WOMEN AND CHEMICAL DEPENDENCY:
A SOCIALIST FEMINIST APPROACH

by

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Abstract

This thesis applies a socialist feminist analysis to our understanding of women and chemical dependency. Most addiction models, such as the disease model, are based on a male norm, and isolate the individual from society. The influences of social and economic inequality are ignored. Socialist feminism examines capitalist patriarchy and its perpetuation of such inequalities. Applying this theory to chemical dependency in women, the social context of addiction can be better understood.

This analysis is enhanced by the inclusion of qualitative and quantitative data collected as part of an evaluative report produced for Maiya House Society (Raby 1991). Forty-nine women who had completed chemical dependency treatment were interviewed.

Women's experiences with chemical dependency are different from those of men. Women are more likely to use alcohol or prescription drugs than hard drugs, to experience social stigma, to develop alcohol-related health problems and to have been sexually abused. These experiences influence the treatment women require. Here, explorative findings suggest feminist, women-oriented treatment is needed. Also, post-treatment employment and a strong support network improve treatment success.

Further research is necessary. The influence of gender roles and the experiences of chemically dependent women of colour and lesbian and bisexual women require investigation, as do the ramifications of feminist treatment.

Table of Contents

List of Tables

Acknowledgments

Chapter I

Introduction

Alcohol and drug addiction is widespread in North America. Most people know someone who is wrestling with chemical dependency or whose life has been influenced by a substance abuser. Yet while chemical dependency has been studied across disciplines, most research has focused only on men. Generally, there has been little attention paid to women as alcohol or drug abusers, perhaps because it has not been as apparent a problem (Sandmaier 1980). Yet clearly women do become addicted to both drugs and alcohol and, in part as a result of more accurate reporting, the number of female addicts appears to be increasing (Hornik 1977, Clemmons 1986, Fellios 1989). Through a socialist feminist analysis, this thesis explores issues that surround women and chemical dependency, highlighting the inadequacies of male-centred explanations of chemical dependency, the female-specific experiences of alcohol and drug addicted women, and the need for treatment modalities that account for these experiences.

My interest in this area arose through my employment in the summer of 1991 with Maiya House Society, a chemical dependency treatment centre for women in Nanaimo, British Columbia. The project involved the production of an evaluation report, based on interviews with forty-nine women who had been through some kind of treatment for chemical dependency one to two years prior (Raby

1991). This project was intended to provide information to Maiya House Society on the effectiveness of different kinds of treatment. It also allowed me to become familiar with the treatment options available to women in British Columbia and to the specific problems these women face, providing the basis for the more analytical examination of women and chemical dependency presented here.

Despite their diverse backgrounds, commonalities emerged between the women I interviewed. For example: many of the women were on welfare, or working in low-paying jobs; most had been abused as children, and later, had been in battering relationships. As these commonalities arose and as I also read literature on women and chemical dependency, some points became clear.

First, few treatment professionals or researchers apply a sociological approach to their understanding of chemical dependency. Despite clear similarities between women's experiences, those from medical, psychological, psychiatriac and social work backgrounds tend to individualize women's drug and alcohol abuse. There are some exceptions, such as Sandmaier (1980), Roth (1991) and Van Den Bergh (1991), yet overall, I felt that the literature was lacking in this area.

Also, while an expanding body of literature purports to explain the causes, consequences and treatments of chemical dependency, few researchers overtly locate their work within a particular theory of society. Fewer still account for gender,

class or ethnicity in their explorations. Certainly some
researchers have attempted to provide a feminist framework for
understanding women and chemical dependency, but there are
different feminist perspectives and while all address sexism and
gender inequality, each emphasizes very different processes and
different solutions to these problems.

The most common feminist approach that is taken is an
eclectic combination of liberal, Marxist, radical and socialist
feminist perspectives. As there are some distinct differences
between these theoretical perspectives, this mix at times results
in individual authors presenting contradictory positions (e.g.
emphasizing social inequality, yet placing the burden of
responsibility on the individual). Other feminist researchers
have taken a clear liberal feminist position, highlighting
destructive sex role stereotypes and gender inequities, yet
lacking an analysis of the underlying inequalities that
inevitably result from the capitalist system (Morrissey 1986).
Only Van Den Bergh (1991) and Greenspan (1983) explicitly
articulate a socialist feminist approach to an understanding of
addictions. I have taken this perspective, and applied it
specifically to women and chemical dependency. Unlike both
liberal and radical feminists[1], socialist feminists recognize the

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[1]Radical feminists consider women's oppression, and not class
oppression, to be fundamental: gender, a "system of domination",
structures all aspects of social life. While there are some
distinctions between forms of radical feminism, most claim that 1)
historically, women were the first oppressed group; 2) women's
oppression is widespread and 3) women's oppression is the deepest,
hardest form of oppression to eradicate. Radical feminism focuses

influence of capitalism in the maintenance of women's inequality. Yet at the same time, socialist feminists do not ignore the role of patriarchy in the oppression of women, as Marxist feminists tend to do[2].

Socialist feminism is a materialist analysis locating the oppression of women in capitalist patriarchy. In many ways, socialist feminism is a Marxist perspective. However, while incorporating substantial portions of Marxism into their approach, socialist feminists believe that Marxist feminism fails to adequately address women's oppression.

As with other theories, differing perspectives are included under the rubric of socialist feminism. Tong (1989), a feminist theorist, outlines two such contrasting perspectives. The dual-systems theory conceives of patriarchy and capitalism as two distinct forms of social relations: they are separate phenomena with different interests but they are also related to each other.

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on the ways in which men have attempted to control women's bodies and the way in which men have constructed female sexuality to serve men and not women.

[2]Marxist feminists seek to understand women's oppression through class analysis, believing women's oppression to result from "the political, social and economic structures associated with capitalism" (Tong 1989:39). Marxist feminists attempt to "give feminist vision to [the] sex-blind categories and concepts of Marxist thought" (Tong 1989:47), focusing on women's work-related concerns. Marxist feminists seek women's participation in the public workforce and full socialization of childcare and housework. However, they do not address the oppression of women by men, believing that women should unite with working men to defeat the capitalist system, the ultimate oppressor.

There are two approaches within the dual-systems perspective: one sees both capitalism and patriarchy as material structures, historically rooted in the mode of production and the mode of reproduction/sexuality consecutively. The other also sees capitalism as materially based, but considers patriarchy to be a non-material, ideological and psychological structure that transcends the bounds of space and time.

Tong criticizes both forms of dual-systems theory. The first maintains a dualism, with patriarchal oppression found in the private, family, "female" sphere and capitalist oppression limited to the public, economic, "male" sphere. Capitalism's initial responsibility for this public/private division and its perpetuation of this division are not addressed. The second, an emphasis on patriarchy as ideological, undermines patriarchy's oppressive nature, suggesting that it is not as oppressive as the "knitty-gritty facts of capitalist life" (Tong 1989:182). Tong sees little difference between this approach and Marxism, both indicating that capitalism is the primary cause of women's oppression.

In contrast to dual-systems theory, unified-systems theorists analyse capitalism and patriarchy together as one: capitalist patriarchy. While recognizing that substantial work has yet to be done in unified-systems theory, Tong supports this perspective as best addressing women's oppression. Similarly, Jaggar (1983) presents a unified-systems theory in her analysis of women's oppression. It is this approach that will be taken

here.

Both dual-systems and unified-systems socialist feminists seek to synthesize radical feminist insights with Marxist tradition. Like radical feminists, they feel that women's specific oppression by men must be addressed. However, socialist feminists root their analysis in an historical rather than a biological approach. Further, unlike Marxists, they do not believe women's oppression to be based solely on class. Rather, they seek to introduce a new theoretical approach: feminist historical materialism.

Socialist feminists believe that traditional Marxist historical materialism[3] fails to recognize the different experiences of men and women under capitalism or "the vested interests men [have] in women's continued subordination" (Hartmann 1981:5). They have therefore elaborated historical materialism to include perceptions of gender, sex and race as socially constructed and historically changing. Not only do specific historical conditions lead to distinctive human types such as capitalist and proletariat (under capitalism), but people also belong to specific sex, age and ethnic groups that influence

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[3]The historical materialist method presents the material forces, or the production and reproduction of social life, as the prime active forces in history. Relations of production are the basis of social structure and of social change. Social existence determines consciousness and not vice versa. Thus a society's mode of production (or specific organization of productive activity) gives it a distinctive character. Similarly, a dominant ideology explaining and justifying social experience is ultimately determined by the mode of production.

their experiences.

Patriarchy, in particular, must be factored into historical analysis. Socialist feminists see patriarchy as pre-capitalist, believing that it has taken various forms at different times and in different cultures. Patriarchy, however, has been greatly influenced by the arrival of capitalism, and a full capitalist-patriarchal system now exists. The current low status of women in the labour market and in the wider society is a result of a long process of interaction between patriarchy and capitalism (Hartmann 1982) and an end to women's oppression requires an end to both.

Historical materialism also informs our understanding of gender roles. Many psychological and physiological differences between men and women are considered to be socially constructed (Jaggar 1983). Any ahistorical conception of human biology is abandoned: gender structuring is related to the historically prevailing system of organizing social production. Further, gender socialization into rigid masculine and feminine roles, a socialization beginning when we are very young, is essential to male dominance. Gender roles are connected to the sexual division of labour, with the private realm considered to be the "women's domain" of family, sexuality and procreation. Women are thus defined by their sexual, procreative and domestic labour. Conversely, men are associated with the "more important" economic and political activities of the public sphere.

Women (and men) are constituted by the social relations

which they inhabit; outside of these social relations, "women" and "men" are abstractions. Marxists seek the full development of human potentialities through free productive labour. Socialist feminists seek to expand this to include the full development of human potential for free sexual expression, for freely bearing children and freely rearing them. This reflects socialist feminists' expansion of the material base to include sexual and procreative activities. Human material needs are expanded from food, clothing and shelter to include also needs for children, sex and nurturance. Consequently, the definition of productive labour is also widened: "sexuality and procreation are a part of the economic foundation of society, partially determining 'the economy' in the narrow sense, and partially determined by it" (Jaggar 1983:136). In turn, these activities become political and economic - developing historically and existing in dialectical interrelation with production rather than biologically determined as radical feminists seem to suggest.

The socialist feminist elaboration of the concept of labour draws attention to the public/private distinction. Marxists view the private sphere as linked to economics, but peripheral, with non-waged labour as not really considered "work". They recognize that the public/private division is important to understanding women's oppression, but maintain that the public is the more important (Jaggar 1983). Socialist feminists challenge this public/private distinction as it obscures the subordination of women, while distorting the complex relationship that actually

exists between public and private, particularly in economic

terms. Similarly, it distorts the relationship between

procreation and production, again creating a dichotomy where one

should not exist. Jaggar believes that by accepting the

public/private distinction, Marxists have accepted a basic

feature of capitalist patriarchy.

Another aspect of socialist feminism is its reinterpretation

of alienation[4]. Socialist feminists broaden the concept of

alienation by using it to address the particular experiences of

women under capitalist patriarchy[5]. They believe that

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[4]Marxists see every transaction under capitalism as fundamentally exploitive. Marx believed such exploitation to deny individuals their true human essence. Reinterpreting a Hegelian term, Marx used the concept of alienation to explain this denial.

Hegel believed the history of humanity to be the history of the "absolute spirit", a self-knowledge that arises through dialectical contradictions; the human spirit is confronted by concrete historical moments which the spirit created, yet is also separated from. This historical moment becomes external and alien to its creator. The spirit is involved in an ongoing desire to recover these moments and to attain a non-alienated consciousness.

To Marx, the "spirit's ceaseless activity" is actually concrete labour. Human beings must transform nature through concrete labour, thus externalizing themselves in nature and society. The consequent objectification of things and people is unavoidable (Swingewood 1975:90). Yet alienation, evident under capitalism, is not inevitable.

Alienation, according to Marx, is "a process by which man is progressively turned into a stranger in the world his labour has created (Swingewood 1975:89). Under capitalism, the product of a person's labour becomes a commodity, which becomes an alien being or power, independent of the producer. Labourers are dominated and their labour expropriated: work becomes exhausting, depressing and isolating.

[5]Some have questioned this application, suggesting that socialist feminists have failed to properly understand the concept of alienation as Marx presented it (Currie 1992).

traditional Marxism fails to account for women's alienation as it does not address alienation other than in the "public" work environment, implying that those not participating in the proletariat-capitalist relationship are not alienated. Work in the home is unpaid and is thus excluded from Marx's conception of productive labour. This perspective is strengthened by the Marxist conception of the home as a haven from capitalist exploitation, despite the tendency for the home to be a workplace for women (Jaggar 1983).

Even in the area of wage labour, Jaggar cites female alienation:

> ...the sexualization of women's work and the sexual harassment of women [at work] create a gender-specific form of women's alienation (Jaggar 1983:316).

Women also earn lower wages than men and are usually in positions of subordination (Wilson 1986). Women in the workplace experience dual alienation - as proletariat workers and as women.

Jagger (1983) suggests that women are also alienated from their own bodies. Women are alienated as mothers when they do not control their conditions of motherhood: whether they will have children or not, how many, and how they will give birth. Further, they are alienated from their own sexuality as they become objectified for men. S. Bartky (1982) believes sexual alienation is tied to gender roles. Women are expected to embrace femininity, just as men are expected to fulfill masculine expectations. Both can be alienating, but femininity particularly so. With femininity comes domesticity, dependence

and powerlessness.

This alienation is internalized. Objectification usually involves an objectifier and an objectified. Bartky suggests that both roles can be fulfilled by one person; a woman sees herself with the attitude of a man, and thus accepts her oppression. An explanation of this can be found in the existentialist literature of Simone De Beauvoir who believed that a woman's socialization disposes her to see her body as "an object destined for another". Knowing how men will appraise her, the woman learns to appraise herself first - she becomes "appraiser and appraised" (Bartky 1982:134); internalization of oppression and consequent self-degradation result.

Socialist feminists believe that such alienation and oppression can be brought to an end. Their goals include reproductive freedom through control over child-bearing and rearing, sexual freedom, free sexual expression, the abolishment of femininity (and masculinity) and the abolishment of compulsory heterosexuality. In the area of labour, socialist feminists call for an end to the detailed division of labour between conception and execution, mental and manual, and between male and female - including the elimination of differential wages between sexes. Finally, socialist feminists seek to overcome all forms of alienation with new conceptions of freedom, equality and democracy, including an end to capitalism.

There are limitations to the socialist feminist perspective. The use of psychoanalytic theory to explain how women have come

to internalize their own oppression at first seems irreconcilable with materialism. Jaggar responds by suggesting that "[psychoanalysts] are claiming merely that certain forms of praxis generate psychological predispositions to perpetuate those forms of praxis" (Jaggar 1983:151). Psychoanalytic theory is also problematic due to Freud's sexism and his underlying beliefs about human nature (that it is unchanging, ahistorical and antisocial), both of which are incompatible with a feminist historical materialism. To avoid these problems, some socialist feminists suggest that psychoanalysis should be rejected altogether (Greenspan 1983) while others seek to revise significant aspects of Freud's work (Jagger 1983). For example, Jaggar posits that children's responses to their sexual anatomy are based on social meaning attached to that anatomy, not the anatomy itself. Further, while what we learn in early childhood significantly influences our future lives, Jagger believes that it can also be consciously modified later in life.

As a unified-systems theorist, Jaggar seeks to escape the dualistic categories evident in other socialist feminist writing. However, divisions seem to reassert themselves regularly. The unitary-systems perspective needs to be fleshed out more thoroughly, with a direct examination of the cross-cutting distinctions associated with the "public" and the "private" and the relation between them. Jaggar recognizes this weakness: "we must develop gendered and racially specific economic categories, where the notions of gender and race are built into the new

conceptions of class" (Jaggar 1983:161). A feminist historical materialism must unfold.

Other weaknesses are evident. Socialist feminists discuss democracy and its importance within society. Like Marxism, socialist feminism is very unclear about how a new democracy would be instituted and how it would be organized. Also a limitation to the socialist feminist approach is its treatment of racism. Socialist feminists often group racism, capitalism and patriarchy into a trinity of oppression, but racism is often peripheralized. The interrelations between capitalism, patriarchy and race need to be examined in more detail.

The unitary perspective of socialist feminism is relatively new, and many aspects of it have yet to be fully explored. However, despite such shortcomings, I feel that this approach best represents my understanding of women's oppression. I also feel that the socialist feminist perspective best informs our understanding of the specific issue of women and chemical dependency.

