). The degree of stability of participants' themes over time is another criterion for evaluating consensus (Kirk & Miller, 1986). In this study, historical materials such as articles from the lesbian press were compared to the interview data to assess the reliability of participants' collective ideologies about alcohol problems.

Credibility

In assessing the representativeness of the sample, feminist research uses a standard of authenticity rather than a standard related to size or randomness of the sample (Hurst & Zambrana, 1980). The focal questions about credibility in this study were: Is this person speaking for others in this group? Is this account recognizable to other similarly situated women? Do participants' stories represent the diversity of the group under study? A crucial concern related to credibility in the present study was to recruit a diverse group of recovering lesbians who would describe their recovery experiences. Credibility of the researcher's results and conclusions includes their compatibility with existing theories, and whether the account seems adequate from the standpoint of how observations were made (Athens, 1984). The credibility of the account includes its recognizability to those who have lived the experience, usually demonstrated through member validation (Acker, Barry & Esseveld, 1983; Bloor, 1983; Denzin, 1989; Emerson & Pollner, 1988). This study incorporated member validation at several points, particularly related to parts of the analysis reflecting a lack of consensus, such as perceptions about AA and depoliticization. Excerpts containing statements from the interview data were reviewed by informants. Domain scholars also verified the adequacy of the literature reviewed throughout the research process (Benner, 1985). Debriefing sessions were regularly held. These are meetings of two or more colleagues involved in ethnographic data collection with the same population in which they discuss their data collection and analysis experiences (Bohannon, 1981).

Honesty, Mutuality and Empowerment

Deception of participants has been used in some past research, ostensibly to avoid "skewing the results" (Ramos, 1989). From a critical perspective, deception is unethical, since it assumes the invalidity of the participants' perceptions in favor of the researchers' (Acker, Barry & Esseveld, 1983; Mies, 1983). The validity of women's experiences is not affirmed in methods that have hidden agendas (Kohn & Smart, 1987). The study participants must not be perceived as "liars" in the design (Briggs, 1986). Adequacy and ethics are both served in the criterion of honesty in research. Reduction of power inequalities between researcher and participant is a means to preserving the subjective validity of participants' statements (Acker, Barry & Esseveld, 1983). In this study, information about the research purposes were provided in terms understandable and relevant to participants. The informed consent procedure in this study incorporated these principles. Also, the investigator attempted to reduce power inequalities by presenting options to participants whenever possible, allowing them to make decisions about the interview process. Interview questions addressing politicized issues were asked in direct form, rather than cloaked as information-gathering questions.

The interviews were patterned on mutual exchange and dialogue. Data was not merely extracted from participants, but rather information that participants needed was given in exchange (Oakley, 1981). Many study participants asked health-related questions that were appropriately but briefly answered by the investigator during the interview meeting. In several cases the investigator mailed printed articles to participants who had requested more information about

particular health-related topics. Approximately six months after the interview process was completed, participants who had asked for a summary of the results were mailed a preliminary summary of the research and estimated time frames for completion of the analysis and a final summary.

Feminist ethnographers grapple with issues of power and exploitation in research projects with women participants (Christman, 1988). The researcher is pivotal in operationalizing research enterprises, which may either serve participants' interests or exploit their vulnerability. Empowerment means that as an outcome of the research process participants should experience increased awareness of relevant options, either immediately or over time. One indicator of empowerment in this study was the capacity of the research design, and the interviewing skills of the researcher, to elicit narrative responses. The prevalence of narratives indicates the freedom of participants to tell their stories, in contrast to the dominance of the interviewer reflected in interrogatory communication (Mishler, 1986). The multiplicity of research questions and the need to determine chronological ordering of reported events necessitated some interruption during interviews. Nonetheless, in-depth narratives were elicited from all participants.

Complexity

Much of traditional research oversimplifies human experience. In contrast, studies that compare the views of many members of a natural group are more likely to approximate the dynamics of a given social reality (Hurst & Zambrana, 1980; Thorne & Robinson, 1988). In this study, attempts were made to access the complexity of social realities

through open-ended questions, probes and seeking clarification of responses that contained jargon or cliches. Usually the jargon and cliches arose in conversation about AA or lesbian subculture, wherein participants would assume the interviewer already understood the meaning of these phrases.

Conscious Partiality

As a matter of survival, oppressed persons necessarily develop a clear understanding of the consciousness of the oppressor group, yet oppressor group members' survival does not require an equivalent understanding of the oppressed group's consciousness. The oppressed therefore maintain a "double consciousness" that is taken for granted and therefore not apparent to them in everyday life. Feminist inquiry about women's experiences makes use of this double consciousness in structuring the inquiry (Mies, 1983).

Conscious partiality is the researcher's limited identification with participants' needs and goals, without simply unreflexively accepting their statements. In other words, the researcher, conscious of her biases, becomes acutely aware of tensions among multiple viewpoints. Focusing on or heightening these tensions is a means to rigor in feminist research (DuBois, 1983). Instead of minimizing doubt through objectivity and distance, feminist methodology considers feelings and consciousness, allowing conflicting realities to coexist in the research process (R. Klein, 1983). Investing the self in the research process renders the researcher vulnerable, much as the participants are vulnerable (Stanley & Wise, 1983a; Webb, 1984). This investment contrasts with the peripheral "spectator" role of the researcher in conventional research (R. Klein, 1983).

Conscious partiality was an integral aspect of data collection and analysis processes. The investigator disclosed to participants the goals of the study. As a nurse, the investigator made clear that health care experiences were a main focus of the study. The investigator also participated in dialogue with many participants about issues which are controversial in lesbian recovery circles. This was an example of how tensions and multiple viewpoints were tracked. Use of the research diary, collegial consultation and reflection were used to make tensions and biases explicit.

Naming

Gender oppression is an ideological aspect of the environment wherein male experiential explanations are used to "name" experiences of both men and women (Roberts, 1981). Thus feminist scholarship considers women's "naming" to be emancipatory theory building. Naming is defined as learning to see what is there rather than what one has been socialized to believe is there. Such naming has two powers: (a) it defines the value of that which is named, and (b) it denies reality to that which is never named (DuBois, 1983). Using the preferred words of the participants to describe the experiences being studied is a way of mutually sharing the naming power and achieving greater validity. For example, in this study of women with alcohol problems, the term "recovery" was used because it is the term preferred by most women in framing their experiences of healing from alcohol problems. The terms "drinking problem" and "alcohol problem" were used in recruitment efforts, so as not to exclude individuals who reject the disease label of "alcoholism." This could be a double-edged sword. Participants sometimes avoided topics they believed were not relevant to a study

about "alcohol problems." In another case, a woman said she had hesitated to disclose past alcohol-related sex with men because the research was designated as a study of "lesbians."

There were some evidences in the interview data that participants lacked words which adequately captured their experiences. For example, in the case of post-traumatic symptoms related to child abuse history, some participants had difficulty explaining their sense of inner fragmentation, using words like "splitting" and "leaving my body." These phenomena are not "named" as typical aspects of alcohol recovery as traditionally understood.

Insider/Outsider Dynamics

It is explicitly acknowledged in ethnographic research that the researcher is an integral part of the research design, procedure, evaluation and findings (Lipson, 1989; Munhall, 1988). To care for themselves in the research process, researchers must consider the timing of intervals between field experiences, and flexibility of scheduling, since the self is the main organizer of qualitative research (Cowles, 1988; Lipson, 1989). Because it was a dissertation project, this study took place over several years, and each phase of the process incorporated adequate time for reflection and reconsideration of findings and inquiry processes.

Overfamiliarity is a threat because participants assume the researcher knows all that they know, and so stop making efforts to explain (Agar, 1980). Spradley (1979) argues that a researcher's role as an outsider to the field enhances the validity of qualitative data, because insiders tend to "teach" the presumed outsider. In stigmatized communities, however, there are often critical differences in accounts

given to presumed insiders versus outsiders (Becker, 1978). Lesbians have historically been disappointed with researchers' accounts of their experiences and thus they are not generally eager to "teach" outsiders the basics of lesbian experience, referred to by insiders as "Lesbianism 101."

Researchers play both insider and outsider roles in the course of fieldwork. Having accurate knowledge of one's position on an insider/outsider continuum at any given time enhances rigor (Christman, 1988). Participants ultimately determine the degree of trust and intimacy they perceive in interaction with the researcher (Lipson, 1989). Interviewers should take note of self-changes in awareness and assumptions, and for signs of their non-receptivity, intrusiveness and manipulation (Olesen & Whittaker, 1968). In this study, this was done through consulting with colleagues, and reflecting on field notes and the research diary.

Women nurses are well suited to study the experiences of oppressed groups (Mies, 1983; Stanley & Wise, 1983b). But during nursing's historical struggle for acceptability as a science, positivist criteria have been applied to nursing scholarship (Meleis, 1985). In this objectivist climate past nurse scholars have avoided studying topics of personal interest for fear of appearing "biased." Others have studied such problems, but without acknowledging their personal relevance (Zola, 1983). Study of one's own group or of a topic having personal significance to the researcher need not be considered methodologically unsound (Knaak, 1984; Lipson, 1984; 1989; Sandelowski, 1986; Smith, 1984).

The identities of the investigator were made clear to potential participants at the recruitment phase of the study. The investigator is a member of the participant community and thus has an awareness of basic lesbian life experiences. She identifies as a woman in recovery from an alcohol problem. The length of her recovery at the time of the study was 18 years. Even though the investigator was an "insider" in these ways, she was marginal to the community by virtue of academic status, social alignments and expertise (Aguilar, 1981). Other potential differences between researcher and individual participants were age, class, race, ethnicity, education, religion, and length of recovery experience.

This study rejected the insider/outsider dichotomy in favor of an explicit accounting for the impact of the researcher self on the research project (Lipson, 1989). Questions that guided the reflexive process, documented in the research diary, were: Who is the researcher? What is her interest in the questions asked? What clinical, academic and experiential background does she have? What may enhance or diminish the researcher's ability to achieve sensitivity, accuracy and trust in interacting with participants? What advantages or disadvantages does similarity with participants have in view of the research questions? What information is likely to be withheld by participants from insiders? from outsiders?

Ethical Issues

In critical ethnography, the accuracy of findings are integrally related to the nature and fairness of the interactive processes by which they were accumulated and analyzed. In addition to ethical concerns about the accurate representation of participants' realities, there are

other, more subtle ethical problems to consider: (a) privacy, (b) informed consent, (c) confidentiality (Diener & Crandall, 1978; Munhall, 1988; Ramos, 1989), (d) researcher role conflicts (Munhall, 1988) and (e) affirmation of participants' authenticity.

Qualitative research often presents a conflict between practice and research roles for nurse-researchers. The consensus in nursing favors therapeutic and advocacy goals over research motives (Munhall, 1988). Many of these needs can be planned for, and referral to appropriate therapeutic resources can prevent researchers from becoming overly entangled in clinical roles during the research process. In this study, a plan was made in advance for how severe emotional distress might be handled by the investigator without taking on a caregiving role in the interview process. Active listening was the first planned intervention, followed by referral to appropriate health care providers. A referral list of mental health resources was carried by the investigator to each interview. Only active listening was needed during the interviews in the cases where participants became tearful while recounting painful past experiences.

The intrusiveness of interview questions was also considered. Informants and colleagues reviewed the interview guide to assess the privacy needs of participants, help anticipate emotional triggers, and develop alternative questions as necessary. Pilot interviews were also done. The confidentiality of highly sensitive material (e.g., sexuality, addiction or stigmatizing features) was of paramount concern (Ramos, 1989). The investigator's familiarity with the participants' social world was a means of avoiding "interviewer intrigue," which could have discredited the researcher, insulted participants, intruded upon

privacy or reinforced barriers between lesbians and health care providers.

Participants' disclosures of illegal activities such as dealing drugs or working in the sex industry were anticipated. The investigator maintained a stance of openness, striving to understand the participant's point of view (Denzin, 1978). These disclosures were usually in reference to past activities that were no longer engaged in. The information was treated as confidential, part of the fabric of the entire interview.

Qualitative research uses a changing, flexible format. For this reason consent is a continually negotiated element of the process (Munhall, 1988; Ramos, 1989). The researcher monitored the interview situation closely for cues that anxiety was heightening for participants (Cowles, 1988). It was planned that in the cases of significant anxiety, the option to discontinue would be offered to the participant. This action was not necessary, however, the initial informed consent agreement was always considered an open-ended commitment, subject to the changing realities of the research relationship and process.

Organization of Results

The results of this study are presented in the next four chapters. They are organized according to the research questions posed. Chapter 4 explores how lesbians identify their use of alcohol as a problem. Chapter 5 answers questions about lesbians' of helpseeking and health care interactions regarding alcohol problems. Chapter 6 describes lesbians' images of recovery from alcohol problems. Chapter 7 examines lesbians' experiences in mutual help groups and identifies consequences of the growth of twelve-step mutual help groups in lesbian communities.

CHAPTER 4

IDENTIFYING ALCOHOL USE AS A PROBLEM

Participants described the series of events that led to their transition to recovery from alcohol problems. Across interviews, it became clear that this transition began with a process by which alcohol use was identified as a problem requiring assistance or action of some kind. For many, this process was one in a series of transitions in which various life difficulties were identified as problems and addressed as such. For the majority, the transition to recovery from alcohol problems was part of a process of "problematization," to be described in further detail. On the basis of the interview data, problematization was defined as the process of identifying and responding to difficulties with alcohol. In addition, problematization included the identification of other emotional, relational or addictive difficulties perceived as associated with alcohol problems. The problematization process unfolded as a series of shifts in focus from one identified problem to the next. Each shift within the process began with the identification of an alcohol-related problem and ended when a period of stability or mastery over that problem ensued. This period of stability then gave way at intervals to other transitions involving the identification of other problems that participants linked to alcohol problems and alcohol recovery. There were similarities in how the initial problematization process was described, and greater variability in the type, number and intensity of subsequent problems identified, depending upon the participant's view of alcohol problems, her history, and the degree of her involvement in twelve-step mutual help groups and therapy.

This chapter addresses the following research question: How do lesbians identify their use of alcohol as a problem? It also partially addresses the question: What are lesbians' helpseeking experiences regarding alcohol problems? The problematization process is described, and its components illustrated in excerpts from the data. Then overall patterns of problematization, identified through narrative analysis, are described, demonstrating the variability in lesbians' experiences of alcohol problem identification.

Problematization: Transition to Recovery

Participants used the term recovery to mean one or more of the following: (a) the period of healing following the identification of an alcohol-related problem, (b) the process of responding to alcohol problems and related issues through reflection and action, (c) a social context or subculture organized around healing from alcohol-related problems, and/or (d) the benefits of participating in the process of healing from these problems. For nearly all participants, recovery was seen as encompassing the period from the initial transition to recovery through the present. In two exceptional cases, participants stated that they did not think of themselves as being "in recovery," that their alcohol problem had been resolved through abstinence and required no further intervention. These participants indicated that whatever problems they had identified subsequent to the point at which they became abstinent from alcohol were simply life problems, unrelated to "recovery."

Problematization was an ongoing process in which participants recognized and responded to difficulties related to alcohol use and recovery. A difficulty was considered to be problematized when it was

identified, named and considered as necessitating helpseeking. Problematization that precipitated the transition to recovery was described in great detail in women's accounts, revealing contextual information about the components and dynamics of the process. Therefore, the problematization processes associated with transition to

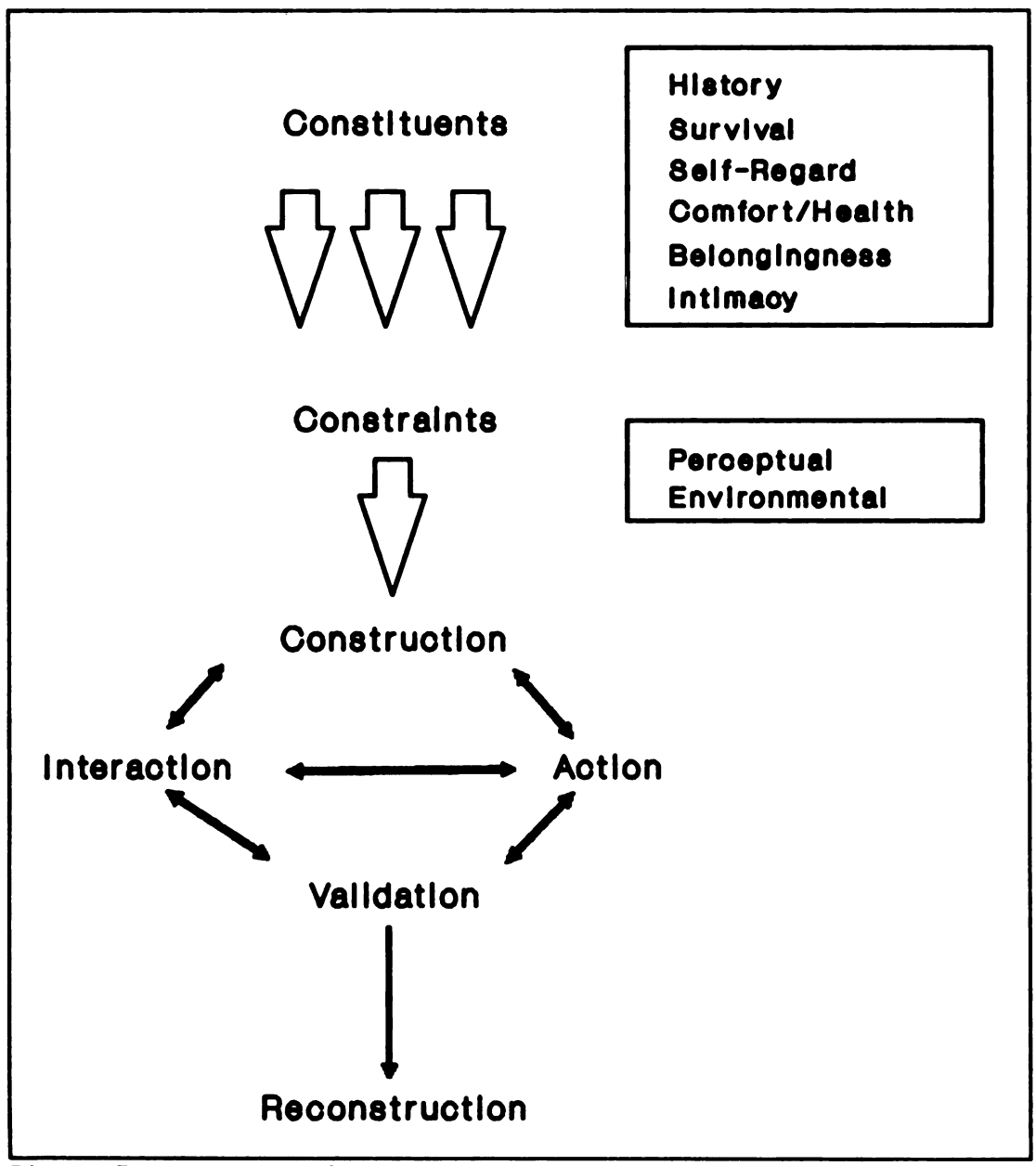


Figure 7 Conceptual representation of problematization.

recovery in each account constituted the basis for the description of problematization presented here. A theoretical model of the process of problematization was developed as a result of this analysis. Figure 7 illustrates the model. The concepts comprising the model are identified, substantiated through examples from the data and discussed in the following sections. More lengthy examples from the data illustrating this model are provided in the section "Interrelationships Among the Components of the Model."

Components of Problematization

Components of the process of problematization emerged from participants' responses to direct inquiries as well as the content of their narratives about alcohol use and alcohol recovery. They include constituents, perceptual constraints, environmental constraints, construction, interaction, action, validation and reconstruction. The component, constituents, is made up of sub-components: history, survival, self-regard, comfort/health, belongingness and intimacy. It was possible to isolate each of these components in every participant's account of recognizing and acting to ameliorate alcohol problems.

Constituents

Participants talked about what their alcohol problem entailed, that is, what conditions and causes they associated with the development of difficulties with alcohol:

> My alcohol problem was tied to a strong dependency on people.... You stick to the ways people tell you to do things because you are too scared. Or you go to the opposite extreme--either being too obedient or too rebellious.
>
> I am scared of alcohol. It made me feel out of control.... I was physically abused by my father when I was a child--only when he was drunk.... My definition of an alcoholic is anybody whose life

> is disturbed, or anybody who disturbs other people's lives, by their drinking.
>
> Drinking seemed to be my only means of coping, and I didn't have the economic power or the health care resources to even begin to wonder whether I was depressed or not. It is a survival mode. Alcohol is all you have.
>
> I grew up in a household where it wasn't ok--I mean you could either be happy or you could be quiet. There was no room for feeling sad or angry or depressed. There was no room for those feelings. So I learned to drink to bottle up those feelings.I wasn't comfortable in California.
>
> I wasn't comfortable being a lesbian. I wasn't comfortable at work. Alcohol made the feelings go away. Numbed them.

The various conditions and causes that were associated with alcohol problems in these accounts were termed "constituents." Constituents are conditions or factors that alone or in combination are interpreted as the basis for alcohol problems. These interpretations reflect personal experiences and beliefs about the "ingredients" of the problem, not limited to causality. Constituents may act as antecedents, modifying factors, restricting factors, stipulations or attendant circumstances, depending upon the particular situations of women's lives. For example, a constituent such as social ostracism might be construed by one participant as a motivation for problem drinking, by another as an indicator of alcohol problems, and by still another as a parallel problem. Several constituent content areas were reflected in participants' stories: <u>history</u>, <u>survival</u>, <u>self-regard</u>, <u>comfort/health</u>, <u>belongingness</u> and <u>intimacy</u>.

<u>History</u>. History refers to genetic, familial, ethnic/racial, socioeconomic, cultural and developmental preconditions that participants linked with the evolution of their alcohol problems. Family of origin history was most frequently referred to in this

category. Specifically, participants talked about abandonment, parental alcohol problems, dysfunctional family dynamics, secrecy, rejection, parental criticism, enforced dieting, childhood sexual abuse, verbal abuse, and battering. Some participants believed that they had genetically inherited their alcohol problems, but more often, family of origin environment was emphasized as a basis for the problem. Many of the women of color cited impoverished environmental conditions while growing up as historical preconditions of the problem. Other historical factors women discussed were rape, traumatic abortion, sexual orientation conflict, adolescent crisis, and oppressive marriage.

Survival. Survival refers to basic subsistence issues participants linked with alcohol problem development. This constituent area involved individuals' interface with larger social structures and included such conditions as: unemployment, underemployment, job stress, lack of health insurance, living or working in violent environments, legal or criminal problems, homelessness, the need to sell drugs, working in the sex industry, lack of lesbian-sensitive services, lack of awareness of treatment options and lack of political awareness.

Self-regard. Self-regard refers to evaluative perceptions of the self that participants associated with alcohol problem development. These included a lack of self-control over alcohol or drug use, weakness for relapse, guilt about compulsive eating, shame, unworthiness, self-hatred, low self-esteem and internalized homophobia. Many participants expressed shame specifically about having engaged in sexual activities that were unwanted or unacceptable to them. There were also references to self-deficits such as lack of creativity, nonassertiveness, inflexibility, missing self-awareness, poor

motivation, and lack of physical "beauty." These self-regard constituents could paint a dreary backdrop to problem drinking. Some participants with particularly poor self-regard feared it "could not be changed."

Comfort/health. Comfort/health refers to women's well-being and the potential for pleasure and satisfaction. Comfort/health conditions that contributed to or made women aware of alcohol problems included weight changes, injuries, fatigue, insomnia, headaches, hangovers and gastrointestinal changes. Discomforts related to compulsivity and obsession, dieting, overeating, purging, self-mutilation were also reported. Many cited the use of alcohol or drugs to escape distressing feelings, ease pain, relax, stay awake, or cry. Mental and psychic conditions that in some cases were constituents of alcohol problems included depression, anger, rage, boredom, panic, anxiety, fear, paranoia, memory gaps, dissociation, depersonalization, suicidality, emotional numbness, the sense of having multiple selves, and feeling overwhelmed.

Belongingness. Belongingness refers to interactional conditions that manifest attachment to others or lack thereof. Experiences as insiders versus outsiders in social situations were factors affecting alcohol problems. Most frequently mentioned conditions of belongingness related to stereotyping and discrimination on the basis of sexual orientation, gender and race. Many women described a profound sense of social isolation in nearly any group they interacted with. They felt delegitimated and outcast. Alcohol and drugs were purportedly used by some to ease social inhibitions and facilitate interaction with other lesbians, especially in the bar scene. This use was linked not only

with initial "coming out" experiences, but was also cited by lesbians who had been "out" for many years. Alcohol and drugs were said to provide confidence, facilitate conversation, lend distraction, and enable one to ask another woman to dance or to pursue sexual interests. Participants also associated alcohol and drugs with rudeness, stealing, dishonesty, manipulation and superficiality. Therefore alcohol/drugs were linked with belongingness in both positive and negative ways.

Intimacy. Intimacy refers to experiences of close personal interaction with friends, partners or family members or lack thereof that participants associate with alcohol problem development. Participants cited blocks to intimacy, including inability to trust, inability to talk about feelings, tendency to isolate, lone drinking, shyness, denial, projection, abusiveness and violence. Lesbian partnerships were discussed by many as being susceptible to the dynamics of "codependency," in which partners engage in excessive caretaking of each other. Women talked about partners who either had their own alcohol or drug problems, enabled them to drink, or objected to their alcohol use, sometimes so strenuously that they ended the relationship. Sexual dynamics were also an intimacy concern associated with alcohol problems, for instance, need for alcohol or drugs to engage in sexual activity, sexual addiction, or unwanted or anonymous sex associated with alcohol use. The influence exerted by a close friend or partner who expressed concern about a woman's drinking was pivotal to problematizing alcohol use in more than half of the accounts.

Perceptual Constraints

Participants spoke of how their awareness of alcohol problem constituents was clouded and how their appreciation of the significance of the problem was obscured:

> I was originally concerned with my father's drinking.... I could only see that. I was trying to figure out how to live with him at the time, so in my head it was his problem that needed the help. I sort of forgot that I was drinking right along with him.
>
> I told her that just because I drink in the morning doesn't mean I'm an alcoholic. I drink because I have a hangover. I just get thirsty and drink and it cures it.
>
> I didn't want to think of myself as needing help.... I had never had a DWI (Driving While Intoxicated). Never been to jail. I mean I had heard all these stories. And they all got filtered through this image of myself as the responsible citizen.
>
> There wasn't that much information about alcohol, or what I did read didn't make any sense. It didn't relate to anything I had observed or felt. And the stuff it talked about I thought was so far down the road that it wasn't real to me.... And it was the time of political upheaval, so I didn't necessarily trust what I was reading anyhow.

Women recognized and defined problems according to the information and conditions at hand. Accounts revealed that individuals were constricted in their ability to recognize problems by blocks in awareness of many kinds. Perceptual constraints were defined as ideas or feelings that obscured individuals' awareness of alcohol problems. Typical perceptual constraints were myths about alcohol use and addiction, perceptual patterns learned in families of origin, misinformation, faulty stereotypes about persons with drinking problems, affective blocks to recognizing problems, traumatic memories or unmet emotional needs. These perceptions could supersede awareness of alcohol problems preventing women from fully comprehending their depth and

seriousness. Perceptual constraints are depicted in Figure 7 as partially preventing the individual's awareness of various constituents.

Environmental Constraints

In most accounts, there were also other factors blocking awareness of alcohol related problems which were not perceptual, but related to conditions outside themselves:

> It was that I was in a place where I had to use drugs and alcohol. I mean if you had the job I had, so demeaning--at that time--you would stay anesthetized, too. I couldn't get to the point of seeing it as a problem until I got out of that place.
>
> My girlfriend thought that if I got treatment for my problem that her drinking was going to be focused on, too. She kept saying, "Just cut down. Don't open yourself up to these therapists and doctors who basically can't deal with lesbians anyway." I really wanted to have that security of being with her, so I convinced myself that my drinking wasn't the problem at all.
>
> Being a dealer was a power base.... It was also a way to bring in cash. I didn't have too many other skills. I couldn't tune up your car--or fix your house.... So it was a bargaining tool in relating to these rich white girls. It's not like I couldn't see my problems--I just wouldn't see them as long as I had these situations to deal with.
>
> Who was going to sit with me and help me face this problem? I had no therapist, no job, no insurance. I mean health problems are for those who have access to help. Otherwise it is easier to just go on drinking and drugging.

As demonstrated in these quotes, problematization was often blocked by barriers outside the self that constrained action. Women were not truly free to acknowledge and name a problem until and unless resources and support were actually available to them for problem solution. In other words, problems without solutions are obscured until viable solutions are accessible. Environmental constraints were defined as social, political or economic conditions that limit individuals' capacities or options for action in response to alcohol problems. Examples of common environmental constraints found in the data were

racism and homophobia in the health care system, lack of social support, scarcity of women-only treatment options, lengthy waiting lists for treatment and psychotherapy resources, lack of money, excessive cost for services, lack of childcare, restricted social service entitlements and significant others who oppose helpseeking. Environmental constraints are depicted in Figure 7 as partially blocking awareness of various constituents in conjunction with perceptual constraints.

Construction

When perceptual constraints eased enough so that individuals became aware of alcohol problem constituents and were able to associate the distress they felt with the consequences of their drinking, they began to name and conceptualize the problems they were experiencing. Relief from environmental constraints, in other words, a change in the social, political or economic conditions that blocked their ability to recognize problems, was also necessary in many cases. Some excerpts from the data illustrate:

> I looked over my whole life and I couldn't see anything positive. Only my failures. They weighed heavy on my shoulders. And I had lost my children. I mean, you lose your keys, but not your children. And I was crying and I couldn't stop.... To me it was a nervous breakdown.
>
> I set fire to a car and got thrown out of the only place that was still accepting me as a human being, despite my drinking.... All this leads irretrievably to the bottom.
>
> I was working in a job that was extremely stressful--people dying all the time. I was starting to think more about how my father is an alcoholic. And there were lots of blackouts. And just more and more things led me to say, "This isn't good. I have to do something about it.
>
> "I'd get drunk and get myself in a mess and have to avoid people for weeks.... I just couldn't get the effects I used to--from alcohol. I tried controlled drinking and realized that I couldn't control it. Then I could start to admit it was a problem, and call a spade a spade.

> It got so I was prostituting all the time...turn the trick, get the money, buy the dope. And I was basically living on the street and not caring about anything. This outreach worker started saying every day, "We got a bed for you--we are saving a spot for you at the detox." He kept repeating it. And that was it. I turned myself in for help at that detox place.
>
> I was sick all the time. I had money problems.... Then I started to see that friends of mine were going to AA and I thought maybe I could try that.... I went to AA and I haven't drank since that day.
>
> I realized I was having a problem when I would drive home at night and drive through every stoplight, just in a desperate urge, an urge to get home. And I'd get up the next morning and find the car parked crooked, the doors all open and the keys in the street.... I really hated a lot of what I did.... I would fight, hit people, throw things.... When I couldn't stand it anymore, I got suicidal. I drove my motorcycle into the back of a car.... Then I was disabled and alone, not working, so I had the possibility of really going to AA meetings, which I did everyday.

Given the presence of particular constituents, if perceptual and environmental constraints were overcome, participants could name and define (construct) problems related to alcohol. Construction, in this process of problematization, was defined as the identification of an alcohol problem and the explanations individuals used to understand and frame alcohol-related difficulties at a given point in time. Bounded by cultural expectations, health knowledge, and availability of resources, women's problem constructions reflected their understandings of themselves and their relationships with others. Their constructions guided women's communication and decisionmaking about the problem.

Interaction

In identifying problems, participants were influenced by interaction with others. They were open to others' criticism, challenge, support, and self-disclosure about alcohol problems:

> At work we did this test about alcoholism. My colleague gave me the Jellinek screening questions. I thought, "I know that. I

have that. Shit, this is terrible." I found six or seven points that applied to myself as she was talking about it all.

My partner got me involved in twelve-step stuff. Before my relationship with her I had another partner who encouraged me to get into therapy. So my partner didn't push it, but I kind of knew it was about time to get into recovery.

The woman I had just begun dating said, "If you have an alcohol problem, here is a book you might want--I found it helpful." Well I read the book and I was ready.

The woman in my office who used to get high with me got into AA. My therapist had suggested I could be an addict. Right after that happened I asked this woman at work if she wanted to go to lunch. She said, "Well actually I am going to an AA meeting. Do you want to come along?" And there was a few seconds and I said, "Yes." And that is how it happened.

There was this woman, a nurse, a lesbian nurse as I later found out. She must have seen my denial about my lesbianism all over me because she said, "I don't think you'll get sober until you get honest with yourself--about who you are".... I got to the point of wanting to kill myself. I had these razor blades in my hands. And I called this nurse.

My girlfriend came home and said there was this queer alcoholism treatment program, and if I didn't check it out, I could check out of the relationship with her.

As a component of the problematization process, interaction was defined as communication with others concerning the problems that were being constructed. Interactions in which alcohol problems were named and externalized were usually emotionally charged, as the interview data showed. Participants' descriptions of these interactions revealed selectivity in seeking others out, sensitivity to their responses, troubled awareness of divergent opinions regarding the nature of the problem and an enduring memory of their impressions of the exchanges, whether positive or negative. The lesbians in this study frequently described interacting with friends, partners, coworkers, therapists, physicians, nurses and treatment facility counselors about their alcohol problems.

