ISSUES WOMEN IDENTIFY DURING THEIR FIRST THREE YEARS OF RECOVERY FROM ALCOHOL AND DRUG ADDICTION

by

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ABSTRACT

Research targeting the chemically dependent woman has received little attention, even though the research indicates a convergence of male and female drinking norms. Research centered on the special issues of the chemically dependent woman also needs to be extended beyond the scope of actual alcohol and drug abuse and resulting treatment to include information on what issues women face in their recovery process. The findings would help treatment providers design more successful interventions for this population.

This study used qualitative methods to investigate issues that 12 chemically dependent women, ranging in actual time in recovery from first to third year post inpatient treatment, discussed as part of a 16 week therapy group. Their recorded responses were transcribed and analyzed, using Glaser and Strauss' methods of comparative analysis, comparing the women between three groups designated by the divisions of first, second, and third year post inpatient treatment.

The findings indicate that all share many of the same issues, however there are marked differences between the groups. All the women had difficulties with intra- and interrelationships, finding it difficult to maintain a healthy recovery in spite of the problems they confronted in experiencing reality without mind-altering substances.

Many issues were influenced by the subjects' family of origin history and sex-role orientation. Conflicts in role obligations resulting in work, family, parenting, and relationship problems surfaced. All the women were aware of additional substance and compulsive dependencies that they would like to
eliminate; however, avoiding relapse of their alcohol/drug addiction was the major concern for most.

The findings reveal that the longer women spent time actively undertaking a concerted program of recovery, the more they experienced integration into the rest of society, and that the acquisition of life skills and resolution of the past were important factors to the success of this integration. The categories and theme issues that emerged from the analysis have implications for social work practice, policy, and further research.
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CHAPTER 1: INTRODUCTION

Focus of Study

The purpose of this study is to identify some of the issues that women experience during their first three years after inpatient treatment for chemical dependency. All of the issues will be obtained from women who have been through the inpatient program at St. Joseph Hospital in Bellingham, Washington, and all of the subjects are currently involved in maintaining a lifestyle free of their chemical addictions. It is hoped that the research obtained in this study will contribute to the neglected subject of the chemically dependent woman, particularly what confronts them after abstinence.

Research on women and chemical dependency remains one of the most neglected areas in the field of addiction (Corrigan, 1980.) Numerous professionals have commented on the scarcity of empirical research focusing on the chemically dependent woman; it is one of the more neglected areas in the field of addiction studies. Very few studies have concentrated specifically on the nature of female chemical dependency, let alone issues women may confront in recovery. Reviews of the literature (Clemmons, 1985; Schuckit, 1972) found that research into women's chemical dependency still lags behind research into men's chemical dependency. Lindbeck (1972) capsulated this situation by saying that the chemically dependent woman has been a stepchild in the field of research. Much of the empirical research conducted on chemical dependency has been concentrated around studies of alcohol and alcoholism targeting the male population. The disease concept-based alcoholism movement during the 1940s, 1950s, and 1960s paid little attention to alcohol problems among women; the research supporting the disease model of
alcoholism tended to focus primarily on men. Often, the research findings were applied to women, even though women had not been included as research subjects. The relative neglect of women's alcohol problems as compared to those of men was of no apparent concern.

Even though the preponderance of research on chemical dependency has centered on the male population, since the 1950s chemical dependency among women has been on the increase. A report of a 1979 general population survey on alcohol consumption indicated that approximately 75 percent of adult males were drinkers compared to about 60 percent of females. Heavy drinkers comprised 20 percent of the males and 6 percent of the females (Clark and Midanik, 1982). Although the result of survey studies going back to 1971 indicate that female drinking behavior has changed little over the decade of the 1970s, and that the ratios of both male/female drinking and problem drink remain similar, there have been some gender studies conducted in the 1980s that indicate a convergence of male and female drinking norms.

Hilton (1987) reported the results of a general population survey in 1984 involving 5,221 adult respondents in the United States. The data showed patterns similar to those revealed in previous surveys; however, Hilton observed a decline in abstinence among young women in the survey, suggesting a convergence. He further noted a statistically significant increase in women drinkers reporting any one of four alcohol dependence problems, from 5.2 percent in 1967 to 8.2 percent in 1984. Statistically significant increases were found in the proportions of women drinkers reporting that drinking had harmed marriage or home life (from 0.6 percent to 2.6 percent) or that drinking had harmed work or employment opportunities (from 0.1 percent to 2.1 percent.) There is speculation that this
convergence has been facilitated by the equal status revolution and by more sophisticated means of detection and intervention.

In addition, treatment specialists repeatedly cite anecdotal evidence that many abusers of alcohol also misuse legal drugs or use illegal drugs, and such polydrug abuse is reportedly greater among women than among men. While this contention receives some support from research (Celantano and McQueen, 1984), the literature tends to be separately organized around alcohol and drug issues. The greatest body of research on women and chemical dependency is limited to an alcohol-orientation; even though a woman who presents herself for inpatient treatment with alcoholism only is becoming the exception rather than the norm. Because of this research emphasis on alcohol abuse and alcoholism, many of the terms used when referencing existing data will refer to alcohol problems, or alcohol abuse, or alcoholism, or heavy drinkers with little mention of the polydrug abuser. And no one of these four different labels for alcohol adequately describe the existing problem. The list illustrates the confusion that exists between different factions in the field of chemical addiction as well.

There is also a convergence occurring in chemical dependency treatment programs. Traditionally, women have represented a relatively small proportion of the patients seeking treatment for chemical dependency problems. However, recently there is evidence that the ratio of female to male alcoholic patients in many treatment facilities has decreased substantially with some facilities reporting ratios of less than 1:3 (Gomberg, 1974).