Understanding women's drug and alcohol abuse requires an explanatory framework that examines the complex nature of social inequality and the social construction of gender. Further, a framework is needed that will recognize the importance of women's experiences with drugs and alcohol. An understanding of women and chemical dependency must examine the material realities of women's lives, and must recognize that these realities are different from those of men. I believe that a socialist feminist

approach provides such an analysis. Finally, when discussing women and chemical dependency, I believe that treatment modalities must be included since feminist treatment accounts for women's experiences in ways that other treatment modalities do not.

Thesis Overview

This thesis draws on feminist research, particularly socialist feminist research, to discuss issues surrounding women and chemical dependency. This presentation is enhanced throughout by the inclusion of women's voices in interviews as well as by quantitative data.

Prominent perspectives on chemical dependency are explored in Chapter Two, linking the theoretical assumptions and the forms of treatment that each perspective proposes. The disease, psychoanalytic, sociocultural, adaptive and feminist models are presented here.

Chapter Three combines two themes. First, the research design and data collection methods are described. Second, the context of women's chemical addictions and the experiences of women as they deal with their addictions are examined. This background provides the necessary foundation for the analytical presentation in Chapter Four.

Chapter Four presents the findings from data collected in the project outlined in Chapter Three. While this is considered to be a pilot study and the sample size is small, some clear

trends are recognized: that many chemically dependent women have experienced sexual and physical abuse, a factor that must be accounted for in treatment, that women fare better in women-only, feminist treatment settings, that women are less likely to resume drinking and/or using drugs if employed, and that women fare better after treatment if they have access to (and use) a support group (particularly if they are involved in Alcoholics or Narcotics Anonymous).

Chapter Five raises areas of discussion that need to be addressed in future research. The powerful impact of strict gender roles on the development and perpetuation of chemical dependency is presented. Also raised are specific issues facing women of colour and lesbian and bisexual women.

The concluding chapter introduces some questions that arise in terms of a feminist treatment and how such treatment can best be applied.

Chapter II

Explaining Chemical Dependency

Chemical dependency as a social problem is defined as a physical and psychological addiction to alcohol and/or mind-altering drugs. According to <u>Mosby's Medical, Nursing and Allied Health Dictionary</u> (Glanze 1990), it is manifested as "an overwhelming desire to continue taking a drug to which one has become habituated... because it produces a particular effect" (1990:309). This "overwhelming desire" controls the user's life to such an extent that "normal" life is disrupted: obtaining the drug becomes a matter of foremost importance. Many models have been developed to explain chemical dependency. Here, some of the more prominent models will be presented, with particular focus on the disease model, the most prominent in the chemical dependency treatment community. All approaches will be examined in terms of their influence on chemical dependency treatment and on their ability to account for the social, economic and political experiences of chemically dependent women.

<u>Disease Model</u>

Currently, the prominent perspective on alcoholism[1] is the

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[1]Clarity of terms is difficult in this area, with most models addressing only alcoholism and with various perspectives defining alcoholism differently. Most chemically dependent women are cross-addicted: using both alcohol and other mind-altering substances, particularly prescription drugs. Here, I will use the term

disease model (Jellinek 1960, Ward 1986). The disease approach, which considers alcoholism to be hereditary, has been most widely accepted through Alcoholics Anonymous (AA) (Jellinek 1960, Ward 1986), though met with some ambivalence by the medical community. The disease model is not to be considered identical to a biomedical model, although the two share many commonalities. Conrad and Schneider (1980) point out that most American medical associations and manuals identify alcoholism as a mental (or personality) disorder, a perception they feel is at odds with the disease model. The predominant medical perspective assumes a certain biological predisposition to alcoholism, but also highlights environmental and psychological influences on problem drinking. These latter factors tend to be disregarded by AA and other proponents of the disease model (Frances and Franklin 1988).

AA was founded in 1935 and has grown to be a world-wide organization that helps individuals cope with their alcoholism. The organization was started by Bill W.[2], an alcoholic who was deeply influenced by the experiences he had had with the Oxford Group, a small religious movement of the 1930s. He sought to

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"chemical dependency", except where an author specifically discusses alcoholism.

"Problem drinking" and "alcohol abuse" are to be considered as any form of drinking that is injurious to the drinker and to others. "Addictive drinking" is evident when an individual has an ongoing craving for alcohol. All forms will be considered as "alcoholism", the social problem.

[2]True to AA tradition, all members are anonymous.

adopt their emphasis on honest, open group discussion and prayer to specifically address alcoholism. The fundamentals of AA are integrated into a Twelve Step Program that includes an understanding of the craving for alcohol as similar to an allergy; a belief that only spiritual guidance can assist alcoholics; and a belief that the disease can be conquered only through total abstinence.

AA rejects any conception of drinking as "merely a manifestation of underlying psychiatric or mental problems" (Conrad and Schneider 1980:89) and does not associate alcoholism with particular socio-economic backgrounds. Focus is solely on the disease aspect. Members must admit their alcoholism, seek guidance from a higher power and abstain from alcohol, for one single drink is believed to result in a loss of control and a return to alcoholism. The popularity of AA has contributed to the widespread acceptance of the disease model of alcoholism and the perception of alcoholics as sick, rather than deviant, individuals. Yet while pointing to disease as the cause, AA continues to emphasize the individual responsibility of the alcoholic for maintaining her sobriety.

Jellinek's contributions

E.M. Jellinek is considered a prominent contributor to our understanding of the disease model. While Jellinek diverged from some key aspects of AA's philosophy, he attempted to build on the

founding concepts of AA[3].

Jellinek disagreed with the conception of alcoholism as an allergy that alcoholics are born with. Coming closer to the medical conception of alcoholism, Jellinek believed certain people to have a biological predisposition to alcoholism, some having a greater vulnerability due to psychological need for tension reduction, biologically low tolerance for alcohol and predisposing socio-economic hardships (Pattison et al. 1977).

However, the six tenets of the disease model as Jellinek understood it are similar to the AA perspective: 1) there is a unitary phenomenon which is alcoholism; 2) alcoholics and pre-alcoholics are essentially different from nonalcoholics; 3) alcoholics experience a craving for alcohol; 4) alcoholics develop a loss of control over their drinking; 5) alcoholism is permanent and irreversible; and 6) alcoholism is a progressive disease with particular, distinct phases. Jellinek believed that treatment requires an awareness of alcoholism as a disease, total abstinence and guidance in coping with the alcoholism. The disease is permanent, but can be controlled.

Jellinek divided "alcoholism" into two categories: "alcohol addicts" and "habitual symptomatic excessive drinkers" (nonaddictive alcoholics):

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[3]According to Pattison et al. (1977), Jellinek recognized shortcomings in his model and emphasized that most of his work was exploratory, not to be set in stone. His goal was to change social attitudes from blaming the alcoholic to concern and treatment of the illness.

> In both groups the excessive drinking is symptomatic of underlying psychological or social pathology, but in one group after several years of excessive drinking 'loss of control' over the alcohol intake occurs, while in the other group this phenomena never develops (Jellinek 1952: 674).

The loss of control, not experienced by nonaddicted drinkers, is a symptom of the disease of alcoholism which affects only addicts (Jellinek 1952)[4]. Disease drinking could be treated (in part) medically, whereas problem or deviant drinking (a moral issue) should be managed via the law (Conrad and Schneider 1980).

Jellinek's belief in the progressive, phasal nature of alcoholism as a disease was outlined by his four phases of addictive alcoholism that he believed to be general across cultures (but faster and less clear-cut for women[5]). These included: the prealcoholic symptomatic, prodromal, crucial and chronic phases. Later, he also categorized drinkers through a Greek alphabet typology, with alpha and beta as problem drinkers, and delta and gamma as alcohol addicts. He left the possibility

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[4]Jellinek later revised this stance, stating that "alcoholism is any drinking that leads to any damage". Yet he maintained a typology that separated those with a disease of alcoholism from those with milder varieties of alcoholism (Robinson 1976).

[5]In 1975, J.E. James conducted a study to see if the progression of symptoms in alcoholic women was similar to that Jellinek observed in men. While James found that women's experiences did not correlate with those Jellinek found in men, a replication of this study by Piazza et al. in 1986 contradicted her work. After a study of forty-one women from four different residential treatment centres, Piazza et al. found a correlation between women's experiences and Jellinek's progression of alcoholic symptoms in men. They suggest this difference between studies may be due to differing research methods and add that future research is required.

open for more varieties in the future. These typologies reflect
an attempt to validate the disease model through science.

Ambiguous role of the disease model today

The disease model of alcoholism is the prominent model for
the understanding of addictive drinking. Yet acceptance of the
model by doctors, alcohol treatment workers, the legal system and
the public has been mixed. While not agreeing with some aspects
of the model (such as AA's allergy analogy), the medical
profession will often treat the physical aspects of alcohol
dependence, while referring patients to organizations such as AA
for further treatment[6]. A part of the disease model is a
conception of alcoholism as a sickness that needs treatment, not
blame. However, Tournier (1986) presents evidence that many
alcohol workers, as well as doctors, legal professionals and the
public, still morally judge alcoholism: alcoholics are treated
with disdain and blamed for actions they commit while under the
influence of alcohol[7].

Some researchers present scientific challenges to the
disease model. Pattison et al. (1977) point out that Jellinek's
phases of alcoholism are factually inaccurate, that alcoholism is

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[6]Interestingly, as with much of psychiatry, the disease
model's approach to treatment creates a paradox where alcoholism
is considered a physical disease whose treatment must come about
largely through non-medical (including spiritual) means.

[7]A medical problem and stigma are not mutually exclusive,
however. Those suffering illness are often blamed (if not
directly) for their conditions.

not a biological predisposition (anyone can develop alcohol dependency through continued, long-term drinking) and that recovery is not necessarily related to abstinence. Even if there may indeed be a biological predisposition to heavy drinking among some individuals, the disease concept is "not based on evidence or scientific argument but rather on values, ideology, public opinion, politics and control" (Conrad and Schneider 1980:96).

Further, the disease model does not address some important aspects of alcoholism, especially for minority groups. The model can be considered an ethnocentric, individualist, patriarchal conception arising from North American society. It does not account for the differing, cross-cultural uses of alcohol, where some cultures do not even have concepts such as "alcoholism" or "problem drinking". It reflects an individualist ethic as it isolates people's experiences from their socialization and places the entire burden of recovery on the shoulders of that same individual[8]. The social context of chemical dependency is disregarded. For women, this approach is even more problematic than it is for men because their experiences are ignored in favour of those of a dominant, male model. As with most explanations of alcoholism and drug dependency, the disease model has generally examined only men. It is not until recently that it has been tested on women (Fellios 1989). Finally, class,

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[8]While AA does provide a support group for alcoholics, the onus of responsibility is placed solely on the shoulders of the individual.

gender and ethnic backgrounds are not considered to contribute to
chemical dependency.

Analyses of the structure of Alcoholics Anonymous have
pointed to a particularly male-oriented treatment approach that
reflects these biases.   In their Twelve Step program,
powerlessness, humility, and the need to turn to God are
emphasized. AA meetings also involve narrations of members'
experiences with alcohol. AA has been criticized by some
feminists as too negative, authoritarian, and indifferent to the
needs of women (Kaskutas 1989) as it perpetuates rather than
counters the powerlessness women feel. In response, Women for
Sobriety (Kirkpatrick 1986, Kaskutas 1989) has developed as a
self-help program for women in North America. This organization
emphasizes self-validation, self-esteem and focus on a positive
future rather than a negative past. Although groups are far less
widely established than AA, the program has been successful in
many communities (Kaskutas 1989)[9].

Psychoanalysis

Psychoanalytic theory has also been used to explain chemical
dependency. Psychoanalysis originated with Sigmund Freud and
provides the basis for psychiatry. Although Freud rarely
referred to alcoholism in his work, he did refer to other

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[9]When examining Alcoholics Anonymous it is important to keep
in mind that challenging the organization also means challenging
the belief systems of many alcholic women and men. It is this
belief system that keeps them sober.

psychopathologies. His ideas were later elaborated by others who saw aspects of dysfunctional personality contributing to alcoholism.

Psychoanalysts believe alcoholism and other pathologies to arise from disturbances in the psycho-sexual development of early childhood, or fixations from an infantile past (Barry 1988). When young, humans are all believed to have passed through four stages of early development: anal, oral, phallic and genital. If excessive gratification or frustration occurred at any of these stages, it interfered with transition to the next stage, leading to fixation at an immature stage, or regression to an earlier stage. These disturbances lead to faulty interactions between the id (our instinctual drive), the superego (our conscience) and the ego (which organizes, copes and balances between the id and the superego). Consequently, the ego functioning is weak or disrupted, and maladaptive behaviour such as alcoholism develops. Two separate problems can arise: excessive drinking due to its "unusually pleasurable" relief of anxiety, and a deficiency in the ability to avoid the consequences of alcoholism (Barry 1988).

The first, drinking to relieve anxiety, can be linked to a variety of disturbances. One such disturbance arises from the search for and the deprivation of sensual satisfaction or physical gratification. When sensuous satisfaction is deprived, a craving for alcohol or some other pleasure substitute develops as the individual seeks relief from anxiety. Under this rubric

is the hypothesis that alcoholism develops to disinhibit

homosexual urges. Sexual "perversion" is released by the

disinhibiting effects of alcohol, which act as a substitute for

that "perversion". Interestingly, such an effect was considered

to influence men and women differently, with men drinking to

overcome the "repression of natural homosexuality" and women

drinking as an expression of the "male side of their bisexuality"

(Barry 1988:115). Another disturbance is linked to a conflict

over dependency. When dependency desires are thwarted, there is

an unconscious craving for regression to the oral stage,

fulfilled by turning to the bottle. This approach is outlined by

McCord and McCord in <u>The Drinking Man</u> (1960). They posit that

social roles do not permit men to express feelings of dependency,

but that through the alcohol, the drinker can display a facade of

independence, while satisfying dependency needs through alcohol.

Only men were studied for exploration of this model, yet the

findings were extended to women with the suggestion that women

drink less because it is more culturally acceptable for them to

be dependent (Wilsnack 1976). As with the disease model, this

approach has been integrated into the Alcoholics Anonymous self-

help program[10].

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[10]David McClelland <u>et al.</u> (1972) challenged the dependency
model by suggesting that men actually drink "primarily to feel
stronger.... [where] those for whom personalized power is a
particular concern drink more heavily" (McClelland <u>et al.</u>
1972:334). Here the consumption of alcohol was shown to contribute
to thoughts of power, aggression and influence. The assumption is
that women, unconcerned with power, naturally drink less (Wilsnack
1976).
    Both the dependency and power models have been incorporated

Similarly, the second deficiency in ability to avoid the consequences of drinking emerges through conflict between the ego, the id and the superego. Such conflict leads to defense mechanisms (such as drinking) and a denial of reality (ignoring the effects of drinking). If the ego fails to reconcile the conflict, neurosis or psychosis will develop. This self-destructive behaviour, sometimes considered a slow suicide, can result from anger at the superego. Such conflict can also lead to a fixation at the oral stage, and consequent guilt and self-destructiveness, or it can lead to deprivations at the oral stage, related to feelings of worthlessness and consequent desires to drink. Finally, this destructive behaviour can also be linked to problems associated with the anal stage of development; the individual is rebelling against the anal traits of orderliness, precision and cleanliness (Barry 1988).

Barry (1988) outlines some weaknesses in psychoanalytic theory, pointing out that psychoanalytic concepts are based on inference, and not direct observations or actions. Further, neither components of the self (ego, id, superego) nor stages of development (oral, anal, phallic and genital) are clearly differentiated. This lack of clarity is compounded as theorists consider the components of the self and the stages of development

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into traditional alcoholism treatment programs. Neither addresses the needs or concerns of women, or the influences of ethnicity and gender. However, when informed by a discussion on gender roles, these perspectives may be useful for explaining men's chemical dependency.

differently. Overall, it is difficult to prove or disprove psychoanalytic theory.

Barry also suggests that the components of self and stages of development may change between societies (both historically and culturally) and that the use of alcohol itself may have different meanings in different societies. This latter criticism is particularly relevant here, and corresponds to a similar critique of the disease model. If the experiences of individuals change across time and cultures, is there also a difference in development between men and women? Are there other distinctions?