Action

Subsequent to their construction of the problem and often in conjunction with interaction, participants took action in response to alcohol problems:

> I went to this colleague of mine who worked in a clinic, and talked with him about my drinking. And he recommended outpatient therapy. I found myself a psychologist then, who had experience working with these problems. I did my first course of therapy with her.
>
> I thought the panic attacks were coming back, and it scared me so much that I got back into therapy.... I also began to look at what I wanted, where I was going.... I got into school. I got into a group of women who really supported me. I began doing things for me.
>
> My therapist said, "Go to the doctor and get some Antabuse, and that will ensure that you don't have a relapse." So I took that for three months.
>
> I went to an outpatient treatment program because my grades were failing, and it was to prevent drinking from ruining my academics.
>
> I stopped drinking for three months. I mean I just said, ok, I can't drink. I thought, ok, stop drinking and then maybe you can drink next time around.

Action was defined on the basis of lesbians' descriptions as strategic behavior to solve a problem that has been constructed. Among the actions taken by participants were seeking help from therapists, entering treatment programs, going into hospital emergency rooms and joining mutual help groups. For more than half of the participants, going to AA meetings was an early action. For several of the others, attending AA was a co-requisite to the other assistance they sought. Two participants attempted suicide in response to their recognition of alcohol problems. Other actions discussed by participants included severing negative relationships (either lesbian partnerships or

heterosexual marriages), starting school, reading about alcohol problems and taking Antabuse (disulfuram).

Validation

Participants talked about the effectiveness of actions and the accuracy of their problem constructions using the language of validation. The responses of others and the manner in which they resonated with self-image, cultural expectations and the experience of being valued as a person were crucial in the unfolding of events in the problematization process. The following are descriptions of how participants felt validated or invalidated in this process, which then affected their view of the problem at hand:

> Just hearing the alcohol screening questions and knowing they were all applicable to me made me think I was finally being understood by someone.
>
> When I was in treatment I would dress really fine, because I didn't want to be the only one who--doesn't have any clothes, doesn't have any cigarettes. Like a big zero. But I looked good. And I had to feel like I was ok as a person first, before I could feel ok around the others.
>
> I didn't want to go for help anywhere where there were men. I thought I just don't need it. How in the world could that ever be supportive for me? It just wasn't relevant to who I was as a woman. I still feel that way.
>
> I thought a prerequisite for being in this alcohol treatment program was being blue eyed and blonde.... I wanted to be the brown one who was different and all that. But what they had to say spoke fully for me in terms of drugs and alcohol and their consequences, what was happening for me. And I knew then that I had to give it up.
>
> When I first got to AA, I didn't feel comfortable at all. Everybody was in their thirties and forties and up. Everybody was old. I had no peers there. People would say to me, "How can you be an alcoholic if you are so young?" And I was wondering about quitting drinking before I was even of legal age to drink. I wasn't 21 yet.... So I decided I didn't need the meetings and then drank for a few more years, basically.

> I went to one AA meeting and ran into a neighbor of mine who was really screwed up. I thought, Jesus, I didn't know she was an alcoholic. I started to feel that I didn't really belong there. I was different.
>
> When I hit the AA meeting I was in tears because I realized I really belonged there. A guy spoke about growing up in a really restricted Catholic family. And what he talked about was how I felt. I could really identify.... I was getting it more and more that I had a serious drinking problem.
>
> I stopped drinking and my friends must have gotten the idea I was making a statement about them. They argued with me that I didn't really need to quit, just cut down. I started to feel isolated because as a lesbian sometimes you don't have that many friends. They made me feel I had suddenly become someone else, an outsider.

As the examples above illustrate, participants evaluated the accuracy and appropriateness of their problem constructions and the effectiveness of their actions according to whether or not they received validation. If they were confirmed and valued for who they were, how they defined their experience and what they did, then they were reinforced in their problematization. If their experiences were not corroborated, if their interpretations of their difficulties were not considered cogent and authentic, if their actions were not sanctioned, if they felt devalued, then women were apt to reject their problem constructions. In other words, validation had two main aspects: confirmation of the problem construction and affirmation of the self in one's cultural and experiential distinctiveness.

Validation was especially important in treatment and mutual help group milieus. One common issue reported in the data was the labeling of "alcoholics." If this identity, pushed by professionals and twelve-step group members alike, was not personally meaningful, women could feel invalidated. If calling themselves "alcoholic" was part of their problem construction, they were validated. While two thirds of

the participants felt comfortable with this label, one third resisted it, finding it exploitive, judgmental or pathologizing.

The degree of belongingness in AA was also a validation issue. About half felt an immediate sense of belonging in AA, particularly in lesbian AA meetings. There were other cases in which lesbian AA meetings were experienced as "intimidating." This was explained by participants as an intensity which they associated with "hearing about things too close to home." They also spoke of fearing rejection by one's closest peers and anxiety about sexual dynamics in interacting with other lesbians. Those who said that AA was "not for me," frequently reported lack of validation regarding ethnicity, race, religious beliefs or disability. Some said they felt invisible in AA. Some of these women did continue in AA as marginal members or searched for different meetings where their experiences were validated. A few avoided AA completely after their initial contact.

Women who had significant problems in addition to their alcohol problems, such as drug abuse, eating disorders, a history of childhood sexual abuse or relational problems, reported that AA and professional treatment services did not often acknowledge these other problems. Several women felt invalidated because they were mothers. AA and most treatment facilities lacked childcare services. The message these women internalized from this state of affairs was that they did not belong. Women with physical disabilities noted that AA meetings were often located in inaccessible church basements and that AA members in general did not view physical accessibility as a responsibility of the group.

Many women had believed that entering recovery would somehow negate their identities as lesbians. They anticipated discrimination

from health care providers and feared separation from the alcohol-oriented lesbian social scene that they were familiar with. In the San Francisco area, many of these women were able to locate validating alternatives that countered these invalidations. They associated with the recovering lesbian subculture, attending lesbian AA meetings, clean and sober dances and women's coffeehouses. About one quarter of the participants said that entering recovery actually convinced them they needed to come to a greater acceptance of themselves as lesbians.

Reconstruction

Based on the degree of validation participants perceived in their experiences of interacting and acting to address alcohol-related problems, participants altered their problem constructions and revised their responses to these problems accordingly:

> As for AA, I just didn't like the: "This is the program and this is the way it is to be done." To me that is not life. Life has many more aspects.... I stopped going there much because I don't want to be stuffed in.
>
> I finally got to talk to a therapist who knew about alcoholism, and she talked to me like a human being, not like I was just an addict who was always dishonest, you know. When she said, "You need treatment," I gave in and said I'd try it.
>
> I said, "You mean I am the first lesbian client you have had?" And when she said yes, I reminded myself I wasn't going to tell her much of anything.
>
> I thought I was your basic garden-variety drunk. But when I started therapy, these things came up about my family, you know, my parents drank and there was violence. I started to fit my drinking with a whole larger picture of what happens when you grow up in a family that is like--disabled.

Reconstruction was defined as making changes in the construction of an alcohol problem, that is, reconceptualizing and adjusting strategies for action. Reconstruction can also encompass the decision

to proceed along the same course because one has received validation. In general, reconstruction reflects the degree of validation received in the course of previous problem construction and related actions. Based on the interview data, reconstruction appears to be ongoing. It is an extension of problematization throughout the recovery period.

To summarize the problematization process as depicted in Figure 7, there were three basic types of components: (a) constituents, the causes and conditions associated with the development of difficulties with alcohol, (b) constraints, the internal and external barriers or perceptual and environmental blocks to awareness of constituents of alcohol problems and (c) dynamic interrelated identifying processes of construction, interaction, action and reconstruction, mediated by a fifth process, validation. The model provides a means of viewing problematization as ongoing; problems are continuously being reevaluated and responses to them are intermittently readjusted.

Interrelationships Among Components of Problematization

While the components of the problematization process at transition to recovery appear discrete and definable on a conceptual level, in the narrative accounts it is evident that these elements are definable only in reference to other elements and within the context of the account. For example, the content of an interaction might be considered a validation, an action might involve interaction, and construction might occur in the course of interaction. Some examples of the interrelationships among the components of the process are provided below.

A number of constituents can be joined in problem construction:

> I answered those twenty alcohol questions and failed the test. It confirmed that I was an alcoholic, but that wasn't a reason to stop drinking.... I was real burned out and only 22. I hadn't been able to work for six months.... Previously I was working in the sex industry to support the kind of drug habit I had, and I was really tired...and in a relationship with someone I didn't even like.... I really hated my life. So I finally quit.
>
> I feel like I'm an ACA and because of the dysfunctional family I grew up in, I didn't learn what you do when you have feelings. I first started using food for that. Then the alcohol and drugs were a kind of substitute for the food. It was a way of being numb...and when I was coming out as a lesbian I know I drank more heavily.
>
> If I would forget something, or get a parking ticket, or have a bad interaction with someone, it would incapacitate me emotionally.... And I would really feel bad about myself all the time.... And I wasn't a very good mother.... I stopped taking note of my little boy's development.... And I always had lots of friends, but by now I had maybe one friend.

Perceptual constraints, like stereotypes and narrowed views of alcohol problems, limit persons' awareness of constituents, consequently affecting problem construction:

> I did lots of drugs and alcohol, but there were no legal consequences. Being stopped by the cops all the time, but never, never, never getting a ticket kept me from seeing what was happening to me.
>
> Being a dope fiend was hip, slick and cool. Being an alcoholic--being a drunk! Hey that was like the people that stand in doorways that shit and piss on themselves and, you know, sleep there.... I didn't want to believe I was one of them.
>
> A friend said I had a problem, but I thought, "I drink like you, so I obviously don't have a problem--you seem to function so well."
>
> I did not want to accept that it was an emotional, a psychological problem.... I couldn't accept the complexity of it. I wanted it to be this physical addiction that I could fix. By medical means.
>
> I still didn't think my drinking was a problem because it wasn't affecting major parts of my life. Or I wasn't feeling all the pain, I think. But then all the anger came out and I became belligerent--violent. I saw it when I realized my personality was changing.

> There were hangovers...and actually a whole number of little markers along the way, markers that I worked around so as not to really see that alcohol was a major organizing factor in my life.

Environmental constraints are barriers to problem construction. Such things as economic stress, child care responsibilities, social discrimination and lack of information stop one from defining a problem and taking action:

> If I had money or insurance I could have got on with it. As it was I didn't have any money, I didn't know where to call or what to do. So I didn't do anything. I just drank more.

> They wanted to admit me to the inpatient treatment unit, and I had a four year old daughter. So I said, "What am I supposed to do with my kid?" And they said, "Oh, we'll think of something...what about foster care?" And I thought, "FUCK YOU." I thought that was the most absurd, impossible thing. I could not believe somebody was suggesting to me that I just go into the hospital and abandon this four year old to a stranger. I wasn't into having a problem that took my kid away. I said, "No, this is not going to happen."

> I know now that I had a lot of problems. But I couldn't let the counselors into my world. What if they were homophobic? That would make me really vulnerable. So I operated on the idea that I was handling everything--I really believed it myself.

> I didn't know what my options were, financially.... It wasn't a conscious thing, like--I'm gonna go get sober. I mean I couldn't see that there was anything out there to fix whatever I had. I didn't know what I had, really. I thought "This isn't a problem, it's just my life."

Interaction is related to problem construction as a source of labels for the problem, a confirmation of its seriousness, a context for encountering role models and a motivation to recognize the problem:

> I got verbally abusive with my lover at the time and was very confrontive. And she said, "You are acting just like an alcoholic ex-lover of mine." And she said if I didn't deal with my anger, the relationship was over.... But I was not considering I was an alcoholic, I thought I was a rage-oholic.

> My lover called me on the fact I was getting drunk a lot.... We went into couples therapy to sort it out.... I heard the therapist say to my lover, "You could be with an addict." I thought,

"What?!" The next week I said I was an alcoholic...it was my way of letting the therapist know I had started going to AA.

I woke up one morning and went into the living room, and there was a stranger on the couch. And I didn't remember who this person was or what was going on. All I remember was having gone to the bar the night before. So that's what made me decide that this was a real serious problem.

And she kept telling me it was a nervous breakdown, cuz she had one, you know. And so to me it was a nervous breakdown, I had never experienced it before.

I saw this woman who had been really a sick drunk, and I saw her sober. She was a completely different person. So that was really impressive. And these women she was with invited me to their impromptu AA meeting.... I was impressed. I mean they must have been able to see I had a problem.

Basically I was having a hellish time. And my therapist was starting to bug me, "How much did you drink this week?"

My ex-husband said he thought I was having a problem...then on my job I started talking to one of these counselors, just one of my customers, really...you know, these two people had mentioned it to me.... I kind of brushed it off and said, "Well, I'm a compulsive overeater and it has just sort of overlapped with alcohol for now".... Then this woman started calling alcohol treatment centers and I said, "Ok, I'll go to AA."

Interaction can be a direct source of action:

I just saw this person who was clean and sober and I thought, maybe I could try that. And six days went by after seeing this person, and I realized I hadn't taken a drink.... And she was talking about AA meetings, and I thought, "Maybe I'll check that out."

I was sitting in the bar, talking with a friend of mine, and we made this agreement to go to AA together that next Monday.... And we made an agreement we'd leave if we didn't like it. It was ok and we stayed.

Validation versus invalidation affects the construction/-reconstruction of an alcohol problem and influences the realignment of action:

My counselor would say, "Why don't you want to deal with those issues that have made you drink and drug?" And I said "Why would you think those are the reasons I drank and drugged? I am the third generation in my family--my grandparents, my mother, my

father, my brothers and sisters--all drank and got loaded! That's the problem." But this counselor--all she could see was that there was incest in my family and in her mind that was what I was supposed to be talking about. I completed the program, but I never trusted my counselor the whole time.

I was in a group therapy and the rest of the members were all white. They kept saying, "I can't believe you sold drugs and rented your own apartment when you were 12".... And it made me feel like I didn't fit in there, and I said, "I can't help it if you don't believe it".... And I stopped going there.

I got to the meeting and what I heard made me think I was with people who had been through what I'd been through. I felt like I was home. It kinda made who I was an ok thing to be.

When I talked about being a person of color, the other women and the counselors would say that was another trap I could get myself into--thinking I was unique or different, and then I would end up using drugs. There was no validation.

Patterns of Problematization Accounts

The narrative accounts were compared on the basis of dominant themes, choice of language, story structure, emotional tone, detail and content in order to determine the degree of variability among them and whether there were distinctive general patterns of problematization. The accounts differed on the basis of two dimensions. The first dimension was the degree to which problems infiltrated and affected life processes. In some accounts, alcohol problems were perceived as specific and bounded; consequences of alcohol problems affected few areas of daily life. In other accounts, alcohol problems were perceived as having profound, penetrating consequences in nearly all life areas. The second dimension was the degree of elaboration, including fluency, depth and detail of the account. Most accounts were rich disclosures, elaborately told; but a few seemed abridged, abstracted, disclosed in a tentative, cautious, controlled manner.

Based on these two dimensions, three problematization account patterns were differentiated: (a) circumscribed, (b) pervasive and (c) abbreviated. These patterns reflect participants' recollections and interpretations of experiences before and after transition to recovery.

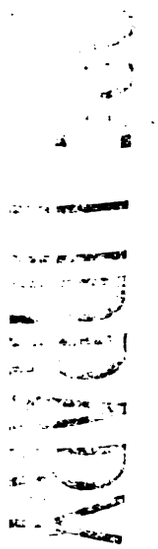
Circumscribed Accounts

Seven (20%) of the accounts were categorized as circumscribed. They were elaborate, detailed depictions of alcohol problems that were confined, delimited, having little effect on other areas of life. These participants tended to be older; their mean age was 41. They averaged 11 years in recovery, although this figure is somewhat misleading because of an exceptional participant who had 25 years in recovery at the time of the interview. These women looked at their lives from a long temporal perspective. They viewed their lives as having been stable, at least at intervals. None of these women reported a history of childhood sexual abuse. None reported an addiction to food. Most did report that they were adult children of alcoholics. All but one reported that their problematization of alcohol use was prompted by job-related or academic ramifications. Nearly all had sought or were forced into alcohol treatment at least once. They were less likely, however, to have received individual psychotherapy. All but two were occupationally engaged in the substance abuse field.

In terms of their transition to recovery, the participants with circumscribed accounts tended more than others to emphasize the following problem constituents: (a) survival; lack of finances, legal difficulties, work problems, unemployment, driving while intoxicated; (b) comfort/health; fears about socializing with other lesbians, alcohol-related physical illness and painful feelings; (c) history;

parental alcohol problems; (d) self-regard; internalized homophobia, low self-esteem; (e) belongingness; lesbian bars as the only safe haven for socialization; rejection by friends.

Many of these women discussed their involvement in the 1960's and 70's drug subculture, saying that drug use had been quite socially acceptable in their cohort. Hoarding drugs and alcohol, or in some cases, dealing drugs to support one's own habit characterized these participants. They cited alcohol-related symptoms: blackouts, "geographic" changes, hangovers, drinking more than peers, morning drinking and failed attempts at controlled drinking. These participants were older, in recovery longer and associated with AA, which likely influenced them to hold more traditional views of alcohol problems.



This group constructed the problem as uncontrolled use of alcohol. They tended to have used substances for a fairly long time before defining themselves as problem drinkers. They participated in the lesbian bar subculture through its ascendancy and peak periods. One participant suggested that besides being addicted to alcohol, she was "addicted to the bars."

Most of these women had identified as lesbians anywhere from 4 to 17 years before they entered recovery. In this group, lesbianism was perceived to be related to alcohol and drug use in several ways. Some said they used alcohol to disguise or conceal feelings that were self-indications of lesbianism. This drinking might be done alone or in straight bars, while relating socially and sexually to men. For others, alcohol and drugs were perceived as facilitating socialization and sexual interaction with other women. Furthermore, these women held that during the period of the 1950s through the early 1980s, bars were so

important in the lesbian subculture that alcohol tended to become central in the lives of those who frequented them. There was divergence in this group as to the value and social effects of the lesbian bar scene. Some thought that the bar scene was a very negative influence, while others referred to the demise of the bar subculture as a loss of valuable social space for lesbians.

With one exception, these women tended not to be actively involved in AA at the time of the interview, but had prior experience in AA. All of these women described difficulties affiliating with AA because of gender, sexual orientation and/or ethnic/racial status. This is consistent with the fact that they encountered AA at a time before there were lesbian AA meetings or other "special interest" meetings. Many did participate in AA for the first several years of recovery and then gradually withdrew from it, suggesting that they tolerated discrimination in AA while they needed its support for the initial phase of their recovery. The individual who was still involved with AA was exceptional in that she had made four separate attempts over many years to affiliate with AA, finally achieving this end in a lesbian AA group.

There were several common themes in the circumscribed accounts. Alcohol and drug problems were viewed as difficulties that developed after a long period of nonproblematic use. They related their substance use to socialization anxieties and to social expectations in lesbian communities. These women had a continuous view of self, believing that they were essentially the same person before and after their transition to recovery. As one woman said, "I had a life before AA." Because many of them were past the early recovery period, it is possible that this continuous view of self was a reinterpretation that had occurred over

time in recovery. There are likely cohort effects having to do with anti-lesbian and anti-drug culture discrimination which have kept these women from internalizing AA's traditional conversion interpretation of their experiences (i.e., "What I was like, what happened, and what I am like now").

Excerpts from circumscribed problematization accounts follow:

> When I came out there were five lesbian bars in the city. That's where we met. They were the safe places.... My support group predated my sobriety. And maybe it's because I am 43. I mean I had a life. I had to find myself. I had lost myself.... I'm learning to step back a little, manage stress.... Drinking was a way to feel more self confidence, and ask a woman to dance or to go to bed.... The first two years I was really into AA, and got some new meetings started. But once I got into school, I didn't go to meetings much. I mean now I am a counselor, and I don't want to run into clients at meetings. But I never intended to give up my life for the twelve steps anyway.... I think the overall message of the steps is being honest, admit when you are wrong, helping people--I mean I do that.... I work a lot now. I have only one free night a week. My life is full. I have a very high profile in the community now, and that keeps me sober.

> I was definitely a bar drinker. And for a long time that was no problem. The lesbian bars--it was just a central social location.... I mean there were these problems every once in a while, but I worked around them.... I just gradually came to where I felt cigarettes and booze were measuring my life. I'd already been in therapy for years, so I mean I wasn't emotionally disturbed, or hurting,--and I was already interested in making my life different--but I was still drinking and there just didn't seem to be much of an excuse for drinking.... It was like an addiction to the bar, too. In retrospect I realize my social skills were not fabulous, but I'd try to get these conversations going in the bars and they were just dead in the water. I realize now that a lot of these people just basically couldn't hold a conversation. Alcohol keeps you stuck in those places, you know.... I was getting these terrible hangovers and I thought, I'm really not having fun anymore.... We were all progressing together, my little crowd. It was a case of diminishing returns.... I started to go to AA, even while still drinking. I sort of developed an observing ego. Little pieces of realization...and these women at AA were impressive. Very warm and receptive. It was easier than the bar, socially. It was a lot easier than the bars. Women were very welcoming. It was easy to make friendships, acquaintanceships, whatever.... For at least five years I went to a meeting every day.... By about 8 or 9 years I went to a lot fewer meetings. I did not feel as

connected. I was in school, the schedules didn't jive. I was studying to be a psychotherapist.

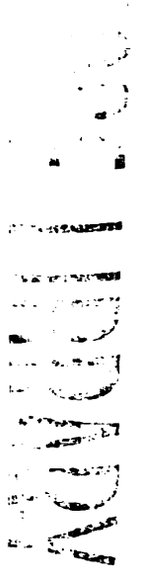
Pervasive Accounts

Pervasive accounts were elaborative and displayed a depth of disclosure. Substantively, they related alcohol problems as unbounded, having effects that penetrated many aspects of life. Twenty-one (60%) of the total 35 accounts demonstrated this pattern of problematization. The average age of these participants was 35, and the mean length of their recovery was four years. Nineteen of these 21 women reported an addictive problem other than alcohol/drug use, for instance, overeating, purging, diuretic and laxative abuse, sexual addiction, overspending or relational addiction ("codependency"). These addictive problems occurred in either the prerecovery period or at points in the recovery period itself.

Each individual in this group reported multiple difficulties that were constituents of her alcohol problem, often representing several constituent content areas. A single account in this group might include descriptions of history, self-regard, survival, comfort/health, intimacy and belongingness as the participant detailed conditions related to the development of her alcohol problem. Examples of frequently reported constituents were: family of origin dynamics, parental alcohol problems, running away as adolescents, arrests/incarceration, dependency, difficulty trusting others, difficulty maintaining interpersonal "boundaries," parenting problems, overresponsibility, excessive caretaking of others, physical illness, history of rape, history of sexual or other childhood abuse, rejection and unwanted/uncontrolled sexual behavior. Also apparent in many of these accounts were

constituents such as: lack of awareness of self or feelings, alienation, food/weight problems, dissociation, alter personalities or "splitting," feeling unsafe, memory deficits, shame, grief, mood swings, emotional crises, depression, rage, violence, self-hatred, self-harm behaviors, and internalized homophobia.

Alcohol and drugs were described by these women as having enabled them to interact socially and sexually, especially with other women. Alcohol was also used to numb feelings or aid in not remembering past traumatic events, such as sexual abuse. Many of these women said that they had used alcohol and drugs to "function" in their daily lives, and some described themselves as "barely functional," even in the recovery period.



These accounts describe women who have had traumatic past experiences in general, but particularly in the transition of adolescence. Many saw their families of origin as dishonest and secretive and their parents as highly critical; they themselves were usually cast in the scapegoat role. Many had engaged in rebellious behavior in the past, developing a self-image as "outcast." They associated with other "outcasts" or endured acute isolation. Some described having been social "chameleons," changing their image to adjust to different groups and situations. Unlike other groups of participants, these women reported very intense affects, including anger, rage, fear and, on occasion, paranoia. In a few cases such feelings were expressed in abusive relationships in which one or both of the partners become physically violent. While many participants reported periods of depression and suicidality, only some in this group

also reported a pattern of self-mutilating behavior in response to depression, anger or psychic numbness.

Their descriptions of low self-esteem were harsh and linked with shame, self-hatred, depression and alienation. Self descriptors that indicated perceptions of inherent negativity were used, such as "bad," "ugly," "disgusting," "damaged" and "defective." Sexuality was affected in many ways. The women spoke of self-control deficits, sexual identity conflicts, negative conceptualizations of themselves as lesbian and inability to maintain intimate, trusting relationships. There was a tendency for those with a history of childhood sexual abuse to be sexually revictimized in adolescence and adulthood.

These participants reported more alcohol/drug use relapses than those with circumscribed accounts. They had conflicts with AA members and health care providers regarding trust, not being believed, feeling invalidated, being urged to forgive abuse perpetrators and feeling constrained by the rigidity of helping persons. All of these women had been clients in individual psychotherapy; most had several courses of therapy over their adolescent and adult lives. Many also had participated in group therapy. Their evaluations of these services are discussed in a later chapter. One finding worth mentioning here is that many of these women reported revictimization experiences in interaction with therapists.

These women were looking at their lives from a fairly long temporal perspective. They communicated the impression that they had always been struggling with heavy burdens or chronic difficulties, both before and after recovery began. They indicated a sense of discontinuity of the self through the stories they told about recurrent

difficulties. They also reported having been "politically unaware" as a result of the many threats to their self-esteem, comfort, sexuality and social adjustment. Two thirds of these women reported that their lesbianism was a significant recovery issue for them. Most struggled in recovery to positively accept their sexual orientation. For some there were also struggles to affirm their ethnic/racial identities.

The following are excerpts from pervasive problematization accounts:

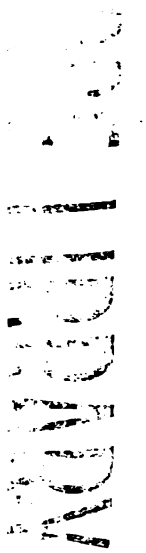
> Either using drugs or drinking, you know, I had to be high every day, because I used to always just do that to bury all my feelings. I mean I am an incest survivor and my mom died when I was 14. And I was battered by my father and sexually abused--I didn't want to feel all those feelings...the alcohol and drugs numbed it.... When I was in high school, you know, I always had problems. Emotional problems because of the incest. I was sent to counselors. I spent two weeks in a nut house around that time.... I have had a lot of therapists, but I took breaks from therapy when I didn't like certain therapists. Now I have a therapist and she helps me with memories, and dealing with things in my life day to day. Survival stuff.... Alcohol and drugs were also ways to not deal with my race, my heritage.... There's so many ways I am affected, on so many levels.

> I never thought about things that were too confusing to me. I would just use drugs or drink. Or when it got too painful I'd use.... Sometimes I would try to make sense out of my life and I would say, "No, its too confusing, I'm not gonna think about it." It wasn't conscious. I had no idea I was an incest victim and, also--um--there was physical battering. Feeling like there was no one there for me, that kind of stuff.... And I think because of the incest, a lot of problems happen. You know, your inability to trust. Your boundaries are all fucked up. It causes you problems you might want to escape through drugs and alcohol. Or maybe you become promiscuous because of your boundaries being messed up, and then you want to drink over that.

> It seems like I have always been in therapy.... I mean I've done rebirthing, psychosynthesis...and what I got from it was that I now understand that lack of self-esteem is my issue.... At one point I was in an abusive relationship, and I was throwing things, breaking things.... I sabotaged my job. And you can try to make your life more sane, but I am not sure you can change the core stuff that you got when you were a child, you know?.... I can't deal with my food issues by going to AA meetings.... I think it's all one "ism." Being put down as a child. Having no emotional

boundaries. Therefore I will use any substance I can to fill up the hole and protect me. You know, try to make boundaries.

My early drinking got me over being shy, worrying what people thought of me.... I remember growing up learning to play the role, swing with whatever crowd I was in.... Alcohol removed a layer of--everything--to where I really felt cushioned.... At one point I realized, ok, I'm queer, I'm not ok, I don't have the support of my family. I am on my own.... I had a self-concept that I was ugly and like really repulsive... I thought of myself as this slimy little asshole.... I went through a time when I slept with anyone who came on to me. I had this therapist who asked, "Have you considered that you were raped as a child?".... And I had these intense feelings over the next two days, just overwhelming. I mean, she was right.... But I couldn't deal with it, and my sponsor didn't get it, so I drank. I had a relapse.... I'm not a multiple personality, but I dissociate pretty heavily and I have different parts that I dissociate to.... and it showed up as a real problem in my relationship. I'm talking about leaving emotionally--You're sitting there but there's nobody home.... I have been working regularly with this therapist now for four years. I had to quit my job and not work during the first two years of my recovery. Fortunately I had some money to live on at that point.... My sponsor in AA was the first person I really trusted, really allowed to see me as I really am.

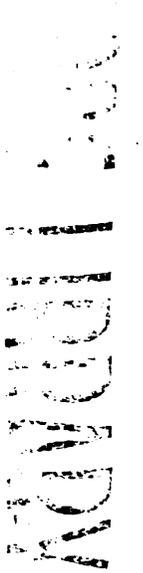


Abbreviated Accounts

In the abbreviated accounts it was not possible to ascertain the pervasiveness of the problem as perceived by the participant; not enough detail and depth were offered. There were seven abbreviated accounts (20% of total). The women who related these accounts suggested that their problems were primarily limited to alcohol overuse. But their narratives differed significantly from the circumscribed accounts described above. Abbreviated accounts were far less elaborative, stunted in the telling. The focus of the accounts was narrowed to immediate recovery issues; few problems occurring in the prerecovery phase were discussed. The problems identified in the recovery period were similar to those identified by the other two groups, supporting the notion that it is not a lack of prerecovery problems, but a tendency not to talk about them that is operative here. It may be that these women

simply did not perceive that they had difficulties before recovery. Because these women were in recovery an average of three years, their attention may have necessarily been more directed to transitional and entry to recovery problems rather than prerecovery experiences. Yet, there was an enigmatic quality to these accounts, suggesting that there might be untold stories.

The women focused on problematic alcohol use. Other difficulties only briefly mentioned were lack of finances, need for childcare, legal difficulties, fears about socializing with other lesbians while not drinking and internalized homophobia. References to childhood trauma were vague, and nobody in this group reported having a history of childhood sexual abuse.



Conjectures about this group of women are: (a) those with abbreviated accounts are a more heterogeneous group, (b) they actually fit the circumscribed or pervasive pattern, but too little information is provided to make this determination or (c) this third group of accounts represents experiences at a relatively early phase of recovery in which problems other than alcohol have not been acknowledged or articulated, and definition of the limits of the alcohol problem has not yet occurred. It is possible that these participants were more insightful than the narrative data revealed; perhaps interactive dynamics within the research interviews prevented these participants from being as expressive as they might have wished. However, careful fieldnotes of interview processes and research diary entries did not indicate that participants were stymied in sharing details of their recoveries from alcohol problems.

These interviews do not provide a clear basis for making a theoretical decision about these issues, yet the abbreviated accounts point to important clinical considerations. The most central of these is the possibility that in a particular phase or condition of recovery, clients may be more focused on current problems and find it difficult to explore the prerecovery period. Another consideration is that abbreviated accounts may be provided by women who have dissociated trauma, and are not ready to become aware of these split off experiences. In this case, the temporal period of recovery might be irrelevant as a predictor of when these women might begin to disclose prerecovery problems.

The following are excerpts illustrating abbreviated problematization accounts:

> Somewhere my drinking changed from drinking with the aim of not getting drunk to drinking with the aim of getting drunk.... I was lurching from crisis to crisis.... I had what I thought was a nervous breakdown, but they said it was drinking.... I just thought if it would make my life easier I would try to quit drinking. Probably the typical story.

> I was in a whole scene with the bars that was conducive to alcohol and drug use.... I actually had to learn how to drink when I went to the lesbian bars.... There was about a four month period where I noticed my use was more than I was comfortable with. I got out of the scene.... I met this woman who became my girlfriend around that time, and she was in twelve-step programs. I thought, well, if you can't beat it, join it. So I went to learn about AA.... I look back and see that alcohol gave me confidence, I mean, I didn't get the encouragement I should have in my household when I grew up.... Now I work on believing I am ok just as I am.... Being glad you are breathing.... Having gratitude.... I'm trying to create my own support system, because that's what I need for recovery.... The world is gonna move into a healthier shift, the numbers of women in the recovering community indicate that.

> At the end it was worse than any other point, but it came in periods in my life. There were times when I drank a lot and then there would be stretches of months where I wouldn't have anything to drink. It's a little too complex to say that times when I wasn't drinking I was more at peace, but to abbreviate it, that's

> what I'd say. It's not that there weren't struggles at those times but the struggles--I could see there was movement--I wasn't stuck. I wasn't going backwards.... I was real careful. No one saw me drink a lot on a regular basis.... I had made serious attempts to stop drinking and had failed.... As I said, nothing was really threatened by my drinking, except that I was going to have to take more alcohol in order to function, and I wasn't willing to do that.... After I quit drinking there were changes, but they were pretty complex and I wouldn't know how to be specific about it.... The alcohol problem situation is not something I discuss in therapy much.... I'm gonna be evasive on these questions because I have a lot of questions about therapy right now.... I did go to AA once with a friend. I was just really uncomfortable. I wish I could articulate better what the discomfort was all about. I've tried to think it through and understand it but I still don't totally.... My attitude is that everybody is, or should be, in recovery, having little or nothing to do with if they've used drugs. We should not try to stop growing, ever. To be in recovery is a positive--good thing.

Summary

A fundamental finding of this study was that alcohol-related problematization was an ongoing process, encompassing an array of potential difficulties that were perceived to be connected. The transition to recovery involved dynamics centered upon the interplay of problem construction, interaction, action and reconstruction, according to whether validation of the individual's view of the problem and self-image had occurred. Racial, gender, cultural and sexual orientation identities were relevant in that invalidation on any of these grounds could affect the entire process.