Some socialist feminists incorporate aspects of psychoanalysis into their theoretical approach when explaining early childhood development. Psychoanalysis is also prominent in some literature on feminism and addictions (Nol 1991). However, both Jagger (1983) and Greenspan (1983) question some aspects of psychoanalysis. Jagger believes that Freud's "anti-female bias, his universalism and his determinism", all of which are deeply imbedded in psychoanalytic theory, must be remolded by feminists to remove that bias. It is also evident that the heterosexist assumptions of psychoanalysis need to be reviewed. It is unclear whether such changes can be possible while maintaining core aspects of psychoanalytic theory. Jagger believes that while this can be accomplished, other, preferable conceptual frameworks may also develop.

Greenspan points to the entrenched dualisms and the individualist emphasis of psychoanalysis as being counter to

socialist feminist beliefs, and suggests that psychoanalysis cannot be successfully remolded. The dualisms of psychoanalysis include the id versus the ego, love versus death, instinct versus culture and the invididual versus society. All echo the separation of public and private that is a hallmark of patriarchy and contribute to the fragmentation, rather than a unification of our social experiences.

Further, by making a specific division between the individual and society, psychoanalysis obscures individualization as a social process. The individual is assumed to be an isolated entity, uninfluenced by society. Through therapy, an attempt is made to understand the individual separately from society, thus "a person's emotional problems are divorced from any current social, historical, or economic context" (Greenspan 1983:17). Psychological symptoms can only be understood as individual symptoms, apart from social relationships. Only influences of the family, and particularly the mother, are considered significant to an individual's development. Essentially, by believing psychoses to be in the individual, with no recourse to her environment, the victim is blamed:

> The objective oppression that women and working people suffer and which contributes to the formation of such symptoms is thereby rendered invisible (Greenspan 1983:19).

The exploitation that is so prevalent in our society is thus "conveniently ignored".

Sociocultural model

Sociocultural anthropologists seek to understand drinking

and drinking problems through examining people's beliefs and

behaviours in various cultures as they relate to alcohol:

> The social, psychological, economic, political and other
> non-organic outcomes of drinking in a given population vary
> as do the beliefs, attitudes and values that members of that
> population hold with respect to beverage alcohol, its
> interaction with the human organism and the propriety of
> given behaviours (Heath 1988).

The sociocultural model is, in a sense, eclectic, combining

diverse approaches towards understanding "how alcohol...is woven

into the very fabric of social existence" (Marshall 1979:3). The

intent of the sociocultural model is to expand our range of

knowledge about variations in human behaviour across both time

and space. Through such an approach, similarities and

differences between cultural drinking patterns are discovered,

challenging many western, ethnocentric perceptions about alcohol

and alcoholism. Mary Douglas (1987) points out that specific

questions also arise from sociocultural investigations; once

again our definitions must be questioned: what is problem

drinking? Do we take our view of problems, or the views of the

people we are studying? Does cultural diversity make any

difference in terms of physical problems related to alcohol

consumption?

This model is particularly useful for examining chemical

dependency in its relation to ethnicity (see Chapter Five). Reed

(1985) suggests that in many respects women and men also occupy

different cultures. This would give weight to the use of the sociocultural model in relation to chemical dependency in women. However, while some women's experiences with alcohol could be compared to a different "culture" than those of men, use of this model implies a division of the genders into separate spheres of experience, ignoring the interconnectedness between "cultures". These experiences are, in fact, different dimensions of one culture, where experiences are dichotomized to maintain social inequality. The sociocultural model is useful in forcing us to examine our assumptions when examining chemical dependency. However, it does not provide a base from which to examine chemical dependency as a social problem in western, industrialized societies.

Adaptive Model

The adaptive model sees addiction as a coping mechanism, rather than as a disease. Adaptive theorists posit that faulty upbringing, environmental problems and genetic "unfitness" contribute to maturity failure, resulting in economic dependence, family problems, self-hate, depression, aggression and selfishness (Alexander 1987). As a way of coping, individuals then turn to drinking and using drugs, or other addictions.

This model differs from the disease model in many ways. The disease model sees addicts as sick people, whereas the adaptive model assumes people to be adapting to an environment within the limitations of their own abilities and perceptions. The

environment itself is crucial, whereas for disease theorists, the environment is of minimal importance.

Disease theorists have criticized the adaptive model, claiming it portrays "the addict [as] consumed by forces outside that conspire to undermine his maturity" (Miller and Gold 1990:32). However, this criticism seems weak, as the disease theory also suggests a predisposing constraint (disease) that cannot be escaped, only controlled by the chemically dependent individual. The adaptive model provides an important contribution to our understanding of chemical dependency as it looks to the environment to explain addiction. However, this model too retains some problematic elements. First, "faulty upbringing", "maturity failure", "environmental problems" and "genetic unfitness" are loaded terms that remain undefined. The reader is not informed as to the specific environments that are considered to contribute to later problems. Further, while adaptive theorists view alcoholism as a social problem, they offer no clear avenue for addressing the issue.

Shoni Davis (1990) attempts to apply the adaptive model to the experiences of women. She focuses on the multiple stressors she believes that women experience: poverty, inadequate education, insufficient job skills, social isolation, and "dysfunctional interpersonal skills". Chemically dependent women, in particular, are said to experience these stressors and also to have poor coping abilities; in response, they try to control their lives through drug use, and a maladaptive lifestyle

develops. Davis places particular emphasis on the effects such a maladaptive lifestyle has on the children of chemically dependent women. She posits that chemically dependent women are not prepared to parent, never having achieved an integrated sense of emotional maturity. This then perpetuates the problem from one generation to the next.

Davis links this maturity failure to the past experiences of the chemically dependent woman. She posits that growing up in an emotionally deprived family, and experiencing sexual victimization and strict sex-role stereotyping contribute to a learned helplessness, passivity and dependency. These experiences in turn lead to feelings of personal inadequacy, anxiety, depression and worthlessness. Later unemployment and abusive partners reinforce this helplessness. As a result of these feelings, Davis feels that many chemically dependent women seek positive self-worth through pregnancy. However, she claims that, in the end, a baby will usually bring more guilt and shame as the women feel that they have failed even in the "basic motherhood role".

While the adaptive model emphasizes the role of the environment in maturity failure, and while Davis highlights the need for women to enter treatment, her approach has weaknesses. Davis recognizes the environmental stressors influencing the life of a chemically dependent woman, yet the tone of her article seems to blame the woman herself. Instead of concentrating on the difficulties faced by the woman, Davis looks to the woman's

role as a mother and the consequent detrimental effects on the child. There is no reference to the father's parenting role, nor to society's obligation to provide the adequate tools necessary to assist chemically dependent women in parenting. Once again, individual behaviour and individual responsibility have been underlined.

The adaptive model's emphasis on environmental factors provides a significant alternative to the disease model, and it needs to be explored further. However, while this model provides an interesting approach to our understanding of chemical dependency, deeper social criticism and proposals for environmental change are lacking. While introducing a social context (the environment), concentration still remains on the individual so that once again the importance of ethnicity, class and gender issues is ignored.

A Feminist Perspective on Addictions

As mentioned in Chapter One, few feminist writers on addiction articulate a specific feminist perspective. However, Nan Van Den Bergh (1991) has pinpointed socialist feminism as useful. She briefly presents some key aspects of socialist feminism, then applies them to a discussion of addictions. Van Den Bergh recognizes aspects of capitalist patriarchy that contribute to women's addictions, yet she too fails to discuss the specific material inequalities that influence addiction. Greenspan's work on women and therapy (1983) discusses these

inequalities and will also be examined here.

In terms of addictions, as we have seen, dominant treatment models are based on a white, male norm. Chapter One describes socialist feminism as a liberation philosophy that seeks an end to capitalist patriarchy. Socialist feminism promotes nurturance of both the self and the collective, valuation of personal experience, recognition of the interconnectedness of social life and the need to end domination. Yet how does addiction relate to this approach? Van Den Bergh posits that capitalist patriarchy perpetuates an environment conducive to addictive behaviours. For example, to reinforce competition, capitalist patriarchy uses the strategy of "divide and conquer", often manifested in military terms. Marxists believe this process perpetuates gender and ethnic inequalities; by dividing the workforce, workers can be pitted against each other, weakening unionization and providing cheap labour. An outlook based on dividing and conquering also contributes to an atomization of the world around us. Things and people are separated from each other, dichotomies are created and the interconnnectedness of human experience obscured. The consequent conflict and isolation may lead people to seek solace in chemical substances. Also, capitalist patriarchy demands conformity to existing beliefs and social norms. The ideal "norm" is the white, middle class, Anglo-Saxon

male[11], with ethnic minorities, lower classes and women relegated to the position of "other", thus isolated even further.

Van Den Bergh believes that both patriarchy and capitalism contribute to social dynamics that allow for "power over and control of others" (1991:4). Through the valorization of ownership and control, status and worth become earmarks of social success. However, limited access to ownership and control is integral to capitalist patriarchy: the aspirations of women, ethnic minorities and lower classes to "climb the social ladder" are thwarted. Van Den Bergh suggests that "addiction can develop as a way to numb and deny [the consequent] sense of powerlessness" (1991:4) that arises as people feel incomplete, imperfect or inferior.

Van Den Bergh links substance abuse to the shame, self-blame and further insecurities that result from past experiences of abuse or neglect. Greenspan adds that the need to numb inner pain can be linked to real socio-economic inequalities as women cope with pink ghetto jobs, economic dependency, poverty, and the double burden of housework and waged employment. Alcohol and drugs can provide a temporary relief from resulting anxieties. Both abuse and economic issues will be examined in Chapter Four.

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[11]This concept of the male norm is particularly prevalent in the health field. For example, Broverman et al. (1970) asked practicing clinicians to describe a healthy, mature, 1) socially competent adult (sex unstated), 2) a male and 3) a female. Male and female "ideal standards of health" were very different. Descriptions of a healthy adult matched those of a healthy male and were, in many respects, opposite to the "ideal" healthy female.

Gender role stereotyping is also associated with addictions. Van Den Bergh believes that women's roles emphasize an external locus of control. Here, objects and experiences that are outside the self give life its focus. Because of women's "caring roles", Van Den Bergh sees the feminine gender role as a "set up" for addiction[12]. Women learn to define their successes and failures through others.

Strict gender roles can also be linked to addiction as they limit women's power. Capitalist patriarchy perpetuates the division between public and private spheres, with the feminine gender role being linked to the latter. The private sphere is also considered to be secondary in importance; consequent political, economic and social inequality may contribute to women's addictions. This issue is discussed further in Chapter Five.

The socialist feminist perspective sees addictions as arising from powerlessness, which may foster a need to become numb to feelings or to control others. Through drugs or alcohol, women can feel either, despite the transience of these feelings and the greater shame and powerlessness that inevitably result. Paradoxically, it is believed that in treatment, a client must first admit powerlessness over her addiction. This becomes empowering as the client learns to deal with her addiction and to

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[12]Extending her emphasis on loci of control, Van Den Bergh points out that men tend to have an internal locus of control She suggests that men who have addiction problems may question their own ability to fulfill their role.

recognize the contradictions and social constraints around her. Powerlessness also contributes to low self-esteem, thus treatment must assist women in gaining self-confidence. Van Den Bergh suggests that such self-acceptance is enhanced in all-women treatment groups where women can learn that they are not alone in their experiences. Women must internalize a woman-identified sense of femininity that sees women as survivors, not victims.

While raising women's self-esteem is important, feminist treatment must examine society as well as the individual, focusing particularly on the influence of patriarchy. As Greenspan emphasizes, therapy must not reflect the status quo and thus share in the oppression of women, rather, therapy is a potential instrument of social change:

> Therapy may help people cope with certain intolerable social conditions, but it cannot improve those conditions unless it contributes to raising the consciousness of patients so that they will be less likely to tolerate them (1983:36).

Therapy must help women to identify the personal and political origins of their anger.

While aspects of other perspectives on chemical dependency will occasionally arise, the socialist feminist perspective on addictions will inform the following discussion on chemically dependent women and available treatment.

Chapter III

Women and Chemical Dependency

The above perspectives on chemical dependency have provided explanations for chemical addictions. As stated earlier, most have focused on chemically dependent men; women have been either overlooked, or simply "added on", after the fact. While it is important that male chemical dependency be addressed, an extensive literature is already devoted to this task. Thus, I will concentrate my discussion on women and their experiences with drugs and alcohol: how women's addictions are manifested, some consequences for chemically dependent women, responses from the wider society, available treatments and their successes. As Sandmaier states, "every dimension of a woman's addiction - its causes, its consequences, its subversive hidden quality, its treatment - [is] shaped by her subordinate and devalued status" (1980:32). This discussion will be supported by qualitative and quantitative data arising from research conducted in the summer of 1991.

Research Design

Between May and October 1991, I produced an evaluation report examining several treatment centres employing different strategies for treating chemically dependent women in British Columbia (Raby 1991). The project was commissioned by Maiya

House Society, a residential treatment centre for women in Nanaimo, British Columbia. The report was intended to provide information to assist in the improvement of services available to chemically dependent women.

In this evaluation, the experiences and impressions of women who had completed various types of treatment were compared. Three groups of chemically dependent women were interviewed: women who had completed a course of outpatient alcohol and drug counselling through an alcohol and drug clinic, women who had completed a coed residential treatment program and women who had completed a women-only residential treatment program[13]. The nature of any chemical use since treatment and present perception of life satisfaction were determined to measure the effectiveness of certain forms of treatment and to provide information that would enhance treatment options.

Forty-nine women were interviewed: 7 from outpatient treatment programs, 18 from coed residential treatment and 24 from women-only residential treatment. Most clients were referred to treatment by alcohol and drug counselling services. Criteria for selection of appropriate treatment modality included

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[13]Generally there are three levels of treatment: detoxification, rehabilitation and long-term follow-up. Detoxification is usually done in a hospital or detoxification centre and, for alcohol, usually takes only a few days for the chemical addiction to be removed. Rehabilitation programs (those under study here) usually require prior detoxification and then involve residential treatment, intensive self-help programs such as daily Alcholics or Narcotics Anonymous (A/NA) meetings, and/or regular individual counselling. The third step, long-term follow-up, may include regualar A/NA meetings and counselling.

availability (which programs had shorter wait lists),

geographical proximity and client desires (eg. non-residential).

To a certain extent, severity of the problem may have prompted

counsellors to opt for residential over outpatient treatment.

Subjects had completed a course of treatment at the above

facilities one to two years prior to the time of interview.

Interviews were conducted in June and July of 1991.

A number of British Columbia Alcohol and Drug Programs

treatment centres were contacted and asked if they would be

interested in participating in the project. Most centres that

were approached did not participate, citing recent changes to

their programs, changing directorships, lack of time, or

discomfort with the nature of the project.

The following organizations participated in the study:

1) <u>Outpatient counselling</u>: The Alcohol and Drug Programs

treatment centres in Delta and Victoria were used for this study.

These non-residential clinics offer regular, individual

counselling sessions and an orientation (and sometimes referral)

to other chemical treatment services. Treatment at outpatient

clinics ranged from four weeks to two years or more.

2) <u>Crossroads</u> is a 32-bed, coed residential treatment centre with

a 28-day program. The program involves lectures, group and

individual counselling and emphasis on Alcoholics/Narcotics

Anonymous (A/NA) and is complemented by nutritious meals,

exercise, communal household chores and recreation. Before

January 1991, Crossroads allowed women to enter their program

with every intake, which occasionally resulted in female clients
being the clear minority in a group of men. Since January 1991,
Crossroads has allowed for women-only intakes, which may have
some effect upon future success rates among female clientele.

3) Maiya House Society is a 7-bed, women-only residential
treatment centre. Treatment is six weeks long and involves
lectures, group therapy, individual counselling, nutrition and
exercise. The program at Maiya House Society includes education
on women's issues and assertiveness training. Women are also
required to attend weekly A/NA meetings and are referred to
outpatient counselling upon completion.

4) Alcoholics Anonymous (AA) is a worldwide organization with
over 76 000 local groups. Its sister organization is Narcotics
Anonymous (NA). While A/NA did not formally participate in this
project, most of the women interviewed had been to A/NA at some
point in their lives. Both programs consist of weekly, biweekly
and sometimes daily meetings where recovering substance abusers
share their experiences and provide mutual support.

Centres that agreed to participate contacted all the women
who completed their program between April 1989 and April 1990.
Many women could not be reached because they had moved or their
phones were out of order. Of those contacted, most agreed to be
interviewed. First names and telephone numbers of these clients
were then sent to the researcher, who telephoned these clients to
arrange an interview time. The overall sample size was 59
subjects, with 49 completed interviews.