Viewing problematization as an ongoing process is consonant with the everyday life experiences that the study was designed to tap. It may be argued that this view of problematization as an ongoing process merely represents the processes of ordinary life for non-problem drinkers as well as problem drinkers. Another way of construing these findings is to consider that the participants in this study were individuals who had multiple vulnerabilities. The narrative data

revealed that alcohol use was usually only one in a series of personal concerns or one among several concurrent distresses. It would not be surprising that this group would share an understanding of life as a series of struggles. The participants were also speaking from the vantage point of a recovery subculture, wherein there are many social and therapeutic sources of problematizing language and ideology. They may have been socialized to understand that "recovery" is a process of grappling with one problem after another. These interpretations notwithstanding, the importance of the current findings about problematization contrast with much extant theory and practice that view alcohol problem recovery as a distinct process, separate from individuals' characteristic patterns of recognizing and responding to difficulties over time.

In many of the accounts in this data base, alcohol use was problematized for months, even years, before the women actually stopped drinking. Others had stopped drinking or using drugs at some point prior to identifying themselves as "addicts" or "alcoholics." These observations challenge models of recovery that equate problematization with abstinence or insist that problematizing alcohol use always entails identification of oneself as an "alcoholic." The findings also challenge the notion that "recovery" cannot begin while individuals are still drinking or using some other drug.

Though all of the accounts evidenced basically the same process of problematization at transition to recovery, there were major differences in the global patterns of problematization revealed in the accounts. Specifically, there were three types of problematization accounts: (a) circumscribed, (b) pervasive and (c) abbreviated. These patterns

differed relative to a number of factors, including age and cohort effects, multiple addiction, period of recovery, cultural background, AA involvement, presence of a history of childhood trauma and participants' trust of the interviewer. Most significant was the distinction between circumscribed problematization and pervasive problematization, which provides a basis for making meaningful clinical separations among lesbian client groups.

How problems are "created" and specifically how alcohol use becomes a "problem" for lesbians is not a simple matter. Interactions with the self, significant others and frequently health care providers are involved. Each situation is quite unique. Social, economic, political and perceptual conditions constrain problematization, obscuring individuals' awareness that problems exist. Description of these factors elucidates the processes heretofore covered by the term "denial."

CHAPTER 5

HELPSEEKING AND HEALTH CARE EXPERIENCES REGARDING ALCOHOL PROBLEMS

This chapter addresses two of the research questions. First, it offers additional findings to a question that was partially addressed in Chapter 4, namely: What are lesbians' helpseeking experiences regarding alcohol problems? The second research question addressed in this chapter is: How do lesbians describe and interpret their health care interactions regarding alcohol problems? The findings in this chapter reveal meanings of health care for alcohol problems from the viewpoint of clients. Women's encounters with physicians and nurses, individual and group psychotherapists and alcohol treatment program staff are described. Areas of consensus and points of disagreement are identified and discussed.

Helpseeking for Alcohol Problems

Access to Care and Utilization of Services

An important aspect of helpseeking which contextualizes the information in the accounts was the degree of access to services and how these were utilized. Of the total 35 participants, only 15 (43%) had health insurance or were members of a Health Maintenance Organization (HMO) at the time they sought help for alcohol problems. Twenty-one (60%) had such health care coverage at the time of the interview. Two other women had minimal coverage through student health services which did not cover alcohol-related services.

Twenty-two (63%) of the 35 participants had received some type of formalized treatment for alcohol problems. Five women (14% of the total) had inpatient or residential treatment lasting approximately 30 days. Three of these five women also lived in a halfway house for

recovering women after their treatment program was completed. The remaining 17 (49% of total) received outpatient treatment over periods ranging from three to 18 months. Twelve of these 17 women received treatment in outpatient programs serving only women.

Thirteen (37%) reported that they did not seek formalized treatment because they were unaware of what services were available, did not have insurance coverage, did not know whether their insurance would pay for alcohol treatment or simply did not consider themselves as candidates for such treatment at their transition to recovery. Of those who did not receive treatment, only a few said they regretted not having done so. Interestingly, a larger minority of these women said that some form of treatment would have been helpful to them later in the recovery process, after the first year. In terms of barriers to helpseeking, five women stated very directly that they considered treatment programs to be unsafe for lesbians, that they would not participate in them at any point. A general consensus was that there were not enough all-women treatment program slots to accommodate those who needed such care.

The following quotes illustrate some of these points:

> I didn't have any money. So any treatment would have had to be really cheap or free. So it couldn't be any Betty Ford clinic. Even a small scale something like that I couldn't afford.

> I didn't start talking about my lesbianism, or even mention my relationship with my girlfriend while in the treatment center.... The whole thing was not very supportive. There was this guy in treatment with us and he was gay. And people just made fun of him, and nobody did anything about it. I mean the guy just eventually left. It was very unsafe.

> Three years ago when I needed it, the Project couldn't take me. They didn't have the space. There was really only the Women's Treatment Center, like a house. Thank God for that place, because where else would I go, unless I had the money for a hospital, and most women I know don't have health insurance. Most of the women there were on AFDC. If not for the sliding scale and welfare I

> don't know where they would go. Especially the mothers. It's the only place where they can go with their children and the children get therapy too.... There just aren't enough treatment spaces for women. I think there should be several centers like that for women. I was lucky to get in.

Several low-income participants identified another barrier to helpseeking: embarrassment regarding lack of finances. For example, even sliding scale fee systems posed social distress. Even the lowest fee was found to be too high for some, and when the fees were collected in front of other group members, the situation became a source of shame and embarrassment:

> I didn't have food, housing or nothing. The sliding scale for individual therapy was fifteen bucks and it took me a long time to pay that. The group therapy was ten bucks and that was too much.... Before the session everybody would be waiting and making out their checks, and I'd be scraping out change... I wish you could pay in private. If you couldn't pay you'd have to say that in front of everybody. They'd say, "That's three weeks you haven't paid up." I'd say, "I'll pay something on that next week." It was embarrassing.

Helpseeking was also affected by the pervasiveness of problems participants were experiencing. Among the 22 women who participated in treatment programs, nine (26% of total) had been through such programs more than once, often repeatedly over a period of years. Seven of these nine also reported a history of child sexual abuse, and gave accounts of alcohol difficulties that were pervasive in their consequences. This finding raises concerns about whether current treatment programs are adequate in terms of staff preparation and resources to meet the special needs of lesbians and other women who have abuse histories and/or suffer from multiple addictions.

Seventeen (49%) of the women had participated in group therapy through a formalized treatment program, either inpatient or outpatient. Ten (29% of total) participated in some form of group therapy outside of

a treatment context. The foci of group therapy included alcohol problems and related difficulties, such as other addictive problems, family of origin issues, "codependency," difficulties of adult children of problem drinking parents, women's issues and sexual trauma.

Perhaps the most telling figure in terms of helpseeking was that 34 (97%) of the women reported having participated in individual psychotherapy. Twenty- two (63% of total) had received individual therapy specifically for alcohol problems in the context of an alcohol treatment program. Many sought individual therapy at intervals over most of their adult life, sometimes beginning in adolescence.

Most of the women generally paid for individual psychotherapy out of pocket, even if they were insured. In slightly more than half the cases, the fee was charged according to a sliding scale based on clients' incomes. The fee for individual therapy at treatment centers was sometimes as low as five dollars per session. In private therapists' fee scales, twenty dollars per session was the lowest reported charge. In view of the low incomes of the lesbians in this study, the cost of weekly or twice-weekly individual psychotherapy was significant. Sometimes those who had insurance policies that would have covered a portion of therapy costs chose instead to pay on their own. With self pay they could choose the therapist, rather than be limited to those in a particular HMO or those who were authorized for third party payment. By choosing one's own therapist the women believed they had a better chance of working with a health care provider who was safe and sensitive regarding lesbians' needs.

As the findings on problematization in Chapter 4 suggest, individual therapy was typically sought at intervals before and during

recovery for a variety of concerns that participants considered relevant to their alcohol problems. Such problems included relationship conflicts, depression, eating disorders, adolescent crises, suicidality, family of origin conflicts, anger, post-traumatic symptoms and difficulties with sexuality. The interconnectedness of these problems and problematized alcohol use indicates that in at least some cases, psychotherapy before recovery was an attempt to address either a "core problem" underlying the alcohol problem, or some life difficulty undoubtedly having the capacity to exacerbate the alcohol problem.

Based on these data, it appears that helpseeking experiences are affected by ethnic/racial, economic, sexual orientational and symptom-related vulnerabilities. Participants often felt marginalized within the health care systems they contacted because of cultural differences, lack of financial resources, lesbian identity and/or pervasiveness of their alcohol problem-related symptoms. Marginalization was understood as the experience of living at the periphery of a group or society, rather than being integrated into its center. It seems that those having multiple vulnerabilities, those who are less and less like the "norm," encounter more difficulty in seeking help and are less likely to find competent, appropriate care for their difficulties. Participants experienced marginalization in terms of access, relevance and specificity of care and legitimacy and safety as clients. This concept of marginalization holds meaning in explaining not only the experiential distance from the mainstream reflected in these women's narratives but also the diversity among the women themselves who all share the designation of being lesbians with alcohol problems. Difference distinguishes marginality. Displaced from the

center where there is a sameness, marginalized persons are different from each other. Marginalization can thus have a privatizing, isolative quality that guarantees heterogeneity.

Helpseeking in Response to Depression and Suicidality

An important finding in these interviews was the frequency and significance of depression and suicidality among the participants, and the relevance of these problems to helpseeking patterns. A total of 11 (31%) of those interviewed had a mental health-related crisis during the transition to recovery, usually involving depression, acute anxiety and/or suicidality. Four of these 11 women were at that point experiencing the emergence of feelings or memories related to past trauma, such as violent crime or child abuse. These figures do not include those for whom such crises occurred at later points in recovery.

Fifteen (43%) of the participants reported having been intensely suicidal at one or more times throughout their lives. Three had acted on these feelings, one of whom was severely injured when thrown from a vehicle in a self-intended collision. Seven of the 15 reported becoming suicidal during the period immediately before or after their transition to recovery. In these cases, the suicidality became a means to contact helping resources. Four women reported suicidal crises occurring years before transition to recovery. Seven women reported having been suicidal after their recoveries were well established. Of the total, four women had repeated suicidal crises throughout the prerecovery, transition and recovery periods.

Eighteen (51%) of the total participant group reported having had at least one period of incapacitating depression in their adult lives. Ten of these women were among those who reported suicidality. Ten of

these 18 reported having been depressed during their transition to recovery. Five mentioned grief, related to the death of a parent, child, or loss of relationship, as the major factor in their depressions. Six participants described recurrent depression. All 18 of the women had sought assistance from a physician or therapist at least once for depression. Most had taken antidepressants for at least one interval of time, although none reported that these medications successfully alleviated their depressive symptoms. Several reported that the medication was not explained adequately to them, leading them to erroneously use it only sporadically. Others found the interaction with the provider, usually a psychiatrist, so unpleasant that they opted to discontinue treatment. Three of the women reporting depression were among those with multiple addictions, and also had histories of childhood trauma. They tended to link the recurrent depression with a "core problem" that fostered extremely low self-esteem.

In summary, helpseeking for depression, suicidality and alcohol problems is complicated by the interrelationships among these problems, health care provider preconceptions and gaps occurring within our specialized health care systems. Although depression and suicidality are not necessarily specific indicators of addictive problems for lesbians, fully half of these participants have been significantly depressed at some point. Since depression continues to surface for some in the recovery period, it cannot be dismissed as an effect of alcohol/drug abuse, but rather needs to be considered a significant problem to be investigated adequately and treated as necessary. The findings raise questions about the vulnerabilities of alcohol/drug problems, other addictive problems, depression, and childhood trauma in

lesbians, who are already marginalized in so many ways. The findings also raise questions about the abilities of health care providers to recognize and effectively address depression and suicidality in this population.

Choice of Health Care Providers

Participants described the decisions they made about health care providers in the course of helpseeking for alcohol-related problems.Many voiced a preference for women providers. Male health care providers, especially physicians, were frequently described as arrogant, cool and objectifying. Men were often viewed as more antipathic toward lesbians than women providers. Women providers were viewed as more empathic and more able to relate to other women's experiences from a mutual standpoint. There were five cases in which a woman health care provider was described as providing the essential emotional relationship through which recovery was initiated. In these cases the provider was described as a role model, one who exemplified not only one's image of an ideal, but who offered emotional support, nurturance and experienced wisdom from a stance of self-confidence and security. In these cases, participants also stressed that these female providers were either in recovery themselves or were well acquainted with the needs of persons with alcohol problems. If they were not lesbians themselves they were very comfortable interacting with lesbians on an emotional level.

Some participants had sought help from women AA sponsors who provided wisdom and emotional support, giving nurturance as health care providers might. The general finding that a majority of the participants placed a high value on a having a role model or mentoring relationship with another woman at transition to recovery suggests that

such relationships are positive and possibly integral to the recovery process.

Only three participants made specific mention of interactions with nurses, all of which were positively evaluated by the participants. It should be noted that health care interactions may have occurred during the periods covered by the participants' accounts that they did not include in their stories. The interviews did not focus on uncovering all such interactions; rather they focused on those which were most meaningful for the participants related to their recovery from alcohol problems.

Other than gender, there was little consensus about preferred demographic characteristics of health care providers. Some women said they would prefer to have a provider of their own ethnic/racial background, but in reality this was often not possible due to the relative scarcity of providers who were African-American, Latina, etc., and the specialized nature of care required for the treatment of alcohol-related health problems. Only a handful of the participants had a personal physician or nurse practitioner whom they contacted regularly for preventive or routine care.

Interactions with Health Care Providers

The narrative accounts spanned adolescence through middle adulthood and revealed patterns of interaction in health care over time. The most prominent theme regarding health care interactions was safety. Safety refers here to the participants' perceptions that they had come through health care interactions with their personal integrity, emotional well-being and self-image intact. Safety was the common theme in many of their stories about health care interactions, and was far

more prominent than other potential concerns, such as the cost of care or the effectiveness of treatments. Specific concerns about safety were categorized in six areas: (a) conceptual compatibility between client and provider, (b) providers' preparedness to interact with lesbian clients, (c) respect for boundaries, (d) emotional climate, (e) provider persuasiveness strategies, and (f) attention to group dynamics.

Conceptual Compatibility Between Client and Provider

A common dilemma faced by participants when they sought health care for alcohol problems was a disparity between the provider's concept of the identified problem and its appropriate treatment and their own view. This often resulted in feelings of invalidation, humiliation, and frustration for participants. Some providers reportedly held the view that in order to recover, clients must become significantly demoralized as they identified alcohol use as the exclusive problem of their lives. Some providers were rigid in insisting that alcohol problems were separate from other addictive problems, such as eating disorders or compulsive sexual behavior. In other cases, providers insisted that a number of problems had a single cause when the client didn't share that view. Examples of these conceptual disparities are:

> The bulimia and alcohol are very closely related, and I wouldn't want them to be separated, and yet I think some health workers won't look at that connection.... I think it is just a matter of an addiction, whether it's bulimia and alcohol or drugs and alcohol.... Symptoms might look different but the cause is the same. I don't think the services should be all divided up.

> I was depressed, suicidal, and drinking heavily. I must have said that fifty times to my therapist, "I'm worried about my drinking." And she'd say, "Let's talk about how you feel about yourself." Or, "Well, I drink, too. How much is too much?" She really wasn't alcohol aware.

> But I hope eventually I will be helped to deal with some of the real basic stuff--the pain of growing up in an environment where

> you have to wear this badge of courage, or maybe ignorance--because you are black, and you are afraid.... The cocaine was a way of disconnecting from the fear I had growing up.
>
> In the current system you are always supposed to say there's a chance to take a drink, and that you are recovering, not recovered. But I don't feel that way. I don't feel I can take a drink--I know what that's like. But the urge to drink has left me. It has been gone for a very long time. What I do worry about is my ability to hold on to my inner self because of the (childhood) damage.
>
> Alcohol wasn't really, as I saw it, really wasn't my problem. It was a symptom of some other stuff that was going on for me. When I gave up alcohol I coped with compulsive sex, and when I got over that, I put on weight, and then it was a food addiction.... Low self-esteem, abandonment issues.... I'm angry at the marriage I felt forced into because I was female. Realizing my idyllic childhood wasn't so idyllic.... I mean, of course I should lose weight, but what about the whole picture--why I have gained the weight, why I have used alcohol excessively, sex, on and on. So many therapists and doctors don't know how to deal with folks like me.

According to participants' stories, some providers viewed recovery from alcohol problems as having specific temporal dimensions, like sequenced stages. They insisted that problems other than alcohol must, or must not, be addressed in the first year of recovery. For example, some providers declared that only alcohol and drug related behaviors should be dealt with in the first year, and not family of origin or childhood trauma issues:

> I don't hold much with the notion of stages. Like, "Oh you are sober for two years so you are going through thus and so." I think providers feel wise and comforted if they think they have discovered a pattern, and now can anticipate what is next for their clients. Although there are some common threads, we are all quite different. For example, if you come into recovery a black woman at age 18, your first three years are going to be very different from a white man at age 64. The differences really override the few commonalities.
>
> I don't think it is right for therapists to be bringing up these incest issues to women early in recovery. There are too many women running off to groups for this and groups for that, and nobody is telling them the simple things like--don't drink no

> matter what. I mean, if sexual abuse comes up for you, deal with it. But it shouldn't be pushed.

Some providers believed that group therapy or treatment was necessary for all those with alcohol problems. Some believed that alcohol problems could not be addressed unless clients participated in AA. Participants agreed that providers needed to be familiar with AA and other twelve-step programs. But they did not want their therapists, for example, to teach them the AA program, or use it to structure the therapy. They expected therapy to be something one could not obtain in AA:

> At the time I went, the women's treatment center didn't push AA. They wanted you to go, but they didn't preach it. And they didn't make the therapy sessions just like an AA meeting.... There might be times I would miss an AA meeting, but I am always in therapy every week.

> I was sent to have outpatient treatment for alcohol problems by this psychologist. It started out fine, but then he seemed to suddenly decide that AA was the answer. He was hell bent on getting me into AA. Badgered me into AA. Wanted me to give my phone number to these AA people. Finally I said, okay. These strange men from AA contacted me. I went to the meetings. And after going to a few AA meetings, this psychologist terminated me. So that was what I was left with--AA.

Of the 35 participants, six reported some contact with a psychiatrist. Interactions with psychiatrists were conflicted in terms of conceptualization of the problem and also frequently reflected sexist dynamics. One woman unsuccessfully sought help from a psychiatrist for being seriously overweight. The other five women had reported major depression either prior to or during recovery and had sought help from a psychiatrist. In one account, the psychiatrist stated that 12 weeks of verbal therapy was needed before any medications could be started:

> Six months I was on this antidepressant called Tofranil.... I had a lot of problems with it. The side effects were more than I had been informed about. I guess they weren't working. I ended up

switching from him to another therapist on the advice of a nurse practitioner.

> I remember about a month before I finally got into recovery I saw this woman physician about my drinking and drug use, and I felt crazy, and she says, "Well you just need to stop drinking and using." And I thought, "Yeah I got that clue, but how do I do that?!" She didn't really want to talk any more about it.... Her concept was that maybe I just needed someone to tell me to cut it out, that I was dumb. And like her job was to just tell me what to do, with no support, no nothing. It humiliated me.
>
> When I weighed about 245 lbs., I got a referral to the mental health department in a large HMO. And I saw this psychiatrist, who said since I didn't fit any of the strict definitions--I wasn't an anorexic and I hadn't made myself vomit--that I didn't have an eating disorder. And so he said there was nothing he could do for me because I wasn't in the diagnostic manual. I argued with him, saying, "You mean that my eating is not emotionally motivated, and that there is no counseling that could help me?" He said, "No, we can't help you here."

Having one's own ideas about the problem incorporated into the providers' views of the problem, and being related to as a whole person, usually facilitated a sense of conceptual compatibility. Most participants spoke in favor of providers who were skilled and knowledgeable enough to take a comprehensive view of problems:

> She treated all of me. She was an RN MSW who saw things in a holistic way. She taught me how to identify feelings.... She helped me get to physicians and dentists the first year.... I wasn't working so she gave me crafts to work on.... I had to learn how to sleep and get up and take a shower and make my bed and eat.... Later I went back to school and she supported me in all these changes.... This therapist explained alcoholism as a family disease...she was looking at child abuse and sexual abuse issues before they were being talked about as they are now.
>
> He doesn't fix you, like say, "Here, take this and your problems will go away." Or more like the doctor's problems will go away. No. He is in it for the long haul with me, and knows that is what these problems are all about.

Providers' Preparedness to Interact With Lesbian Clients

The narratives revealed provider behaviors that alienated lesbian participants. Some of these were: heterosexual assumption, fearfulness

of lesbians, pathologizing lesbians and ignorance of lesbians' social and cultural realities. Often these behaviors were institutionalized in typical, customary patterns of health care provision. For example, participants reported that intakes were conducted using language that excludes lesbians by referring to "husband" instead of "partner," to "family" instead of "significant others." Traditionally, many health care policies, program formats and materials assume clients with alcohol problems are male; likewise they assume heterosexuality.

Many participants reported instances in which a relationship with a health care provider was ended, not because the provider was thought to be negative or discriminatory toward the client, but because of a general ignorance about lesbians and the social conditions they faced. The women found they could not extend their trust in a relationship with a provider who had not made the effort to know the client's cultural situation. Participants held that there are a number of basic issues and kinds of social interaction common to most lesbians with which health care providers ought to be familiar. These are socialization patterns, relationship concerns, family of origin issues and the coming out process. Participants expressed the need for providers who understood their cultural experiences without stereotyping individuals:

> I didn't want to have to explain my life to a therapist. I mean with a straight therapist you have to make sure that they understand that you, the client, are okay with being a lesbian. You know--the lesbianism isn't a problem. And that usually takes--I mean you are spending money the whole time they are coming to understand that your lesbianism isn't a problem--so you are spending three or four or five meetings at $70 apiece. Forget it. It's a waste of money.
>
> It doesn't enter my mind to worry about whether he is anti-lesbian, and I am very sensitive to that with doctors. He never intrudes. He smiles at me every time I see him. He is soft-spoken. When I was too depressed to remember how to take the

> medicine, he knew to talk with my partner about it. I hear other lesbians talk about their trips with psychiatrists and I always wish they could see this doctor I go to.

Lesbians of color reported frustration with providers' lack of knowledge and their lack of sensitivity and openness toward ethnic cultural experiences. The following quotes articulate participants' needs for providers who are prepared to deal with them as members of a heterogeneous, culturally diverse aggregate:

> I'm not straight. I'm not a man. I'm not white. My issues are different--I don't want to have to educate you about my issues. And if you do know some things about black women's issues, don't assume they are mine just because I am a black woman. Regard me as me and not as some stereotype, and not as some statistic.

> My counselor was very compassionate, very loving. When I talked about my girlfriend she was all right about that and she was still there for me. Very consistent. But no background on lesbian lifestyle, any of those issues.... I felt like with counselors I was always educating them about lesbians or being a person of color.... Like health care providers need to understand what it means when I say I am first generation Japanese, Filipino or whatever. What does it mean? What kind of struggles will this person have? Because the individual isn't going to be able to articulate these issues right away.

> I wanted a lesbian therapist, someone who had some empathy about issues of gender, sexual orientation and race.

The chances of childcare being provided as a part of therapeutic programs were slim. That childcare must be available for lesbian mothers who need treatment was adamantly expressed. The idea of placing children in foster care, for instance, was anathema for women who already felt significant threats to their legitimacy as mothers due to societal prejudices and the courts' tendencies to wrest custody of children away from lesbian mothers.

Participants gave many examples of how health care providers revealed their fear of lesbians, often referred to as "homophobia."

Providers commonly changed their behavior or demeanor after clients disclosed that they were lesbian. Silence was a common means of communicating disapproval or discomfort. Lesbian clients noticed when providers were unable or unwilling to even say the word "lesbian." There were reports of providers stating directly that disclosure of sexual orientation in treatment milieux was inappropriate. Ostensibly these admonitions were made to "protect" the client. In the meantime, antipathy toward lesbians was allowed to thrive in the milieu.

Another typical way that health care providers communicated antipathy toward lesbians was through pathologization: the suggestion that lesbianism is in itself a problem. Providers communicated their prejudices by holding standards for successful recovery that included the woman's movement toward more "feminine" dress or affect, or that they become heterosexual:

> I had attempted suicide when I was pretty young. I saw this doctor on three occasions, because he was the one the HMO had and I had no choice. The first two times I remember I told him about myself. I'm gay. I'm 18. I'm scared, I'm not sure what I'm doing. On the third appointment he said, "Next time you come in and see me I want you to wear a dress." And I was so taken aback. I think he was convinced that if I changed my clothes, put on a little makeup, little earrings, I would feel like a "girl" again. Well, I never returned, and I became very disillusioned about the whole idea of getting help.

> It's a really insidious combination. The crazy woman--the alcoholic--it's perfect for discounting someone. Ooh, put lesbian on top of that--oh! It's a situation that is just ripe for all kinds of acting out on the part of the provider.... I am a pretty good advocate for myself in health care encounters. I am highly educated.... I feel free to walk out on the interaction if it doesn't meet my needs. But I am the exception rather than the rule.... The provider is the one who has the power. So self awareness is mandatory on their part.

Respect for Boundaries

Intruding upon the clients' rights to identify or not identify themselves by particular labels was an example of a boundary issue in health care interactions. The major difficulty was with providers' applications of the term "alcoholic." Though many treatment programs and twelve-step groups promote the idea that recovery cannot proceed unless individuals apply the term "alcoholic" to themselves. Aside from the fact that no empirical evidence has been offered to support this claim, these interview data indicate that some participants have felt themselves further marginalized by this label. Other distress producing provider-stipulated labels were sexual abuse victim, manic-depressive, codependent and self-destructive:

> It's like they want you to say you are an "alcoholic." I hate that word. They want you to say that, I guess so they are sure you have admitted defeat. They have to plant that word inside you. I mean, I already knew I didn't want to drink or use any drugs. It seems like the label thing was like a detour in my recovery. A waste of my time, and it made me pretty mad, too.

> I don't think therapists or any health care people should say that people are self destructive. I mean if I drink and that's a problem, it needs to be addressed. But when you tell me that I am self-destructive you are adding in this very negative label, and it implies I am at fault not just for drinking too much, but for destroying myself. It makes you sicker, more pathological than you actually are.

The fear of exposure contributed to a number of participants' decisions not to seek care. Intense probing, shaming and premature conclusions about clients' experiences were examples of provider intrusiveness that reached unacceptable levels. Another concern participants had about their health care providers, especially therapists, was their ability and willingness to maintain therapeutic and social boundaries with clients. This was especially problematic in

lesbian communities, where many members know one another. A lesbian therapist might have social connections within the friendship circles of clients. Positive and negative examples of these points follow:

> My doctor once asked me something about my family and I told him I didn't want to do that kind of therapy with him, and he just stopped that. He lets me know the information and then I make the decisions. I am in therapy now with a woman therapist, and he just takes a supportive role in that.
>
> I didn't know what I was trying to do. I was acting out these transferences all over the place with this therapist, and it was like I was trying to seduce her. The problem arose when she didn't do what she was supposed to do professionally. I mean she agreed to see me out of session. And she didn't either terminate with me, or refer, or redirect, or help me get through this, or anything. She just sort of--got involved--not exactly sexually, but emotionally. I mean it was a weird sick game. I guess she really wasn't a very good therapist.
>
> This woman I used to see at the lesbian bars whom I knew walked into the counseling office carrying my file. She worked there!.... After talking to me for about five minutes she says, "Does it bother you that you know me?" And I said, "Yeah!" And that added more anger, cuz I thought, "God, how fucking insensitive." And so she left and another therapist came in.
>
> I've seen a lot of women go into the mental health field...there's plenty of codependents among them. There's plenty of therapists who lose their boundaries, and plenty who project their own feelings on their clients. It's a very intimate relationship and I think it's a difficult job. I had one therapist who wouldn't even say hello to me on the street. Other therapists are like your best friend.
>
> When I first got into recovery I had therapists and I never saw them in places where I socialized. They kept a distance. They kept it a professional relationship. Now a lot of my friends have become substance abuse counselors. And I have gone to seek services and I can't get help because the counselor is my friend.

Emotional Climate

A key factor in participants' interpretations of providers' words and actions was the degree of emotional warmth they generated in interactions with them. A protective, supportive, nurturant, warm emotional climate was almost unanimously preferred:

> I went to see this MD psychiatrist. His methodology was to sit. I was just supposed to free flow about my feelings, thoughts and fantasies. And I can only free flow to a stone wall for about ten minutes.... I felt like I was talking to my father, you know, who wasn't listening to me. I mean I left there in tears. It was terrible. It was a terrible experience and so I just decided to give it up.... I had told him one of the things I expected out of therapy was someone to care about me. He said, "You don't need that. You do that from the inside." It was too brutal for me, you know? It was too lonely--too uncaring.... This guy with the big degree and the megabucks could never come close to caring about anybody. I felt like a piece of furniture.

> I saw a nurse therapist one time, for overeating problems, mainly. I didn't feel any empathy coming from her. She would say, "Just do this!" She reminded me of my critical mother.

Another aspect of emotional climate discussed by participants was the overall sense of positivity and hopefulness generated by providers' responses. Participants preferred providers who stated things positively whenever possible, avoiding doomsaying and instead verbalizing potential:

> There were so many people, staff members, giving me these negative vibes. Instead of encouraging me they were telling me--"Well, with your attitude--you won't make it a day." Another one said, "I'll give you five days." Another one wanted to throw me out right away, you know? So I just did the minimum, and they pissed me off some more.

Provider Persuasiveness Strategies

A common concern regarding health care interactions about alcohol problems was the type and degree of persuasiveness used by providers. Persuasiveness is defined as pressure, inducements and/or ultimatums communicated by health care providers, intended to raise consciousness, shape behavior or precipitate decisionmaking. The nearly unanimous consensus of these participants was in favor of mild, flexible, intermittent forms of persuasiveness, versus intense, rigid, constant or coercive measures. Concerns about persuasiveness surfaced in stories

about pre-recovery encounters with providers who attempted to make clients aware of their alcohol problems and in stories about treatment.

Confrontation was referred to in many forms. The severity of confrontation depended not only on its intensity, but also on its frequency and constancy. One woman perceived confrontation this way:

> I think that's what happens in therapy--they beat you up with the psychojudo and then everything I do wrong is my projection--if I feel a certain way, it is all just my "projection".... I think they need to walk the line carefully between pushing you and caring for you.

The most serious and unwanted form of confrontation cited by these women was the presentation of an ultimatum that a client must comply with or suffer the abrupt termination of the therapeutic relationship. Many participants talked of providers, often therapists, who badgered them about alcohol problems and then discontinued the therapeutic relationship. The excerpt from a single account demonstrates two different therapists' approaches to a woman who was drinking heavily while in therapy:

> My first therapist was starting to bug me. When I had started with her she asked me how I relieved stress, so I told her that I drank. So she started asking me every week, every session, "How much do you drink?" And I would try to change the subject. So every week it was, "How much did you drink this week?".... I had another therapist later who said to me at one point, "I want to tell you that if you don't stop drinking and drugging that I won't work with you any more. But I'm not gonna say that because I know you will just quit therapy." Which she was right about. And I thought, "It's a good thing you are not telling me that." It felt like a mix between scaring me, and pleasing me that someone had noticed something was wrong.

Participants described what they perceived as a more acceptable, safe level of persuasiveness on the part of health care providers. Especially favored were such strategies as inquiring if there was a

drinking problem, suggesting tallying or control strategies and gentle, compassionate confronting:

> You know, she would say, "When was the last time you been to sleep?" And sometimes I couldn't remember, and she said, "Your body needs a rest." She would try to get me a hotel room.... Sometimes she would make me mad and I would yell and scream at her, and she would just stand there, trying not to look nervous.... She said I was like a time bomb, "You say you love yourself, but you are killing yourself, slowly." I would say this is how I survive, and she'd say, "There's a better way. You don't have to live like that." I said, "You don't know anything about me." And she said, "It's ok if I don't know anything about you, but you had better learn about yourself." I just kept coming back to see her, and she'd give me half her lunch. I could see she was genuinely interested in me.
>
> When I talked to the counselor, she asked me to tally my drinks. And she had me promise her that if I started to have more than six drinks a day, I would go to AA. And so that's finally what happened, really.
>
> Right before I quit drinking, when I was having failed attempts, then I started talking about it in therapy. And my therapist never dwelled on it. If I was willing to discuss it, then she would listen. That was her attitude. Never forced me to talk about it. Never forced me into any treatment program or threatened me, like "I won't see you unless you do some treatment." She never said that. Never dwelled on it. She pretty much let me call the shots about whether I would want to talk about it.

A common untoward effect of intensive persuasiveness reported in the data was the precipitation of crises such as suicidality, relapses to substance use or acute sense of abandonment. One participant contrasted degrees of persuasiveness. Her report also demonstrates the potential risks involved in precipitating crisis:

> I called a nurse at the place I work and I said I really need to talk. And we sat down, and she actually started the conversation. She said, "I need to ask you something and it is very personal. If it is not true, just let it go. Do you have a substance abuse problem?" And I said, "Yeah, I really do." And she referred me to a counselor there, and I sat down with this guy and we went through all this information about every kind of drug I had used, and he asked me what I thought was the problem. And I said "I am really depressed and I can't get my work done." And he looked up and said, "I think that you have a very serious drug and alcohol

> problem and that you are going to die." And I said, "Oh no, I am not going to die, I need some help to figure things out." But he said, "There's no possible way that will work. You need to go to some meetings and when you are ready you can come back." I insisted I was ready, but he said no, and I just sort of exploded inside.... I walked out onto the street and got on the bus.... I was in acute withdrawal, and extremely depressed. I wanted to die. If I had a gun at that given moment, I probably would be dead...that seemed an easier route than putting the pieces together."