One third of the interviews were done in-person, with the remaining interviews completed by telephone[14]. The eleven-page questionnaire had sixty-three questions and was constructed to be as open-ended as possible, while maintaining a quantitative structure. It included questions regarding the nature of treatment received, subjective evaluation of treatment, and pre-treatment and post-treatment life situations such as relationship status, income and education (see Appendix). Most in-person interviews were tape recorded and some quotes from these interviews are included in the following discussion. To protect anonymity, pseudonyms are used[15].

It was hypothesized that women-oriented residential treatment programs would show greater success rates for female substance abusers than other programs. This would result from their attention to the specific societal pressures shown to affect the female substance abuser, and the need for women to work through their addictions in a safe, supportive environment.

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[14]The selection process for in-person interviews was based on treatment type and geographical location, with an attempt being made to be as representative as possible while accounting for a limited travel budget.

[15]Two women were interviewed independently of this project: one was in residential treatment and volunteered to be interviewed when she heard about my work and one was referred to me by another woman interviewed during the course of the project. Information from these interviews has been included in the qualitative, but not the quantitative data presented here.

Demographics

Most of the women interviewed had used more than one type of drug before entering treatment, although alcohol was the most popular drug of choice. Forty-eight (95%) had used alcohol abusively at some point in their lives. Twelve (24%) had used prescription drugs[16], 23 (47%) had used marijuana and 19 (39%) had used hard drugs such as speed, heroin or cocaine at some point in their lives. Most of the women started using or drinking in their teens and tended to drink or use drugs daily.

Half of the women interviewed had been divorced at some point in their lives. Most were heterosexual, with only four open lesbians interviewed. Most women (36 or 74%) were also parents. Twenty-two (61%) of the 35 women involved in relationships (and who responded to the question) had partners who were either recovering or using addicts. Of all the women who responded to the question, 76% of them had been physically abused by partners at some point in their lives (see Table 1). Most women said they found their current relationships to be satisfactory.

Most clients were between 26 and 45 years of age, and had completed some or all of their high school education. Thirty-six of the respondents were Canadian-born whites. Five women were immigrants from either Europe or the United States. One woman

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[16]"Prescription drugs" was left undefined during interviews, although questioning implied problem usuage (as defined by the client).

immigrated from Costa Rica. Seven women were either native or metis.

Thirty-three (67%) of the sample grew up with their natural parents. The remaining women grew up in a variety of environments ranging from single parents and stepparents, to relatives and family friends. Consistent with other findings (eg. Corrigan 1980), most women (33 or 67%) had at least one alcoholic parent.

Table 1: Demographics of the population entering treatment[17]*

	Women-only		Coed		Total	
	n	%	n	%	n	%
Employed full/part	16	(64)	11	(50)	27	(57)
Unemployed	9	(36)	11	(50)	20	(43)
Enough money	11	(46)	10	(46)	21	(46)
Barely enough money	4	(17)	4	(18)	8	(17)
Not enough money	9	(38)	8	(36)	17	(37)
Sexually assaulted	21	(88)	17	(77)	38	(83)
Abusive partner	18	(82)	13	(68)	31	(76)
Alcoholic parents	16	(70)	13	(65)	30	(67)

*Due to rounding, percentages may not total one hundred.

There was little difference between the backgrounds of women entering each treatment modality in terms of age, monetary

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[17]Original data was categorized into women-only, coed and outpatient treatments. For this thesis, only women-only and coed categories will be presented, with the inclusion of data from outpatient clients who clearly participated in either a coed or women-only program.

security, area of residence prior to treatment (urban or rural),
percentage with alcoholic parents, or percentage with enough
money when growing up. Those in coed treatment were slightly
more likely to be parents. Employment was slightly higher among
those entering women-only treatment. On the other hand, those
entering women-only treatment were more likely to have
experienced sexual abuse at some point in their lives and to have
had abusive partners.

Drug use among women

In order to properly apply a socialist feminist analysis to
the issue of women and chemical dependency, the nature of that
dependency must first be presented. For example, historically,
women and men have tended to use alcohol and drugs for different
reasons, with women using chemical substances for medicinal or
theraputic purposes or to stifle anger, while men use drugs or
alcohol for recreation and pleasure (Gomberg 1982). A similar
pattern arose in the course of interviewing:

> So I made up my mind that I would just do [pot] for fun and
> not do it when I was angry or bothered about something and
> the very next day I got angry and so I rolled a joint....
> (Liz)

> I was taking [antidepressants] to stop feeling and every
> time I'd feel, I'd increase the dosage. (Jamie)

Corrigan (1980) also notes that most women offer escapist, not
social, reasons for drinking.

While most women interviewed were alcoholics, generally,
women are more likely to become addicted to prescription drugs

than to hard drugs or alcohol. It may be that alcoholic women are more likely to receive treatment. Prescription drugs are legitimized by their legality (unlike other drugs such as marajuana or cocaine), their social acceptability and by the doctor's role in their distribution:

> We see large numbers of women "doped" into a passive acceptance of the female condition by physicians too willing to placate women they see as complaining, hysterical patients (Nichols 1985:85).

The pharmaceutical industry also plays a significant role: "Literally millions of dollars per year are spent by [the pharmaceutical industry] on advertising and the target is the doctor because he is the one who decides what the patient will buy" (Innes et al. 1984:31). These advertisements are regularly aimed at the treatment of female patients.

Despite their popularity, prescription drugs can be dangerous. Antidepressants and tranquillizers can contribute to a variety of "side effects" that include confusion, depression, headache, slurred speech, dizziness, nausea, inability to control urination, changes in sex drive, and blurred or double vision (Burnside 1990)[18]. Similar side effects are evident for other prescription drugs. For some women, new medications are then prescribed to counteract the side effects (Greenspan 1983); some women thus become addicted to more than one prescription drug. Others become addicted to both prescription drugs and to

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[18]Furthermore, women, particularly older women, are not routinely involved in the pre-testing of prescription drugs (Burnside 1991).

alcohol[19], seeking to supplement their alcohol intake with "a few pills":

> I went to see a psychiatrist a few times and I would never really tell them how much I drank or that I did drugs just that my husband got killed and I suffered from anxiety so then they would prescribe me the Syrax [a benzodiazapine or sleeping pill]. And they also put me on anti-depressants. (Janet)

Robe (1980) indicates that the addictive effect is greatly compounded through the combination of prescriptions drugs and alcohol. Taking one drink and one pill together can increase the effect by up to eight times that of either drug alone (Robe 1980).

> ...and pills came, so I became a drug addict.... They put me flying high... it almost killed me... it just annihiliates me, it just eliminates me and I can't act and I can't think. And I'm an alcoholic, eh?, so I drink. That is like an atomic bomb.... (Maria)

Women are far more likely to use (and abuse) prescription drugs than are men. In Canada, the female-to-male ratio for tranquillizer prescriptions is 2:1 (Cariboo College 1990).

Also, when women do drink alcohol, or use other drugs, two-thirds will do something to hide their drug use, undoubtedly due to the social stigma women experience:

> Eventually I ended up drinking on my own, when my husband was out of town and my kids were in bed so that nobody saw me drinking and I'd hide the problem from myself. (Edith)

For example, rather than visiting the bar with friends, many women drink alone in their homes.

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[19]Corrigan found that almost half the chemically dependent women she studied used other drugs (usually prescription drugs) while drinking (1980).

The Stigma of the Alcoholic Woman

Generally, it is considered less socially acceptable for women to be either alcoholics or drug addicts than it is for men (Fillmore 1984, Kirkpatrick 1986, Robertson 1991). When a man drinks to excess, he may be seen as caving in to a good thing, but for women, drinking is seen as an aberration (Sandmaier 1980). Historically, women were celebrated as the guardians of social values, and their abuse of alcohol (and other non-prescription drugs) was seen as a threat to social stability. This continues to be the case. Substance abuse is inconsistent with societal expectations of women as nurturing, refined, chaste, and committed to self-sacrifice. Also, the consumption of alcohol tends to result in "masculine behaviour": the drinker becomes louder, more aggressive and less concerned about the impression she makes (Sandmaier 1980:10)[20]. Such behaviour in a woman is considered intolerable and women internalize these judgements:

> Studies repeatedly show that alcoholic women suffer
> significantly more guilt, anxiety, and depression than
> alcoholic men, have lower self-esteem, and attempt suicide
> more often (Sandmaier 1980:9).

Women evaluate themselves by society's standards, becoming both "appraiser and appraised".

> That's the worst part of being an alcoholic, you know? You
> don't know the mess that I did. You don't know the damage
> that I caused.... Unfaithfulness in my marriage... I don't

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[20]A 1989 national survey found that most Canadian men and women believe it is acceptable for men to drink to feel the effects, but not for women (Health and Welfare Canada 1990).

know how my alcoholism went so deep, to such a degrading stage. I don't know why my husband didn't leave me. (Maria)

Yet social prejudices against chemically dependent women have not prevented substance abuse, they have just influenced how it is manifested, with more women on prescription drugs and alcoholic women hiding their drinking (Badiet 1976).

Women who drink have also been associated with sexual promiscuity and "loose", immoral behaviour, even though research fails to support this assumption (Sandmaier 1980). As Morgan notes "even today a woman who is a victim of assault or aggression and who has been drinking will likely be blamed in some way for her victimization" (1987:130). This is an example of how drinking is used to explain what happens to women when they depart from their traditional roles; the threat of deviance and blame maintain social control, keeping women within their prescribed roles (Morgan 1987)[21].

For alcoholic men, low self-esteem is a significant problem; for chemically dependent women, this problem is even more acute (Beckman 1978, Cariboo College 1990, Calkins 1991). As women, their self-esteem is already likely to be lower than it is for men. This, in turn, leads to low expectations of themselves (Reed 1985). For example, it has been shown that women are more likely to blame themselves if they fail in a task, yet to attribute success to luck. Men, on the other hand, will

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[21]Conversely, the use of alcohol is often used as an excuse for male aggression, such as assault and spouse battery (Morgan 1987).

attribute success to their own abilities and explain failure as a

result of external handicaps (by saying, for instance, that a

test was particularly difficult) (Deaux and Emswiller 1974).

This tendency was evident in women's responses to their failure

in treatment:

> I tried church, I tried AA, I tried treatment centres, I
> tried detox, I tried them all and they didn't work and I
> think it's because I didn't really want any of them to work.
> (Lori)

> They never really focused on personal issues [at
> Crossroads], you know? Compared to Maiya House, I don't
> think I got anything out of Crossroads but then, that could
> have been my frame of mind too. (Jamie)

Seldom did the clients attribute treatment failure to the

program. However, treatment success was invariably attributed to

the programs.

With chemical dependency and its concomitant stigma, shame

and guilt are heightened and self-esteem plummets as women

internalize their lower status:

> When I came out of treatment... my self-esteem was pretty
> low in a lot of ways when I left and that was me, it wasn't
> the program, it was the way I was... cause I don't think I
> dealt with the shame, the shame part of being an alcoholic.
> (Edith)

Further, women who are mothers experience added shame and guilt

as they feel they have failed to fulfill society's expectations

due to their chemical dependency:

> I was crying in a group session and [this woman was] saying
> I'd lost my children... because of alcohol and she said
> "well, you should have though of that before you had them".
> (Lori, said while in tears)

Then, when they finally go into treatment, they are concerned about the well-being of their children who are often staying with a friend or a family member; sometimes this arrangement can impede the woman's recovery process:

> There were things happening at home and I wrecked my own treatment again. So I'm hoping to go back, hopefully in the fall. Things were happening at home and they kept phoning and I wasn't able to concentrate on myself. (Fay)

Many women also feel guilt for having to give up their children temporarily while they enter treatment (Cooksey 1991).

The stigma upon the chemically dependent woman may influence the treatment she receives. Most women who are chemically dependent find little support from their families or from society at large (Sandmaier 1980). People do not like to admit that a woman may be an alcoholic. Families will sooner hide or deny the problem than address it. Generally, women alcoholics have been "protected" by their families, particularly among ethnic minorities (Lopez-Lee 1979). Not only are women discouraged from seeking treatment but they are also encouraged to ignore the problem or, often, to seek treatment for other ailments such as depression. Also, female alcoholics are less likely to have supportive partners than are male alcoholics. Nine-tenths of men with alcoholic wives desert the relationship, whereas nine-tenths of women stay with their alcoholic husbands (Hall 1983)[22].

Unwillingness to recognize chemical dependency, particularly

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[22]In Corrigan's 1980 study, however, only 15% of husbands (3 out of 20) said they left their marriages due to their wives' heavy drinking.

alcoholism, is also found in the doctor's office. When visiting

the doctor with alcoholic symptoms, women have often been treated

for depression instead (Sandmaier 1980).   This contributes to

the above mentioned prescribing of anti-depressants or

tranquillizers, thus compounding the woman's dependence problem

(Sandmaier 1980, Kirkpatrick 1986, Strega 1990):

> Stuff happened to me that sent me over the edge... and then
> I went to see my doctor because I was suicidal... and he
> prescribed antidepressants and he said "you don't have to
> worry because they're not addictive", right? I said "well,
> that's right on!". You know? And [the antidepressants]
> didn't do anything and I went from bad to worse... I stayed
> on anti-depressants from that time on, for a year.... I
> couldn't get down off them, I had all the feelings that I'd
> been stuffing with the antidepressants and it wasn't
> working. (Jamie)
>
> I think [doctors] should ask people more questions. I think
> the medical profession is really naive to addiction and they
> feed it. There was actually one physician I would see who
> would give me diet pills and tranquillizers at the same
> time. I would go in there drunk and he would know I was
> drunk and he would still prescribe these medications.
> (Janet)

Such diagnoses, while augmenting women's chemical dependency to

include addiction to prescription drugs (Fellios 1989), also

prevent treatment of the initial dependency.

Health Issues

While dealing with stigmatization and low self-esteem, women

who are heavy drinkers or drug users may experience health probl-

ems not encountered by chemically dependent men. It has been

found that women absorb alcohol faster than men do (particularly

during ovulation), thus becoming inebriated more quickly and that

the effects of alcohol last longer in women (Burnside 1990). In fact, Frezza et al. (1990) found that women receive 30% more alcohol into their blood than men who weigh and drink the same[23]. Also, the effects of alcohol have been shown to last longer in women. This contributes to the "telescoping" of their alcohol problems: the time between the onset of alcoholism and "hitting bottom" is shorter for women than it is for men (Robbins 1989)[24]. Physical consequences of high alcohol consumption, such as liver damage, can progress much faster for women (Roman 1988, Johnson 1991). Other women's health problems that have been linked to substance abuse include breast cancer, infertility, miscarriages, and brain damage (Cariboo College 1990). Further, if a woman is drinking during pregnancy, fetal alcohol defects may develop in the child[25].

Many women, particularly alcoholic women, also have a problem with eating disorders including anorexia, bulimia, overeating and not eating (Beary 1986, Cooksey 1991). In my

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[23]Further, women taking oral contraceptives have been found to metabolize alcohol more slowly, further lengthening alcohol's effects (Jones and Jones 1984).

[24]However, not all researchers have found this to occur. Corrigan (1980) found no evidence of telescoping.

[25]Most work on women and alcohol is in the area of fetal alcohol syndrome. While this is an important area of concern, these works often ignore issues associated with the mother, focusing only on the child. Interestingly, a number of women interviewed for this project mentioned abstaining from alcohol and drugs for the nine month duration of their pregnancy. Similarly, Corrigan (1980) found that half of the chemically dependent mothers she interviewed did not drink during pregnancy.

research study, nine (20%) of the 46 women who responded had experienced anorexia or bulimia at some point in their lives. Another eleven (24%) had experienced some other eating problem such as overeating, not eating, colitis or binge eating. Eating disorders in turn can be linked to control issues and to low self-esteem. As Chrisler (1991) discusses, women who feel powerless and unable to control the world around them may gain a sense of power through control over their own food consumption. Whether they are anorexic or bulimic, women seek feelings of power as they attempt to exercise self-control. Those who are compulsive eaters feel they lack control, and seek solace in food.