Persuasiveness was an issue for participants in terms of health care policies that mandated compliance to certain rules. For example, many treatment programs, both inpatient and outpatient, have policies which mandate termination or suspension if a relapse to drinking occurs. Some participants who experienced relapses acknowledged these as mistakes, but explained the negative consequences the sanctions had for them:

> The rule was after the second slip you were out, and I had the second slip. I was very emotional, and I was crying a lot, which was not something I do much.... They said I had to stay out and have thirty days of sobriety and start again. I was pissed off at myself and I was pissed off at them, and what I did was drink for six weeks solid. I went in once a week to see the counselor.... I knew I needed some stronger intervention.... I had made the decision while drinking--hey I'm gonna party until I find a place for treatment. And finally I got into residential treatment.

> I had a bad experience with group therapy through a women's outpatient treatment program. I was the only woman of color and the only mother in the group.... And I thought, "Why should I go and peel off my skin for people who look blank-eyed when I talk?" And I asked, "Is there another group for women of color?" And the answer was, "Nope." And so I didn't go to the group, and as a result I was discharged and had to lose my individual therapist, too. And I thought, "Who the hell is this for, anyway?"

Another concern voiced by some participants was about the policy of compelling clients to attend AA meetings or work the AA steps as part of a treatment process. Those who voiced objection to these policies, some of whom were themselves AA members, said that they expected treatment to be something different from AA. They pointed out that it

seemed unethical for treatment programs to charge fees for information and support that is available free of charge in a mutual help group:

> There was no way I was gonna go to inpatient treatment. Never. I couldn't control it if they wanted me to do things that I wouldn't want to do.... It's just that I don't want to do something like AA unless I want to do it. I don't want someone telling me I have to.... I think that I'd get really angry and develop a fuck you attitude.
>
> One of the things they made me do if I was going to be in the program was that I had to go to AA. You have to go. They escort you. And of course I didn't want to go because I didn't like the Christian aspects of it. I was certain they were cult members and were trying to warp my brain.
>
> I was in this residential treatment program, and on Sundays you either had to go to church or you had to go to the AA step study meeting. This wasn't much of a choice was it?

Some treatment programs and health care providers maintained a strict "no medication" policy, ostensibly designed to prevent relapses. Some women agreed with this approach. Others found that ruling out prescription medication use posed serious problems:

> I knew a woman in recovery who was being treated with Valium--I mean you don't give Valium to an addict. These doctors should get it that a drug is a drug is a drug.
>
> If I am a patient coming to you for care, and I decide to tell you that I am a recovered alcoholic, because I want you to know that there's this aspect of my physiology that you need to know if you are going to prescribe drugs, or anesthesia--what I don't want is for you to immediately jump to--I wonder if she is just seeking drugs?
>
> Or I wonder if she is drinking? I wonder if she is nuts? All the stereotypes.... Or that you will simply not give me medication I need without talking to me about it. There are all these ways of discounting someone.
>
> I had a therapist through an outpatient treatment program and I had to have some surgery, and there were drugs involved. I mean, painkillers would be needed. I talked to the staff, and my therapist said, "No, we decided you cannot take this medication. You can only use Tylenol." And I said, "I am not going to go through pain like that with no medication that will help me. It's not gonna work." So I left their program, and had no therapist as a result. Just like that. I had been honest about the

> medication, but they just refused to break down these rules.... It turned out I didn't abuse the pain medication when I had the surgery. But I did end up starting back on the liquor again...and that lasted off and on for two more years.
>
> I remember lying in my bed and crying and saying to myself, "I cannot be in this much (psychic) pain. If I continue to be in this much pain I will drink." Any kind of pain. The old conundrum about whether the alcoholic should use painkilling medications is solved for me right there. There is a point where the pain is more dangerous than the medication is.

Lesbians' constricted social support resources, alcohol-oriented subculture and experiences of societal disapproval make harsh relapse and medication use policies seem punitive. This raises the question of evaluating the effectiveness as well as the risks involved in terminating treatment, particularly when working with members of vulnerable populations. And if one assumes that relapse is actually part of the recovery process for many people with alcohol problems, punishing confrontation does not seem appropriate.

Milder forms of persuasiveness are generally preferred by lesbians with alcohol problems for several reasons. First, these forms of persuasion are more compatible with the overall need for "safety" in therapeutic encounters. Second, lesbians may have fewer sources of social support, and therefore are less prepared to weather crises. Third, lesbians have a more difficult time finding an appropriate, knowledgeable, safe provider and therefore cannot as easily find a new provider if services are withdrawn. Fourth, lesbians' transition to a non-drinking lifestyle may be delayed or hampered by the fact that much of their social support has previously come from the bar subculture. Fifth, lesbians may experience confrontation and other intensive forms of persuasiveness as anti-lesbian discrimination, even when this is not the intent of providers. Sixth, lesbians who have a history of physical

and/or mental abuse may find that intensive persuasiveness resonates emotionally with the dynamics of their abuse, and therefore it is experienced as revictimization.

Attention to Group Dynamics

Health care providers in treatment and therapy contexts often had the responsibility of managing group interactions. There was a wide variety of groups, both inpatient and outpatient, which participants had attended in the course of their recoveries, including facilitated support groups, group psychotherapy, nurse addict groups, treatment program groups, mixed gender and all-women's groups. Groups usually addressed many topics, including general recovery issues, feelings, sexism, body-image, self-esteem, assertiveness, parenting, family of origin dynamics, ACA problems and post-traumatic effects of childhood trauma. The group scene was especially risky for lesbian clients, because more people were involved and the chances of experiencing prejudice were therefore greater. In addition, group interaction could accelerate anti-lesbian dynamics, increasing the lesbian client's vulnerability. Several participants stated that they could not tolerate a group format. They felt it was unsafe and too exposing:

> My therapist was very helpful to me.... I am very shy and I didn't want to go to any sort of group and be exposed to 15 or 20 people.

As in the case of individual therapy, participants said that facilitated groups provide a degree of safety in discussing sensitive topics, more so than mutual help groups, such as AA.One of the major differences is that in AA one is not allowed to "crosstalk" or comment on what other persons have talked about. Feedback, emotional support

and in some circumstances, peer confrontation, were dynamics expected of group therapy:

> There are too many recovery issues that I cannot bring out in an AA meeting. Like maybe talking about childhood physical or sexual abuse. Or abandonment. That stuff can be talked about in AA, but I'm not gonna get anything back. But in a group setting or in individual therapy you can talk in depth, and feel safer.

> I wanted to start working on some uh, family issues. Stuff that I couldn't get at an AA meeting. So I got into a group therapy, you know, to deal with roles you play in your family of origin. There's a lot you can talk about in an AA meeting, but you can't get any feedback.... I've got too many issues I can't put out in an AA meeting, like child abuse or sexual abuse. Or relationships. And in a group you can look at these things in depth. And to feel safe you need the therapist there for some issues.

> When you spend that much time with the same people you start to interact like you did in your family growing up. This drama gets played out that's really really painful.... I would come out of the group pretty much a mess for two days. It was very confrontive.... And I began to find my missing emotions.... Sometimes whatever happens in the group is intense because it reminds me of something painful that happened to me in the past. And my job is to make the connection.

A great deal of competence and perceptiveness in managing group dynamics was required of a therapist or group facilitator. These providers needed to be able to handle the group situation when alcohol and drug issues were "on the table," as well as demonstrate sensitivity to post-traumatic distress and cultural, gender and sexual orientational biases and fears:

> This group therapist was in AA herself. So she had three years of sobriety and a masters degree. And she was in charge of this women's recovery group--six women sitting in total pain, and this far from the edge. This far. You know, this therapist had no idea what she was doing! She didn't. She didn't have the background to be processing all of these issues of family trauma. I became very panicked in the group and so afterward I told her I was afraid I couldn't get myself home. She said, "I'm not gonna play that game." Or something equally compassionate.... This kind of therapy is a serious thing. Just being in recovery doesn't make you ready to run a group like that.

A frequent complaint about many treatment programs was that they tended to have far more male than female clients, causing women's needs and experiences to be ignored or minimally addressed. Many programs advertised that they served gay and lesbian problem drinkers, but participants found them to be much more oriented toward gay male experience. Although there was a general consensus that women-only programs were necessary and good, most agreed that lesbian-only programs would be too segregated and not logistically feasible. Many participants voiced a desire to be in a treatment setting with a mixture of individuals from various social backgrounds:

> That's why I didn't go to a lesbian recovery home, if there is such a thing. I know all about lesbians. I need to know about the real world and different people, and be able to interact with different people and stop stagnating myself.... Some of my friends say, "Damn, why go with all these white people?".... I make myself go, you know? I make myself be a part of that.

Being the only lesbian or the only person of color in a treatment program or recovery group engendered fear and anticipation of rejection and social attack, according to several participants. A partial solution to this dilemma suggested by participants was that women of color and lesbians be welcomed and then given opportunities to meet separately in their own groups where topics of identity, social stigma, cultural conflicts and discrimination issues could be safely discussed. Participants favored having these separate therapy or support groups occur within larger treatment milieus, rather than having the entire treatment process segregated by minority status. The exception to this trend was a consensus that women-only treatment was preferred to mixed gender treatment because of wide differences in experience and treatment needs. They named areas of need that women brought to treatment: ACA

issues, relationship concerns, sexual abuse, eating disorders, women's oppression, and need for information about the physiological effects of alcohol in women.

The milieu established for group interactions, especially in treatment programs, was an issue for most participants. Settings that visually and organizationally reflected only white, middle-class, male values and cultural patterns alienated lesbians. Environmental cues and role modeling by providers were important to these women:

> I was the only lesbian in this treatment center, among 14 other women. The staff was very good. They didn't seem to discriminate at all. But some of the clients--Well, I think that if there had been any encouragement from anyone--particularly the staff--overtly or otherwise--to discriminate against me--then it would have happened. I had my moments of paranoia, but I didn't have any confrontation.... I mean all these other women got dressed up in spike heels to go to the Saturday night AA meeting. It was a little weird. Weird. I really felt very odd. It could have been made an issue very easily. If there had been one person who wanted to make it an issue, my life would have been hell. I think the environment was ripe for that. I had the luck of the draw that it didn't happen.

Some women talked about what it would be like to be in a group with all lesbians early in recovery, dealing with issues of coming out and internalized homophobia. There were similar comments regarding ethnicity/race issues by women of color. Some found the idea problematic in that being in a group of very similar others would hit "too close to home" and would intensify feelings of low self-esteem, intimidation and fear of other women at a time when vulnerability was already pronounced. Some participants suggested that such groups might be more useful in later recovery, when questions about self-acceptance of lesbianism had emerged for them. However there was no consensus about when these issues emerged or when they should be addressed. These quotes represent some of these opinions:

In the last year, my third year of sobriety, things started to change for me. I've always had a fear of women actually. And a sort of fear of lesbians. I'm not sure of what that's really all about. But in the last year I have really overcome my own fears, my stuff around being a lesbian.

It hurts to hear lesbians saying it's wrong to have a lesbian meeting.... It hurts because this kind of talk is internalized homophobia. It comes from the fears in the greater culture. Why else would lesbians say they are intimidated, terrified of each other.... All the racism, classism and homophobia are barriers to recovery. And they are recreated in the lesbian community. Most of the people who need treatment are not even going to see these as barriers because they have internalized the idea, "I have no rights."... If someone doesn't identify racism or homophobia as a problem, maybe you should bring out these submerged issues. You have to probe.

At treatment I was walking past a mirror and caught a glimpse of myself, and I saw my eyes and my cheekbones and I thought to myself, "Is this how I really look?" For the first time I saw this Asian-looking woman looking back at me from the mirror and I thought, "Who is that?"

Recovery issues change for me. Especially being a black woman.... Like in early sobriety it didn't matter, because I just wanted to get sober. But now other stuff matters a lot. I am thinking of group processes. I need people around me so that I feel safe.... We are just coming into our own. As women, as healers.... Racism, homophobia, patriarchy. What is all that about? I am constantly aware that there is something going on aside from the little cocoons we call our lives.

The focus shifted after the first two years. To my relationships with people. Not my relationship to alcohol. I felt like the focus expanded. How to be in the world.... Not just gazing at my own bellybutton. Family, friends, work. Much more broad.

Summary

Safety was a major recurring theme throughout the participants' descriptions of their health care interactions. Through analysis of the various types of health care lesbians received regarding alcohol problems, the concept of safety was explored in detail as having several dimensions: (a) conceptual compatibility between client and provider views of the problem, (b) providers' preparedness to interact with

lesbian clients, (c) respect for interpersonal boundaries, (d) emotional climate, (e) providers' persuasiveness strategies and (f) management of group dynamics.

The idea of safety in health care is reflected in the problematization processes of interaction, action and validation discussed in Chapter 4. Questions about helpseeking and health care that become relevant to lesbians in the process of problematization and recovery are: Is it safe to define oneself as a problem drinker? What health care contexts seem safe for lesbians (or lesbians of color)? Can one be safe assimilating into social contexts with others trying to heal from alcohol problems? Are heterosexual environments safe for revealing intimate parts of the self? Is it safer to remain in a pattern of drinking and socializing in the lesbian bar scene than to enter the recovery subculture and health care settings?

There are many tensions embedded in lesbians' interactions with health care providers: (a) disparity between lesbians' needs for services and those available in terms of safety, cost, cultural sensitivity and focus; (b) conflicts about the nature of alcohol problems, especially related to multiple addiction; (c) threats to lesbians' self-esteem and personal security, including homophobia, heterosexual assumption, uncertainty, and racism; (d) negatively evaluated interactions between lesbians and psychiatrists, which narrow options for lesbian clients and (d) diverse needs among lesbians in terms of group interaction, therapeutic boundaries, medication issues, forms of persuasiveness, and needs for flexibility. The safety concerns about labeling, boundary violations, gender stereotypes and

confrontation reflect additional bases for marginalized experiences on the part of lesbians seeking help for alcohol problems.

In summary, lesbians' health care experiences relative to their alcohol problems reflect complexity on many points, including the way each individual constructs the problem, the degree of safety each perceives in interactions with various sources of help for that problem, their access to services, and their actual experiences in health care encounters. The extent to which health care resources can adapt to these diverse needs is a measure of lesbians' relative vulnerability as clients in health care contexts. Lesbians having alcohol problems are a heterogeneous group whose daily experiences of vulnerability create distinctions separating them from mainstream culture and mainstream health care as well as isolating them from one another. This form of vulnerability is therefore best defined as marginalization, being pressed to the outside, the periphery, the edge of a group or a culture. Health care experiences described by these participants commonly take the form of stories from the edge--the edge of safety, recognizability, validation, communality and belongingness.

CHAPTER 6

RECOVERY IMAGES

Describing Recovery Experiences Through Images

How do lesbians describe their experiences in recovery from alcohol problems? The ways in which participants conceptualized recovery served as frameworks for interpreting the meanings of their experiences, and for determining which aspects of life were salient to their recovery efforts. Images of recovery were the general descriptions participants offered that framed their experiences in healing from alcohol problems. These images were sometimes metaphorical. They could communicate the totality of the experience of recovery or reflect only particular features. Individuals sometimes employed a single image of recovery; more often they described a repertoire of images, each representing a particular aspect or period of recovery.

Prominence of recovery images in each account was determined through narrative analysis, including consideration of numbers and types of stories told, choice of analogies and metaphors, repetition of themes, indicators of emphasis, story content, self-descriptions and allusions to AA or other ideological systems. Field notes and interview assessments were used to corroborate impressions of the data.

From least to most conspicuous, the recovery images elaborated in the interview data included: conversion, physical transition, cycle/celebration, social transition, vocational change, personal growth, struggle with compulsivity, empowerment, reclaiming the self and connection (see Table 4). Conversion, the least prominent image of recovery discussed by lesbians in this study, is presented first to

serve as a contrast to the other images. Conversion is the prominent recovery image in AA ideology. The AA view, which has contributed heavily to predominant mainstream views of alcohol problems, combines moral and spiritual difficulties related to excessive drinking with the medical profession's disease notion of "alcoholism" (Peele, 1986, Shaffer, 1986). Rather than a radical departure from the moralistic discourse of the temperance movement, AA can be viewed as a transformation of that discourse, preserving some of the moral overtones surrounding alcohol problems (Royce, 1986). The obvious Christian imagery and terminology used in AA writings is illustrative of this. AA's dual focus on "alcoholism" as both a disease and a cause for "defects of character" relieves addictive drinkers of guilt for having the problem while holding them accountable to do something constructive about it. Because AA, as a philosophy and a subculture, is a key influence on the ways people conceptualize alcohol recovery, it is incorporated into this discussion of findings about recovery images.

Table 4
Prominence of Recovery Images From Least to Most Conspicuous

- Conversion
- Physical Transition
- Cycles/Celebration
- Social Transition
- Vocational Change
- Personal Growth
- Compulsivity
- Empowerment
- Reclaiming Self
- Connecting

Conversion

Conversion is an image some participants used to describe their recovery experiences. Conversion is traditionally associated with AA philosophy, religion, and the temperance movement (Gusfield, 1963; Kurtz, 1988; Royce, 1986). It refers to a unidirectional change from negativity to positivity. As in the notion of being "born again," conversion implies the creation of a new person and the abandonment of old ways of living. In religious terms this might be expressed as sin or moral decline, transformation, and then moral virtuousness. Dichotomies such as sinner/saved, lost/found, drunk/sober are typical of the conversion image. The conversion understanding of recovery has three phases, which are reflected in the format of telling one's story in AA: "What we were like, what happened, and what we are like now." Classically, conversion is conceptualized as a once-in-a-lifetime occurrence (James, 1902).

The conversion image is of importance because of its relevance to AA and extant treatment philosophies. The conversion image, however, was notably and unexpectedly absent from most of the women's narratives. These women's stories suggest that a once-and-for-all transition from problem drinking to continual abstinence is the exception rather than the rule. The following is an example from the data of the conversion image:

> Through this emotional pain I was having trouble working, and I was sick to my stomach. Couldn't work very well. I called this guy in AA and since I couldn't leave my job, he said to go into the bathroom, get down on your knees, and ask for help. So I did just what he told me to do. I didn't really have a higher power at this point. So I was in the bathroom, down on my knees and said, "I can make it through this if you give me the strength." And as I said these words the shaking stopped and the pain in my stomach went away. And so for me that was a spiritual awakening.

> A very real and physical experience...And so that's never left me. That reassurance has changed me.

Although popular in AA, the conversion image was seldom seen in these data. It seemed an inadequate framework for the variety of recovery experiences these participants described. The other nine images used by participants to describe their recovery experiences are described in the following sections and illustrated by selected quotes. They are presented roughly in the order of their prominence in the data, from least to most conspicuous.

Physical Transition

Some participants emphasized physical changes, improvements or awarenesses as signifying what recovery meant to them. These images were most often employed in discussing early recovery, (i.e., the first year or two). Themes about physical transitions included increased perceptions of health and illness phenomena, initiation of more appropriate exercise and daily living habits and taking responsibility for preexisting chronic illnesses:

> When I stopped drinking, and I was a daily drinker, I got one virus after another for a year. My immune system must have been in shambles from the damage I had done. It wasn't like I was just getting sick in recovery, but that only without the alcohol was I really aware of just how physically messed up my addiction had made me.

> I didn't deal with emotions or anything for the first year. I had to learn how to physically live, and that meant learning to make my bed every day, shower, eat. And that was all I could do. I rarely left my house.

> The doctors told me I had liver damage. It took a long time for it to sink in what that meant. It was serious. And when I was drunk and stoned I never took care of my diabetes. A big thing in my recovery is that I show up for the appointments, I follow my food plan, and I have to be responsible for my illness. I already have neuropathies. But I can regulate the diabetes now so those things don't get worse. I can't go back and do it over, I have to look ahead.

Cycles and Celebration

Recovery was characterized by some women as a temporal, cyclical process, highlighted by celebration and commemoration. These temporal markers of recovery included both positive and negative events such as detoxification, AA "birthdays" (anniversaries of sobriety dates), commonly accepted "difficult periods" in sobriety, precipitants and timing of relapses, attachment to people who entered recovery at the same time as oneself, annual AA conferences such as Living Sober, and celebration of holidays in a "clean and sober" state.

This image of recovery was also reflected in statements about the need for predictability in recovery. Participants sought knowledge about recovery as a "universal" experience. They tried to develop insight into their own individual rhythms and idiosyncrasies, attending to experiences that recurred in a cyclical fashion throughout recovery. Sometimes rituals were employed to mark turning points in recovery, to celebrate change or to energize individuals to face new challenges:

> I always remember the women who got into recovery the same time I did, especially each year when we celebrate our sobriety date together. I grieve for the ones who are not in recovery any longer.... And then every year there is Living Sober when for five days I am intensely immersed into the issues and victories of my recovery.

> Lately I feel overwhelmed, with my birthday coming up. You know I was really sick. Really sick. I guess I feel pretty grateful. Getting in touch with the goddess and my own feminine aspects, my cycles, was like coming home for me. I began to study and do rituals.

> When I was sober two years I had a weird experience, which changed everything. It was a ceremony, called a "spiritual cleansing." This ritual loosened me up so that I could access my memories of my childhood and be present emotionally like never before. The compulsion to drink left me...I hardly ever talk about this, except in general terms. My friend says she doesn't know what it was all about, but it sure worked.

Social Transition

Lesbian bars have traditionally been centers for socialization, where friendships and affectional relationships can form and where lesbians can be themselves, away from societal scrutiny and prejudice. These bars have also served stigmatized communities' collective needs for affiliation and protection, usually met in the "mainstream" by family, church, law and government. Leaving the bar scene, therefore, presented a particular social threat to lesbians that is not paralleled in recovery experiences of straight people.

Recovery became for many participants a process of rebuilding a social network that was no longer centered around alcohol use and lesbian bars. Lesbian and lesbian/gay AA groups and "clean and sober" social events organized by lesbian communities seemed to absorb some of the social functions previously provided by the bar subculture. Lesbian and gay-only treatment programs, lesbian support groups and a variety of mutual help groups were used by participants to make new friends and to stay in touch with lesbian community life in recovery. For some participants the social transition was a great upheaval and change, while for others it was a smooth move from a niche in one social milieu (the bar) to a similar niche in the recovering lesbian community:

> At first I was really interested in meeting lesbians in the AA groups. I was chasing the girls in the program, just like before.

> For nine years I hung out at the same lesbian bar on a daily basis. I would get there about 5 pm and sit talking to the owner until it got busy. There were about five of us regulars who did that. The owner was more than just an owner. She kept the community safe, and made sure we had this place where we could be ourselves. I couldn't imagine not going there every day.... When I quit drinking I found out there was this coffee shop where all the AA dykes hung out, and I was back in my element. It was even easier to be there than in the bars, because people would talk to

> you more willingly. And I discovered I could even sometimes go to the bars with lesbians in recovery, and not drink alcohol.
>
> Now its easier for lesbians to be sober because it has become a strong cultural value here on the coast.... I remember being at a party two years ago when, out of 15 women, I was the only one drinking.... Lesbians don't go to bars anymore, they go to AA meetings.
>
> Part of recovery for me was learning not to go in bars, closing the doors I still had left open that could lead back to alcohol and drug use. I had to call my dealer up and say I wouldn't ever be talking to him again.

Vocational Change

Many participants had made decisions in their early recovery to return to school or change careers. They saw recovery as an opportunity, perhaps for some a duty, to contribute to society through their work. Often they chose helping fields such as nursing, counseling and social work. Admittedly these are also among the occupations historically most open to women in general. Significantly, many chose to specialize in substance abuse work. They described how they were stimulated to continue their own recovery through first-hand observation of the pain and suffering of addiction that they encountered in their work:

> When I was using drugs and booze, I was doing the corporate ladder climb; everything on the outside looked good...but I hated my life, I didn't know how to live my life.... So in recovery I just dropped out of that. I am in school to study massage and holistic healing techniques.
>
> I was a client in a newly formed, nonprofessional gay/lesbian treatment program on the east coast.... What they had to say rang true for me.... I ended up as an alumni, then a staff member, and eventually an administrator of that program. I had a degree in psychology, but I was hired more for my recovery experience.

Personal Growth

Some women referred to recovery as a journey of personal growth and spiritual development. They recalled various phases in this

journey, which were characterized by specific focal issues. Among these issues were isolation, self-centeredness, judgementalism, disbelief in a power greater than themselves, willfulness, dishonesty and grief. For these women, abstinence from alcohol and other drugs was a prerequisite to the journey, but not the journey itself. They reported that progress in the journey was marked by increases in serenity, that is, self-acceptance, wisdom, and inner peace. Most of these women were involved in AA, which is evident in their choice of language. These women often said that recovery was, for them, an "inside job:"

> It's about growth, it's a stretch.... I don't isolate now. I don't want to judge people. I don't gossip.... I haven't had major awakenings but gradually I have changed.... I couldn't do this without the AA program.
>
> I had a great deal of guilt. I would tell everybody everything, compulsively. It was overexposure. I had to stop doing that because it was really like beating myself up all the time. I was still atoning for sins or something.
>
> I used to be self-centered, egotistical, omnipotent, but under that was pure fear. I dealt with fear by showing anger or rage. I was this mean cobra. I can own my fears now, and I don't have to convince myself of being superhuman, like I am beyond such primal emotions.

Struggle With Compulsivity

Patterns of recovery from alcohol problems for many women, including lesbians, are interwoven with patterns of recovery for similar problems such as eating disorders, overspending, smoking or "codependency" (focusing excessively on others' needs) (Hepburn & Gutierrez, 1988; Tomko, 1988; Wilson-Schaef, 1987). Many of those interviewed described having several "addictive" problems. Alcohol abuse was seen as only one "symptom" of a larger, often nameless life disturbance characterized by compulsivity. Other drug abuse,

overeating, anorexia, overspending, "sex addiction" and "codependency" were some of these concurrent problems.

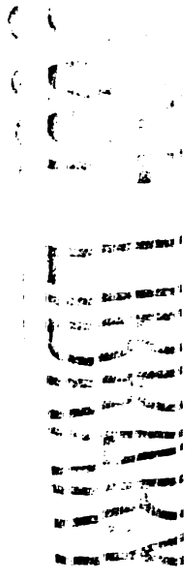
For these women recovery was serial or simultaneous struggles with one or more of these compulsive syndromes, for which similar strategies were applied. Twelve-step programs, such as Narcotics Anonymous, Overeaters Anonymous, Sex and Love Addicts Anonymous, Debtors Anonymous, Codependents Anonymous and Alanon were typically used. Approaches to recovery that included all of their compulsive tendencies were valued by these women. AA involvement became problematic if concurrent problems were deemed unimportant or unrelated by fellow AA members. These women battled a sense of fragmentation fostered by an array of health services, each specializing in only one compulsive behavior area:

> My strongest conviction says that the professionals shouldn't discount the power of food, that addiction. Don't belittle it. Cross addiction and polyaddiction are real, and it could be lots of things--gambling for instance. You have to treat all these things across the gamut because they all can kill you.... You should keep the doors open for different experiences.

> I did some work on codependency after I stopped drinking. I depended on therapeutic support groups and went to AA only periodically. From the fourth year on I have had a lot of money problems. I have lots of debts from that. And the alcohol and my eating disorder were very much related. I was always aware that alcohol had calories. To keep my weight I'd fast all day so I could give myself permission to drink.... The speed allowed me not to eat. I hope to get to the place where the self-hatred and shame go away, because they tie in with the alcohol and the weight thing.

Empowerment

For many, alcohol problems were viewed as products of an addictive, racist, patriarchal society, and therefore recovery was viewed as a process of personal and collective empowerment. This empowerment included affirmation of themselves as women, lesbians, and women of color. AA was viewed negatively by some of these women because

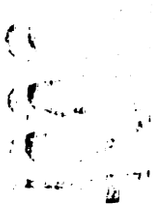


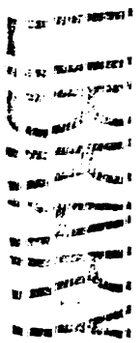
it retains the trappings of white, male, Christian, middle-class culture, and recommends that persons with alcohol problems surrender their wills, declaring themselves to be "powerless" (Alcoholics Anonymous, 1976). This seemed incongruous to many participants because of their perception that most women, lesbians in particular, had felt powerless for much of their lives. An empowerment image of recovery encouraged them to take control, to be critical and to trust their own instincts. Further, they gained the insight that issues of addiction should not be separated from the politics of race, class, gender, disability, sexual orientation and age:

> I got married very young and it didn't work. I used to think, when I was still drinking, "What's wrong with me?" Now I think, "What's wrong with the setup?"
>
> "Recovery" isn't the way I define my whole existence any more, like I did in the beginning. Now the daily problems I face are due to being a woman in a misogynist culture and a lesbian in a homophobic culture.
>
> AA needs to get out of the patriarchy and incorporate blacks and women, lesbians more.... This stuff didn't matter to me when I first came into the program, but it does now.
>
> I still hate the Lord's Prayer and I refuse to say it at AA meetings. The Christian flavor of AA is insulting to me as a lesbian.
>
> As a Latina I have a lot of issues around race and culture and living in the U.S. that I have not really resolved yet in sobriety. But I know these are the issues which can make me relapse. And I have a real hard time with sexual abuse, which is so active in the ghettos and barrios.... And it's not a multicultural lesbian community yet. We have to deal with the reality of our oppression in recovery.

Reclaiming Self

Many women reported that their alcohol and drug use were symptoms of underlying, unresolved past trauma. They found that at some point after they stopped using alcohol or other drugs, they experienced the





emergence of memories and feelings that had been denied or were dissociated from painful past events. These included rape, incest, battering, neglect and abandonment, usually having occurred in childhood. As memories were recovered and feelings named, these women believed that they were literally retrieving and restoring parts of themselves. Some used individual and group therapy, bodywork and alternative healing methods in attempting to understand their own responses to the trauma as well as to explore family of origin dynamics. This work was often kept separate from AA involvement, and in some cases, AA was seen as not fully sensitive to the impact of these family and trauma issues. For example, AA emphasizes forgiveness as a core element of recovery, however many of these women felt it was not appropriate to forgive the perpetrators of their abuse:

> The problem with AA is that they take out the newcomer's brain at the door and insert the twelve steps. How can you really recover, how can you learn about yourself?.... What happened to me as a kid has everything to do with who I am now.

> The slip I had when I was sober two months was about sexual abuse, incest. My therapist had said, "Have you considered that you may have been raped in the past?" The next two days I had intense self-hatred, and I knew she was right even though I had no memories yet... My sponsor didn't get it, so I accused her of not giving a damn about me and immediately got drunk.... But after three days I started back, because I knew I had to deal with this in sobriety.

> I got really scared at a group meeting and started remembering childhood things.... I went out of my body, everything was in slow motion. This lasted five days, where I was helpless and a friend had to take care of me.... But I realized I had survived this pain without a drink...For me it was feeling responsible for my whole family, feeling I didn't help them, didn't measure up...and there was physical abuse, threats.... I'd have these out-of-body experiences whenever I had a crisis, and my emotions were becoming flat. I had big black gaps in my memory, I mean before I ever used drugs or alcohol.... I realize now that I wasn't a horrible, inadequate person, but that there was this stuff that had happened to me, and that the effects were reversible.

The work of reclaiming self was problematic in some AA environments for other reasons. For some women in the study, the issues of childhood trauma were not personally meaningful or were not currently pertinent. They perceived the discussion of family of origin dynamics and childhood abuse as straying from what they saw as the focus of AA: abstinence from alcohol and working the twelve steps.

Connection

Isolation and a feeling of being alien in the universe was a common experience for these women with alcohol problems. It was not clear which occurred first, the feeling of being "outside" or the alcohol abuse itself. For many of these women, being lesbian was a strong basis for feeling like an outsider, a feeling that had plagued them from adolescence on. Recovery was presented by many of those interviewed as a process of finding meaningful connections with others like themselves, experiencing belongingness in groups or communities and relating to a spiritual reality. It also included the process of reconnecting with past community ties and affiliations in the course of healing.

Connecting with other women, especially with lesbians, was a key part of recovery. Some participants described having been unable to fully, positively accept being lesbian before they stopped drinking and using drugs. Many referred to their involvement with Living Sober, an annual lesbian/gay AA gathering in San Francisco, as a turning point in their connection with the recovering lesbian community. Likewise, some African-American and Latina women interviewed described recovery as a process of accepting their racial and ethnic heritages and of

confronting painful racial conflicts which they had "buried" through their substance use.

The need to connect with others "like me" is reflected in womens' choices about which kind of AA meetings to attend, although the bases for these choices changes during different periods of recovery (Vourakis, 1989). Some lesbians chose to attend lesbian AA meetings, while many reported feeling out of place or intimidated even in these meetings. The milieu of comfort in AA tended to change over time for individuals, depending on their needs. General mainstream AA meetings, or those specifically for lesbians, people of color, women, or atheists, were examples of meetings chosen to meet specific needs for connectedness. In a few cases, the sense of connectedness came through linking up with others who were dissimilar from the self. The following are illustrations of these various types of connecting:

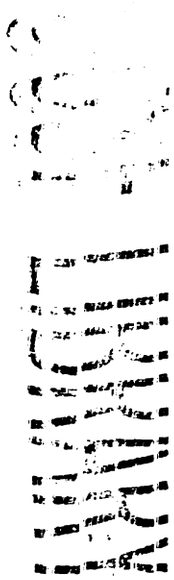
> You get this higher power connection when you realize that to sit with someone, really be with them, is a spiritual experience.... There's something powerful about being in a room full of people who have something in common.... I'm bigger than what's in here, in this body of mine.

> I go to all lesbian meetings now. I have to be able to be myself, to feel safe. This wasn't a big deal for me at first, because then I just wanted to get by one day without drinking or using dope.

> I go to straight AA meetings.... I think it is a chance for me to learn tolerance, and for me to teach them tolerance about gay people. It's a way of connecting with other parts of the world I would never have before recovery.

> I think the AA Big Book has historical significance.... I like to see myself as a part of that tradition going all the way back to the beginning of AA.

> It's about comfort levels. Some lesbians can't deal with all lesbian meetings, and some people of color can't start out at the people of color meetings. You know, it can feel too close to home.... It shouldn't be assumed where someone will feel comfortable. Sometimes you connect with the most unlikely people.

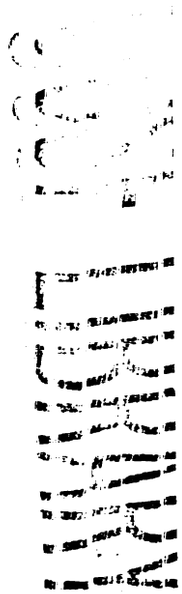


> I used to think as an adolescent that one of these days I'd be white. Even cocaine was a way of disconnecting from the blackness, the black community.... Black on black crime disgusted me.... All my life my education was all about proving to me that I am not black. After two years in recovery I can say education is for education's sake.

Patterns of Recovery Images

Because of the variety of recovery images seen within and across the accounts, questions emerged as to which images were dominant and which images were used by various subgroups of participants. The two most dominant recovery images in each account were identified and the overall frequencies of these images across accounts was determined. The three most frequently encountered images across all accounts, in order of most to least dominant, were: connection, reclaiming self and empowerment. Struggle with compulsivity and personal growth were also seen fairly frequently, while vocational change, social transition, cycle/celebration, physical transition and conversion occurred with markedly less frequency. The interview procedure and questions may have directed the focus toward discussion of certain aspects of recovery which evoked the dominant images found in this analysis, however, it was noted that images surfaced in response to several different kinds of interview questions and in stories participants told in response to open-ended inquiries.

The images participants used to describe their recoveries reflected personal styles and particular issues they faced. The preference for certain recovery images was also related to interaction with others. For example, connection, conversion and struggle with compulsivity surfaced in accounts of women who were highly involved in twelve-step programs. Reclaiming the self surfaced in discussions of



therapy, especially in reference to healing of past trauma. The dominance of a particular image in a particular account may have also been a result of reinterpretation, that is, reviewing one's past through the lens of a more recently embraced perspective about one's recovery. Without a longitudinal approach to the question, contemporaneous views could not be clearly differentiated from later reinterpretations. Participants were fairly explicit, however, about earlier views and how those views changed as recovery progressed, which suggests that reinterpretation cannot be the sole explanation for central recovery images.

Using matrix analysis techniques, several comparisons of salient recovery images were made across subgroups of the sample to try to discover patterns. Accounts were compared according to: age of participants, level of twelve-step program involvement, length and period of recovery, pattern of problematization, history of childhood trauma, ethnicity/race of participants, and coming out pattern/acceptance of lesbian identity. Women with histories of childhood trauma depended heavily on the image of reclaiming self as described previously in the discussion of that recovery image. The only other comparisons that yielded insight about patterning of recovery images involved ethnic/racial identity and lesbian identity. The other comparisons did not reveal remarkable differences.

Ethnic/Racial Identity

Lesbians from five ethnic/racial groups participated in the study: 24 Euro-Americans, 6 African-American, 3 Latina, 1 Native American and 1 Asian-Pacific Islander. For the purposes of this analysis, comparisons were made between Euro-American women and women of color (see Table 5).

The most striking difference between the groups was that the image of empowerment was decidedly more prominent in the accounts of the women of color. There were also 10 Euro-American women for whom empowerment was among their two most dominant recovery images. Four of these women were political activists before they entered recovery. Seven of the ten had histories of childhood abuse. These two factors may partially explain the preference for the empowerment image among some Euro-Americans. The Euro-American women were likely using the image in a different way than the women of color, who clearly associated it with overcoming racial discrimination and internalized racism in recovery.

Table 5
Prominence of Recovery Images From Most to Least Conspicuous in Comparing Euro-American Lesbians to Lesbians of Color

Euro-American (N=24)	Women of Color (N=11)
Reclaiming Self	Empowerment
Connecting	Connecting
Personal Growth	Reclaiming Self
Compulsivity	Personal Growth
Social Transition	Social Transition
Empowerment	

Examining combinations of dominant themes in each account provided some information about how these themes interact, and how they might be used differently by specific cultural groups. For example, of the eight participants who had both empowerment and connecting among the three most dominant images in their accounts, six were women of color. For women of color it appeared that both connecting and empowerment were related to re-affiliating with one's own ethnic community as a part of recovery. Overtones of empowerment linked with connecting were

expressed in participants' stories of how difficult the process of assimilating into AA was for them as women of color. These women often spoke about fighting for the "right to recovery," meaning just and equitable access to the supportive connection that mutual help groups offer.

In contrast, the 13 women who had connecting but not empowerment among their three most dominant images, all were Euro-American. Nine of these were among those who reported serious problems with their families of origin. Many spoke of recovery as an experience of finding a "family," haven or home. It was in this "family" sense that they used the connecting image, rather than in the more ethnic pride, anti-racist, political sense expressed by the women of color. There were at least two distinct uses of the connecting image. Nevertheless, the image of connecting had the greatest currency as a unifying theme for recovery among most participants in this study.

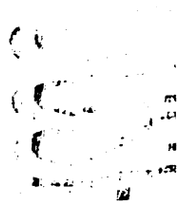
Lesbian Identity

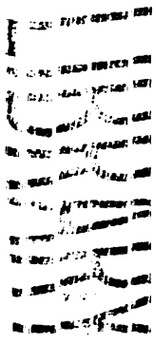
There were two aspects of the process of coming out as a lesbian that were meaningful relative to problematization and recovery: identification of self as lesbian and acceptance of that identity. Table 6 outlines these aspects. Twenty (57%) of the participants had identified and positively accepted themselves as lesbians prior to entering recovery from alcohol problems. Eight (23%) had identified themselves as lesbians before entry to recovery, but reported that they had not accepted this identification as positive until they were in recovery for a time and had worked on decreasing their internalized anti-lesbian feelings. Some had intimate relationships with women, but were not identifying themselves outwardly as lesbian, nor were they

identified as lesbians in their social networks. Frequently these were women of color, and/or women who had Catholic backgrounds; they were under significant pressure to maintain a heterosexual presentation in their communities. Some had for a time identified themselves as bisexual. Four (11%) women reported that their identification as lesbians coincided with their entry to recovery. A crisis of self-acceptance of lesbianism was directly involved. Three (9%) identified themselves as lesbians only after being in recovery for a number of years. All three of these women had been married to men for some years and were in their late thirties when they identified themselves as lesbians. They were from religiously conservative backgrounds and stated that they simply had never previously considered that they might be lesbian.

Table 6
Patterns of Identification and Acceptance of Self as Lesbian Relative to Entry to Recovery
(N=35)

Pattern	Frequency	%
Positive identification as lesbian prior to entry to recovery	20	57
Identification as lesbian prior to recovery not positively evaluated	8	23
Identification as lesbian directly associated with entering recovery	4	11
In recovery for 6 months to several years before identifying as lesbian	3	9





The fascinating result of comparisons across these subgroups of participants was that there were no distinguishable differences in the ways women framed their recoveries. In opposition to the few extant studies (Kus, 1988a; McNally, 1989), this analysis did not yield any clear patterns associating types of coming out experiences, acceptance/nonacceptance of lesbian identity and processes of alcohol recovery.

Looking from another angle, relationships with lesbian partners had an impact on the initiation of helpseeking and recovery for 19 (54%) of the participants. Fifteen (43% of total) entered recovery at least in part because of a lesbian relationship. Loss of a relationship, initiation of a new relationship or criticism of one's substance use by a lover were types of relational motivations.

Summary

Images of recovery can be expected to change over time and circumstance. As well, various images can be simultaneously present. Recovery images are important ways in which change and stability are framed within personal and collective recovery experience. A health care provider who has a fixed vision of what recovery is or should be unduly constrains the creative dimensions of the process in favor of a "recipe" approach. This is especially unsuitable for those whose life experiences differ significantly from mainstream culture. Lesbians definitely fall into this category. The images lesbians use to represent their progress and the difficulties they encounter in recovery provide important bases for developing relevant resources, therapeutic techniques, and social support.

Uncritical promotion of the standard AA image of conversion is inappropriate and fails to capture the multiple images lesbians find meaningful. In becoming well versed about alcohol problems, it is important that health care providers avoid packaging their wares exclusively in the language and images of twelve-step programs. More, not fewer, images of recovery are needed to validate the range of life experiences lesbians have.

CHAPTER 7

MUTUAL HELP AND COLLECTIVE THEMES

This chapter addresses the research question: What are lesbians' experiences in mutual help groups associated with recovery from alcohol problems? The recent development of a recovering subculture and the movement away from substance use among lesbians are part of the history of lesbian communities, in which alcohol and the lesbian bar subculture have played important parts. In the interview data about mutual help groups, the larger historical and political implications of community alcohol use and alcohol recovery were much more evident than in other portions of the interview accounts. The role of twelve-step programs in lesbian communities was contextualized by participants via stories and opinions about the interpersonal, social, cultural and political ramifications of how they, and lesbians in general, have used alcohol. It became apparent that individuals' experiences reflected larger cultural and political changes within lesbian communities.

Based on these patterns in the interview data, and the close relationship between the twelve-step mutual help phenomenon in lesbian communities and lesbians' experiences and perceptions of alcohol use in lesbian contexts, the chapter addresses both of these aspects in answering the research question from a critical ethnographic perspective. This chapter, therefore, outlines first the findings regarding participants' recollections and understandings of the lesbian bar subculture and the growth of a recovery movement among lesbian communities. Second, findings about personal, social and relational aspects of alcohol use and alcohol recovery are presented. Third, findings regarding experience in twelve-step mutual help groups are

presented, including identification of points of debate and tension about these programs that persist in lesbian communities.

The participants were excellent informants regarding collective alcohol use and recovery issues. In addition to having personal experiences in mutual help groups, most had been integrally involved in the lesbian bar subculture, a social scene associated with lesbians' alcohol use patterns and alcohol problems. They had done a significant amount of reflection on the meanings of their personal use of alcohol and that of the lesbian community as a whole. Seventy-four percent of the participants were actively involved in AA, and the 26% who did not participate in AA were at least familiar with twelve-step program format through literature, prior involvement or the influence of friends. In summary, alcohol use, alcohol recovery and the twelve-step phenomenon in lesbian communities were attached to deeper social and political concerns about what it means to be a lesbian among other lesbians, including basic issues of survival, health care, social support and community development.

Historical Views

Feminism and the Legacy of Lesbian Bars

Participants framed their narratives about mutual help groups within historical events and trends. Some mentioned their involvement in the hippie/drug scene of the 1960s and early 1970s. They spoke of drug use as part of their rite of passage. Given the mean age of this sample, there were many who were active in the feminist movement in the ensuing years. The common story was that they came out as lesbians in the milieu of the feminist movement and then began socializing in lesbian bars that were already in existence:

> I worked and lived in a women's household in about 1981, and we did a lot of political work. I was in a women's carpentry collective. And some of my friends were doing the back to the land thing. And we also would hang out in the women's bars and drink beer and shoot pool and stuff. All very much a part of the times.
>
> When I came out there were about five lesbian bars in the city, and that's where things happened. That's where we met, where we danced, where we made deals. They were just very important centers of our community at that time. I think we resented that they were bars and that alcohol was what pulled women in. But at the same time we were in support of them.... It was the only safe place, you know, even when an occasional man came in, we were so strong together.... The bars were real important. We would have our feminist consciousness raising groups--and then we would go out to the bar.... Bar culture was clearly our way of connecting.

The San Francisco lesbian bar scene differed from the typical situation in less urban settings, where for economic and political reasons, lesbians and gay men usually gathered together in the only gay bar in town:

> I would hang out in the lesbian bars in San Francisco and in the queer bars down in Fresno. Because there was no real separation between gay men and lesbians in Fresno. They just couldn't afford to. Economically and politically you just couldn't afford to separate. It is still that way in most of the country in smaller cities and towns. There will be one bar in town where everyone goes, women and men.

According to the women in this study, the peak period of lesbian bar proliferation in the San Francisco area encompassed the late 1970s and early 1980s. At that time, there was an assortment of lesbian bars, each having its own ambience and clientele. These bars functioned to meet many needs in the lesbian community. They provided for a feeling of "family," safety, socialization and political solidarity:

> The bar was a central social location. You go there and see your friends. You call up somebody and say, "Are you going to the bar tonite?" Or you go in hoping to see friends. You get there and wait for them to come in. You might just try to run into them--or maybe you know that they come in every night. You can go in and hang out with the bar owner, or whoever was tending bar.... I'd go sometimes in the afternoon, when everyone would just sit around

> and talk. You could talk to women you didn't know. There was more of an open atmosphere in the daytime.... The bar served a lot of social functions--there were football teams, softball teams--and after the games you would come back to the bar.... The bar owners were very responsible to the community. They kept the bar safe. And you know, we were protected in there.... Men could come in, but if they were in any way inappropriate with the women there, they would be asked to leave, and if necessary the police or private security would escort them out. Bullshit was not tolerated...if you did drugs there or in other ways endangered the bars you would be kicked out, because you couldn't do things that were gonna cause the bar to close--it was a community center.
>
> Some bars were pool bars, some bars were pickup bars, some were drinking bars.... There was Peg's Place. The butch fem bar, where the older women went. Everyone drank there, lots of beer, and liquor, too. It was social.... There was Scott's Place, where the motorcycle dykes hung out. It was a hard bar. Smoky, dark, pool playing, drinking bar. Like a neighborhood bar. Rowdy and loud.... Then there was A Little More, where it was just girls hanging out, dressed in jeans and a blouse or whatever. After some incidents at the other bars in the city, this bar was where most of the women of color started going. When Amelia's opened up it became <u>the</u> bar. There was dancing there, and the women of color went there, too. It became known as the cruising bar. Kelly's and Maud's--they were both drinking bars. Kelly's was known for pool shooting, too, and it had a dance floor but not many people used it.... Heart's Delight was way out in the mission.... And there was Kito's, a pool shooting bar.... And there was Mother G's, which was a dancing bar--a party bar--more for partying than drinking--that means you don't just sit at a bar and drink. You socialize, you dance, you cruise, you might meet somebody. Mother G's was for more of the younger women, mostly white--working- or middle-class, but that one only lasted a year.... There was a black lesbian bar in Oakland called the Jubilee. And in Hayward there was an all white bar called the Driftwood.

Many participants agreed that during this period, non-drinking lesbians were in the minority and somewhat stigmatized within the lesbian community. Gradually, the influence of the feminist movement began to make members of the lesbian community question why their socialization was confined to bar environments. They began to interpret this phenomenon as confinement to a male-dominated, oppressive, socially stigmatized context.

Evolution of the Lesbian Recovery Subculture

Participants referred to a collective transition toward abstinence, which they said began in small pockets of the community in the mid-1970s and accelerated during the 1980s, as waves of women stopped using alcohol and drugs and entered recovery. Some participants specifically mentioned the 1978 assassination of the first openly gay elected official, a member of the San Francisco Board of Supervisors, Harvey Milk, and his ardent supporter, George Moscone, the mayor of San Francisco, as a turning point for lesbians and gays in their relationship toward alcohol:

> There had been the whole anti-gay movement with Anita Bryant, and then I think the gay community saw the need to change, to deal with serious issues, when Milk and Moscone were killed.... And then it really accelerated with the AIDS epidemic. We had to learn to nurture ourselves. Because we were social outcasts, and that was made more evident with the AIDS crisis.... The whole recovery movement here is part of the way the Bay area is on the cutting edge.... So the alcohol is not nearly as prevalent, and the focus isn't so much on partying now.

> I remember telling my lover at the time that I was worried about my drinking. And that was right around the time Harvey Milk was killed.... When he was killed, I remember we were housepainting at the time, and when we heard it on the radio we quit working and sat down and had a drink right there.... We had beers, instead of going to the candlelight vigil.... When there were the Dan White riots (the lesbian and gay uprising in response to the acquittal of Harvey Milk's assassin), I was already in AA. On the way home from an AA meeting that very night we stopped to go to the rally--we didn't know it was going to be a riot. But we had that sense of the community.

> I would say in 1986-87 the recovery thing was becoming really big in the lesbian community.... I have one friend who is not in any twelve-step program, and she laughs and says, "I used to drink the least of anybody I know, and now I drink the most of anybody I know. And my drinking hasn't changed at all."... I think there has been a cultural value change as far as substance use goes.

According to one participant, the first lesbian AA meeting in San Francisco began in 1975. Another participant described the first

gay/lesbian alcohol treatment program in San Francisco, operative at that same time:

> My girlfriend told me about this queer alcohol treatment outpatient service. And it was different. It was a pretty intense program. The founder of it had tried twelve-step programs in his recovery. But he had found his miracle, so to speak, in EST. So he used a lot of ideas from EST. The human potential movement was in full swing then. The Gay Health Services Hotline had been set up about then. And there were surveys in 1971, 1972? And they found that drugs and alcohol were like the number one problem.... The methodology used in this program was: "You are a queer. You are a drunk. You are an addict. You grew up all fucked up. So what? You are here now. Deal with it." Everyone on staff was in recovery. Everyone was out (as gay or lesbian).... They used yoga and visualization and guided meditation.... It was total abstinence, and you signed agreements, contracts about that.... I think my fee was forty bucks a month.

Lesbian bars were steadily closing during the 1980s. The last lesbian bar in San Francisco closed in 1991, shortly after the completion of these interviews. Participants gave a number of reasons for this trend: economic constraints, decreased alcohol consumption among lesbians, growth of non-alcohol-related spaces and events. Many pointed out that closure of the bars did not necessarily mean that lesbians had abandoned alcohol and drugs, rather they were more likely to drink alone or in home settings. The loss of the lesbian bars made several women sad:

> The first year of my sobriety a lot of the bars where I hung out were still around. Like in 1987 they just started closing. Peg's closed, Maud's closed. And I don't see a lot of those faces from the bar in the (AA) program.... I don't know why the bars closed. I don't know if it was that more women are getting clean and sober. I don't think so. I think there's just competition, like the dance clubs. I mean I don't know if I'd want to sit in Maud's if I was drinking now. I'd want to be where there was some excitement.... The money is going elsewhere--or women are just expanding more. There's more than just the bar scene.
>
> I think it is a real fallacy to say that it is a sign of mental health that the bars are closing. A real fallacy, a generalization. I think a lot of lesbians are home drinkers. Especially if they are in relationships--they just go home and get

> blasted. They have their little world together. And also economics of lesbians have not gotten any better, so women do not go out and support the bars. So I think those are two issues right there that discount the whole generalization.
>
> I worry a lot about lesbian bars closing. Even though I don't use them. Because it is a loss of women's space. It makes me very nervous. Very nervous.

Recovery Movement Accelerates

Participants identified several historical factors influencing lesbians' entry into recovery from alcohol problems: the feminist movement, Harvey Milk's assassination, the AIDS epidemic, self help movement, proliferation of twelve-step programs, recession in the early 1990s, etc. Some women also cited increasing social awareness about childhood sexual abuse as influencing women who had been sexually traumatized to enter alcohol recovery. The following quotes illustrate some of these factors:

> Lesbians go into recovery, into the twelve-step scene, because they want a part of the system. You know, those are some of the same women who are going into careers that compromise their ethics.... Going into AA is making a connection from a patriarchal perspective.... Maybe it's disillusionment, for those in the women's movement who lived their values and tried to do it outside the system, and found after twenty years they are poorer and have less status, and less power. So they figure they have to go and get those tools in the male world and then bring them back to their own values at some point. But recovery almost seems to be a part of the American Dream.
>
> It is a disturbing thing--that lesbians want to be a part of the American Dream.I see that these recovery issues follow along generational lines. I mean generational in the lesbian sense. The women who came out in the seventies versus the late eighties. Those who came out in the seventies are clean and sober for the most part. So you have a lot of the women who are in leadership positions politically in recovery, and they influence how the political and social scene is going to look.

In contrast to the trend a decade before, lesbians who continued to drink through the late 1980s and early 1990s faced stigmatization

within the lesbian community. This phenomenon reflects a definite shift in San Francisco lesbian community perceptions of the drinker:

> Drinking was mass promoted among lesbians back in the 1970s. It was the social norm. If you wanted to meet lesbians, you'd go to a bar--where most social things happen. Not in San Francisco so much anymore, but clearly back East it is still that way. It all happens at the bar, and if you don't drink, you are looked upon as a (non-drinking) alcoholic, or--weird. Somehow different. There was that social stigma attached to being a non-drinker.... So I would drink non-alcohol beer so it would look like I was drinking beer.
>
> I noticed after living here a couple of years, that all my old drinking buddies were sober. And it was like, ooh, this was really depressing. It was like in '83 or so. Like nobody will drink with me. I hated it. I became real isolated, and didn't really build up a circle of friends.
>
> Some women I know are currently working on getting a clean and sober entertainment space opened up. For music, and socializing. And they are pretty accepting of everybody. Whatever you are into, as long as there's no alcohol or drugs or smoke on the vicinity. And that is not just for recovering women. Those are the three rules, right there.
>
> When I drank it seemed like, "Damn! The whole world's over there in recovery and I'm over here." And when I went into recovery, and when I saw that many lesbians in AA, in recovery--it just seemed like everybody was there.... I don't know, I guess I was behind the times. I was out of synch.

Lesbian recovery subculture in San Francisco had, by the late 1980s, expanded into a myriad of women's, lesbians' and people of color AA groups and other twelve-step programs. It seems fitting that upon the closure of a string of diversified lesbian bars, there appeared an array of diversified twelve- step groups to accommodate the differentness and marginalization felt by lesbians:

> I think recovery is different for lesbians today because there's so much support out there. I think more lesbians are finding it--in the Bay Area (San Francisco) --I don't think it is that developed in the midwest or anything. But in the Bay Area if you have the slightest desire to get clean and sober or whatever kind of recovery--I can take you to 500 groups in this area--from Sex and Love Addicts to Overeaters, to Emotions Anonymous, to Clean

> and Sober Atheists. I mean the choices are endless and it is really exciting. Anybody can find a niche in the recovery thing if they are looking for one.

In summary, these participants described a two decade history of transformation in San Francisco, whereby the lesbian community's relationship to alcohol radically changed. The community's stigmatization of non-drinking members changed to the stigmatization of drinking members in a matter of 20 years. There was a major shift in values and socialization patterns, which remains a source of debate.

Lesbians and Alcohol: Relational Influences

The interview data provided information about participants' uses of alcohol, the meanings it held for them and how those meanings had changed in their recoveries. Participants identified personal barriers to relationships and external sources of interpersonal strife as bases for alcohol use. These factors were integral to women's patterns of relating to others. Relationships exerted an impressive influence on participants' perceptions about alcohol use and recovery from alcohol problems. Findings about the process of problematization presented in Chapter 4 are supplemented by the collective, relational focus of this analysis.

Sources of Feeling Unacceptablee

Many participants spoke of difficulties with the self that made them feel isolated or unacceptable to others. Some of these problems were described as originating in childhood, such as being battered, verbally abused and sexually molested. The sense of alienation, contamination, and inability to trust, fostered by these problems became "reasons" to drink. Drinking helped women override these feelings so that they could interact with others:

> I have had total childhood memory blocks. I think the alcohol and drugs somewhat kept me from remembering stuff. You know, now the challenges are dealing with, grappling with the things--the pain I had as a child (clears throat). Um--a lot of familial stuff.... I really have a hard time with the sexual abuse in my--life. Hard time talking about it. Things I have stuffed and not really dealt with, have not resolved. I don't like to deal with those things--if I deny those things, those are the kind of things that can make me drink again. Like I'd drink just to not feel all that.

Adolescence, a time of self-image changes and sexual possibilities, was particularly distressing to many participants because of internalized damage from familial rejection. It was also discussed as a time of great risk for lesbians in general:

> All through high school I was drinking steadily. Every night a six-pack, two six-packs of beer. And then smoking pot and bingeing after I drank. You know, on all kinds of food. On school nights we would go out and sit in this field in this friend's car and we'd get real loaded. And then college came around and I felt like I couldn't go to any type of function--this was right when I was coming out--couldn't go to any type of party without beer or wine in my gut.... I remember stumbling, blacking out--meaning I didn't remember--I woke up places where I didn't know where I was, sleeping with guys I didn't know, going on trips to other cities--totally unplanned trips. I'd get real sick and resolve to never do it again. That resolve was consistent, but of course I always did it again. I started drinking when I was 12 and the things I told you about went on all the way through high school.
>
> In this town where I lived, everybody drank. And like I did pot, too. It was a defiant thing towards my parents. I did the thing in high school of dancing between groups. I'd hang out with the jocks one night and drink, and then with the stoners the next night, and then be the honor student in some leadership thing the next night. I dated boys some, but very little. Mostly I was into going out and meeting with other girls. I was not out, or really thinking of myself as a lesbian in high school. But then when I was 18, I'd say I crossed a line with my drinking. When I came out to my parents, and they rejected me totally, I realized I was alone. I drank more and more as I cared less and less about everything.

A belief common among these lesbians was that internalized negativity absorbed from a pervasively heterosexist culture precipitates alcohol use:

I drank to deny the feelings of being gay. I pictured myself as super-sick: I was not only an alcoholic, but I was also gay. Disgusting.... For me it was difficulty accepting myself as a lesbian, and that was harder being a person from the Latino culture, a person of color.

There is the component of being a person who has no society.... You are a profanity. An abomination...the larger society is still there with all the messages about what wholesomeness is, about what belonging is, about what the goals of well-developed adults are.... Lesbians and gays don't get to participate. Not really.... We are these outcasts.... You will never be reintegrated--you are not a part of the larger society.

I think that a lesbian can feel ok about who they are in the lesbian world, but the oppression of society can cause you to drink.... When you don't want to feel what that is like to be oppressed, you use substances to nullify those feelings that are coming up. So I think you get it from internal and external factors.

For me it's about things too painful to talk about. Intimacy stuff. And I don't know what to do with my anger. I don't think I ever have.... And then there is the "of course you're a drunk, you're a lesbian" thing.... I mean this is perhaps a Southern attitude. Something like: It's just another perversion for a perverted person. It's just another thing you can't deal with, another way you are different.

I knew that within me I was ashamed of being a lesbian. And I hadn't come to grips with that, and it had a lot to do with my drinking.... You know, we tend to get very defiant and act as if we don't give a shit about some things--that are very deep, and sometimes around shame.... I heard a speaker once say that we are beautiful women who fuck ourselves up because we can't accept who we are, and what is so beautiful about us. And I thought, "She is talking to me."

I think a lot of lesbians drink because it's hard coming out (as a lesbian). Just within themselves, because it's not ok, you know? And in society, and on a real personal level, lesbians drink because they feel alone. And there's no one to talk to so you just kind of stuff it.... When you don't have a voice to say you are a lesbian elsewhere, and you don't know if the person you are talking to out there in the straight world is gay or straight, and thinking that any straight friends you have are going to have all these negative issues if they knew, or if it was actually talked about. Makes you feel left alone.... And when you disclose, it is final, in that sense of right then. It's not about bars, it's not about cruising, it's not about meeting women. It's about just being ok with ourselves and having it be ok. In this world we have the potential to lose our family, friends, any support you might have. What a scary thing.

Actual discriminatory experiences were related to alcohol use. Ethnic/racial and anti-lesbian discrimination were cited most frequently. These women often spoke of using alcohol to gain power or to override feelings of powerlessness. Selling drugs was also mentioned as a role affording power:

> Alcohol and drugs as a way to cover up feelings is an issue for black women. It's about breaking the silence. You know, as a black woman I learned to keep my mouth shut. What happens in the household is no one's business. And that's what's going on for a lot of woman--a learned behavior--not to speak of your feelings, or what your mother did, or what your father did, or what happened to you as a child.
>
> In our ethnic communities we are like scum, right? We were really bad girls. We are not accepted at all as lesbians. We are violating every rule in our families, in such a major way. And so there is that much more hiding that goes on. So as Latinas we often get into drinking and drugs along those lines. And we are targeted for violence as well. So there is that fear, that oppression. And the recovering community and the lesbian community are not multicultural, not really.
>
> I was in this pretty white college.... I was distrustful of systems, and was aware of how the quota system worked if you were a Latina.... Anyway these students had a lot of disposable income. So I moved in on that, go into the business end of it, bringing dope onto the campus.... I used drugs to feel more comfortable being around other people. But I never talked about that. I used the dealing aspect as a power base. Being a dealer, having the connections. The access to drugs was one element that could be brought into any relationship. A quick way to get cash. A bargaining tool.

Socialization and Sexuality

Participants described the ways they used alcohol to facilitate relating with women. They emphasized that there was no "blueprint" for how such interactions should take place:

> I felt important, like a big shot. With alcohol. I had attitude. I was like, "I'm not afraid of nothing--live for today." It gave me all the self-esteem and the relaxed warm glow.... Alcohol loosened me up verbally and sexually and physically--I felt like I could dance better.... Alcohol was there for me to control fear--and it can be old ghosts, not in the present--trauma.... A big part of drinking for lesbians is our intimate life.... One of

> my fears about getting sober was that I'd go straight. My god, if I quit drinking I might like men.
>
> In retrospect I know my social skills were not fabulous.... And we thought that if we got drunk enough, you know, maybe we could make a move. Talk to another woman, ask her to dance, whatever.... We believed the alcohol would help.... I remember when I first fell in love, I drank a lot to be able to make those social moves that would indicate my interest. And I was like drunk when I actually made those moves. I don't know that it helped--being drunk. But, I may not have been able to do it otherwise.
>
> I think it's hard enough, being gay. And then to meet other women--I didn't know how to do it. So a couple of drinks are gonna make that easier and it's gonna give me something to put in front of my face, so I don't have to look around, or look somebody in the eye. I've got something in between us. I mean, it eased it. Having a drink--may have opened up a conversation or something.

Many recalled using alcohol in sexual interactions. Some, who had been married to men in their early adulthoods, spoke of using alcohol to cope with the sexual conflicts they interpreted as consequences of repressing their lesbianism:

> Drinking was involved with the stresses of being a lesbian, for me. Being a lesbian I had extraordinarily difficult times with my family--I was barred from their house. And I was drinking more and more to deal with these issues.... I actually drank more when I was married. Then as soon as I got rid of my husband, my drinking decreased.
>
> My lesbianism and low self-esteem were behind my drinking. I felt good when I drank. I was married, and eventually I got rid of my husband and I came out. But before that happened, I felt incredibly trapped. And I didn't see any options. So I used the alcohol to cope. It was a great way to keep me trapped, actually.

Others had related sexually to men they had encountered in straight bars. In their stories they also talked about heterosexual men searching lesbian bars late at night, looking for intoxicated lesbians to exploit for sexual purposes:

> I was blacking out a lot and having sex with strangers--I was one of those women that got picked up at women's bars by men.... Now whenever I am in those bars I look at the sleazeball asshole men who walk in there looking to pick up drunk women--couples that

> walk in looking for drunk women. I go crazy when I see it because I remember my own experiences--about being fucked up and taken advantage of.
>
> Being a lesbian, the rest of the world says what you do is bad.... Instead of talking about it, I would just deny it, and go out with men, and I would have sex with men. I call these my women-hating phases. I wanted to be straight--I thought if I could be straight it would solve everything.... It is really difficult to be black and gay, whether you are male or female, and to grow up in an environment where there is a lot of emphasis put on machismo, and on family, and on fitting in.
>
> I had fantasies about women from way back. So on the subconscious level I am sure my struggling to come out as a lesbian was something I treated with alcohol.... I was real sick. It was straight bars, by myself. Going into straight bars and tossing up. I was a toss up for sure. Once I came out as a lesbian, I didn't do that. Wasn't in the lesbian bars much. I pretty much stayed with one woman.

Participants who had worked in the sex industry described a cycle of drinking, using drugs, having sex for money, feeling remorse, and blunting these feelings through more alcohol and drugs. These lesbians felt ostracized from other lesbians because they were having sex with men:

> My girlfriend has said, "How could you turn tricks when you don't like men sexually?" I told her it had nothing to do with me having sex with them. It had to do with, they needed something, I needed something. They wanted to have sex with me--they have to pay.... Women, especially white people in general don't understand this whole life.

Most participants gave some account of how alcohol was specifically used in the process of sexual interaction with women. They spoke of using alcohol to override fear, feelings of inadequacy, uncertainty, shame, guilt and cultural and religious repressiveness. They talked about using alcohol as an excuse or explanation for sexual activity, or as a way to avoid being fully "present" during sexual relating:

> I had been raised as a good Catholic Latin girl--wearing crucifixes and behaving really well around my grandmother.... By the time I got to lesbian bar drinking I was very sexually curious, and very promiscuous. So, you know, if you are going to be picking up different women every night you pretty much have to be drunk to do it.... There I was, dressed in leather, screwing everybody, having a ball, but then I'd sober up and I didn't like it--I mean, who is this person?

> Without the drugs and alcohol, the sex would not have been possible. Cuz' I'd be beating myself up that this is not right--all that little Catholic school girl bullshit would be traipsing through my mind.... Drugs and alcohol allowed me to compartmentalize all that. When I get to hell I'll deal with that, but right now I want the sex, and I'm gonna deal with that now.... When I was drunk or high I really was never present for the sex.... She was never present, I was never present. It was like the blind leading the blind. How could I have any good feelings about it later when I was medicating myself to do it in the first place.