There is also a significant overlap between chemical dependency and depression in women. Women are three times as frequently depressed as men and their depression is often treated with prescription drugs. Some women also self-medicate with alcohol. Once again, the symptoms are treated without any examination of the social environment. Depression is a significant health concern, "ranging in severity from normal, everyday moods of sadness to psychotic episodes with a risk of suicide" (Burnside 1990:13). Providing a socialist feminist perspective, Greenspan links depression to the reality of oppressive inequality:

> People without power, people who look around at the world and do not see themselves reflected in it, learn to feel marginal, unimportant. People for whom the social order shows contempt learn to hate themselves. Powerlessness breeds depression (1983:194).

Burnside echoes this stance: "negative thoughts are a natural response to social powerlessness, the root cause of depression" (1990:35). Both Gomberg (1982) and Greenspan (1983) suggest that women's depression is, in part, a survival strategy, for it is the only way a woman can legitimately receive care from others.

> A couple of weeks ago [I attempted suicide] and I'm going why? You know? Like what? And it's not really trying. It's not really trying. It's just like "Listen to me. I am trying to tell you something. I hurt." (Lori)

Yet in the end, like chemical dependency, depression does not work, instead it results in defeat.

This chapter has raised some areas of divergence between female and male experiences with substance abuse, providing some background for the following presentation of findings. Inevitably, issues raised here have not been exhaustive, but social stigma, low self-esteem and health consequences are key areas that should not be overlooked.

Chapter IV

Findings

Methods for treating chemical dependency have not been well tested, despite their extensive use across North America. We do not know what works; in fact, it is estimated that up to one third of all addicts actually recover without treatment at all (Liscow and Goodwin 1986, Robertson 1991). Recently, researchers have begun to question the success of some of the more popular treatment modalities although most of this work again focuses on the male (or "androgynous") client (Peele 1990).

Emphasis has been placed on testing the success of individual and group counselling, psychotherapy and treatment based on education, lectures, residential treatment, Alcoholics Anonymous, marital therapy and a "broader spectrum" approach (social skills, group, and assertiveness training, stress management et cetera). Length of treatment has also been examined (Miller and Hester 1986).

Miller and Hester found marital therapy and the "broader spectrum" approach to be most successful, suggesting that clients must be matched to treatments. For example, severity of alcoholism and nature of life problems could influence the usefulness of specific treatments. Additionally, the availability of choice of treatment for the client improves overall success (Miller and Hester 1986). The importance of

matching clients to treatment is also highlighted by Peluso and Peluso (1990)[26]. Similarly, a 1990 Review of Quebec drug addiction literature found that there is no ideal treatment for drug addiction; rather, individualized service is needed (Chamberland 1990). The report also emphasizes the need for standardized clinical evaluations.

While these studies are important, the sex of subjects is usually unstated and treatment success among women unaddressed. Only one prominent study has examined the success of women in treatment (Corrigan 1980). In 1980, Corrigan conducted a comprehensive, longitudinal study of female alcohol abusers in New York City. One hundred and fifty women in treatment centres were interviewed when they first arrived for treatment, and again thirteen months later. Corrigan found that forty-one percent of the subjects had not consumed alcohol since treatment. A further twelve percent drank on rare occasions. Seventy-eight percent attended AA, although Corrigan found that AA had minimal impact if it was the only form of treatment used. Corrigan also found that two-fifths of the women had at least one parent with a drinking problem.

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[26]Peluso and Peluso advocate oupatient care programs, emphasizing the difficulty some clients have in entering a residential program due to job and family commitments. Outpatient programs are also far less expensive than inpatient treatment. Peluso and Peluso do emphasize, however, that some clients require inpatient care and its availablity should not be compromised due to cost (1990).

Corrigan's findings suggested that socio-economic status and ethnic background influenced treatment success rates. For example, 71% of professional women either abstained or only drank socially as compared to 45% of non-professional women. Professional women were also more likely to be employed (71%) after treatment than non-professional women (32%). Similarly, 75% of those in a high socio-economic bracket abstained or only drank socially compared to 51% in the middle bracket and 34% in the low[27]. In terms of ethnic background, Corrigan compared white and black women, with 63% of white women abstaining or drinking socially, but only 22% of black women[28]. However, Corrigan did not compare women-oriented treatment to traditional treatment orientations.

Annis and Liban (1980) have also taken sex into account when evaluating treatment. They found that women's success rates were usually either equal to or better than those of men going through the same programs. Yet, as they point out, their study creates more questions than it answers. Do women generally fare better than men in any kind of treatment? Would there be an even greater improvement in women-only centres? What factors contribute to one woman's success over another's? What about those

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[27]Corrigan categorized socioeconomic status based on the respondents education and income (both source and amount).

[28]Corrigan suggests that a lack of social networks, low socioeconomic status, living in deprived situations and living with men who drink contribute to the low "success" rates for the black clients.

who drop out?[29]

*　　　　　*　　　　　*

In this project, thirty-three (70%) of all women interviewed were no longer drinking and/or using abusively. These findings are comparable to those of Corrigan (1980). Also similar to Corrigan's findings (1980), it was found that age, area of current residence (rural or urban), level of education, and parents' alcoholism did not influence outcomes in terms of drinking and/or using.

Other factors did influence outcome, however. Although sample size is small, ethnicity appeared influencial. Of the 36 Canadian-born whites, 19% were still using alcohol or drugs at the time of the interview. Of the seven respondents who were either native or metis, 5 (or 71%), were still using alcohol or drugs.

Post-treatment education was also linked to success. Of the 24 women who took some post-treatment schooling, there was a higher rate of success (20 or 83%) than among those without post-treatment education (15 or 63%).

There was a strong relationship between regular using and/or drinking and a low evaluation of life satisfaction. Six (43%) of those who were still using drugs and alcohol were not satisfied with their lives compared to 1 (3%) of those who were no longer

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[29]For instance, Sandmaier states that more women than men drop out of coed treatment programs (1980:229).

using drugs or alcohol. Similarly, there was a relationship between not using and a high personal evaluation.

There was little difference between responses from women interviewed over the phone and those interviewed in-person, in terms of abuse or using. However, those who were interviewed over the phone were more likely to find a women-only environment to be positive (18 or 90%) than those interviewed in-person (5 or 63%).

Of further importance, and discussed in more detail below, are the links between success and women-only treatment, post-treatment employment and support networks.

Women-only versus coed treatment

A socialist feminist approach to treating chemical dependency helps us to recognize the need for women-only, feminist treatment centres[30]. Feminist counselling recognizes that we must examine society as well as the individual when treating chemical dependency; women's addictions cannot be addressed without recognition of the inequalities women experience. Feminist counselling thus includes a critical pedagogy where women learn about their oppression. Further,

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[30]Women-only and feminist treatment centres are not necessarily the same. Women-only treatment may not include a feminist perspective. Also, some would argue that feminist treatment could be coed.

In this project, women-only treatment was also feminist in orientation and coed treatment was not. I also believe that, at this point in time, feminist treatment for women needs to be women-only.

feminist counselling does not accept the male norm that is so often used to guide treatment, using a women-centred approach instead. The influences of economic inequality, strict gender roles and past physical and sexual abuse are accounted for. Feminist counselling will also emphasize the strength and potential of women, recognizing that women have generally been expected to nurture, while themselves being deprived of nurturance. Instead of helping women to accept their prescribed gender role, counsellors help them (and their families) to recognize their "central and essential needs as [people]" (Levine 1976:39). There is also an emphasis on self-esteem and assertiveness training (Strega 1991).

A small number of such treatment centres are emerging. These centres are important for a number of reasons: 1) They validate women's experiences by providing an environment where women are comfortable sharing personal stories. As women hear others discuss issues and events that relate to their own lives, they realize that they are not alone in their experiences. 2) Gender inequalities are recognized and women's dependency is examined in light of the social environment in which they live. 3) Women are provided with a safe, women-only environment in which to work through their chemical dependency. Such an environment is particularly important for women who have been mentally, sexually and/or physically abused by men at some point in their lives, as these women may feel uncomfortable in a coed setting:

> I think that having a women-only [treatment] was really
> positive for me because I don't think I would have been as
> open if there had been men there... too much of a people
> pleaser. I think it would have been harder to open up about
> my relationship issues and sexual abuse if there'd been men
> present. (Edith)

> I could talk about those feelings without having to worry
> that somebody would say "well, you shouldn't feel like that,
> those aren't real".... I just felt a lot safer at Maiya
> House [than Crossroads]. (Jamie)

For heterosexual women, attendance at a coed clinic can generate
interest in sex and relationships, replacing drugs or alcohol,
reinforcing codependency problems and detracting attention away
from work on the self (Calkins 1991):

> When I first went to counselling I found that if there was
> male participation there and it was about the age group that
> I might be interested in... I found that I edited what I
> said and that I always felt that I wanted these people to
> look on me in a favourable light so of course I said what
> was going to do that at the time. And I found that when I
> was in women's sessions that that didn't happen... I found
> that I was much more open and much more honest about who I
> was and what was going on. (Debbie)

> When you have a little girl who is highly intelligent and
> brought up with an alcoholic father and a manipulative
> mother you're going to get a grown up woman who's going to
> manipulate men. So, it would be better if there were
> women's programs only, I think, because I've done the coed
> stuff and I've used my manipulative skills on men... just to
> create a diversion and to have some fun and take the place
> of alcohol. (Lori)

Another advantage of a women-only environment is that women can
come to their own conclusions there, without following the norm
created by men in a group (Cooksey 1991).

Women-only treatment needs to be made available as an option
for women. Through my study, I found client success rates to be
higher among those who attended women-only treatment (see Table
2).

Table 2: Using by treatment source[31]

	Women-only		Coed	
	n	%	n	%
Using	6	(24)	8	(36)
Not using	19	(76)	14	(64)
Total	25		32	

While this is only a pilot study and the sample size is small, these findings highlight the need for further investigation.

The women interviewed also stated a preference for women-only treatment environments. In comparing coed and women-only treatments, eleven (34%) of the women who discussed coed treatment found the coed element of their programs to be positive. A much higher percentage, (23 or 82%) of those who commented on women-only treatment said that they felt the women-only environment to be a positive aspect of their programs. Also to be noted is that 20 (87%) of the clients who had been sexually abused and went to women-only treatment felt positive about women-only treatment. Only 11 (42%) of those who had been sexually abused and went to coed treatment felt positive about their programs. Many women pointed out that they feel more comfortable discussing sexual abuse issues when men are not present.

Overall, it is concluded that many women need (and value)

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[31]"Using" includes women who drank a little less than, as much as, or more than they had prior to treatment. Included under the "not using" category are social drinkers (two drinks or less per week or one joint of marijuana in a week), and those who had occasional relapses (less than three in the past year).

women-only treatment as an alternative for chemical dependency treatment. The provision of treatment options to potential clients is of key importance, as well as regular, comprehensive evaluation of treatment programs available to women.

Unfortunately, while women-only, feminist treatment may be necessary for some women, available treatment facilities are limited. Even in terms of traditional treatment, often fewer beds are available to women than to men. In Canada, men outnumber women 2 to 1 in having alcohol problems; however, in treatment, males outnumber females 3.5 to 1 (Working Groups on Alcohol Statistics 1984). Data could not be found on the proportion of women with specific alcohol problems in British Columbia; however, the availability of treatment for males outnumbers that for females by a margin of 3 to 1 - a small improvement over the national ratios, although still insufficient[32]. Alcohol and Drug Programs in British Columbia funds almost three times as many treatment beds for men as it does for women (Maiya House Society 1990), despite the increased number of women seeking treatment (Working Group on Alcohol Statistics 1984). The Working Group on Alcohol Statistics recognizes the need for formal treatment for women:

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[32]Wait lists of up to four months were reported by Maiya House Society; Aurora Society, a women-only treatment centre in Vancouver, reported up to three months. Maple Ridge Treatment Centre, a coed environment for treating alcoholism, reported a three month wait; Pacifica, a coed residential treatment centre in New Westminister reported one month. The wait at Crossroads was said to be about two months. These wait periods were reported to the researcher in early August, 1991.

> One wonders whether or not these [treatment] programs, which
> have primarily dealt with male clients in the past, are
> equipped to deal with women, who may have different kinds of
> problems and require different treatment (1984:85).

While the situation has improved since 1984, service shortages

continue. For women interested in feminist treatment, these

shortages are even more acute.

In addition to coed residence facilities, a very popular

avenue for addressing chemical dependency has been Alcoholics

Anonymous (AA) or Narcotics Anonymous (NA). Many women found AA

and/or NA to be essential to their recovery:

> I go to Narcotics Anonymous and I believe what they teach
> me. Which is, you're an addict, it's a disease that you
> have and you always have it.... I believe what my program
> teaches me. For myself, I have to believe that... to live
> the life I've started to live I have to believe that. (Liz)

> AA is the only thing. I am a firm believer in AA. Every
> time that I stop going to meetings, it happens and I slip.
> (Lynn)

However, as has been discussed, AA has been criticized by some as

a male-centred approach (Kaskutas 1989), and some women noted

problems they had had with it.

> There was a guy there [at AA] who pretended he was my friend
> or something... he took advantage of me sexually and I
> never went back there. (Fay)

> I don't like AA. Every time I go to AA, I just want to
> drink... everyone's talking about their stories, everyone's
> talking about how much they drank, you know? It just wasn't
> a system that worked for me. At all. (Lori)

> Another thing about women is that it makes you question
> whether or not places like AA are really appropriate for
> women and whether the programs are appropriate. I don't
> find them particularly appropriate. I find most of the
> people in them are very hard-lined and very narrow and are

afraid to go beyond those little twelve steps and their kind
of bleak concept of what those twelve steps mean. (Rachel)

Overall, it seems that while many women and men have found A/NA
to be successful for them, others may benefit from an
alternative, women-centred self-help organization such as Women
for Sobriety.

Economic Issues

Researchers have not succeeded in identifying specific
causes of chemical dependency, although some correlates such as
parental alcoholism have been found. Another contributor, and a
factor that is central to a socialist feminist analysis, is
economic hardship (Sandmaier 1980, Greenspan 1983). Obviously,
with significant economic inequalities between women and men,
women are more likely to experience economic difficulties (Wilson
1986) and consequently are more vulnerable to its effects.

Despite an increase in the percentage of women currently
entering the workforce, women's roles continue to be defined in
terms of the family. As Wilson notes, "among women, singleness,
childlessness, or devotion to a career continue to be treated as
exceptions" (1986:16). Some women are homemakers, dependent on
their husbands' earnings. Other women juggle the dual demands of
housework and full-time, paid employment. Family structures that
associate women's responsibilities with household duties have
been linked to the needs of patriarchy and capitalism. As women
are associated with the private sphere and, therefore, household

duties, they perform essential social functions without financial
remuneration. They provide for the reproduction of people, for
the maintenance of the home, for the socialization of children
and for the purchase of consumer goods (Wilson 1986). All these
contributions help in the maintenance of capitalist patriarchy.
Further, housework is considered to be a "natural" labour of
femininity, a labour of love and not of work. Thus, housework
does not receive a wage, in turn reinforcing the assumption that
housework is not really work (Greenspan 1983). The work women do
in the home remains unrewarded and, often, unrecognized.

In addition to economic dependency in the family, women must
face inequalities in the workplace. Despite a few "token" women
in positions of power, women are still more likely to be low paid
and more likely to take than to give orders (Greenspan 1983). In
Canada, women still earn, on average, 65.3% of what men earn
(Labour Canada 1990). Often resulting from an "assumption of
primacy of [the] wife/mother role for women" (Wilson 1986:15),
women in paid employment are considered secondary labourers and a
transitory group. Occupational segregation reflects the sexual
division of labour in the home, with women clustered into
clerical, sales and service industries (Labour Canada 1990).
These areas of employment tend to be lower status, lower paid and
less likely to be unionized than other job categories.

Historically, women have come to make up a reserve army of
labour, available when the economy requires an influx of workers,
yet also able to "return to the home":

> Women have always acted as a buffer for the economic
> problems experienced by advanced capitalist countries....
> When conditions favour women's labour-force participation,
> domestic responsibilities - such as child-care - are defined
> as social responsibilities. When conditions are not
> favourable, women resume their domestic responsibilities and
> again become economically dependent on their husbands
> (Wilson 1986:120).

In order to retain this "buffer", the perpetuation of traditional

gender roles is required, with women believing they must (or

being forced to) compromise economic independence in order to

fulfill a homemaker role.

Sexual harassment in the workplace also undermines women's

economic independence, for when a woman experiences such

harassment at work, "she is unable to participate fully and

equally in employment" (Bennet and Humpage 1989). Sexual

harassment can jeopardize a woman's work performance as it

undermines and trivializes her contributions to the workplace,

creates an unfriendly work environment, may interfere with her

ability to work as successfully and may, if the harassment is

coming from a superior, impede her advancement or threaten her

job tenure.