Ethnic/Racial Tensions Regarding Alcohol

Within lesbian communities ethnic/racial tension was felt by women of color. Alcohol and other drugs entered this conflict in several ways. First, African-American and Latina lesbians viewed alcohol differently from Euro-American lesbians due to cultural and political conditions. The lesbians of color in this sample were more likely to have used cocaine as their primary substance of abuse. Alcohol use was acceptable in lesbian communities; other drug use was perhaps widespread, but less openly tolerated. According to these participants, lesbians from minority cultures who used alcohol and drugs were more likely than Euro-American lesbians to engage in sex with men. All of these factors contributed to ethnic/racial tensions within lesbian communities related to alcohol and drug issues. These tensions over alcohol and drug use reflect larger sociopolitical environmental conflicts which clearly heighten the intensity of the dialogue:

> The political unfairness--I internalized it. I had become bitter and depressed and less articulate. And the anger and hostility

was chemically induced. And that was how I perceived the world. In recovery I started to look at the liquor industry, how it targets Latino and other poor people. The number of bars and liquor stores in our neighborhoods. I realized that was racism, too. You take away poor people's basic health and you don't have to worry about them. They will destroy themselves. All you need is time.... My sense is that white Americans are very culturally diffused, and when you puncture the materialism there really is nothing there. No core identity. And AA is something to fit that need. There is a set of rules, some values, some boundaries. Some traditions that happen. A language. Membership. And it happens for white folk the way it can't for colored folk. Because despite our oppression, we still have those things, from our communities. And these dynamics play out in the lesbian community as well--the pressure coming from there to be in twelve-step programs if you are in recovery.

I have issues with the lesbian community--it is so controlling. I mean it is our background. We should all end up in recovery for something--live and let live, you know? I mean this idea that we are so susceptible to being victimized and having our power taken away--no one can take my power.... I feel very strong and capable and empowered today, much more of a role model for other lesbians or anybody.... I have a lot of issues around race and culture in the U.S.... People talk about the lesbian community, the recovering lesbian community--well in my mind I automatically think white.... I go to lesbian meetings and frequently I am the only woman of color there.... Among Latina lesbians there is much more bisexuality--probably bar-related, but a lot of denial around it in sobriety. And this has implications for AIDS. But if you talk to a Latina lesbian in recovery she may deny that she also has sex with men because it's not a cool thing to do.

See, the lesbian community I came from was the women who had men, you know, when you hear about the racial or economic--cultural whatever.... In that world you still got to be who you are--or who you aren't.... It's not a very good place to--be somebody. So like my friends--the butches were butch--you knew that you had to totally stand up in a man's world. And the fems might be sleeping with a man, you know, and have a female lover.... Around the time I came into recovery I realized there was this other lesbian community--mostly white. And it was like--different.

The Influence of Peer Relationships

There were numerous examples throughout the interview data illustrating how women were influenced in their use of alcohol by other women who were significant in their lives, either lesbian friends,

partners or admired role models. Some women even formed pacts with other women to stop drinking together.

Not all peer interaction regarding drinking was directed toward moving individuals into recovery. Peers sometimes minimized or denied the existence of alcohol problems, exerting pressure to continue abusive consumption:

> The hallmark of my early recovery was, when I got around to telling my friends, they would say, "You? A drinking problem? You don't drink that much." It was hidden from them.
>
> Alcohol and crank were my drugs of choice. But I laid it on my lover. I thought, "Hey, if she didn't bring it into the house I wouldn't get loaded." My friends didn't think I had a problem. Of course they had bigger habits than mine. What I used in a day they might do just to get going in the morning.

Many participants also described the influences that primary partnerships had on their recovery experiences. They spoke of the difficulty of being in relationships with partners who were not in recovery. Twelve-step programs were seen as interfering with the processes of these relationships in some cases. The interaction between individuals, their significant others and the lesbian recovering subculture can be seen in this example:

> My former relationship ended when I got more involved in AA. I mean my lingo changed. When you start hearing program stuff you start speaking it. It was clear the relationship wasn't gonna end as a direct result of getting sober, but of getting recovery.... My present girlfriend is not in any twelve-step program. There's some benefits to that and some drawbacks.... We don't have to process everything to death.... It is just much lighter.... What's hard is that she doesn't understand what I am going through sometimes.... She doesn't understand because she is not part of that process. She doesn't go to meetings. She doesn't understand the language and some of the concepts.

There were those who felt that being in recovery was itself a pressure towards establishing a relationship, especially in the context of the lesbian recovery subculture. They expressed a desire for more

information and support in helping them make decisions about relationships:

> I was in a lot of trouble in July, with my relationship ending.... I went to a meeting, but it was scary, because I was breaking this relationship and it was hard to be around other women...my food problems really got out of control, because I was grieving--grieving the relationship ending.
>
> A lot of times ending a relationship brings me to a surrender point that has turned my life around. I guess losing or ending a relationship says, "Hey, something is really wrong with this picture.
>
> "On the other side now in recovery, I have had one relationship with a woman. Before that I was with women and might have had sex, but it wasn't a relationship.... I never can get that right, I mean--like relationship is spelled in three foot high block letters in the sky: RE--LAY--TION--SHIP! --I have started to think that's the only thing that can make you a dyke, if you were in a relationship with another woman.... It's something that comes up for me more in recovery. I do therapy around it when that happens, but nobody seems to have the answers.

Experiences in Twelve-Step Mutual Help Groups

The findings regarding mutual help and collective themes reflected a significant amount of divergence in viewpoints, even among these 35 women. All participants had some exposure to twelve-step mutual help groups, ranging from attending a single meeting at one point to daily participation in several meetings. The most commonly used twelve-step program was AA. Other programs used included Narcotics Anonymous, Overeaters Anonymous, Adult Children of Alcoholics, Alanon, Debtors Anonymous, Codependents Anonymous, Sex and Love Addicts Anonymous and Incest Survivors Anonymous. All of these programs are adaptations of AA's twelve-step approach to addictive problems.

Resources these groups provided these participants included: meetings, literature, outreach to institutions, telephone information and support, sponsor relationships and social networks of other

recovering persons. A specifically relevant AA resource cited by many participants was the Living Sober conference, an annual gay/lesbian four day conference held in San Francisco. Usually participants experienced this event positively, however a few participants recounted being overwhelmed and in crisis because of the intensity that was generated through hearing about issues, such as childhood trauma, without having an ongoing safe and supportive context available to them. The following quotes exemplify contrasting views about these conferences:

> I probably go to three or four lesbian/gay AA conferences a year. I like the diversification of people...there's different things to hear, and it just doesn't seem like "the same old same old." And it feels like getting my battery recharged and then I can go on that for a while.

> Yeah, I went to Living Sober this year. I was overwhelmed by it. Emotionally. Jesus, it brought up a ton of stuff for me.... I just felt overwhelmed with feelings and I wanted to be held and nurtured.... I wanted to cry.... It made me feel very sad. I felt detached from the people that were there.... People talk about this instant bonding, and I didn't feel like that.... And I just didn't feel safe.

AA meetings were described by participants as varying considerably in format, group membership, location and organization. Because of the large number and variety of AA meetings in the San Francisco area, it was possible for women to attend as many as five meetings in a day. The other twelve-step programs offered far fewer meetings, although one could attend at least a meeting per day in any of these programs. Participants referred to so-called "special interest" AA meetings, each designated for a particular minority group such as women, gay men, lesbians, people of color, atheists/agnostics, young people, those with five or more years of sobriety, etc. Those who attended lesbian AA meetings exclusively were few among this group of participants. Most

varied in their group selection, so they were all familiar with the dynamics of "mainstream" as well as "special interest" AA.

Tensions Regarding Twelve-Step Groups

While there was general consensus about the history of the lesbian community's relationship to alcohol, when AA and other twelve-step groups were discussed, a number of tensions became apparent, dividing participants sharply on certain issues. There were many instances in which a single participant expressed seemingly opposite opinions on the same issue at different points in her account. Also, there were instances in which participants spoke of an unresolved tension or ambivalence about an issue related to lesbians and twelve-step programs. Each of these tensions represented a dialectical process in which lesbian communities can be seen as containing and attempting to reconcile two polarized views of an issue.

Assimilation versus Differentiation

Assimilation refers to integration with mainstream social contexts of AA. As a goal, assimilation implies inclusion without essential change in the values, ideology or politics of AA. Differentiation refers to a sense of separateness and distinctness as members of minority groups in AA. Whether AA was an appropriate, safe context for lesbians was one of the questions embedded in the tension, assimilation versus differentiation:

> I think AA is fine the way it is--I don't think we should be changing anything.... I think AA is great for adding onto.... I think AA is an extremely responsive organization.... There has been a gay brochure in AA--we need a lesbian one.... It's just a marvel how it has grown and changed... I think Bill W. did a good job, that the power of the organization is in the broad base.... The power is in the meetings, and you can have any kind of goddamn meetings you want.

> I'd go to meetings in the beginning--give out my name and number, and have these odd people who are not like you who are interested in keeping you sober call you--and you don't know why they wanna be around you, but they do anyway. People would check on me, and that would be really valuable. Cuz' I thought it was beautiful that these strangers that I had nothing in common with would call me and cared about me and would sit with me.
>
> I'd like one pamphlet to go out to AA members as a whole. And it would explain in words of one fucking syllable that the only requirement for membership is a desire to stop drinking--and that means no one has a right to exclude! You hear criticism of these "special interest" AA groups. Well, these groups came into being in response to this exclusion that goes on among white, especially male heterosexuals. So the white heterosexual AA community needs to hear this.... They say "We're all alike." Who says this? Rich white men. I am sick of the racism and homophobia.
>
> I think that AA is a problem for lesbians because it sends the message that the problem you are here to deal with is that there's something wrong with you. And we have a program that will fix you and make you better. And leave your politics at the door. AA has this little pamphlet, "So you think you are different?" Well, you are goddamn right we are different! I mean this is a group of deeply oppressed people--that's a little different than being heterosexual in this culture. To minimize or trivialize that is a very political statement. And I think that is my biggest worry. No, it is not safe.

Participants spoke of involvement in "mainstream" AA as a context for integrating as lesbians with the heterosexual society. In some cases the disease concept of alcohol problems provided a basis for individuals' assimilation into the AA group; the common bond is that all are sufferers of a single disease:

> There's a lot of real important allies I have made through AA, in the straight community. These are straight people in AA who have befriended me because of this common bond we have. I may not have met them otherwise. It is an enormous amount of human compassion I get to have. I remember sitting next to a Hell's Angel type guy in an AA meeting. He was probably a rapist. And we are sitting there talking and it's like, "Yeah, I understand you." And for some reason I love you, you old creepy Hell's Angel. But he was changing his entire life and I was changing mine.
>
> I go to meetings with straight white suburban people in their fifties and sixties. And I feel perfectly comfortable being who I am. They invite me to parties at their houses, and some of my

> most important AA support are straight people.... It has taught me tolerance and it's a chance for me to teach them tolerance.
>
> I go to this AA meeting where there are all these older men. There's a lot of foul language--and they are very bigoted. I hear the words "nigger" and "spic" a lot. And I have called some of them on their prejudice. That's been good for me. And I have come out to a lot of them. Individually. And that's been real good for me to find out that even though some of those people seem real cold and unfeeling on the outside, that when they actually get to know me, and decide that they like me, then they find out that I'm gay--they can be accepting.
>
> It's comforting for me to see people from all walks of life who have the same disease as me. It's not just a bunch of dykes, you know? I don't know, I just need to see that sometimes.

Differentiation without assimilation was possible in some participants' estimations. They believed that AA had been made safer and more suitable to lesbians because of the development of lesbian AA groups:

> The lesbian AA groups are so much more open-minded.... The straight AA groups I find are real traditionally AA. In lesbian meetings other things can come out, like talking about incest, or just about living the life of a lesbian. The emotions come out a little more.
>
> I went back to AA to the lesbian meeting, after I was 12 years sober. And I knew the minute I walked into the room that I was home. This was AA as I had always envisioned it to be.
>
> I began to go to lesbians AA meetings because I knew I had all this shame. I knew somehow that if I was gonna get healthy, not just stay dry, I needed to get healthy about accepting every part of myself.... So I went to lesbian meetings--I felt shitty, you know--and I talked about it. And nobody thought I was weird.

Some participants also had criticisms of lesbian AA as social settings for "cruising" (looking for sexual contacts), much like the lesbian bars they had left behind. Some criticized lesbians' choices of meeting topics and indicated that those who attended lesbian AA seemed less healthy or less spiritual than other AA members. These issues

reflected the tension about assimilation: Who is a good AA member? What is a proper meeting format? Can one expect to find a peer group in AA?:

> I think that a lot of the bar culture, bar values, gets into one of the lesbian AA meetings.... The most attractive women would get the most attention.... This meeting was a point of entry for many lesbians, so yes, it had that "cruisy" flavor.
>
> See, I think the thing that is missing a lot in the women's meetings is spirituality.... And I know a lot of those women associate that religion is patriarchal and male dominated, and so they have basically shunned it. Understandably so, I guess. But when you throw it all out, I mean, you lose a lot.... I mean if you say religion is bad, therefore there is no spirituality at all, and you can't even say the word God, then you can't even get your hands around the first three steps.... If you can't get to the idea of a God, or a higher power, then you can't get the whole program--the spiritual awakening.
>
> There are some women in the lesbian AA meeting--if they are there at the meeting, we can't say the Lord's Prayer. And I don't quite get that.... I mean I think this still needs to remain a twelve-step program.... So if someone walks in on their first or second meeting, they can tell that they are at AA and not a lesbian rap group.... It is real important to me that there is consistency.... Not to be talking about what it is like to be a lesbian, or relationships, or some personal trouble and not relate it to alcoholism, or the Big Book, or the steps.

Authority versus Autonomy

Another tension lesbians articulated relative to their experiences in twelve-step mutual help groups emanated from differences in beliefs about how these programs should be used. The differences might be summarized in the contrast of "blueprint versus tool box." Some individuals felt strongly that there was an orthodox way to practice the twelve steps and twelve traditions of AA, and that deviation from this authoritative method, or "blueprint," was dangerous. Usually the stated danger was relapse into drinking. Other fears associated with not attending to the authority of AA were limited personal growth or loss of "serenity." Some of the aspects of this "blueprint" practice included having a sponsor, writing out the steps, reading the Big Book

(Alcoholics Anonymous, 1976), attending meetings more than once a week, doing voluntary AA service and making regular "program calls" on the telephone. The authority-oriented AA member was perceived as supportive of saying the Lord's Prayer at meetings, more likely to refer to the Higher Power as "God" and more likely to emphasize the necessity for spirituality in recovery. Frequently mentioned problems were sexist language in AA literature and the invisibility of lesbians in AA literature. Yet authority-leaning participants stated they were opposed to rewriting these pieces of literature, in deference to AA's "tradition:"

> All the answers were in the Big Book. We used the "12 and 12" (Twelve Steps and Twelve Traditions book) also. But that was all.... Where I got my indoctrination to the steps was I sat in a step meeting every week for several years as they read the steps and discussed them--over and over again. Every week they did another step.... I still think that the Big Book was divinely inspired. I mean that's what I believe--that the answers are in there.
>
> I think that the Big Book is definitely culture bound. It was written by a bunch of straight, white, middle-class men in the thirties.... But now I think I am not in favor of changing the Big Book at all.... It doesn't speak as clearly to Asians or Blacks or all kinds of groups.... But I guess I'm not in favor of seeing the language change.... The book came from where it came from, and I honor that.... But I hate the Lord's Prayer. I think it is Christian and it doesn't belong. I have written a letter to the AA "Grapevine" about it. I basically trust the process of AA--a slow decision-making process with the minority voice.
>
> I would refine the literature of AA and make gender-neutral pronouns. I think that would be the most essential change for me.... In my early days I got white-out and took out all the "gods and he's." I put in the word "hope" for higher power or god.... I have told newcomers, if you object to the literature, don't read it. Or fix it. I wish they--AA--would fix it.

Those who favored autonomy viewed AA as a collection of possible strategies, a "tool box" of implements that could be used in any way that made sense to the individual. Sponsorship and working the steps

were valued as long as there was flexibility in expectations, a context for negotiation, and the individual made the final determination about an issue or course of action. Another debate related to autonomy pertained to whether or not one must continue attending AA meetings indefinitely. Some participants had decreased or discontinued attending mutual help meetings. The perception of AA as dogmatic prompted the tapering:

> To focus every day on "Hi I'm somebody and I'm an alcoholic" wasn't getting me where I needed to go.... I thought, well, it must be me, I'd better keep going to the meetings.... Finally I got up and walked out one night, and thought, "I am more than an alcoholic."..... So then when I would see these women from the AA meetings there was judgement on me. They'd say, "What meetings are you going to?" I'm not. And it's always painted like what I'm doing is dangerous, risky--I'll forget I can't drink.... I guess I didn't get into this to make a lifetime commitment to stay in the ship. I kind of feel like I'm moving on in life.
>
> I have gone to a few AA meetings. And I have walked out.... I'm grateful to know there are people gathered in the name of sobriety somewhere around the world at every hour. That thought is wonderful.... But I don't have to be there. And I don't have to say the "Our Father."
>
> I go to a lot less meetings now. I'm not regimented. I don't set up a structure for how I do it.... In my later sobriety I have gotten a lot less dogmatic. At first it was important for me to label myself an alcoholic. I got into that whole "different/same" mindset.... The separations were cut and dried. Now there is a synthesis in me. I am many things, not just an alcoholic. I used to be afraid God would come down and force me to drink if I said that. (laughs) Now I would say AA is not the only way.... I know of some lesbians with 8 or 10 year off drinking and drugging, but they don't deal at all with the word "alcoholic," and they don't go to AA and they never have.

<u>False Consciousness versus Politicization</u>

A third tension evidenced in these interviews was the view that twelve-step programs promoted false consciousness versus the view that these programs assisted communities to be politically aware. False consciousness refers to ideologies that act as a screen, obscuring

political awareness. A false sense of belonging is a middle-class context is an example. False consciousness removes political implications from real situations, reinterpreting them as individual non-political matters. Politicization refers to a heightened awareness of the collective implications of situations, seeing them on a socioeconomic plane as illustrating power dynamics. Politicization is awareness of oppressive conditions. One participant described the tension:

> Everybody who is anybody is in recovery. And I think that's a real problem.... Because the focus is on the individual instead of the structural problems. So you never really look at what could be causing this (oppression) on a grander scale.... It is not good that as a lesbian, in order to be accepted, you need to be in recovery. That you have to redefine who you are and your sense of yourself. You have to take on this self-image and this prescription for how to live your life.

Internalized homophobia and anti-lesbian discrimination were also reported to be evident in twelve-step interactions, reflecting a type of false consciousness:

> I had a sponsor in AA and I told her about my lesbian relationship. And after that she was different toward me. I had asked her if she had ever had any type of friend that had any relationships with women. Sexual or emotional relationships with women. And she said no.... Usually we would sit and talk after the meeting, and that didn't happen any more. She would always look too busy.
>
> You can enter almost any women's meeting in the city, and there are always lots of lesbians there. And maybe there are several of your ex-lovers there. And that doesn't feel safe. You know, how do you get serious about yourself when you are trying to defend yourself.
>
> I went to the lesbian AA meeting.... I hated it but I kept going anyway. It was very scary for me. I sat in back...I said, "I don't like those dykes!" I felt like I was better than those women. Because I could "pass." Once a woman at a lesbian meeting told me I shouldn't be there because this meeting was for lesbians. I had long hair. I get the feeling that if I was bisexual I'd feel I was betraying the community. And now I

realize I even share all these strong judgements about other women.

Racism was cited by participants as both a personal and interpersonal obstacle to the social support that AA was supposed to offer to all its members:

> At this meeting in the area where I live I am the only black female there.... I feel like I am invisible there. They don't acknowledge me, and that's probably why I feel they have a chip on their shoulder. The problem isn't as intense in the city.... I don't know if people have never dealt with black women or if they don't know what to say--I really don't know--have they never dealt with a black woman? Or have they got this perception that all black people are a certain way?
>
> I go to the meetings, but I don't want to be rejected.... If I think they are not gonna ask me something, I'll say something, to head off the rejection.... I am usually the last one in and the first one out.... White people go and they fit right in! They go and stand at the coffee machine and talk to people. After the meeting people will stop to talk with them. I mean stop them. But I go, and it's like no one says anything to me and I say nothing to no one, and I run down the stairs.... I don't know whether it is them or me. I see cliques.... My sponsor says, "Let them know you want to be a part of it." And I say, "Fuck you!" I come to these meetings--a newcomer as far as you know--somebody is supposed to be welcoming me, as the Big Book says.... We are not able to open up in that room. We can go and stand in line if something is being given away for free, because there's no rejection involved in that. But to open up in AA meetings. It's hard.
>
> Racism is what I perceive plus what you perceive.... You might think I am better than you because I am black and powerful. That black women have such strength. (laugh) Then I might go over here and they may think I am shit, and gross... "Children, don't look." That type of thing.... Once when I was giving out chips at the lesbian AA meeting, this woman didn't want to hug me--which is what always happens. I don't know exactly why she didn't want to hug me. I suppose we'll never know why.... We have this gay and lesbian meeting for people of color.... And there are white people who come regularly to this meeting... One white man says how comfortable he feels there.... I think white people are guilty.... He loves my hair, my size, and my blackness.... He wants me to hug him and like him the way he likes me.... He wants me to approve of his innards.... It is really distasteful.... I wish they'd stay out of our meeting, because I wouldn't want to stand up in front of a white meeting and say, "I'm insecure today because I'm black, and I need to talk about it." I need a place to say that.

Some participants found reason to believe that twelve-step programs increased political awareness, or at least did not interfere with this process. They focused on how gaining a chemically-free physiology, social support and time that was formerly spent drinking enabled individuals to see power dynamics in their environments more clearly. Some acknowledged that this process might take individuals away from activist endeavors temporarily, but felt that the long term result would be greater political awareness in the community. Changes lesbians have made within the political structure of AA itself were also cited:

> I have always conceptualized that higher power or energy as inside myself.... And I never bought that I was powerless, as they say in twelve-step programs.... So for me it hasn't taken any energy away from political work.... I think it would add to it. Once you get clean and sober...you have so much more ability to see the world clearly.... I was very politically active when I was using and drinking, but it wasn't coming from a well thought out place for me.... You can use that thing of being an alcoholic as an excuse to not do anything political, like "Oh I am just a lowly alcoholic, what can you expect from me?".... That's just "alcoholic behavior".... I'm an alcoholic so I don't really have to change, or look deeper--at me--at my "isms."

> When I first started to work on Living Sober the women were outnumbered by men, ten to one, and they had everything their way. There were no scholarships for low-income people, no childcare, no access for people with disabilities.... And over time all those things have changed.... Now every committee has to have a male and a female co-chair.... And now we have a lesbian AA meeting at a time when nothing else is scheduled.... I went to an AA conference that had a session on the history of lesbians and gays in AA and they didn't mention Living Sober.... In two hours they only said the word "lesbian" about five times.... We had a protest, right there.... I think this is very political work.

Relationships Among Tensions

These three tensions were interrelated in many ways. For example, many of those who argued that twelve-step programs politicize lesbians were usually advocates of assimilation. On the other hand, many who

argued that these programs promote false consciousness held that assimilation was in fact part of this false consciousness. Many who argued for an authoritative interpretation of the AA program favored assimilation, while those who favored autonomy tended to differentiate themselves from other individuals and groups. The polarities involved in these tensions did not always surface in clear patterns, however. Individual accounts often reflected ambivalence about these issues, appearing contradictory at points in the narrative. For example, when discussing how she applied the AA steps, one individual reflected the authoritative pole of the tension. Later in the interview, when speaking about AA from her perspective as a lesbian, a preference for autonomy predominated. The interview process tapped larger collective level tensions. These findings confirm that the prerogatives of lesbian communities regarding alcohol practices have implications beyond the individual clinical issues of treatment, but reflect the health of lesbian communities on a larger scale.

Summary

Lesbian communities have a specific history regarding their collective and interpersonal interpretations about alcohol. Community members incorporate these interpretations into their personal conceptualizations of alcohol problems and recovery. The findings in this chapter demonstrate the importance of interpersonal and community relations in the dynamics of alcohol practices, alcohol problems and alcohol recovery for lesbians. A great deal of tension surrounds mutual help and its use in lesbian communities. This situation reflects a number of cultural differences that act as barriers in AA, not the least of which is gender conflict. Traditional AA emphasizes that discussion

in meetings should be focused on staying sober, (i.e., not drinking alcohol), rather than on other life problems. Nevertheless, these "life problems" do surface in meetings insofar as they are associated with drinking/abstinence-related conflicts. In addition, because AA was founded by two white male Americans, and most of its early members were also male and much of AA literature, lore, language and rituals incorporated and validated male concerns. In other words, work, finances, egotism, etc., have probably become more prevalent than relational concerns as topics for discussion at AA meetings. Thus, when women entered AA in large numbers, their daily concerns, many of which are relational in nature, were not legitimized as AA topics. Lesbians are likely to feel this delegitimation even more, since they and their partnered relationships are not validated by the larger culture. It seems that this is at the base of the many references participants made concerning "recovery versus non-recovery issues," "real AA," and "real alcoholics." This analysis has also provided a closer view of the linkages and gaps in the interface between the lesbian recovery subculture and traditional mainstream AA.

CHAPTER 8

CONCLUSIONS

Summary of Findings

The data analysis focused on the following research questions: How do lesbians identify alcohol use as a problem? What are lesbians' helpseeking experiences regarding alcohol problems? How do lesbians describe and interpret their health care interactions regarding alcohol problems? How do lesbians describe their experiences in recovery from alcohol problems? What are lesbians' experiences in mutual help groups associated with recovery from alcohol problems?

Participants identified alcohol problems as part of a larger, ongoing process of problematization. In this process, problems other than alcohol were included and were linked by participants to their alcohol problems. The process of problematization was found to have several components: constituents, perceptual constraints, environmental constraints, construction, interaction, action, validation and reconstruction. The problematization sequences that occurred at the transition to recovery point provided the data base for conceptualizing this process.

Participants' accounts were categorized according to overall patterns of problematization on two major criteria: the degree of pervasiveness of alcohol-related problems expressed and the degree of elaboration of detail. Three main patterns of problematization were identified: (a) circumscribed, elaborating that alcohol-related problems are relatively bounded, (b) pervasive, elaborating that alcohol-related problems have penetrating effects in many life areas, and (c) abbreviated, providing little detail so that the degree of

alcohol-related problems' pervasiveness is not clear. The predominant pattern among participants was to view alcohol-related problems as pervasive, affecting many life processes. For these women, difficulties were expressed in considerably more negative and extreme terminology, and helpseeking was an ongoing, frustrating and often disappointing process.

Helpseeking and health care interactions were examined together within the interviews. There were several findings in these areas. First, helpseeking was found to be an interactive process, involving selectivity regarding providers and concerns about safety in alcohol treatment and other health care contexts. Safety was discussed in the following specific forms: (a) conceptual compatibility between provider and client about alcohol-related problems, (b) providers' preparedness to interact with lesbian clients, (c) respect for boundaries, (d) emotional climate, (e) provider persuasiveness strategies and attention to group dynamics. Particular difficulties were identified in these areas for subgroups, such as racial/ethnic minority women, those with multiple addictive problems, those with depression/suicidality and women with histories of sexual and other violent trauma.

Access to care was found to be limited predominantly by lack of finances/health insurance, few treatment programs for women only, relative lack of lesbian-sensitive treatment programs and providers' unpreparedness to relate to lesbian clients. In addition, many participants lamented the segmentation of services for problems that they viewed as contiguous with alcohol problems, including eating disorders, post-traumatic stress, depression and low self-esteem. Participants showed a preference for individual psychotherapy as a form

of help and for women-only treatment settings. They expressed relatively negative evaluations of interactions with male psychiatrists. Nurturant, flexible, gently persuasive providers were preferred by the vast majority of participants. The distinctions of race/ethnicity, economic class, gender, sexual orientation, the presence of severe or additional symptoms and the frequently combined effects of these factors were summarized in the term "marginalization." The concept of marginalization, reflecting the experiences of those at the social periphery accounted not only for differences in recovery experiences and health care needs between participants and more "mainstream" persons, but also for significant diversity among participants.

Descriptions of recovery experiences were compared according to dominant recovery images in the accounts. Participants generally used a repertoire of images to characterize their recovery experiences. Very few participants used the traditional AA image of conversion to describe their recovery processes. The following images were seen in order of most to least prominent in the interview data: connection, reclaiming self, empowerment, struggle with compulsivity, personal growth, vocational change, social transition, cycles/celebration, physical transition and conversion. Some preferences were noted for subgroups. For example, women of color focused on the image of empowerment, survivors of childhood trauma focused on the image of reclaiming self and women with multiple addictive problems saw recovery as a struggle against compulsivity.

Findings about mutual help in recovery were focused on AA and other twelvestep programs, which were familiar to nearly all participants, though there were varying degrees of reported involvement.

A few women rejected AA, some attended AA sporadically, some attended AA regularly and others were primarily involved in non-AA twelve-step programs, such as Overeaters Anonymous or Alanon. Involvement in the non-AA twelve-step programs reflected participants identification of multiple problems associated with alcohol problems, such as a problem drinking parent, history of abusive trauma, eating disorder, overspending or sexual compulsivity.

The stories about mutual help group involvement were linked by participants to the larger historical, cultural and political dynamics regarding alcohol use and alcohol recovery among lesbians as a whole. The history of the lesbian bar subculture was an important context for lesbians' understanding of alcohol use and alcohol recovery. In lesbian subculture and relationships alcohol was reported to facilitate social and sexual interaction and ease the pain of societal discrimination and ostracism. Relational influences appeared to be very strong, both in terms of alcohol use and alcohol recovery.

The combined influences of the coming out process, the onset of alcohol/drug use in the teen years, and heavy peer pressures regarding sexuality made adolescence a very risky transition for many participants. This risk was further intensified for those women with a history of childhood sexual abuse, for whom adolescence triggered memories and feelings regarding their victimization and exacerbated disturbed family dynamics, leading to suicidality, substance abuse, running away, sexual confusion, unsafe sex and other health risks.

Collectively, the accounts reflected the San Francisco lesbian community's movement away from alcohol use toward formation of a recovery subculture in the last two decades. This represents an extreme

shift in community perspective from the non-drinker as stigmatized to the drinker as stigmatized, according to participants. The conflicts among lesbians about meanings of alcohol, male-dominated organizations, Christian values and political ideology were crystallized in discussions of AA experience in the interview data. The ambivalence and controversy that marked the conversations about AA reflect three tensions about the value, correct practice and safety of the twelve-step approach for lesbians: (a) assimilation versus differentiation, (b) authority versus autonomy and (c) false consciousness versus politicization.

On the whole, the findings of this study reflect heterogeneity of experiences and interpretations. Nevertheless, there were some areas of consensus, and some basic themes, such as marginalization, safety, problematization and recovery images which were common to all of the accounts and which therefore formed a basis for comparison among individuals and subgroups. In order to compare these findings with extant views they are discussed below in further detail with references to related literature.

Discussion of Findings

Identifying Alcohol Problems

Problematization

Problematization of alcohol use was found to be an interactively based process, supporting prior findings that women are responsive to input from social networks and significant others about their alcohol problems (James, 1975; Mulford, 1977). Some participants spoke of social network opposition to their problematizing alcohol use, as has been seen by others (Beckman & Amaro, 1984; Fewell & Bissell, 1978; Wood & Duffy, 1966). Social networks of lesbians differ from kin-based

networks (Browne, 1985; Kurdek & Schmitt, 1987), however, making comparison of these findings less meaningful. Unsafe or unwanted sexual behavior was a prominent problem constituent for participants, which probably has different implications for women than men, and is beginning to appear in the literature (Schmidt, Klee & Ames, 1989). The wide variety of problem constituents described in these interviews argues against screening and assessment for lesbians that is focused on drinking and "control" (Jellinek, 1960; Keller, 1972; Marlatt & Gordon, 1985; Miller & Hester, 1980) in favor of more holistic narrative approaches that reveal sociocultural environmental conditions and relational needs.

Denial on the part of problem drinkers and their significant others and its role in furthering problem drinking has been discussed by many (Cermak, 1986; Eels, 1986; Fewell & Bissell, 1978; Tweed, 1989; Wegscheider-Cruse, 1984). However, these findings suggest desegregating "denial" into components of perceptual and environmental constraints. More consistent with a feminist approach, this contextualizes denial within a person's environment rather than locating it intrapersonally as a psychodynamic defense mechanism.

The concept of validation, described in this study as part of problematization, may be related to Vourakis'(1989) AA group selection calculus. However, participants not only selected groups, but constructed and reconstructed the problem itself, based on whether they saw themselves reflected and accepted, that is, validated, by others. Finding others "like me" (Vourakis, 1989) was not the only basis for validation. In many cases, validation involved others who "see me." Individuals want to be recognized as they are, including ethnic/racial

and sexual orientational "differences." This is a key phenomenon needing further study. Perhaps marginalized persons use different processes to select AA groups, treatment programs and providers, because of their specific needs for safety and their decreased chances of finding similar others in these milieux.

Compared to more conventional views (Alcoholics Anonymous, 1976; Brown, 1985; Frank, 1974; Taylor, 1979), most participants did not describe their problematization of alcohol use in terms of demoralization and powerlessness. Most problematized their drinking in response to self-criticism and interaction with others. Many commented that they were not sure when they had actually "hit bottom." This suggests that for lesbians, the language of powerlessness does not correspond to their experiences of transition to recovery. Issues of power became more relevant at a later point, when recovery was framed as "empowerment." Power and powerlessness in this case referred to the realities of racism, sexism and heterosexism, rather than "powerlessness over alcohol."

Childhood Influences and the Transition of Adolescence

The centrality of personal history was an unexpected finding in many participants' problematization accounts. Parental alcohol problems and child abuse, including childhood sexual abuse (CSA), were problem constituents emphasized by participants. These factors are also emerging in other research about womens' alcohol problems (Black, Bucky & Widder-Padilla, 1986; Covington, 1982; Gomberg & Lisansky, 1984; Evans & Schaefer, 1987; Kovach, 1986; Woititz, 1983).