Women's poverty is reinforced for single women with children

who do not receive spousal child support and have limited access

to reasonable childcare. Often they must depend on government

welfare payments and the arbitrary regulations that accompany

them. Yet many women feel that welfare is not an acceptable

alternative: once again, they must live in poverty and

dependency. As one women I interviewed pointed out:

> Another problem with welfare is [that] it's addictive. I

> don't know what the solution is. I think that if there's
> somehow they could do it and build self-worth, I think by
> acknowledging parenting and homemaking as a valid and
> extremely important occupation.... (Liz)

Economic dependence and poverty can contribute to chemical

dependency (Sandmaier 1980, Greenspan 1983). For women, who are

often economically dependent or living in poverty, this link may

be particularly acute. As women are denied power over their

lives, some may seek feelings of power and control elsewhere

through alcohol or to drugs. Others may use chemical substances

to numb the pain, insecurity and low self-esteem that result from

powerlessness (Robertson 1991, Van Den Bergh 1991). Poverty and

dependence are, in turn, perpetuated by addiction:

> Most of my resources went to support my habit. I made the
> mortgage and to hell with the groceries. I'd buy cat food
> rather than groceries, so I was... we were getting by.
> (Corinna)

Chemical dependency and economic dependency become intertwined,

obfuscating the influence of economic inequality in contributing

to addiction in the first place.

Women's poverty and economic dependence are deep-rooted

problems that will not be easily overcome. However, for

individual women, employment is an important factor in dealing

with chemical dependency. It allows women to escape dependence

on welfare, validates their role as valuable contributors to

society and provides a support network.

> When I'm out of work [how I feel is] way down, when I'm busy
> and active it's way up and in order to keep it up when I'm
> not working, that's when I go to the transition house.
> Garden's doing great... you know, I feel like I'm doing
> something for someone else. (Corinna)

In my study, those who were employed were less likely to be
drinking and/or using than those who were either unemployed,
mothers at home, or students. Before treatment, 13 (27%) of all
clients were working full time and 15 (31%) were working part
time. The remainder were working in the home (mostly as
mothers), studying, retired or unemployed. After treatment, 17
(35%) were working full time and 15 (31%) worked part time.

Table 3: Using by employment after treatment

	Employed		Not Employed	
	n	%	n	%
Using	4	(13)	10	(59)
Not Using	28	(88)	7	(41)
Total	32		17	

Table 3 shows that those who were employed after treatment
had better outcomes in terms of not using than those who were not
in paid employment. These findings suggest a strong link between
waged employment, whether part-time or full-time, and treatment
success, perhaps due to several factors. First, waged employment
is generally valued above housework by our society; women
working outside the home may thus feel higher self-esteem.
Second, outside employment allows women to be in a supportive
environment with co-workers. Third, women earning a wage tend to
fare better financially than those on welfare and have more
independence than those who rely on a husband or partner for
income.

Success can also be measured by life satisfaction. Table 4

illustrates the greater life satisfaction among clients who were employed at the time of interview.

Table 4:   Life satisfaction[33] by employment after treatment

	Employed		Not employed	
	n	%	n	%
Not satisfied	4	(13)	3	(18)
Somewhat satisfied	3	(10)	3	(18)
Very satisfied	23	(77)	11	(65)
Total	30		17	

The link between employment and treatment success would indicate the need for post-treatment job training and instruction in how to get (and to keep) a job. This recommendation is also found in <u>Substance Abuse Curriculum Resources, Issues</u> (1990) which states that women need programs with childcare, counselling about incest and battery, assertiveness training, financial management and job training.

<u>Support</u>

Another significant aspect of treatment is the role of a support group. Support networks have been recognized as important for many forms of healing. For example, Waxler-Morrison <u>et al.</u> (1991) found that women were more likely to

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[33]Clients were asked to indicate, on a scale of 1-9, whether they were currently satisfied with their lives, nine being "very much so" and one being "not at all". Here, answers have been grouped together into three categories: not satisfied (1-4), somewhat satisfied (5), and very satisfied (6-9).

survive breast cancer if they had a wide network of friends. Many treatment perspectives recognize the need for support groups and feminist treatment is no exception. Not only do social networks provide emotional support, but practical assistance as well. Here, a direct relationship was found between treatment success in terms of drinking and/or using and the clients' use of a support system (see Table 5).

Table 5: Using by support[34]

	Support		No support	
	n	%	n	%
Using	9	(23)	5	(56)
Not using	30	(77)	4	(44)
Total	39		9	

After treatment, nine (23%) of the 39 with a support system were using drugs or alcohol regularly. Five (56%) of the nine who did not have a support system were using.

Similarly, there was a significant link between the success of treatment and post-treatment attendance at A/NA (see Table 6).

Table 6: Using by Alcoholics/Narcotics Anonymous

	A/NA		No A/NA	
	n	%	n	%
Using	5	(16)	9	(53)
Not using	26	(84)	8	(47)
Total	31		17	

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[34]Clients were considered to have a support system if they answered "yes" or "sometimes" to the question "Do you have a support system of friends or family that help you stay clean and sober?" (see Appendix).

Women were also more satisfied with their current lives if they used a support system and/or went to AA or NA (see Table 7 and 8).

Table 7: Life satisfaction by Support

	Support		No Support	
	n	%	n	%
Not satisfied	4	(11)	3	(33)
Somewhat satisfied	4	(11)	2	(22)
Very satisfied	30	(79)	4	(44)
Total	38		9	

Table 8: Life satisfaction by A/NA

	A/NA		No A/NA	
	n	%	n	%
Not satisfied	1	(4)	6	(36)
Somewhat satisfied	4	(14)	2	(12)
Very satisfied	24	(83)	9	(53)
Total	29		17	

Less conclusive is the use of other counselling or self-help programs after treatment. Other than A/NA, Adult Children of Alcoholics (ACOA) and women's groups showed high success rates, although numbers were very small.

The importance of a support group and/or A/NA for the recovering client has been the most significant finding here. Success rates are much higher among women with such support, despite the concerns regarding A/NA discussed in Chapter Two. The success rates of women attending such groups as Women for

Sobriety could not be tested for this paper as few of the women interviewed had access to such groups.

Abuse

This research found that a significant level of childhood sexual abuse, rape and spousal abuse was experienced by the women under study.

Economic and gender differences support and are supported by patriarchal power relations. Patriarchal power is also reinforced through violence against women and children.

> In the last two years I worked as a prostitute so that
> [sexual abuse] happened a lot... they just couldn't leave
> without abusing a few times. (Allison)

Abuse of women often starts very young. As children, young girls have very little power and many are sexually abused by men. Here, inequality is based not only on gender, size and economic dependence, but on age as well. When women are sexually abused as children, and later as adults, the power of the male to intimidate and control is established. A woman learns early on to link her self-worth to her sexuality while, at the same time, feeling dirty, worthless and shameful.

> I deal with my brother, the [abuse] that he did and I
> forgive him and I forgive myself because I feel dirty and I
> feel like I'm a slob and so I have to understand that I am
> not guilty. Guilt, condemnation and depression: to me they
> go together. (Maria)

> I developed behavior patterns which were consistent with how
> I was treated as a child, which was abominably. My
> behaviour was negative and self-destructive. My self-esteem
> was non-existent. (Rachel)

Growing up with such shame and feelings of worthlessness, low self-esteem becomes overwhelming.

Some connections have been made between abuse and later problems with chemical dependency (Sandmaier 1980) and it is probable that abuse contributes to adult chemical dependency as it perpetuates low self-esteem, depression and feelings of powerlessness. Sandmaier suggests that up to 80% of chemically dependent women were sexually abused as children (Sandmaier 1980). Thirty-nine, or 81%, or the women I interviewed had been sexually assaulted at some point in their lives. Twenty-one (45%) had been physically abused as children. While many chemically dependent men experienced childhood sexual abuse, women's abuse tends to start when they are younger and to last far longer (Cooksey 1991):

> There was an uncle who lived with us as a hired man on the farm who sexually abused me starting when I was around three - that's as early as I can figure right at the moment. And he actually did rape me and I do have memories of being in a dissociated state, and being sort of up on the ceiling watching things. My father began molesting me at a very young age, possibly around four or three, as well. (Rachel)

Women I interviewed also cited emotional and physical abuse.

> My father was very, very cruel when he drank. He used to beat me and that I could handle, but I couldn't handle the stuff he said to me... "you disgusting little bitch", "you parasite", "you've destroyed my life". (Lori)

In "Women, alcohol and incest: an analytical review" (1991), Dorothy Hurley explores similar characteristics between alcoholic women and women with histories of incest, and the significant overlap between the two. While noting that research on

alcoholic, incest-surviving women is very sparse, Hurley begins
an exploration into this area and encourages more, questioning
why some incest-surviving women become alcoholics and others do
not (see also Kovach 1986).

Unequal power relationships between women and men are
reinforced later in life as most chemically dependent women have
experienced some form of abuse from a spouse or significant other
(Strega 1990, Robertson 1991):

> Then there was some physical abuse and I started going to
> class and there were bruises all over my face - then once
> that started happening I was really humiliated and didn't
> want to be seen like that so to deal with that I started
> drinking every day and stopped going to school. (Janet)
>
> I felt guilty because I felt happy when [my husband] died
> because he was a really violent man... beat me up a lot.
> (Fay)

In a study on spousal violence among alcoholic women by Miller et
al., "alcoholic women were found to [receive] higher levels of
spouse-to-woman negative verbal interaction, moderate violence
and severe violence as compared to... [the control group]"
(1989:533). These findings were evident even after spouses'
alcoholism, income, parental violence, and parental alcoholism
were controlled for. Emotional abuse in relationships can also
be very difficult:

> It was more emotional abuse [from my husband], mental
> abuse... it's awful. I wonder sometimes if it's not worse
> than the physical, you know, because it messes with your
> spiritual, your psyche and stuff. (Jamie).

Abuse, whether emotional, physical, sexual or economic[35],

maintains an unequal relationship between women and their

partners to a point where many women are living in total fear and

isolation. Once again, the abuse can perpetuate and may be

perpetuated by chemical dependency in the home.

Miller _et al._ (1989) link childhood sexual abuse and later

involvement in abusive relationships. Such a link was echoed

during interviews:

> The guy was an absolute asshole. He beat me up so many
> times. I just accepted this. Like, my father beat me up,
> my ex-husband beat me up, this boyfriend beat me up... so
> what am I going to do? I accepted it, which is really dumb,
> but I couldn't seem to get away from it. (Lori)

Further, chemically dependent women are often involved with

chemically dependent men and alcoholism has been linked to

spouses' violence. N. Lehmann and S.L. Krupp found that 72% of

abused women in a shelter reported their partner had a drinking

problem (1983/84).

The high levels of abuse experienced by chemically dependent

women supports the need for women-only treatment environments

where women may discuss more freely their past experience.

Treatment must address childhood sexual, physical and mental

abuse and also deal with the abuse chemically dependent women

have experienced as adults. Interestingly, my data found that

those who had been sexually assaulted or abused were more likely

to be abstaining from drugs or alcohol than those who had not.

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[35]Economic abuse includes keeping a woman from getting or
keeping a job, making her ask for money or taking her money.

This may be due to added counselling these women may have received to deal with abuse issues.

Limitations

A number of limitations may have influenced these research findings. While some are particular to this study, others will arise in any work on women and chemical dependency.

A primary problem encountered in this study was treatment overlap. Many women complete more than one form of treatment, combining residential facilities and outpatient sessions and various self-help groups in an attempt to find an ideal environment. The influence of other treatment experiences could contribute to the success or failure of treatment under examination. In this study, a little under half of those interviewed had been to more than one treatment centre. However, these women often pointed to a program that was particularly helpful to them.

This problem could be overcome by limiting the sample population to those who have been to only one form of treatment. However, this would significantly decrease the available sample population and would also ignore those clients who have had problems with various treatment programs. Overall, the only solution may be to document treatment attendance both before and after the particular treatment under study and to record the forms of treatment which stood out for the client as either positive or negative.

A number of treatment facilities contacted for this study did not wish to participate, citing various reasons. Consequently, the project does not cover a wide range of facilities. To avoid this limitation, any future project should be larger, more consistent in contacting all clinics that fit the project's specifications (or it should select clinics randomly), and it should be commissioned by a neutral body.

All studies such as this face the challenge of an elusive population. This study specifically examines outcome success of full treatment in differing programs; the study does not account for those who dropped out of treatment early in the program. Already, the population under study is limited to more "successful" cases. Those who never enter treatment are neglected altogether[36].

Of those who had completed a treatment program, many could not be contacted because they had moved, they had no telephone, and/or their telephone was out of service. Thus, those who were contacted represent the far more stable population from among the women who have completed treatment. This problem could be rectified with a longitudinal study that would follow clients

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[36]One possible way to contact this population may be through a "snowball" sample collection: asking each individual interviewed if she knows of any other chemically dependent women who may be willing to be interviewed as well. Such a technique would limit samples to those sharing a similar background and would fail to include "closet" addicts, but it may reach a wider sample population than those reached through treatment centres or A/NA. The snowball technique has been used by other alcoholism researchers (Miller et al. 1987).

from their first entry into treatment, similar to Corrigan's work (1980). However, such a task was beyond the scope of this project. Such a study also may itself influence findings by supplying added incentive for successful treatment completion among those being studied.

A few women refused to participate in an interview when first contacted and it is possible that those who refused did so because they had returned to drinking and/or drug use. This may also have influenced the sample to some degree. However, percentages of refusals did not vary greatly among participating organizations.

A further limitation is that the study could not control for the initial assignment of clients to treatment. As mentioned earlier, a number of different factors would have influenced client assignment, including the possibility that "harder" cases would be assigned to certain treatment types. This limitation could be overcome (to a certain extent) through a longitudinal study that includes cooperation with counsellors to ensure random assignment. Geographical location, length of treatment and ethical concerns may continue to limit the random nature of the assignment, but at least these factors would be documented.

Also of concern are reliability and validity. For this project, the consistency of each individual's reporting within each interview was checked through the rewording and repetition of certain questions within the questionnaire. These repetitions consistently yielded similar results. Consistency among

interviews with clients was attempted through the use of a standardized questionnaire and a single interviewer. Interviews were conducted within a two-month period, although they were conducted at different times of the day, and in different environments, which may too have influenced the findings.

Validity is the accuracy of reporting and can be checked by external criteria such as drug testing and clinical reports. The possibility of dishonesty and deception on the part of clients was minimized by the emphasis on confidentiality in all interviews. Consequently, deception should not be a factor in comparing types of treatment. In future studies, responses could be compared with official Alcohol and Drug Programs records - a useful check which I did not have the authority to perform.

Sample size can be a limitation in any small scale project such as this. This project would have benefitted from an increase in numbers. A sample size of 49 actual interviews can be considered insufficient for detailed analysis. For example, analysis could not control for any variables to determine the relative effects of various factors on treatment outcomes. However, as a preliminary study, a sample of 49 women cannot be discounted. The records of these women's experiences and impressions are, individually, as valid as those of 500 women. Ideally, future research will expand on these findings.

A final intervening problem may be specific differences between treatment programs or individual counsellors. It is unclear whether outcome measurements are testing the success of

the program or the counsellors within each program (Bains and Taylor 1981). Ideally, enough centres would participate that this would not be a problem. Here, individual counsellors may have influenced the findings to some degree.

Chapter V

Discussion

While the above findings address some important elements of women's treatment experiences, there are other significant issues that require discussion. These topics could not be researched for this study, but I would like briefly to explore them here, anticipating their inclusion in future research. The influence of gender roles, the experiences of chemically dependent women of colour and also the experiences of lesbian and bisexual chemically dependent women are raised in this chapter.

Gender Roles

Traditional approaches to understanding women and chemical dependency have suggested that women can deal with their alcoholism "simply by living the role most approved by her society" (McCord 1972:162). This emphasis on gender roles is reflected in many treatment programs. Yet strict gender roles may in fact contribute to substance abuse (Van Den Bergh 1991).

Gender deeply influences an individual's personal identity. As we have seen, Reed (1985) suggests that women and men live in different cultures altogether and that a cross-cultural approach

is needed for these differences to be understood[37]. To Reed, these "cultural" differences may be based entirely on power and status, with power in the hands of the male "culture". By emphasizing the unequal power relations between genders, Reed introduces a political element into our understanding of gender roles. She recognizes the inequalities that result from the public/private dualism where men are associated with the public, economic sphere, and women with the private sphere of the family. Further, she sees this public/private separation reinforced and maintained by female/male socialization. Women are socialized to be more affectively and socio-emotionally oriented, dependent and reactive; men are to be instrumental, competitive, autonomous and proactive (Reed 1985:25). Reed challenges this stereotyping, suggesting that "gender stereotypes and socialization for rigid gender roles are limiting for both genders" (1985:25). Strict gender roles are particularly limiting for women as they maintain women's position in the private sphere and, consequently, in economically unequal, socially inferior roles. As long as the public/private dichotomy remains and masculine characteristics are valorized over feminine, women will not attain equality.

In a culture that gives primacy to individualism and independence, gender roles also restrict women's power as "feminine traits" such as cooperation and care-giving are

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[37]Reed also points out that gender is only one cultural variable, with many areas separating chemically dependent people including class, age, ethnicity, religion, location of residence, and so on (Reed 1985).

undermined as desired skills.   Women receive ambivalent
messages, suggesting they must choose between femininity and
competence (Wilson 1986).   Further, while women are dissuaded
from pursuing challenging careers in positions that involve
decision-making and high incomes, their "caring" skills remain
unpaid and unrecognized as valuable to society.

Furthermore, women constantly receive contradictory messages
about their social roles.   As Wilson (1986) points out, women are
raised to believe men and women have different roles, yet men's
roles are given more social importance.   Further, women are
expected to aspire to the role of wife and mother yet most women
must also work outside the home.   Women are socialized to fulfill
the roles of wife, caregiver, mother and lover, despite the
contradictions that may emerge among these roles.   When
constantly bombarded by such contradictory demands, it is not
suprising that women believe that they have failed to meet
society's expectations (Sandmaier 1980).

In an attempt to understand the influence of strict gender
roles on chemical dependency, C.H. Hoar (1983) compared the
personality traits of chemically dependent and non-chemically
dependent women.   She found that alcoholic women are more
dependent and passive than other women and experience a greater
discrepancy between their self and ideal-woman perceptions.
However, it is hard to know whether this behavior caused or is
caused by alcoholism.   However, Wilsnack (1973) found that women
who drink may feel some confusion or insecurity about their

femininity and that women drink to produce a sense of enhanced "womanliness". While demonstrating more masculine traits than non-alcoholic women, they believe they should be more feminine. Wilsnack notes that such insecurities can arise due to social pressure to conform to the feminine gender role, pressures that contradict a woman's "masculinity" (Wilsnack 1976). In either case, social pressure to conform to strict gender roles has been internalized, creating a particularly acute inner conflict for chemically dependent women.

As previously discussed in Chapter Two, Van Den Bergh (1991) suggests that female gender roles are a "set up" for addiction as they create an "external locus of control". Women, having learned to care for others, measure self-worth through the happiness of those around them. This need to rely on external factors to validate self-worth, Van Den Bergh believes, can lead to a need to rely on external stimulants, such as drugs or alcohol.

Reed (1985) discusses gender roles in terms of the treatment chemically dependent women receive. In the past, substance abusing women were considered sicker, less motivated and more sexually deviant than male clients. With an increase in research into women and chemical dependency, some changes can be observed:

> Rather than "sicker" or "less motivated", women are now understood to exhibit less psychological denial in general and to need less focus on the consequences of their chemical dependency [than men] to create sufficient anxiety and discomfort to motivate movement toward recovery (Reed 1985:21).

When fewer women were entering treatment, counsellors could believe the problems women had in treatment were inherent to those women. However, as more women have entered programs, it has become clear that it is not the women who are the "problem", but the lack of available treatment related to their needs.

I would concur with Reed's belief that treatment must begin to account for the different gender role socialization that men and women experience. Rather than trying to deal with chemical dependency by strengthening gender roles, we need to emphasize skills linked to the opposite gender. Men need more instruction in expressing emotional needs and in experiencing dependence. Among women, self-esteem, independence and an ability to evaluate their own abilities in a positive manner must be cultivated. Further, these behaviours need to be validated as socially acceptable. On a practical level, Reed argues that women's programs need job-skills training and education that is not limited to women's traditional sphere. Also of importance is the need for treatment centres to offer childcare, so that women may enter treatment without feeling guilt and concern about the well-being of their children.

Women of Colour

A number of research projects, primarily anthropological studies, have examined drinking patterns world-wide (Pittman 1962, MacAndrew 1969, Marshall 1979, Douglas 1987). Cross-culturally, our experiences with alcohol vary greatly: how, when

and where we drink is culturally specific - from "avid immersion to total rejection". Most societies have some form of alcohol, but very few have "alcoholism" (Heath 1987). Instead, across societies drunkenness is considered to be a normal expression of culture - drinking is a "social act in a social context" (Douglas 1987:4), viewed differently as food, tranquillizer, sacred, sacrilegious, poison and aphrodisiac by various cultures (Heath 1987).

Marshall (1979) acknowledges the diversity in drinking patterns across cultures, but he finds some consistencies between cultural groups as well. First, across cultures, women are less likely to drink alcohol than men are. Second, Marshall found that addictive drinking is not often found in small-scale, traditional societies, but only in "complex, modern, industrialized societies" (Marshall 1979:451). Such a perception has also been noted among other anthropologists (Douglas 1987). As Douglas suggests, the atomization and exclusion of large-scale, industrialized societies may generate problems with chemical dependency. Further, perhaps with industrialization and a concomitant emphasis on efficiency and punctuality, a more critical perspective on alcohol develops. Linked to this perspective and congruous with our sociological models is Marshall's later point, that "beverage alcohol usually is not a problem in society unless and until it is defined as such" (1979:452).

The use of alcohol and other addictive substances may vary

across cultures, but within North America diverse cultures are faced with similar messages about alcohol consumption and about self-worth. Both minority ethnic and native groups, and particularly the women in these groups, must not only negotiate between their own experiences with alcohol and North American norms, but must also deal with economic inequality and racism as well.

Few researchers have studied the chemical dependency of women of colour and most information that is available originates, once again, in the United States. Fillmore (1984) reports that, in the United States, there is more heavy drinking among black and Hispanic women than among white women. However, there are also more black women abstaining or drinking only weekly than white women (Fillmore 1984). Sandmaier's findings indicate that both black and white women are equally susceptible to alcohol problems, but that greater numbers of American Indian women die from cirrhosis of the liver than any other group of women (Sandmaier 1980). These findings suggest that chemical dependency is indeed a problem among some minority women in the United States.

Canadian information regarding ethnic minority women and substance abuse could not be found, yet chemical dependency within this group is not improbable. Many ethnic minority women are employed in poorly paying jobs, with little or no security. Often, they may be working illegally, which gives the employer added control over their working conditions. Working long hours

while also attempting to provide appropriate childcare, many women find themselves unable to address their own needs. To cope, some may begin taking prescription drugs, or may turn to alcohol. For other women, unemployment or work in the home causes to economic dependence and isolation. For new immigrant women who do not have access to community support services, a homemaking role may cause added problems. Difficulties with a new language and culture may be compounded as some women in the home are isolated from the wider community:

> We may assume that lack of acculturation affects [them] more severely...since they have fewer opportunities to participate in the mainstream (Lopez-Lee 1979:108).

Others have lived in North America for many generations, yet still feel the effects of racism and cultural loss.

Adding to, and often reflected in ecomomic inequalities, racism is a destructive element in the lives of ethnic minority women. It denies access to avenues of power, well-paid employment and, often, respectable housing. It also perpetuates low self-esteem, as racist comments and actions are internalized. Further, for ethnic minorities who turn to alcohol to escape this alienation and oppression, the usual stigma of the alcoholic is intensified. Alcoholism may be a strong break with traditional roles; also, if the problem becomes public, it is seen to reflect on the entire ethnic community.

There are few culturally sensitive environments in which ethnic minority women can be treated; it is most likely that they will be alone in a "mainstream" treatment environment.

Further, when these ethnic minority women come to treatment, they may bring "mental sets, emotional attitudes, and socio-economic realities not sufficiently taken into account in the course of treatment" (Lopez-Lee 1979:105). In effect, treatment services are not prepared to address the specific issues of ethnic women.

Unlike ethnic minority women, some information is available on native women and chemical dependency in Canada. Generally among First Nations men and women in Canada, chemical dependency is reported to be very high. For instance, in 93% of the native communities in B.C., alcohol abuse is considered a common problem (Alcohol and Drug Programs 1988). However, York (1989) suggests the stereotyped image of "drunken Indians" may be exaggerated. Unlike white people who drink in private, First Nations people drink publicly, leaving them vulnerable to stereotyping. Also, native people who are drunk are more easily remembered both because of their visibility and because their drinking corresponds to preconceived notions about native people. The many native peoples in treatment and acknowledging a problem in their communities may also reflect their willingness to identify that there is a problem, which some white communities may be unwilling to do.

York (1989) also discusses the influence economic dependence has had on Canadian native communities. Since the early fur traders and their introduction of alcoholism into native communities, native people have experienced a dependent relationship with whites:

> By keeping the Indians addicted and desperate, the American
> traffickers could obtain an entire buffalo robe in exchange
> for a single cup of whiskey (York 1989:190).

After World War Two, native dependence on alcohol also grew to
include social assistance from the Canadian government. As new
government programs cultivated a dependence on the state,
traditional native lifestyles were being eroded through
industrialization and a cash economy. Even traditional hunting
and fishing activities were challenged by logging, mining and
hydro projects. Unemployment, economic dependency, cultural loss
and powerlessness came together with historical events to result
in high alcoholism rates in native communities:

> Old Man Canada has forced Indian people to drink themselves
> to death just as surely as if he had held us down, used a
> funnel and poured the booze down our throat.... When your
> land has been taken, when your language has been degraded,
> when your spirit has been crushed, when you have been forced
> to live in squalor, when you face existence without hope,
> and when you are offered escape through drink... what choice
> do you really have? (Mohawk journalist Brian Maracle cited
> in York 1989:200).

Finally, while chemical dependency among native women is not
specifically examined in the research literature, and while women
may drink less than the men around them, many native women are
chemically dependent. As First Nations peoples, women have also
experienced economic dependence and cultural loss. Additionally,
native women must cope with the patriarchal values of western
society.

Racism also follows native peoples into treatment programs.
Until the 1970s, native peoples were thought to have a lower
tolerance of alcohol because of their metabolisms. While this

has since been disproven, many people continue to believe it to be true. Further, mainstream treatment, while attempting to deal with the specific experiences of native peoples, reproduces racism in more subtle ways, or simply cannot provide appropriate treatment. One third of the women at both Maiya House Society and Aurora Society (a women-only residential treatment centre in Vancouver) are native as are one quarter of the clients at Pacifica (a coed treatment centre) in New Westminister. According to the director of Pacifica, native clients seem less confident than other clients, particularly in group sessions, perhaps because they are often the sole native client in an all-white group (Gray 1991).

Some treatment has developed that is specifically directed towards native peoples, including traditional sweat lodges and sweet grass ceremonies, although once again, there is less emphasis on treating native women than men (Alcohol and Drug Programs 1988). Only very recently have native treatment facilities emerged that specifically target First Nations women in British Columbia. These centres provide an alternative to "mainstream" treatment facilities, and have been shown to be effective (York 1989)[38].

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[38]For an excellent, comprehensive discussion regarding native issues surrounding alcoholism, see "Native Issues" in Substance Abuse Curriculum Resources, Issues (1990).

Lesbian and Bisexual Clients

Special issues also arise in the treatment of lesbian and bisexual clients. K. O'Halleran Glaus (1988) and B. Underhill (1991) point out the problem of alcoholism in the lesbian[39] community. Underhill cites that 25-35% of the lesbian/gay community have alcohol problems compared to 10% of the general population, although she adds that accurate statistics are unavailable.

Underhill believes that the predominance of substance abuse in the lesbian community is due to their minority status, stigma and discrimination. Both lesbian and bisexual women must cope with society's response to their sexual orientation; homophobia can be very isolating and destructive. Many decide to keep their orientation secret for fear of social rejection. Others, being open about their sexuality, face the consequences:

> Because of their sexual preference, [lesbians] are fired
> from their jobs, expelled from their schools, kicked out of
> their apartments, ostracized in their own neighbourhoods,
> and forcibly separated from their own children (Sandmaier
> 1980:182).

Internalization of society's hostility towards them can contribute to lesbians' and bisexuals' chemical dependency. Such criticism and rejection, coupled with uncertainty about personal worth can be a lethal combination.

Further, for some lesbians and bisexuals there is a reliance on bars for lesbian socializing (Sandmaier 1980, Glause 1988,

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[39]I could not find any literature that specifially addressed chemical dependency among bisexual women.

Underhill 1991). Such bars may be the only places where lesbians and bisexuals can feel comfortable expressing their sexuality. While some non-alcoholic events may be available, "overall, access to alternatives to the bar often requires higher visibility as a lesbian, a price some women...may be unwilling to pay" (Glaus 1988:133). While attendance at bars can lead to problems, lesbians who drink or use drugs alone are also at risk.

When chemically dependent, lesbian clients experience a triple stigma: as a woman, a lesbian and as an alcoholic. While facilities specifically for women are few, those for lesbian and bisexual women are even more rare. While in treatment, even in a women-only environment, they may be discouraged from being thoroughly honest about their sexuality and their specific issues may not be understood by treatment staff (Strega 1991) or other clients. The homophobic and heterosexist assumptions of the wider society are replicated in treatment. One treatment professional I interviewed in Vancouver suggested that women "find" their heterosexuality during treatment. Lesbian relationships were seen purely as searches for love and affection that these women could not, at the time, find in men. Further, many clinics integrate educational materials into their programs, materials that assume heterosexuality among clients. Finally, many treatment professionals are not trained to deal with the specific concerns of lesbian or bisexual clients, nor educated about community resources for them.

Underhill (1991) suggests that lesbian women need a "supportive, nonmoralistic, nonjudgmental treatment environment" (1991:76) that will allow them to recognize the power that alcohol has over their lives, but to also feel empowered as women and as lesbians. Staff must be comfortable with their own sexuality and knowledgeable about lesbian subculture. Staff must also be aware of the hostility some bisexual women receive from the lesbian community (Hutchins and Kaahumanu 1991). Ideally, lesbian and bisexual women need to participate in group sessions with other lesbians and bisexuals to help sort out individual problems from their experience as a minority:

> By hearing the commonality between women's experiences, lesbians can come to see that the "problem" has a systemic root (1991:78).

The isolation and self-blame some lesbian and bisexual women may feel can be addressed among other women with similar experiences.

The problems associated with "coming out", accepting being lesbianism or bisexualism, integrating it into personal life, and dealing with the responses of family members and others, must also be recognized[40]. The point at which a woman may be in her "coming out" process will affect how she is dealing with her treatment for chemical dependency. For some women, they must "come out" all over again as they go through treatment for

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[40]Many lesbian and bisexual women experience hostility and anger from their families. This not only compounds feelings of social rejection, but also cuts off an important area of support for women experiencing chemical dependency (Underhill and Osterman 1991).

chemical dependency.

There are many complex issues associated with the treatment of chemcially dependent women. Some were addressed in Chapters Three and Four, others have been discussed here. This short review merely skims the surface of gender role stereotyping and chemical dependency among women of colour, lesbian and bisexual women. Clearly more research is required in these areas.

Chapter VI

Conclusion

A socialist feminist perspective on women's chemical dependency and its treatment has been presented, along with some qualitative and quantitative data arising from interviews with chemically dependent women. Yet while feminist counselling is a viable and desirable alternative that must be made available to women, some questions should be raised.

Does feminist counselling impose an ideology on others?

Perhaps because it so clearly challenges the status quo, the bias of feminist counselling has been questioned. Helen Levine raises this issue in her article "Feminist counselling: A woman-centred approach" (1989). In responding to such a challenge, Levine points out that all counselling (and treatment) alternatives have biases. For some, such as feminist counselling, these biases may be more visible because they do not conform to current social expectations.

In terms of feminist counselling, there is an obligation on the part of the therapist to make her own perspective explicit, allowing the client to choose whether this form of counselling is desirable for her. Thus most feminist counselling should begin with an introductory interview where the client articulates what she hopes to receive from treatment and the therapist outlines

her own background and her approach to therapy. A similar approach should be used in group counselling.