The differentiation of circumscribed versus pervasive problematization accounts suggests that among lesbians struggling with

alcohol problems there is a sizable subgroup of women who are also grappling with post-traumatic effects of childhood abuse, including CSA. More than two thirds of the participants were abused as children; 46% reported a history of CSA. The incidence of CSA among participants exceeds the 25% rate found in a sample of women AA members (Kovach, 1986) and the range of rates, 19% to 38% found in women in general (Bass & Davis, 1988; Finkelhor, 1979; Finkelhor, Hotaling, Lewis & Smith, 1990; Russell, 1983; Timnick, 1985), but approximates the higher incidences seen in women with alcohol problems (Evans & Schaefer, 1987). Alcohol may be used by women who have survived sexual and other trauma to avoid remembering it, or to ease the related emotional impact. From a feminist perspective, this has implications about the dynamics by which privatized oppression is internalized and compartmentalized by women. Moreover, lesbians with histories of CSA may feel ostracized, alienated and "sexualized" not only on the basis of sexual orientation, but also as a result of their sexual trauma. Alcohol and drug problems in this very vulnerable population are accompanied by needs that are not specifically and adequately addressed in current treatment and mutual help contexts.

These findings indicate that adolescence is a crucial transition for lesbians. Usually a variety of factors combine to intensify the oppressiveness of lesbians' adolescent experiences including rejection by family of origin (Slater & Mencher, 1991), effects of past or current sexual abuse (Aiosa-Karpas, Karpas, Pelcovitz & Kaplan, 1991; Cavaiola & Schiff, 1988; Schultz, 1990), societal/peer ostracism, depression/suicidality, sexual confusion and lack of trusted adults in whom to confide (Fein & Neuhring, 1981; Kremer & Rifkin, 1969; Saunders

& Valente, 1987). Viewing transitions as both potential periods of risk and opportunities for intervention heightens the importance of these findings about lesbians' experiences in adolescence. Little information is available about this transition in lesbians due to reluctance on the part of caregivers and society to admit that sexual orientation issues are relevant for adolescents and children, moralistic prohibitions about discussing the diversity of sexual orientations, avoidance of the issue of adolescent suicide, and in cases where applicable, denial that childhood sexual abuse occurs on such a large scale. The findings about lesbians' adolescent vulnerabilities and their relationship to alcohol/drug use, other addictive problems, depression, low self-esteem, suicidality and intense social isolation are most alarming. Even though these are retrospective accounts, institutional and familial patterns have not changed appreciably in the interim to improve the situation for lesbian adolescents.

Helpseeking and Health Care Interactions

The concerns about personal and emotional safety in health care interactions voiced by participants are not reflected in extant literature about alcohol treatment, since much of the research has focused on white, middle-class males' treatment experiences. Yet these safety concerns seem very germane to women's treatment needs in general.

Successful "confrontations" by others regarding one's problem drinking, as described by participants, would be more aptly termed "commiserations." They were informal, sometimes occurring over weeks or months, initiated by partners or friends, and involved the emotional expression of concern and pain about the others' drinking, rather than ultimatums. This contrasts with the abundant literature about formal,

health care initiated confrontation (Lewis & Messner, 1986; Tweed, 1989; Williams, 1989). It is an insight gained through a feminist narrative versus a conventional episodic approach to inquiry.

There were significant tensions between providers and lesbian clients regarding conceptualizations of alcohol problems. Rather than being centered on consequences of drinking (Cahalan, 1988; Knupfer, 1967) participants' views of alcohol problems were holistic, as some nursing authors hold (Naegle; 1988; Murphy, 1988; Tomko, 1988). They were usually broader in scope, including "codependency" (Cermak, 1986; Zerwekh & Michaels, 1989), compulsive drug use, eating, spending and sexual activity (Marlatt et al.,1988; Room, 1992). Some saw their alcohol problem as only one among many manifestations of a core problem, such as sexual trauma (Glaus, 1988; Schetky, 1990; Tice, Hall, Beresford, Quinones & Hall, 1989).

Another reported conflict was the question of medication use in recovery. While some participants feared being given habituating prescription drugs that might cause relapse or cross-addiction (Celantano & McQueen, 1984; Ogur, 1986; Russo, 1985; Sandmaier, 1980; Schuckit & Morrissey, 1979), many others feared that being refused medication might sometimes be more damaging. Moreover, several participants told of relapses precipitated by rigid anti-medication policies of caregivers and treatment programs. This concurs with the view that self-medication of mental symptoms or post-traumatic stress and use of prescription medication for pain ought not be pathologized (Khantzian, 1985; Szasz, 1972; 1985).

Participants were frustrated and humiliated when providers said to "Just quit" (drinking/drug use) without giving any information or support as to how this might be accomplished; this apparently occurs often in health care interactions (Waitzkin, 1991). Controlled drinking (Roizen, 1987; Sanchez-Craig, 1980; Sobell & Sobell, 1978) was not a recovery goal voiced by participants in this study, suggesting that this goal is preferred by men, or that AA ideology and the disease concept of alcohol problems in the lesbian recovery subculture precludes consideration of this option.

Participants' concerns about caregiver-client boundaries are especially relevant, in view of several factors. Lesbians frequently report intrusive or intimidating health care interactions (Stevens & Hall, 1988; 1991). There are increasing numbers of recovering lesbians entering counseling roles, attracting clients from relatively small, insular lesbian social networks (Krieger, 1983; Lockard, 1985), multiplying the probabilities of dual relationships occurring. The complex aftereffects of CSA, known now to be fairly common among women, increase client vulnerability to revictimization by caregivers (Armsworth, 1990; Gelinas, 1983; Rose, Peabody & Stratigeas, 1991). Inadvertent revictimization of CSA survivors is of concern, given that educational preparation of many caregivers does not include information on post-traumatic difficulties (Rose, Peabody & Stratigeas, 1991; Schetky, 1990).

While women are more likely to suffer from and be treated for depression rather than alcohol problems (Ettorre, 1986; Russo & Sobell, 1981; Winokur et al., 1970), these data show that serious depression in these women was not treated successfully, nor explained to them

adequately. Attention to depression could be a means to prevent alcohol problems or prevent relapse in certain women. This needs further study.

The findings confirm the persistence of caregivers' stereotyping and ignorance about lesbians and their health needs, as noted in previous studies (Anderson & Henderson, 1985; EMT Associates, 1991; Hall & Stevens, 1988), although many positive interactions with providers were also reported. Lesbians of color in particular reported that even providers who had shed their sexist and heterosexist biases often remained unwilling to address ethnic/racial issues in the treatment process.

Participants were in agreement that professional treatment should not be patterned exclusively upon the AA model, nor should AA be "taught" through treatment processes, a concern which is increasingly supported in the literature (Brower, Blow & Beresford, 1989; Herman, 1988; Marlatt et al, 1988). Access to services is still poor, especially for women of color, low-income women and those with children. This may be because these women do not fit the demographic profile for typical problem drinkers, nor in many cases the clinical definition of alcoholism. Their needs for services are largely self-defined, using distinct criteria relevant to their experiences, relationships and communities, a reality which is not addressed in the current U.S. treatment system (Room, 1980).

Recovery Images

The narrative data did not generally reflect the typical images and processes of the disease concept of alcoholism and the conversion model of recovery discussed in the literature (Gusfield 1963; Kurtz, 1988; Royce, 1986). Descriptions of entering the subculture of AA have

been described (Maxwell, 1984) in ways that resemble the images of social transition and connecting seen in this data. Not all participants, however, who were involved in AA saw themselves in a process of "changing their entire lifestyle" as has been reported elsewhere (Robinson, 1979). Moving from the lesbian drinking subculture to the recovering lesbian subculture was the most prominent social transition participants described.

It would be difficult to reconcile the variety and number of recovery images seen in these individual narratives with extant models that view recovery as a process having fixed stages or components (Denzin, 1987; McNally, 1989; Taylor, 1979). Neither the narratives nor the chronological representations of participants' accounts revealed a consistent pattern of events or changes after the problematization at entry to recovery was completed. It may be that the diversity of the group and the degree of marginalization experienced by these women assured that their recovery processes would be more heterogeneous than those of the typical Euro-American male research participants of past studies.

Reconstruction of the self in the context of other recovering persons (Brown, 1985; Denzin, 1987; Thune, 1977) is similar to the image of reclaiming self found in this study. Often this image was a way for participants to frame the joint processes of recovering from alcohol problems and recovering from childhood trauma. This was usually done not only in the context of others who were in recovery, but also often with the help of psychotherapy.

The prominence of the empowerment image for women of color in this study is consistent with historical and ethnic differences in the

understanding of the role of alcohol in maintaining oppressive conditions (Douglass, 1846; Watts, 1986). The empowerment image was invoked by many participants to describe a process of gaining awareness during recovery about racial, gender and sexual orientation oppressions. The fact that "connecting" was the most common image, especially among AA members, corroborates that mutual help groups are means to achieve group identification (Biernacki, 1986; Cahalan, 1988; Caplan & Killilea; Dumont, 1974; Herman, 1988; Maxwell, 1984; Robinson, 1979). A feminist view of connecting would raise the question of whether belongingness needs of women are as linked to conformity and organizational membership as those of men.

Mutual Help and Collective Themes

Interview data regarding lesbian bar subculture confirmed the historical patterns of collective resistance, safety and socialization documented by others (Adam, 1987; Abbott & Love, 1972; Davis & Kennedy, 1986; D'Emilio, 1983). There were a few participants who critiqued the bars as exploitive, from a feminist viewpoint, as reported by others (Barrett, 1989; Hepburn & Gutierrez, 1988; Nicoloff & Stiglitz, 1987), but there were also many who saw the closure of the bars as a loss of women's "turf" (Hunt & Satterlee, 1987; Saulnier, 1991). Whether lesbian bar subculture contributed to lesbians' development of alcohol problems, was also marked by a division of opinions. Most denied that their socialization in lesbian bars caused problems (Oberstone & Sukoneck, 1976; Herman, 1988; Saulnier, 1991; Woods, 1981), whereas some believed that lesbian bars did cause more drinking problems (Glaus, 1988; Johnson & Palermo, 1984; Lewis, Saghir & Robins, 1982; Nardi, 1982; Nicoloff & Stiglitz, 1987; Weathers, 1976). The narratives

illustrated the San Francisco lesbian community's transition away from permissive drinking to clean and sober values (Hastings, 1982; Saulnier, 1991), demonstrating a rapid cultural shift away from alcohol. The feminist implications of this shift may prefigure a similar trend among women in general as liberating images of alcohol are replaced by images of alcohol as a means of oppression.

Collectively, participants' accounts differed from extant representations of recovering problem drinkers (Brown, 1985; Denzin, 1987; Taylor, 1979; Maxwell, 1984). Problematization of alcohol use and recovery from alcohol problems were relationally grounded, often initiated in dyads with lesbian friends or partners. Alcohol problems notwithstanding, the tendency for lesbians to identify with one another and to form strong bonds is believed to be a source of strength and support in the face of oppressive societal conditions (Krieger, 1983; Lockard, 1985; Ponse, 1978). Some participants thought that lesbian relationships tended to be too "enmeshed," or that "codependency" was very prevalent in lesbian relationships (Gardner-Loulan, 1983; Hepburn & Gutierrez, 1988; Krestan & Bepko, 1980; Nicoloff & Stiglitz, 1987).

Having a family of origin with parental alcoholism was believed by many participants to inevitably produce certain serious relational and personal difficulties. This notion is reinforced by some twelve-step programs, such as Adult Children of Alcoholics, Alanon, and Codependents Anonymous, and recovery-oriented literature (Cermak, 1986; Wegscheider-Cruse, 1984), and reflects the impact of the Adult Children of Alcoholics movement (Room, 1992) in lesbian communities. Some twelve-step programs, not primarily AA, promote "codependency" as a term problematizing certain other-centered behaviors. Many women of color in

this study, however, resisted the concept of "codependency" as pathologizing their cultural relational patterns of interdependence (Hidalgo & Christensen, 1976-77; Moraga & Anzaldua, 1981; B. Smith; 1983). Even for Euro-American lesbians it seems crucial to avoid pathologizing interactional and situational patterns which differentiate lesbian relational and family life cycles from those of heterosexuals (Herman, 1988; Slater & Mencher, 1991). Women in general have demonstrated relationally centered ways of knowing and responding to their environments (Belenky, Clinchy, Goldberger & Tarule, 1986; Gilligan, 1982), that are unfairly pathologized when evaluated from a traditionally male perspective.

The popular associations of alcohol use with lesbians' social and sexual interaction were represented in the data. These associations included the use of alcohol as an aid to: accept lesbianism, deny lesbianism (Colcher, 1982; Kus, 1988a; McNally, 1989; Rofes, 1983; Schilit, Clark & Shallenberger, 1988), ease isolation, and decrease awareness of societal stigmatization (Glaus, 1988; Johnson & Palermo, 1984; Ziebold, 1979). Alcohol was also used to feel powerful and to rebel against straight culture (Beckman, 1981; Clark & O'Connell, 1985). The data showed alcohol was used to facilitate social interaction with other women (EMT Associates, 1991), make sexual overtures or engage in sexual behavior with women, ease feelings of guilt and shame about sexuality, excuse sexual behavior as due to intoxication (Gardner-Loulan, 1983) and avoid emotional pain resulting from childhood sexual abuse (EMT Associates, 1981; Evans & Schaefer, 1981; Kovach, 1986). Not specifically discussed in extant literature but reported by participants, lesbians used alcohol in order to tolerate sex with men,

often in the context of marriages. Another association between alcohol and sexual behavior was in reference to the problem of heterosexual men preying upon intoxicated lesbians for purposes of sexual exploitation.

The three major tensions regarding involvement in AA and other twelve-step programs were assimilation vs. differentiation, authority vs. autonomy and false consciousness vs. politicization. These are fairly consistent with themes identified in prior observations of lesbians interacting in AA (Hall, 1990b). A few women critiqued the lesbian focus on recovery and twelve-step involvement as an attempt to assimilate into the "mainstream" of society (Herman, 1988; Saulnier, 1991). Several women described their forays into traditional heterosexual AA meetings as attempts to force the mainstream to accept them as lesbians. A majority, however, had sought out lesbian AA meetings at some point in their recovery, suggesting a need for identifying and affirming one's cultural distinctions and connecting with one's own community.

The findings indicate that those who are more marginal in relation to "mainstream" AA (Euro-American, middle-class, male), such as lesbians of color, tend to value autonomy, as is also reflected in the image of recovery as empowerment. Euro-American women were heterogeneous regarding their preference for autonomy. Those with a background of fundamentalist religion tended to favor greater structure and conformity to the AA program. Room (1992) has argued that the individualistic ideology of codependence is in conflict with traditional AA's value on service to others and mutuality, which suggests this as a basis for the authority/autonomy struggle. Yet patterns based on ethnicity, for example, indicate that the more community-oriented women of color might

value autonomy but oppose the idea of codependence. Therefore the authority/autonomy struggle seems to have a number of potential underlying sociopolitical bases to consider.

Most participants were current AA members, yet there were a few who argued against AA for lesbian communities because of its tendency to individualize problems, encourage "surrender," clothe recovery in the language of Christian spirituality and reinforce racism and sexism through its literature and interaction, a position also advanced by others (Ettorre, 1989; Herman, 1988; Johnson, 1989; Saulnier, 1991). Very few participants held that AA promotes the politicization of women, people of color and lesbians, though this possibility is suggested by some literature of the local recovering subculture (Room, 1992). Instead, most acknowledged and lamented the racist, sexist, anti-lesbian, conformist and Christian aspects of twelve-step programs, but they continued their involvement in these programs because of perceived benefits. They held that AA does not prevent any recovering person from pursuing political goals (McDaniels, 1989), and that reform of AA through lesbian participation may be considered political activism. There were many who expressed that moving away from alcohol use is in itself a political act for lesbians and other oppressed people. Documentation and analysis of the histories of womens' activism regarding alcohol, including temperance, Mothers Against Drunk Driving and Women For Sobriety (Gusfield, 1956; 1963; Kaskutas, 1989; Kirkpatrick, 1976; 1977; Lacerte & Harris, 1986) would be enhanced by a feminist analysis of organized movements away from substance use in lesbian communities.

Implications for Research

Limitations of the Study

This study involved one-time interviews covering rather sensitive personal information. Inherent in such a design is the possibility that some relevant material was not obtained. The accounts were retrospective; the efficiency and accuracy of memory, especially for stressful events, is to some degree questionable, and varies from person to person, or even within a single account. Themes and impressions from this data are therefore more dependable than are facts and specific temporal sequences. Much of the data consists of narratives. Narratives are specific forms for relating experience which require summarization and express more meaning than simply the recollection of experience as it occurred in actuality. Hence, while narratives provide important information about the narrators' view of themselves and their past in their present meaningfulness, the narratives cannot be strictly taken as factual reports of events.

Participants in the study were voluntary and self-selected. Therefore their accounts may not be representative of the entire range of alcohol recovery experiences of lesbians. In fact, because of pronounced regional differences, the study is probably reflective only of San Francisco area lesbians' experiences. For instance, many lesbian communities in the midwest and south are still socially organized around gay/lesbian or lesbian bars, rather than in transition away from alcohol use. San Francisco is unique in terms of lesbian history and culture because of the large numbers of lesbians who have migrated there, resulting in development of greater lesbian visibility, political power and social freedom. San Francisco's lesbian aggregate is also very

culturally diverse, and reflects heterogeneity of regional origin, because so many lesbians move to the area to escape greater repression in more conservative areas of the country. These are all reasons for caution in generalizing from the study findings beyond the participant group and similarly situated women.

Those who were more sparsely represented in this data were lesbians who had moved away from alcohol use, but who were not participating in the twelve-step recovery subculture. In addition, the numbers and diversity of women of color in this study were fairly limited. The notion that marginalized persons, even of the same social category, are experientially more heterogeneous than those of nonmarginalized persons compromises the generalizability of specific findings even more than is true of a study of "mainstream" experience using the same sample size. However, describing these diverse experiences can result in more accurate and culturally appropriate theory development which employs broad, inclusive concepts.

Further Study

In relating the findings to extant literature, attention is directed to several areas for further study and consideration: (a) perceptual and environmental constraints to recognizing alcohol problems, (b) personal and family history constituents involved in individuals' problem constructions, (c) the impact of aftereffects of CSA for lesbians with alcohol problems, (d) the role of relationships in lesbians' alcohol problems and alcohol recovery, (e) experiential differences and validation needs of lesbians and lesbians of color in recovery, (f) purposes of recovery images, (g) adolescence as a high risk period for lesbians, (h) the specific uses and cultural

understandings of alcohol as related to sexual interaction, and (i) relationships among caregivers' methods of persuasion, tensions between authority and autonomy in AA, and the needs for empowerment and political consciousness in marginalized persons in recovery.

Implications for Nursing Practice

The findings of this study have many implications for nursing care. An assumption of this discussion is that all types of health care provided to lesbians for difficulties related to alcohol are relevant for nurses to consider, regardless of the type of health care practitioner who is involved. Nurses in a variety of clinical contexts are in key positions for understanding these phenomena, creating new interventions and revising current modes of care accordingly.

Individual Care

Nursing care of lesbians who have alcohol problems needs to incorporate diversity. There are differences, even in this small sample, based on socioeconomic class, ethnicity/race, age, type of addictive problems, political views, current family configuration, family history, trauma history and self understanding as a lesbian. The notion that there might be a common approach to all lesbian clients should be abandoned in favor of an approach that addresses some central issues of recovery as described in this study. As the theoretical basis and the findings of this study indicate, recovery from alcohol problems is a process guided primarily by the needs, timing, awareness and history of the self. The role of the health care provider in this process is one of support and facilitation, rather than control and directiveness.

Care of individuals in traditional nursing practice settings and in the context of individual psychotherapy or substance abuse counseling, whether facilitated by nurse therapists or therapists from other disciplines, will be discussed in reference to transition to recovery, problematization patterns, images of recovery, and issues of the self.

Transition to Recovery

Transition to recovery involves a number of actions and interpretations which determine whether and what kind of help is sought. Nurses are often in a position to refer individuals having alcohol problems or related problems who have varying degrees of awareness about these difficulties. Though alcohol problems have often been neglected by nurses and other health disciplines, nurses have become more alert to the subtle indicators of alcohol problems in women. It is counterproductive, however, for clinicians to insist that alcohol problems be strictly prioritized when the client holds different priorities. Based on these findings, nurses might anticipate that other problems will be prioritized by clients, including eating disorders, relationship difficulties, domestic violence, acute anxiety, depression, self harm, and aftereffects of past sexual trauma. In most cases the construction of the central problem is in flux, subject to change as a result of interaction with others. Knowing this allows the clinician flexibility in responding to the client's view.

Even brief provider contacts with these individuals can help to raise the client's consciousness, if trust is preserved in the process. Participants in this study cited many instances wherein providers were able to express concern and gently suggest that alcohol may be a problem

deserving of professional attention. If the individual did not share this view, the topic was dropped, and the individual was supported in her definition of the problem. Over time individuals tend to reconsider this suggestion, and often return to that provider to obtain assistance once the alcohol problem is self-acknowledged.

Nurses should assess clients' stated needs and socioeconomic circumstances and provide them with as many options as possible. The goal should be to engage the individual in a process of increasing self-awareness in a context of safety and support, at the client's pace, regardless of the presenting complaint. Implicit in this approach is that referrals be made only to providers known to be affirming of lesbians and sensitive to gender and ethnic/racial issues.

In this study there were only a few cases in which participants found it helpful for providers to give an ultimatum: "deal with the alcohol problem, or I will not continue as your provider." Such a tactic risks the therapeutic alliance itself, however, and should be considered only when the therapeutic relationship is well established, the client's strengths and social support are adequate to meet the crisis which might ensue, and significant attempts have been made to raise the clients' awareness by other means. As these data indicate, lesbians having difficulties with alcohol are usually facing multiple threats to self-image, including societal discrimination, conflicts with family of origin, relationship conflicts, and internalized homophobia. Threatened withdrawal of the therapeutic relationship may precipitate isolation, hopelessness, suicidality, depression and/or increased substance abuse rather than the intended outcome of acknowledgement of the alcohol problem. Clients having a history of childhood abuse

experience the ultimatum as a replaying of abusive family dynamics, fostering distrust and an acute sense of abandonment.

Nurses have advocated confrontation of those failing to see the problems their drinking has engendered for them and their significant others. This technique, however, was developed primarily to address adult male problem drinkers in a setting that provides safety to the spouse and children, and uses the group approach to reduce the egotism of an individual who is in a dominant position. Success of the confrontation requires affordable, available, appropriate options for treatment of the problem. Reports of long waiting lists for the two lesbian-sensitive women's treatment programs in the San Francisco area indicate that immediate treatment for lesbians is often not an option. Lesbians in this study were often estranged from families of origin, and had developed new family structures that were different from heterosexual nuclear families. The circle of friends who would act as family members in a confrontation might constitute the individual's entire social network. Participants in this study gave ample evidence of social adversity and threats to self-esteem and self-determination, and little evidence of being egotistical or dominating. Whether or not the confrontation intervention has merit in general, it is certainly not an appropriate or efficacious approach to most lesbians with alcohol problems.

In these data, statements of concern by a partner or trusted friend, without coercion, were most effective in moving an individual toward recognizing and seeking help for an alcohol problem. Rather than arranging a confrontation, nurses could intervene with significant others, role playing with them how they might express their concern and

providing them with accurate information on treatment options to offer the problem drinker.

Psychotherapy

Feminist critiques of psychotherapy have viewed it as repressive to women. However, individual psychotherapy was frequently used by participants for emotional problems, healing from trauma, exploring the self, changing compulsive patterns and dealing with the alcohol problem itself. This indicates that in their daily experience, lesbians do find value in this resource. Unfortunately, affordable therapy is often not available for women of lower socioeconomic status.

Nurses could take a larger role in meeting lesbians' needs for individual psychotherapy. Nurses, most of whom are women, are well suited to work as individual therapists with lesbians in recovery from alcohol problems. Nurses have a basic, biopsychosocial understanding of many of the difficulties identified in this study, such as eating disorders, depression, low self-esteem, medication issues, post-traumatic stress disorder, and information deficits regarding nutrition, sexuality, parenting and alcohol's effects on the body. Nurses are educated to approach clients in a nurturant, mutual way, which was valued by participants.

Constraints to such a proposal are many. Nurses' basic preparation does not currently provide expertise in psychotherapeutic dynamics, nor impart adequate knowledge regarding alcohol problems, other addictive problems, family of origin issues and the aftereffects of childhood sexual abuse. Many nurses continue to hold negative views of lesbians as well as persons with alcohol problems. Current structures of mental health and substance abuse services do not often

reimburse nurses for individual psychotherapy. A solution to these dilemmas might be to establish workable career ladders within nursing that allow baccalaureate prepared nurses to obtain advanced degrees and become skilled in psychotherapeutic theory and technique.

Changing therapists was fairly commonplace in the accounts of these participants. Nurses can assist such women to evaluate the quality, ethics, efficacy and sensitivity of their individual therapist, present options and provide support in the case that transition to a new therapist occurs. Women having histories of sexual abuse are more likely to need therapy, but have difficulty in investing trust in a provider, and are susceptible to sexual and emotional revictimization by therapists. Nurses may be of help to lesbians who are in non-productive or abusive therapy relationships, if they are well versed in the ethical, professional, theoretical and practical aspects of individual psychotherapy and can distinguish a functional therapeutic process from a dysfunctional one. This is a form of advocacy which, from a feminist viewpoint, requires that women's interests and needs be prioritized.

Clients need to hear about realistic alternatives to substance use in order to acknowledge it as a problem. Some questions that might be used to explore these constraints are the following: Have you known anyone with an alcohol problem? How did you view that person? Were you ever given any information about alcohol problems? If you were assured that your needs would be met, and that you would feel safe, would you be able to consider that alcohol was a problem for you? What do you think people need in order to stop drinking, assuming that is what they want to do?

The findings do not support the maxim that no therapeutic gains can be made while the individual is still using alcohol. Interaction with a client who is still drinking provides an opportunity for information giving and establishing trust. One tactic that appeared to be quite effective in raising consciousness about alcohol as a problem was to have clients tally drinks or attempt controlled drinking, such as one to two ounces of alcohol per day. From a feminist perspective, it seems that women feel empowered by collecting their own evidence and making the decision that alcohol is problematic, rather than accepting the judgement of others.

Problematization Patterns

The transition to recovery process described here may be culturally characteristic of San Francisco area lesbians whose social interaction patterns may differ from those of the general population. This limits generalizability of the findings to lesbians in other regions or to the general population. Given that all participants were women, the findings may also simply reflect characteristic ways in which women face problems.

This study described three basic patterns of problematization. Those who elaborated a view of the problem as circumscribed would benefit most from interventions geared toward finding social alternatives to alcohol use, and identifying alternative means of coping with emotional stresses. Those who elaborated a view of the problem as pervasive would benefit most from interventions that address multiple addictions, post-traumatic stress symptoms, and low self-esteem. Unfortunately, clinicians do not always have access to detailed accounts of the problematization process, and these views of the problem are not

always discernible at the point of entry to recovery. Relevant assessment questions to elicit clients' views of their problems include the following. Have your problems with drinking affected other areas of your life? Do you think your problems with drinking result from any other problems or stresses? Do you ever have the feeling that all of the problems in your life are overwhelming to you? How happy was your life before you started drinking? Client history-taking should focus on such issues as self-esteem, self-harm behaviors, adolescent experiences, trust, intimacy, memory problems and multiple addictive problems. After ascertaining that clients feel safe and have trust in the therapeutic relationship, nurses can help them explore the sensitive areas of sexuality and questions of possible childhood trauma including sexual abuse.

Nurses are often in supportive roles for clients who are in the process of trying to add yet another stigmatized identity, that of having an alcohol problem, to their already stigmatized self image as lesbians or women of color. The choice of language in communicating with these women is crucial. It should not be considered a necessary step in recovery for a person to take on the term "alcoholic." Individuals ought to be encouraged to define themselves and their problems in their own terms, and these terms should then be used by the clinician. This process will empower individuals to actively name and critique their recovery experiences, rather than conforming to the clinician's conception of the problem and/or model of recovery.

Images of Recovery

The range and combinations of images used by participants to frame their recovery experiences argue against developing standardized methods

of care that address recovery as a single, normalized process. Instead, providers need to build a repertoire of many images of recovery to accommodate the needs and experiences of clients in their gendered, cultural and socioeconomic differences. Exploring the ways in which clients conceptualize their recoveries provides important information about the perceived constraints and resources in their situations, relevant relationships in their lives, personal and career goals, values and health in general. Assessment questions might include the following. What does being in recovery remind you of? Are there any words or images that give you hope and strength in your healing process? How would you explain to someone who has never been in recovery what it is like, from your viewpoint?

Providers are in a position to multiply options for clients, by collecting and redistributing imagery which has been helpful to others in similar circumstances. Adding rather than replacing images seems to be appropriate in most cases. In other words, images such as conversion or struggle with compulsivity may over time cease to fully incorporate clients' recovery experiences. Providers can provide new images, such as empowerment or personal growth, to validate the experiences that don't "fit" with earlier images. Clients can be encouraged to develop a range of images for organizing and interpreting their experiences. Incorporating new images for recovery experiences is itself a basic process of health promotion and maintenance which holds promise for application in other areas of health care.

Particular groups seem to have preference for one or more of these images. Survivors of childhood trauma speak in terms of reclaiming the self. Women of color often use the language and imagery of empowerment.

Women AA members often speak in terms of connecting. Without stereotyping these groups, clinicians can adapt educational and therapeutic strategies that "fit" with these imagery frameworks, and decrease the sense of alienation and marginalization that these women experience.

Issues of Self-Image

While not all participants reported low self-esteem, all faced questions of identity and self-acceptance during recovery. Nurses could be more specific in their assessment of self-understanding and acceptance by raising questions about ethnic, racial, sexual orientational and other bases for self identification in early recovery as well as at subsequent intervals. The findings suggest that more specific, effective intervention is needed to address problems of low self-esteem. The many constructions of low self-esteem reported suggest the need to explore in more depth the origins and meanings of clients' low self esteem. For example, is racial or heterosexist discrimination involved? Is the client viewing herself in the way she was viewed by her alcohol abusing parent? Is she unemployed or disappointed with her work life? Is she suffering the effects of childhood sexual abuse? Cognitive restructuring or assertiveness training may miss the mark for women whose self-esteem problems are related to a history which they have not resolved or to living in a social milieu where they are not safe or not respected. Referral to a support group of others with similar experiences, recommendation of literature that validates these experiences, and active listening to the details of the client's history may be more to the point.

Identification of women who have primary affective disorders is difficult when transition to recovery involves no clinical assessment, as when individuals refer themselves to AA. Many women receive help solely through mutual help groups. Official AA literature notwithstanding, local groups often socialize members to avoid medications of any kind, including antidepressants. Unfortunately, many providers are unskilled in recognizing affective disorders, especially in women already diagnosed as problem drinkers. Persistent untreated depression in recovery can lead to self-blame and a sense of failure to progress in twelve-step programs and in recovery generally.

Substance Abuse Treatment Programs

Traditional versus Alternative Programs

Traditional treatment programs, designed for male employed problem drinkers, were found to be of limited value and questionable safety for these lesbians. Treatment philosophies that stress honesty, but do not provide for safe disclosure of sexual orientation, create emotional, cognitive and social dissonance that deeply interferes with the recovery process. Written anti-discrimination policies need to be actualized in terms of staff and client ethnic, racial, gender and sexual orientational diversity. Providers who verbalize acceptance of lesbians' sexual orientation, but lack specific knowledge about lesbian culture, relationships, social networks, alcohol practices and lesbian AA groups are not competent to meet their needs in recovery from alcohol problems. Lesbians have a right to expect providers to not only be sensitive to their difficulties, but provide concrete, relevant options for coping with these difficulties. It is unethical for nurses and other providers to expect education about lesbians' life experiences to

be provided by their lesbian clients at the expense of lesbians' time, money and right to competent care.

Two fairly unique women-only treatment programs in San Francisco represent workable basic models for substance abuse treatment for lesbians. Both have a significant proportion of clients and staff who are lesbians and offer a range of services at sliding scale fees. They offer individual therapy and a series of facilitated groups focused on phases of recovery, with evening scheduling to accommodate daytime workers. One offers residential treatment including therapeutic child care and parenting classes. There are waiting lists in excess of six months for these programs. Compared to the rest of the country, San Francisco is among a handful of cities where such programs are available at all. Nurses in the substance abuse field need to advocate more intensively for allocation of resources and programs for women that are appropriate and safe for lesbian clients.

Longer term outpatient programs were most effective in meeting early recovery needs. Facing new aspects of the self, additional addictive problems, one's family of origin dynamics, past sexual and other trauma and experiences of oppression occurs over many months to several years. Programs that provide support during these crises are needed. Ideally, individual and group therapy would be available in the early treatment period, with open ended, ongoing groups available after that point.

Most traditional treatment programs aim for involvement of spouses or family. Lesbian partnerships, families and social networks are not often legitimated as "family." These significant others need to be

included in the treatment process, and interventions need to reflect knowledge about lesbian socialization and culture.

Dealing with Diversity

Lesbian-only treatment facilities are not feasible in most regions. The few residential gay/lesbian treatment programs scattered throughout the U.S. are relatively costly, separate clients from their social networks and usually have a predominance of gay male clientele. Most participants preferred women-only treatment environments. Not all lesbian clients, however, would wish to have treatment in a women-only or lesbian-only setting. Some women in this study envisioned a women-only setting to be intimidating in early recovery because of unresolved personal conflicts related to gender and self-image. Gender differences in alcohol-related experience and social and political dynamics suggest that the option of women-only treatment should be available for all women.