While such disclosure is essential to feminist counselling, it is difficult to imagine that a client can make an informed decision in a society that is so steeped in patriarchy and where women have internalized misogyny (Ballou and Gabalac 1985). Yet, as Levine points out, it may even be dangerous for some women to enter traditional treatment programs. For example, it would be inapproprate for a women in a destructive marriage to be advised to "stick it out", or to improve her housekeeping skills, as some treatment professionals may advise. The most that can be done is to encourage potential clients to explore some of these myths when deciding on the form of counselling they would prefer.

A further note to add here is that, as Chapter One pointed out, there are differing feminist perspectives and their impact on counselling varies. Remaining true to a feminist counselling approach, a counsellor should make it clear to the client the kind of feminism which informs her work. Such a disclosure may prove to be untenable, however. An incoming client may not be interested in the detailed differentiations among all forms of feminism, or what the subtle academic debates may be. The individual counsellor must judge the appropriate level of information that should be provided in each initial interview situation.

Is a feminist approach more appropriate for particular women?

Levine believes that feminist counselling is useful for most women, despite fear of terms such as "feminist". This perspective is supported by Enns and Hackett (1990) who found that female clients, both feminist and non-feminist, prefer working with a feminist counsellor for career and sexual assault issues with no significant preferences observed across counsellors for personal concerns. However, Ballou and Cabalac (1985) suggest that "some women have pathology which is too severe to be dealt with through feminist therapy" (1985:38). They feel that the reciprocal relationship required of feminist therapy may be unsuccessful, in itself, for deeply troubled clients. They add that feminist therapy is not irrelevant here, but that it should play a role in combination with more traditional orientations to treatment for such clients.

While the concerns noted by Ballou and Gabalac can be understood, it is difficult to be sure a combination of traditional and feminist therapy could be successful. In fact, some of the contradictions that may arise might prove to be more detrimental than useful. Perhaps for such clients, traditional therapy could be used, but only with the guidance of a feminist therapist to ensure a compatibility between forms of treatment.

As a further note, it is important to remember that in any treatment environment, specific groups require special consideration: age-based treatment focusing either on youth populations or elderly women, treatment oriented towards specific

ethnic backgrounds, treatment for those who have dual-diagnoses such as manic depressive alcoholics, and treatment that accounts for the specific experiences of lesbian and bisexual women are needed. All forms of treatment must be sensitive to the particular needs of the women entering. A women-only environment may address some important concerns, but other groups must be considered as well.

Can men be feminist counsellors?

This is a controversial issue. Levine believes that men cannot be feminist counsellors because they have not experienced the inequalities that women encounter. In fact, she believes that "a form of biculturalism and bilingualism - two solitudes, two languages - exists between women and men" (1989:243). Full understanding of a woman's concerns requires a female counsellor who is familiar with "the daily process of editing one's thought, censoring one's statements, remaining silent in the face of controls or insults, withholding ideas and anger..." (Levine 1989:243). Sigman (1982) agrees, pointing out that a female counsellor has "no vested interest in maintaining patriarchal power" (1982:335), that women seeing male counsellors may fall too easily into a passive recipient role and that a female counsellor may provide an important role model. Similarly, Greenspan (1983) believes that, with rare exceptions, female feminist counsellors are essential, although she also suggests such counsellors can work with male clients.

Ballou and Gabalac, on the other hand, believe that men can be feminist counsellors and that it is appropriate for them to counsel female clients. The requirements for feminist counselling should, they argue, be based on competence and commitment to feminism and not on gender. They posit that an advantage to having male counsellors is that the treatment environment will thus more closely resemble the real world. Students can learn to deal with men in a positive environment, one that will demonstrate that men might be able to move beyond sexism.

Perhaps, in a world of equality, it would be appropriate for men to participate in feminist counselling and feminist treatment groups. Yet at this point in time it is clear that women need safe environments in which to work through their experiences of sexism, inequality and abuse. Further, many women experience codependency issues that must be dealt with in an environment free of men. While some may feel a reflection of the "real world" is necessary for successful treatment, it may also be true that women need an occaisonal "escape" from the inequalities and stresses that real world provides.

What happens after treatment?

Most forms of therapy, including treatment for chemical dependency, seek to "adjust the patient to society" (Ballou and Gabalac 1985), yet this is not the case with feminist therapy. Rather, feminist therapy challenges dominant cultural

expectations. For this reason, Ballou and Gabalac believe post-treatment issues must be addressed. Contacts must be maintained with women's networks because feminist therapy can put women in a position of conflict with their usual support networks. Generally, Ballou and Gabalac feel that clients' reentry into the dominant culture is not sufficiently addressed by feminist counselling.

I would agree with this concern. Feminist counselling provides women with essential information about the social inequalities that influence their individual experiences. Yet long-term follow-up must also be included in this recovery and consciousness-raising process.

Is prior detoxification required?

Specifically in terms of chemical dependency, further questions emerge. For example, most treatment agencies require prior detoxification; clients must go through treatment programs clean and sober. Women who return to alcohol and/or drugs while in treatment are often expelled from the treatment program. Yet, in treating depression, Burnside (1992) feels that the requirement of previous detoxification would disallow many women from coming to treatment. Ethically, she believes that people should not be turned away. To date, Burnside had found this approach to be successful, with many women ending their drug abuse voluntarily though the course of treatment.

Some of the women I interviewed also expressed interest in

programs that do not require clients to be drug-free. This is,
however, a controversial issue that might best be researched
further in order to determine the best treatment alternatives.

Conversely, Hardin suggests that immediately after
detoxification, a clients is "cognitively and emotionally too
unstable to derive the most from her treatment experience"
(1991:176). Hardin believes treatment involving education and
life skills would thus be more useful six months to one year
after detoxification. Further, a case manager would remain with
a client for two to three years as the client progresses through
treatment.

The above points all indicate the need for more long term
treatment, beginning prior to detoxification and lasting two to
three years after the client quits drinking and/or using.

Counsellor experience with chemical dependency

Many women who have been treated for chemical dependency
feel that counsellors must have personal experiences with
addiction in order to be effective. They feel this to be
important for two reasons: first, only someone who has been
through a similar experience can fully understand the clients'
recovery process[41]. Second, only experience would allow a

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[41]This issue also came up in my own research. Some women that
I approached for interviewing felt that I, having never experienced
chemical dependency, could not fully understand their experiences
and that consequently, I should not be interviewing them. This has
been a concern for me throughout this project. In the end,
however, I feel that this research is important and that while I
cannot fully understand other women's experiences, I can listen to

counsellor to identify the "con games" clients play when they are in treatment.

Some counsellors echoed this perspective (Cooksey 1991, Robertson 1991), although Robertson also believed that counsellors with no personal addiction experience could be effective for some clients. One woman I interviewed also felt this way, suggesting that an experienced counsellor was necessary for the early stages of chemical dependency treatment, but that later, such addiction experience was no longer necessary.

*   *   *

Women's experiences with alcohol and drugs can be very painful and destructive to their personal lives. For those who turn to treatment and receive sexist, individualized counselling that does not account for the social influences in their lives, their pain may only be deepened. It is essential that women's specific treatment needs be identified and fulfilled. On a much wider level, the destructive nature of our capitalist-patriarchal society must be addressed if real, structural change is going to be realized.

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them and learn from what they tell me. In fact, a number of women I interviewed expressed appreciation that this research was being done.

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Appendix

Questionnaire

A) Case Number _ _ _
B) Treatment centre:_____
C) How arrived at treatment centre?_____
D) Nature of interview: Phone_____   In person_____
E) Date of interview:_____
F) Time interview begins:_____

1) Maybe we can begin by talking about the treatment that you received at _____. I have a standard outline of the program, but what kinds of activities were you involved in? (circle all that apply)
   1 Individual counselling
   2 Family counselling
   3 Group sessions
   4 Educational sessions
   5 Assertiveness training
   6 Exercise, specify _____
   7 Other _____.
   8 No answer

2) What parts of the program at _____ did you find to be most useful?
   1 _____
   2 No answer

3) Before treatment, what types of drugs or alcohol were you using?
   1 _____
   2 No answer

4) How often did you use or drink?
   1 Every day
   2 A few times a week
   3 Weekly
   4 Binging, how often_____
   5 Other _____
   6 No answer

5) How much did you use at once?
   1 _____
   2 No answer

6) What age did you begin using alcohol/drugs:_____

7) How long were you addicted prior to treatment?
    1 _____
    2 No answer

8) How long were you in treatment at _____?
    1 _____
    2 No answer

9) How many people were in your treatment session besides you?
    1 Women,_____
    2 Men,_____
    3 No answer

10) A number of people who go through treatment stop using drugs
    or alcohol, others drink socially after treatment. Others
    go back to regular drinking or using. Have you used drugs
    or alcohol since treatment?
    1 Yes, specify type, amount and how often_____
    2 No, never
    3 No answer

11) Since treatment, do you generally feel good about yourself?

         1   2   3   4   5   6   7   8   9
        (never)   (all the time)

12) When were you born?   __ __ __
                           month day year

13) How much education have you had?
    1 _____
    2 No answer

14) Have you attended a training program or school since
    treatment at _____ ?
    1 Yes, specify_____
    2 No
    3 No answer

15) What is your ethnic or ancestral background?
   1 Native Indian
   2 Canadian-born Caucasian
   3 Canadian-born other _____
   4 Immigrant Caucasian
   5 Immigrant other _____
   8 Other _____
   9 No answer

16) What is your relationship status?
   1 Married
   2 Widowed
   3 Divorced
   4 Remarried after divorce
   5 Remarried after widowed
   6 Separated
   7 Common-law relationship
   8 Never married and not involved in common-law
      relationship
   9 Lesbian relationship
  10 Other _____
  11 No answer

17) If applicable: is your current relationship
   1 Very satisfactory?
   2 Satisfactory?
   3 Unsatisfactory?
   4 Very unsatisfactory?
   5 No answer

18) If applicable: does your current partner use alcohol or other chemicals?
   1 Yes
   2 No
   3 No answer

19) If applicable: do you consider the amount your partner consumes to be excessive?
   1 Yes
   2 No
   3 No answer

20) Do you have any children?
     1 No children
     2 One child, age____, sex_____
     3 Two or more children, ages and sexes_____
     4 Other _____
     5 No answer

21) If children, were any separated from you before treatment?
     1 To father
     2 To MSSH
     3 To other relative
     4 Other_____
     5 Not separated
     6 No answer

22) If children, have any been separated from you since treatment?
     1 To father
     2 To MSSH
     3 To other relative
     4 Other_____
     5 Not separated
     6 No answer

23) Do(es) your child(ren) live with you now?
     1 Yes
     2 No
     3 No answer

24) Do you have joint custody of your child (children)?
     1 Yes, _____
     2 No, _____
     3 No answer

25) In the year before treatment, did you have enough money to meet your needs?
     1 Yes, _____
     2 No, _____
     3 No answer
     4 Not applicable

26) Do you have enough money to meet your needs right now?
     1 Yes, _____
     2 No, _____

        3 No answer
        4 Not applicable
27) Is your current source of household income stable?
        1 Yes, always
        2 Usually
        3 Sometimes
        4 Rarely
        5 No, never
        6 No answer
        7 Not applicable

28) When you were growing up, did your family have enough money
     to meet your family's needs?
        1 Yes,_____
        2 No,_____
        3 No answer

29) Where did you grow up? (eg, urban/rural)
        1 _____
        2 No answer

30) Where did you live in the year prior to treatment at
     _____?
        1 _____
        2 No answer

31) Where do you live now?
        1 _____
        2 No answer

32) Were you working in the year prior to treatment:
        1 Full-time outside home,_____
        2 Part-time outside home,_____
        3 Employed inside home
        4 Not employed
        5 Other _____
        6 No answer

33) Are you currently working:
        1 Full-time outside home,_____
        2 Part-time outside home,_____
        3 Employed inside home
        4 Not employed
        5 Other _____
        6 No answer

34) Are you satisfied with your work situation?
1 Yes
2 Sometimes
3 No
4 No answer

35) In the year before treatment, have you had any (negative) involvement with the law?
1 Yes, specify_____
2 No
3 No answer

36) Have you had any (negative) involvement with the law since treatment at _____?
1 Yes, specify_____
2 No
3 No answer

37) Do you have a support system of friends or family that help you stay clean and sober?
1 Yes
2 Sometimes
3 No
4 Don't know
5 No answer

38) If yes, is this system mostly friends, family or others?
1 Mostly friends
2 Mostly family
3 Equally friends and family
4 Other _____
5 No answer

39) If yes, is this support system mostly women or men?
1 Mostly women
2 Equally men and women
3 Mostly men
4 No answer

40) If yes, do you use this support system?
1 Yes
2 Sometimes
3 No
4 No answer

41) When you were growing up, who raised you?   (circle all that apply)
    1 Raised by natural parents
    2 Single natural parent
    3 Male step parent and natural mom
    4 Female step parent and natural dad
    5 Adopted
    6 Someone hired to take care of you
    7 Grandparent(s)
    8 Foster home(s), number_____
    9 Group home(s), number_____
    10 Other_____
    11 No answer

42) Did any of the people who looked after you regularly drink or use other chemical substances?
    1 Yes, often
    2 Sometimes
    3 No
    4 No answer

43) Do you feel any of the people who looked after you regularly abuse chemical substances?
    1 Yes
    2 No
    3 No answer

44) When you were a child did anyone ever touch you sexually?
    1 Yes, how often?   _____
    2 Not sure
    3 No
    4 No answer

45) When you were a child, did anyone ever push, shove, slap or hit you very hard?
    1 Yes, how often?   _____
    2 Not sure
    3 No
    4 No answer

46) As an adult, have you ever been touched sexually when you did not want to be?
    1 Yes, how often?   _____
    2 Not sure
    3 No

4 No answer

47) As an adult, have you ever been pushed, shoved, slapped or
hit by your partner?
1 Yes, how often? _____
2 No
3 No answer

48) Since treatment, have you been at risk of physically hurting
yourself?
1 Yes, specify_____
2 No
3 No answer

49) Since treatment, have you been at risk of physical harm from
others?
1 Yes, specify_____
2 No
3 No answer

50) Have you ever had a major illness?
1 Yes, specify what and when _____
2 No
3 No answer

51) Have you ever had anything like a miscarriage, an abortion,
a hysterectomy, or a particularly difficult labour?
1 Yes, specify what and when_____
2 No
3 No answer

52) Have you ever had an eating disorder?
1 What and when_____
2 No
3 No answer

53) Do you have any disabilities such as blindness, loss of
hearing, etc.
1 Yes, specify_____
2 No
3 No answer

54) Have you experienced any major life changes since treatment? (check all applicable)
1 Divorce
2 Separation
3 Lost custody of children
4 Moved, number of times_____
5 New job
6 Lost job
7 Death in family/friends
8 Other_____
9 Nothing
10 No answer

55) If you had any major life changes, were they a result of treatment?
1 Yes,_____
2 No,_____
3 Not sure
4 No answer

56) Are you involved with AA/NA?
1 Regularly
2 Occasionally
3 No
4 No answer

57) Do you attend any other support groups? (eg. OA or Battered Wives Support Group)?
1 Yes,_____
2 No
3 No Answer

58) Before going to _____, had you tried any other treatment facilities?
1 Yes, _____
2 No
3 No answer.

59) Have you undergone any other treatment since you finished at _____?
1 Yes, specify_____
2 No
3 No answer

60) What aspects of the treatment at _____ do you think were successful?
1 Individual counselling
2 Family counselling
3 Group sessions
4 Educational sessions
5 Assertiveness training
6 Exercise, specify _____
7 Coed format (or women-only format)
8 Other _____
9 No answer

61) Did _____ have a philosophy or focus that made it a difference to your treatment?
1 Yes,_____
2 No
3 No answer

62) Do you think that the coed (women-only) environment made any difference to your treatment?
1 Yes, _____
2 No
3 No answer

63) a) On a scale of 1 to 9: In general, are you satisfied with your life right now? (1 is very low, 9 is very high)

    1   2   3   4   5   6   7   8   9

b) How would you rate your health at the present time?

    1   2   3   4   5   6   7   8   9

c) Are you satisfied with your sexual expression?

    1   2   3   4   5   6   7   8   9

d) How would you rate the overall success of the treatment you received at _____?

e) How do you feel about the treatment you received at _____?

63) Is there anything you would like to add?
     1 Yes,_____
     2 No
     3 No answer

Time interview ended:_____