Most lesbians of color agreed that treatment programs should attract a culturally and racially diverse clientele, and that cultural diversity should be discussed as a recovery issue in the course of treatment. Specific groups should be scheduled for persons of color to meet separately to discuss self-image and discrimination issues. Such groups could be formed on an ad hoc basis, for example, to meet the particular needs of lesbians, women of color, sexual abuse survivors, or multiply addicted persons within a larger client population.

Alcohol treatment programs should not base their structure and content on the AA model. AA and other twelve-step programs can instead be recommended, explained, and meetings made accessible for clients who choose to become involved in them. But treatment programs should be

meaningful alternatives or supplements to mutual help. In group settings, clients should feel welcome, validated, and able to disclose feelings or needs, regardless of choices they have made about involvement in twelve-step programs. Privileges and sanctions should not be linked to attendance at AA meetings.

Womens' treatment programs clearly need to address the reality of multiple addictions. Discussion in early recovery about the potential for women to change from alcohol use to overeating, bulimic behaviors, and overspending, accompanied by a discussion of related dynamics and alternatives available to address these problems, could forestall this eventuality for some women. Caution should be used not to suggest that all clients will substitute addictions. But, the persistence of addictive patterns indicates that there is a need not being addressed. Childhood trauma, grief, disruptions in relationships or self-image could be presented as some of the issues commonly discovered as "underlying" multiple addictions. Client education about these issues may decrease the length of time that some individuals spend unsuccessfully attempting to cope with one addictive problem after another.

Relational and Sexual Issues

There were many relational and sexual issues that women in this study identified as relevant to their recoveries, many of which have already been discussed, including acceptance of sexual orientation, lesbian socialization, relationship "addiction" or codependency, battering, sexual abuse, violence and safe sex practices. For many, these issues do not become the focus of recovery in the first year, when most treatment resources are available. More research is needed to

determine when and what type of intervention could be made to address these issues as they become the focus of individuals' attention in recovery. It is unclear whether it is possible or efficacious to attempt to identify women in treatment who may have been sexually abused as children, since many women have dissociated their trauma. Basic information about the prevalence, signs, and significance of having been sexually abused in childhood could be presented in a group setting. This presentation should emphasize that if and when such abuse would emerge as an issue, there are options available for help, such as individual therapy, mutual support groups, and group therapy. Further pursuit of the issue should not be undertaken if the client is not interested at that point. On the other hand, clients who do wish to explore their childhood abuse in treatment or early recovery should not be told that this is inappropriate or a diversion from "real" recovery issues.

A feminist perspective applies criticism to the concepts of relationship addiction and codependency as they relate to women, especially lesbians and people of color. This is not to deny that there are damaging relational patterns which should be explored and changed. In fact, these findings suggest that relational issues are central to the recovery process. Rather than using terms such as "codependency," specific relational behaviors might be explored as strategies having both positive and negative effects. Role playing and other techniques could be used to expand clients' behavioral repertoires.

Safety Issues

Treatment groups that continually have new members or new facilitators do not foster trust and a sense of safety for those in

early recovery. Flexibility in scheduling focused recovery groups of limited size and a specified duration would accommodate the need for stability, without unduly increasing waiting periods for clients. Lesbians did not generally find confrontational groups acceptable or effective. Mutual support groups and those addressing early recovery topics, such as expressing feelings, identifying patterns of substance use and developing new coping styles were validating for participants. Educational groups were of value; many women made changes in their behavior solely as a result of being presented with accurate information. Essential from a feminist perspective is inclusion of information on alcohol's physiological effects in women's bodies.

The major recommendation for treatment programs as they affect lesbians clients is the need to promote safety. Language, audio visual materials, visiting policies, staff preparation and milieu management should all reflect openness and affirmation of women from all socioeconomic levels, races, ethnicities, and sexual orientations. Marginality, a form of vulnerability common to these participants, is not only the condition of being distinct and isolated from the majority, but is a sociopolitical region in which marginalized persons are experientially distinct and isolated from each other (Adam, 1978). Feminist analysis would add that women's lives are marginalized in that everyday experiences are often privatized. Multiple oppressions create even more fine distinctions among individuals' experiences. While it is arguable that there is indeed a "mainstream" experience, there is very little homogeneity in the experiential region of the marginalized. Therefore health care geared toward marginalized groups and individuals cannot be standardized and reified, but must begin with broad strokes to

meet basic human needs, and finish with fine detail and careful attention to specific individual realities.

Community Health

Obviously, health care providers cannot develop community interventions for lesbians having alcohol problems without adequate knowledge about the lesbian subculture in the locale. This includes familiarity with language, norms and values so that the provider doesn't have the need to ask inappropriate questions of lesbian clients or groups. Community health nurses need to be aware of lesbian organizations and places of socializing, including lesbian bars. They should have knowledge of demographic characteristics, the relative political power of lesbian communities and the perceptions of lesbians in the local community. Community health nurses should not assume any audience is completely heterosexual.

Social Alternatives

Because many lesbian communities continue to be organized around a bar subculture, health promotion about alcohol use should incorporate social alternatives to drinking and the bar scene. It should not be assumed that all lesbian bar drinkers are problem drinkers, nor that all of lesbians' drinking takes place in bars. Simply providing information about alcohol and its effects on individuals and relationships, possibly through group forums, workshops or adult education classes may motivate women to examine their own drinking behavior. Forums for discussing the links between lesbian oppression and the use of alcohol and other drugs from a nonjudgmental perspective could raise consciousness in the lesbian community about patterns and meanings of alcohol use, collectively as well as individually. Health promotion efforts should

not present alcohol use as intrinsically negative, but as a practice that results in problems for some.

Mutual support groups are a community resource with which community health nursing should be well acquainted. Lesbians can be expected to have varying degrees of comfort in AA. Unfortunately, many communities do not have lesbian-only AA, but women-only AA may be preferable to traditional mixed-gender AA meetings. The development of lesbian-only AA and other twelve-step programs should be supported by community health nursing as sources of mutual support, however, they ought not be promoted as the only way to address addictive problems. Efforts in lesbian communities to develop alternatives to AA should be supported, since significant cultural barriers to affiliation in AA remain.

Access to Care

Community health nurses need to develop extensive referral networks to assure that lesbian clients and lesbian communities have access to safe, sensitive, knowledgeable health care providers who can address alcohol problems. From a feminist perspective, the significant numbers of women, including lesbians, who have suffered childhood sexual abuse point to an ongoing community health crisis. Incest and other childhood sexual abuse continue to be surrounded by an aura of stigma and secrecy promoted on institutional levels as well as in families themselves. Communities should be evaluated in terms of what educational, legal and therapeutic resources are available. School nurses need to develop clear policies regarding suspected abuse, policies which unswervingly support those victimized, attempt to heal

their families, and apply consistent, adequate sanctions against perpetrators.

Adolescent Health Risks

Efforts should be made to identify and support distressed adolescents at a time when alcohol and drug use, sexual issues and effects of childhood trauma are prevalent. Adolescents who are in the process of defining themselves as lesbians are even more vulnerable. Combined assaults on an adolescent's sense of self created by societal homophobia and the relational, emotional, psychological and familial effects of childhood sexual abuse create very severe health risks for this aggregate. Community health nurses could coordinate prevention, identification and treatment efforts in this area, including runaway shelters, hotlines, safer sex education and health care services.

School nurses are in a position to establish trust with students and to be perceived as experts on issues of substance abuse, sexual orientation, child abuse and HIV prevention. School nursing is dangerously under-supported. School nurses managing health programming for ever larger student populations are consequently removed from actual student contact. This trend needs to be reversed through political activism, community education and action to prioritize school health programs.

Marginalization as a Guiding Theme

The variety of these women's experiences in recovery from alcohol problems contrasts sharply with the more discrete scientific and clinical definitions of these problems. Elaboration of participants' experiences with health care providers, treatment agencies and mutual help groups explodes the idea that a singular approach will effectively

meet lesbians' needs in alcohol recovery. Conventional language and understanding of such concepts as denial, "codependency," "alcoholism" and recovery are critiqued through participants' contrary perceptions. Accounts of recovery told by lesbians with multiple addictive problems reveal feelings of fragmentation, frustration and invisibility in a culture that does not reinforce a holistic view of the person. The narratives harvest alarming information about the impact of childhood abuse on the lives of lesbians, raising questions about whether current professional services and mutual help groups can meet the needs of these clients.

This study provides needed clarification in terms of how and why lesbians and women of color find it difficult to enter and continue recovery from alcohol problems. Their accounts detail health care interactions and experiences in twelve-step groups that move the discussion about minority claims of exclusion and discrimination beyond the question of whether these things occur to questions about how they can be stopped. The image of empowerment, identified as a major metaphor for recovery, can frame nursing interventions for this vulnerable group.

Marginalization is an overriding theme that captures many of these findings of differentness. In the concept of marginalization the "mainstream" society is depicted as at the center and those relatively excluded from power and resources are at the periphery (Darwish, 1984; Derrida, 1978; Ferguson, Gever, Minh-ha & West, 1990; Lorde, 1984; Moraga & Anzaldua, 1981). Experiences at the center are homogeneous, normative and predictable. Multiple oppressions "repel" individuals outward from the center. As one is thrust out toward the periphery,

experiences become more and more diverse. Thus, the edge is an experiential place in which peripheralized, vulnerable persons are not only distinct and isolated from the majority, but also from one another.

The value of marginalization as a guiding theme is in avoiding universalizing empirical and clinical approaches to vulnerable groups. This conceptualization impresses upon nurses the need to approach vulnerable groups with an ear to their relational experiences and an eye to their struggles in oppressive social, economic and political environments. Many lives are lived on the edge, at the margins. Will nursing be flexible and compassionate enough to make a safe path for lesbians as marginalized persons in their journey of recovery?

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APPENDICES

Appendix A

The Twelve Steps of Alcoholics Anonymous

1) We admitted we were powerless over alcohol and 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 life and our will over to the care of God as we understand him.
4) Made a searching and fearless moral inventory of ourselves.
5) Admitted 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 a list of all persons we had harmed and became ready 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 knowledge of his will for us and the power to carry that out.
12) Having had a spiritual awakening as a result of these steps we tried to carry this message to other alcoholics and to practice these principles in all our affairs.

Appendix B

Overview of Studies: Lesbians and Alcohol Problems

Study	Focus	Sample	Method	Findings
Curran (1937)	social & personality factors	N=50 women alcoholics Bellevue	clinical hx social hx interview	96% deny homosex. act. 32% "chron. frigidity" 46% more attracted to women 38% hallucinations accuse homosexuality

Implications: Researcher preoccupation with alcohol-homosexuality link.

Study	Focus	Sample	Method	Findings
Saghir & Robins (1973)	sex. orient & women's drinking	100 women 57 DOB memb. 43 hetero. controls (in 1968)	structured interview	lesbians-higher ETOH consumption alcoholism seen in 33% lesb., 7% cont. bar-going not a factor

Implications: Lesbians may have higher incidence, unrelated to bargoing.

Study	Focus	Sample	Method	Findings
Hawkins (1976)	lesbian & alcoholism link	N=30 alcoholic lesbians LA	interview psychometric tests	refused psychometric tests, (discontinued) 93% report lesbianism non-contributory 60% say treatment needn't require all-lesbian staff

Implications: Weakens alcoholism/lesbianism link. Supports education of mainstream treatment to improve care to lesbians.

Study	Focus	Sample	Method	Findings
Oberstone & Sukoneck (1976)	psychologic adjustment	N=50 SWW 25 lesbian 25 heterosex	MMPI & structured interview	no differences in: adjustment consumption bargoing

Implications: Amount of alcohol or bargoing may not differ, but content of experience may. Drinking practices are the same for both groups, yet could "alcoholism" be manifested differently in each?

Study	Focus	Sample	Method	Findings
Fifield, Latham & Phillips (1977)	incidence	N=98 bartenders LA gay bars	questionnaire	15.7% patrons deemed "problem drinkers"
		N=200 gay patrons (gender?)	questionnaire	48% abuse ETOH regularly 32% gays classified alcohol abusers
Fifield, Latham & Phillips (1977)	treatment	N=46 staff	interviews	Staff estimate only 1% of clients gay
		N=190 staff 168 trad. agencies 22 from gay agencies	survey	few overtly gay staff non-gay staff more authoritarian, etc.
		N=53 gay post gay treatment (gender?)	structured interviews	75% now without relapses 79% say prior non-gay treatment was unsuccessful

Implications: Questionable number of lesbians in sample. Gay/lesbian treatment programs potentially efficacious for a subgroup of clients.

Diamond & Wilsnack (1978)	lesbians' drinking motives	N=10 lesbian alcohol abusers	depth interviews	dependency conflicts low self esteem lo-self esteem relationship conflicts

Implications: Lesbian drinking motives similar to those of other women.

Lohrenz et al. (1978)	incidence (midwest)	N=174 145 gay 29 lesbian	self-report questionnaire & MAST	lesbian data deleted 29% gay men alcoholic (MAST)

Implications: Midwest incidence gay alcohol problems similar to west coast rate. Typifies bias/sampling problems re: lesbian incidence.

Study	Focus	Sample	Method	Findings
Beckman (1979)	sexual feelings, behavior & alcohol	N=477 120 lesbian alcoholics 120 alc M 119 non/alc F 118 non/alc F psych pts.	survey	alcohol "disinhibits" F alc say drinking decreases sexual behavior discrimination F alc more often report being "homosexual"

Implications: Does drinking "improve" sex for women? Do alcoholic women label self as "homosexual" due to "blocked" lesbian identity? Negative labeling as in low-self esteem? Accounting for decreased interest in sex?

Anderson (1981)	personality traits	N=60 women in treatment 30 F alc 30 non/alc sisters	interview	more alc women divorced, live alone. alc women report being "withdrawn", less interest in boys during adolescence

Implications: What is the relationship between alcohol use and self-referencing for lesbian adolescents?

Burke (1982)	social cultural factors	N= ? alc lesbians non/alc lesb hetero. F	factor analysis	lesbian bargoing alienation associated with lesbian alcohol problems

Implications: Lesbians spend more time in bars, but unclear if drinking is a cause or effect. How does alienation contribute to lesbian alcoholism?

Driscoll (1982)	evaluation Homophile Alcohol Services (HATS)	N=33 79% M 21% F 21 post HATS 6 pre HATS	mailed survey (low reponse)	planned abstainers: 71% sober at 3 mos. 58% sober at 7 mos. sign. longer sobriety with HATS few women entered prog.

Implications: Critical period between 3 and 7 months sober. Is special outreach needed for lesbians? HATS seems useful for gay males who choose abstinence (vs. controlled drinking).

Study	Focus	Sample	Method	Findings
Colcher (1982)	quality of services to gay/lesbian alcoholics	N=75 alc in therapy 47 M 28 F	clinical rep.	clients of 2 types: comfortable with sex orient vs. not comfortable self-oppression, disclosure = key issues "sober bargoing" strategy noted

Implications: Lesbians with alcohol problems may or may not have lesbian identity conflicts in recovery. Bar continues as social support in recovery for some.

Morales & Graves (1983)	gay/lesbian subs/abuse & quality services	2 samples: N=453 266 gay 129 lesbian 59 bi/het.	self-report survey	ETOH most used for all cocaine #2 for lesb. lesbians-more negative alc- rel. experiences AIDS=#1 concern for all alc #2 prob for lesbians lesbians prefer F staff
		98 staff 40 alc prog 58 drug prog	mailed survey	uninformed re: gay/lesbian issues tend to see gay/lesb. as "no different" alc staff more "homophobic" vs. drug staff

Implications: Evidence lesbians are concerned about alcohol use and problems. Alcohol and drug staff in the Bay area have less actual knowledge re: gay and lesbian recovery than their self-perceptions of expertise suggest.

Israelstam & Lambert (1983)	alcohol-homosex. theory link 1900-1980	psychiatric & social sci. publications	historical survey of documents	less attention to F many links posited re: alcoholism & homosexuality psychometry of 1940s + begins to refute links psychoanalytic views persist, pathologize

Implications: Points to a cultural association of alcohol use and homosexuality, alcoholism as latent homosexuality, etc. Has gay/lesbian liberation effectively countered these pathologizing notions?

Study	Focus	Sample	Method	Findings
Covington & Kohen (1984)	sex dysf & subs use	N=70 35 F alc (13 bi, 2 lesb) 35 F non/alc controls	survey of women in treatment	sexual dysfunction, sexual abuse & chronic phys abuse assoc with alcoholism

Implications: Alcoholic lesbians, like other women, are more likely to have experienced abuse as well as "sexual dysfunction". Is sexuality a key facet of women's alcohol problems, or researcher preoccupation?

Clark & O'Connell (1985)	women's sexuality & recovery	N=9 women 5 lesbian 2 bisexual 1 hetero 1 ? (all in recovery 3 mos.-4 yrs)	structured interview	addiction linked to avoidance of psychic pain/stressful life events alc increases sense of power bar socially central but drinking optional sex issues are central

Implications: Emphasis is on sexuality and powerlessness issues for a variety of women with alcohol problems.

Davis & Kennedy (1986)	lesbian bar culture Buffalo,NY 1940-1960	N=20 lesbian narrators, 15 from 50's white comm 5 from 40's white comm 1 from 40's black comm	oral history	bars "anchored" comm "wonder-ful", "terrible" times 1940's weekend scene 1950's daily scene & "street dykes" butch/fem roles bars diverse site of public defiance

Implications: What effect did role playing have on meanings of alcohol for lesbians in the past and now? What is the current function of bars in lesbian subculture in terms of drinking practices, socialization and political activism?

Study	Focus	Sample	Method	Findings
Klassen & Wilsnack (1986)	sexual experience /dysfunc & women's drinking	N=917women, natl survey 39 recov 378 abst- light drkg 500 mod-hvy	survey, administered questionnaire	temp self-quitting link with same-sex feelings alc "disinhibits" esp for heavy drnkrs drinking assoc with unconventional sex

Implications: Raises questions about the meanings alcohol is given, especially as a "disinhibitor", for both lesbians and/or women experiencing same-sex sexual attraction.

Schilit, Clark & Shallen- berger (1988)	social sup, prevention lesbian alc problems	N=30 lesb 15 non/alc 15 alc many in AA	interviews, MAST, history	alc lesbians: less happy childhoods felt "unwanted" "less popular" few support persons distance from father more religious involve

Implications: Suggests vulnerability to alcohol problems begins in childhood or adolescence for some lesbian women, though this study does not differentiate the experiences of heterosexual women with alcohol problems.

McNally (1989)	identity changes recovery AA	N=8 lesbians AA white mid class 30-45 yrs.	semistructured interview	drinking: coping with stigma, deny lesbian identity need for "safe" arena for recovery conflicts with "main- stream AA" 5 stages lesbian alc recovery, identity integration

Implications: Traditional treatment and AA are perceived as unsafe environments for recovery for some lesbians. Normative stages of recovery are very tentative in view of great individual diversity in demographically homogeneous sample.

Study	Focus	Sample	Method	Findings
McKirnan & Peterson (1990)	epid. & psycho-social factors	N=3400 2652 gay 748 lesb.	questionnaire survey	gays/lesb. abstain less, drink moderately (vs. heavy), compared to gen. pop., but report more alc. probs. (23% vs. 12%) subs. abuse related to social discrim., but not to relationship status or conflict re: gay/lesb. identity

Implications: Do lesbians problematize drinking more easily than others? Why is this tendency is shared with gay men?. Does different pattern of role expectations lead to less constraint of drinking in lesbians, vs. heterosexual women? With aging, are lesbians less likely to reduce drinking? Could "bar-going" be spuriously related, while social discrimination accounts for both bar-going and drinking?

EMT Assoc. (1990) for SF Lesb/Gay Subs Abuse Planning	incidence psycho social factors recovery	N=734 416 gay/bi 318 les/bi	questionnaire survey	lesbians use alcohol/ drugs more than women in gen pop. 66% of lesb. used alcohol, 30% used other drugs. 1/3 lesb. have problematic drinking. 48% lesb. report childhood sexual abuse; 29% sexually abused as adults. 1/4 of total, men and women active 12 step. Twice as many men as women receive services for substance abuse

Implications: Lesbians continue to be seen as having higher incidence of alcohol problems, thought this is not a probability sample. They also appear to be polydrug abusers. Lesbians are underserved in terms of access to treatment. There is a growing sense of a link between alcohol problems and sexual abuse history within lesbian communities. Lesbians reasons for drinking here were: to avoid emotional pain, reduce social discomfort and to avoid thinking about problems.

Appendix C

Conceptual and Operational Definitions

The following is a list of relevant terms used in this study, accompanied by their conceptual and operational definitions:

(1) Lesbianism is a social construction designating a culturally heterogeneous aggregate of women whose primary sexual orientation is toward other women; sexual behavior may in actuality include bisexuality and celibacy. Operationally, lesbians were defined as adult women (over 21 years) who self-identified as lesbians by volunteering for this study of lesbians' alcohol problems.

(2) Alcohol problems are difficulties or negative consequences associated with the use of alcohol and sometimes other mood-altering substances. They can be identified by the drinker herself, significant others, or may be collective concerns of the lesbian subcultural group. Alcohol problems were operationalized as participants' verbal accounts indicating the negative aspects or outcomes of alcohol and other drug use.

(3) Problem drinkers are those identified by themselves or significant others as having serious consequences related to alcohol/other drug use in terms of health, relationality, cognition, self-image, finances, legalities or occupation. Problem drinkers were operationalized as women who self-identified as having an alcohol problem, from which they considered themselves to be "in recovery" for at least one year at the time of interview. Their alcohol problems were often accompanied by other drug problems. Participants were not required to have had total abstinence for the previous year. Neither were they required to refer to

themselves as "alcoholic," "chemically dependent" or by other labels.

(4) Recovery from alcohol problems is a health-related change process beginning with the identification of problematic use of alcohol, having personal, social, cultural and political dimensions. Recovery facilitates emancipation from constraints through increasing awarenesses. Recovery was individually operationalized as participants' personal narrative accounts of their experiences in dealing with alcohol problems. It was collectively operationalized as those elements or patterns common to accounts of several or all participants in the study.

(5) Helpseeking is conceptualized as patterns of action by individuals or significant others in response to alcohol-related difficulties, with the purpose of obtaining assistance from other persons or agencies. Operationally, helpseeking referred to verbal accounts of attempted or completed contacts with other persons or agencies to get relief from alcohol-related difficulties, whether or not alcohol was the actual identified problem at the time.

(6) Actions are ideological, cognitive, behavioral, verbal, interpersonal or collective responses undertaken to obtain relief from negative consequences of alcohol or other drug use. Actions were operationalized as verbal descriptions of individual, interpersonal, collective, ideological actions, changes, or plans which were perceived as responses to alcohol problems.

(7) Treatment refers to a myriad of institutionalized programs designed to assist the problem drinker/drug abuser to modify or stop the use of such drugs. Treatment was operationalized as

those resources, programs, and paid care providers that were discussed by participants as formal entities (not mutual help groups) addressing alcohol problems. Individual psychotherapy that was not formally attached to an alcohol/drug treatment program was not deemed to be treatment, but was considered separately.

(8) Health care providers are persons whose occupational interaction with individuals or groups has direct relevance to the evaluation or improvement of physical or mental well-being, through generally recognized mainstream or alternative means. Operationally, health care providers were defined as paid workers with some formal education and documentation of expertise in the area of their health-related employment. This included nurses, physicians, counselors, social workers, trained acupuncturists, therapists, etc. It did not include lay healers, volunteers, and AA members.

(9) Mutual help groups are non-professional voluntary networks or organizations fostering reciprocal social support relations among members in response to a need or problem they share in common. Operationally, mutual help groups included AA, Alanon, a plethora of other twelve-step programs, Women for Sobriety, and any voluntary support group participants discussed as relevant to their recovery from alcohol problems. Mutual help groups did not include churches, professionally-run therapy groups, or for-profit self-help programs.

(10) Sobriety is an AA-related term describing a two-pronged state of well-being: (a) abstinence from alcohol or other abusable, mood-altering substances and (b) a serene general outlook.

Sobriety was operationalized as self-descriptions of periods of abstinence, especially as related to twelve-step practices. From contextual cues it could be seen that sobriety was sometimes used as a synonym for "recovery." Sobriety often referred to a component, but not the totality of the recovery experience. For some participants, the term was irrelevant.

Appendix D

Recruitment Notice

ATTENTION: LESBIANS RECOVERING FROM ALCOHOL PROBLEMS

Your participation is needed in completing a study about the patterns of recovery, treatment evaluation, and sources of support experienced by lesbians who have identified an alcohol or alcohol/drug problem and are now trying to recover from it. You would need to spend 1 1/2 to 2 hours in an interview with the investigator, Joanne Hall, who is a lesbian nurse in doctoral study at UCSF. She is also recovering from alcohol/drug problems.

Your participation is voluntary, and all materials are kept confidential and anonymous. Lesbians who have been in recovery for at least 1 year are needed, but you need not have continuous abstinence for the period of your recovery. You need not be a member of any mutual help (self-help) groups, nor must you define yourself as "addicted", "alcoholic", "chemically dependent", etc. to participate.

The purpose of the study is to identify what has been helpful to you, the barriers to your recovery, and the issues which have been raised by alcohol/drug problems in the lesbian community. Women of color, working class women, and women of all ages are encouraged to volunteer. Participants will be given a written summary of the results when the study is completed.

CALL: (415) 664-6823

JOANNE HALL, RN

1612 NORIEGA ST.

SAN FRANCISCO, CA 94122

Appendix E

Alcohol Use Assessment

Please complete these questions, but feel free to explain answers or comment on back if necessary.

During the last 12 months of a period when you were using alcohol:

How often did you drink any kind of alcoholic drink (includes wine, beer and liquor)? (CHECK ONE)
___ 3 or more times a day
___ 2 times a day
___ once a day
___ nearly every day
___ 3 or 4 times a week
___ once or twice a week
___ 2 or 3 times a month
___ about once a month
___ less than once a month but at least once a year
___ never

About how often did you drink enough to feel a "buzz"?
___ more than once a day
___ once a day
___ nearly every day
___ 3 or 4 times a week
___ once or twice a week
___ 2 or 3 times a month
___ about once a month
___ less than once a month, but at least once a year
___ less than once a year
___ never

About how often did you drink enough to get drunk? (CHECK ONE BELOW)
___ more than once a day
___ once a day
___ nearly every day
___ 3 or 4 times a week
___ once or twice a week
___ 2 or 3 times a month
___ about once a month
___ less than once a month, but at least once a year
___ less than once a year
___ never

During the last 12 months of a period of alcohol use, have you

Had an illness connected with drinking that kept you from working, or from your regular activities for a week or more?
YES___ NO___

Been told by a doctor or health worker that the amount you were drinking was having a bad effect on your health?
YES___ NO___

Had any of your friends, relatives or acquaintances say anything about your drinking, or suggest that you cut down?
YES___ NO___

Had a spouse/partner permanently break off a relationship with you because of your drinking or things you did while drinking?
YES___ NO___

Lost a friend, or almost lost a friend because of your drinking?
YES___ NO___

Please check all of the agencies or people you have had contact with during the last 12 months of alcohol use, as a result of alcohol problems:
___ the police
___ courts or probation officer
___ hospital emergency room or paramedics
___ doctor or health worker from some other place
___ social services, child welfare/child protection services
___ domestic violence (battering) program
___ mental health center or psychiatric unit
___ drug treatment program
___ alcohol treatment program
___ someone else _____

(Questions adapted from 1988-1989 Contra Costa County General Population Survey, Form 4, and the 1989 health and alcohol practices study of Alameda and Contra Costa counties, Medical Research Institute, Alcohol Research Group, 1816 Scenic Ave., Berkeley, CA 94709. Used with permission)

Appendix F

Interview Questions

This is a list of potential questions, followed by related probes, which may be posed within interviews. The interview is semi-structured, focused on experiential meanings. Therefore some of these questions will not be used, and other questions or probes may be improvised or modified as is necessary to elicit stories of recovery experiences from participants' perspectives.

1) What led you to believe that drinking (and drug use) was becoming a problem?

   Were there other/earlier clues?
   Did anyone else influence your perception of your drinking?

2) Did you ever seek help for drinking or problems related to it?

   Did you personally believe that alcohol was really "the problem"?
   Who did you contact for help? What happened?
   What was positive about this experience for you? Negative?

3) Did you ever go to a treatment program for alcohol or drug problems? If yes:

   How did you get into that program?
   Could you describe the basic program there?
   What was it like for you to be there?
   What was positive about the experience? Negative?
   Have your thoughts about this changed over time?

   If no:

   Have you ever wanted to go to a treatment program?
   What stopped you from doing this?

   What would you expect to happen in such a program in order to help you in your recovery?
   Are there negative things you anticipate might happen?

4) What actions did you take on your own in the past to deal with problems related to drinking?

   How did these things work out?
   What things do you do now, on your own, to deal with these problems?

5) Have you ever been involved in any mutual help groups, like AA? (or NA, Alanon, ACA, or Women For Sobriety, etc.?)
   If yes:

   How did you get involved?

What has that experience been like for you?
What has been most helpful about it?
Anything you think could be improved upon?
Have your ideas about this changed in any way?

If no:

Do you have any thoughts about how these groups work?
Have you known anyone else who was in these kinds of groups?

6) How do you go about maintaining your recovery (or staying sober, staying balanced, continuing to grow, etc., using the participant's own terms here)?

What was it like in the beginning of this process?
How does it happen on a day to day basis now?
Are other people involved in it with you? How does that work?

7) Are there any obstacles you have faced, or are facing now in trying to recover (or preferred terms)?

What resources are available for you?
How would you advise other lesbians/women in your circumstances to go about getting help?
Are things different as your recovery gets longer? How are they different?
What are the main issues in longer term recovery?

8) When you think of drinking, in general, today, what are you reminded of? What does it mean for you today?

How does that compare with your earlier views?
Where do you think people's ideas about drinking come from?
How about the lesbian community?

9) Do you think alcohol/drug problems are any different for lesbians?

In what ways?
How have your experiences with alcohol/drug use compared to those of other women? Other lesbians?
Has your background, (race, class, age, religion) been a factor?

10) How do you think health care workers (medical doctors, nurses, psychiatrists, therapists, counselors, etc.) could best help someone like yourself deal with an alcohol or drug problem?

Are some health care workers easier to deal with? How is it easier?
Are there things you fear in dealing with HCW on these issues?
Ideally how should HCW try to respond to lesbians, or women in general with alcohol/drug problems?

11) Are these the kinds of questions you expected when you thought about coming here today?

How did you expect the interview to be?
Did anything surprise you?
Are there some questions you think it would be important to ask other women?
Are there questions you would avoid asking?
Are there certain groups of lesbians/women you think would be important to interview?
Do you know anyone you think might be open to an interview about these issues?

Appendix G

Template for Interview Assessment

Setting:

Interviewee's motivation, definition of the interview situation and of the interviewer role:

Power issues, disruptions in flow of interaction:

Non-verbals:

Emotional atmosphere? Congruency with verbal?

Interviewer responses - Conflicts? Feelings? Fears?

Constraints - gender, race, class, SES, sexual orientation, age, religion, time, space, etc.

Appendix H

Information Sheet

A. PURPOSE AND BACKGROUND

Joanne M. Hall, a PhD candidate in the School of Nursing at University of California, San Francisco, is doing a study about recovery from alcohol problems in lesbians, which you are being asked to participate in.

B. PROCEDURES

If you agree to be in the study an interview will be arranged at a time and place that is convenient for you. In the interview Joanne will ask several open-ended questions related to: How you came to realize that your alcohol problems existed, how you sought help, what you see as barriers to recovery, what strategies you used in beginning and maintaining recovery and what, if any, are your experiences with twelve-step programs (like AA). It is likely that the interview will last about two hours. It will be audiotaped if you agree, but this is not essential.

C. RISKS AND DISCOMFORTS

If any of the questions make you uncomfortable or upset, you are free to decline to answer, or to stop the interview at any time. You may raise a hand to indicate that you wish to pause or stop, if you do not wish to say so verbally. Confidentiality and anonymity will be guarded carefully. At no time will your name be attached to any materials related to this study. All study records will be identified anonymously with code numbers and kept in locked files. Audiotapes will be destroyed when the study is completed. No individual identities will

be detectable in publications, media presentations or oral reports of the study findings.

D. BENEFITS

The anticipated benefit of the study is increase the understanding of recovery from alcohol problems as reflected in lesbians' experience. It is not anticipated that you will receive direct benefit from your involvement in this study.

E. ALTERNATIVES

You are free to choose not to participate in this study, or to terminate your participation at any point in the interview.

F. QUESTIONS

If you have any questions or concerns about this study, either now or in the following days or weeks, you may contact Joanne M. Hall at (415) 664-6823. If you wish not to do this, or have further unanswered questions, you may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. You may reach the committee office between 8:00 AM and 5:00 PM, Monday through Friday, by calling (415) 476-1814, or by writing to the Committee on Human Research, Suite 11, Laurel Heights Campus, Box 0616, University of California, San Francisco, CA 94143.

G. CONSENT

Your willingness to participate in the interview indicates your consent. PARTICIPATION IN RESEARCH IS VOLUNTARY. You will not be asked to sign any documents. You are free to decline to participate in this study, or to withdraw from it at any point. Your decision about whether or not to participate will have no influence on your present or future status as a patient, student or employee at UCSF.

Appendix I

Demographic Questionnaire

Please briefly answer these questions.

Age

Ethnicity/Race

Religion

Types of drugs involved in your problem, and which were "drugs of choice"

Time in recovery?

Experience in 12 step programs, if any?

Other recovery groups (Women for Sobriety, etc.)

Your recent average yearly income

Who is in your household (no last names, please)? What is their relationship to you?

Economic status in household where you grew up, compared to your own?

Your history as a lesbian (whatever you think is important for others to understand about your coming out, relationships, how "out" you have been).