However, evidence from treatment programs clearly indicates that many more men than women are seeking and receiving treatment (Mulford, 1985.) In addition, epidemiological evidence shows that men have substantially higher rates of alcohol problems than women (Clark, 1982.) However, due to the shortage of longitudinal
studies of women and chemical dependency, questions are arising about the validity of these and other studies. Women with chemical dependency problems are labeled the "hidden alcoholic/addicts" due to the discrepancies between epidemiological and drug consumption data and rates of intervention and treatment. From this discrepancy and other unknown factors about the "hidden alcoholic/addict," issues arise around the assumption that American women's chemical dependency problems are greater than the treatment statistics show. Some studies indicate that females with alcohol and/or drug abuse consistently show more signs of psychological disturbance than males on measures of psychopathology. On MMPI profiles for male and female drug abusers in treatment, females were significantly more deviant than males on scales indicating neurosis and drug proneness (De Leon, 1979). Thus, questions increase about whether treatment programs are appropriately designed for the needs of women, particularly since most programs are designed around the male focused disease concept.

Issues centered around theories developed principally from data about chemically dependent males, a lack of research information that takes in consideration the unique processes of the chemically dependent female in the creation of evaluation and referral strategies, and a narrow and bias design of treatment interventions have resulted in fewer women entering treatment. Some additional factors that preclude women from seeking and entering treatment include the following: sexism and harassment within treatment programs; social stigmatization and/or social protection of the alcoholic woman; family responsibilities including child care; and economic barriers.

Perhaps because of the lower numbers of women seeking treatment, researchers have also tended to exclude women from their studies. Much of the
new developments in treatment for women with alcohol and drug problems has been based more on speculation and intuition. This trial and error form of model development has included separate facilities and programs, the fostering of women's self-help groups, androgynous therapy, and feminist counseling. There remains a great need for outcome studies to substantiate the more successful forms of intervention available and to point the direction for the new innovations necessary.

Chemical dependency professionals have long recognized that treatment intervention practices need to be extended and individuated to meet the ongoing needs of their clients. There can be few more central questions about the treatment of chemically dependent men and women than what happens to them after they leave a treatment program. It is unfortunate, therefore, that this apparently simple question has received so little research attention (Gossop, Green, Phillips, & Bradley, 1989). Relapse is a serious problem in chemical dependency, and is one of the most important reasons to conduct further research. However, this area is poorly researched with much of the available research literature focusing on alcoholism. However, even here, the details of relapse and continued abstinence is poorly researched (Litman, 1986).

It is becoming clear that it is not enough to provide just a specific period of concentrated education and rehabilitation period for every alcoholic/addict. Research that focuses on the relapse potential of the alcoholic may not be the same as the relapse risk factors for the multiply chemical dependent, such as the individual coming into treatment physically addicted to alcohol, marijuana, and cocaine. It is important to consider the biological, psychological, and social factors of each chemically dependent individual presenting for treatment when assessing a treatment plan.
A further complication in the application of intervention methods that will be successful in helping the chemically dependent individual to maintain abstinence along with the development of a healthy lifestyle, is the recognition that chemical dependency is often a part of a larger addictive system which may include dependencies to other licit and illicit substances and also to habitual behavior patterns. Testimonies from people who have been successful in maintaining abstinence from alcohol and drugs reveal that many became aware of dependencies to more socially accepted substances such as caffeine and sugar after they completed treatment. Rosenfield and Stevenson (1988), in a study designed to determine the oral coping behaviors in normal, overweight, and recovering alcoholic women, found that for the recovering alcoholic women, when the oral behavior of choice was removed (e.g., alcohol in alcoholics), the tendency to substitute another oral behavior (e.g., sweets, cigarettes) was seen. They concluded that the tendency appears to be for addictive oral consumers to substitute one oral behavior for another rather than to achieve total recovery. Many recovering women also talk of overworking, overspending, overeating, gambling, and/or become obsessed with relationships and sex. Most of the research evidence of this addictive system has been through personal accounts and needs research attention.

Recovery needs of women and men need to be better defined beyond the average of 16 weeks of treatment and aftercare that most inpatient treatment programs offer. In order to better define the needs of women attempting to maintain abstinence from chemical dependency, it would be helpful to know some of the issues women face in their recovery process. Research that would aid clearer definition of women's needs for treatment and beyond is of value to the 'system', whether it be treatment, family, or society.
Study Purpose

As has been earlier stated, the goal of this study is to identify some of the issues that women face during their first three years of recovery from some form of chemical dependency. Because of the expansive nature of this subject, the issues identified will be focused in four major areas as follows: 1) relationships; 2) self-awareness, which includes self-esteem; 3) life roles including work; and 4) other addictions, substance and behavioral. Because the issues will be exclusively derived from women who have been through the same inpatient program for their chemical dependency and are all currently involved in maintaining a lifestyle free of their chemical addictions, the information obtained from women with some of these similar variables will be richer, more authentic, and will contribute to knowledge for the woman chemical dependent.

It is hoped that this study will contribute to both practice theory and treatment policy development for women within the field of chemical dependency. Should chemical dependency professionals more clearly identify some of the issues that women have to confront as part of their process to maintain sobriety, they could feasibly design treatment interventions that address these issues and offer ongoing education and therapeutic support in confronting and resolving them.

Results of this study will be instrumental in this researcher's development of a more comprehensive treatment and aftercare focus for women entering treatment at St. Joseph Recovery Center in Bellingham, Washington. Even with the financial constraints of a new program, the research results would help make some incremental program changes at the treatment and aftercare level.

Further, the focus group therapy technique used for data collection proves a very useful tool in this exploratory study. Utilizing a mixed group of women in
various time stages of their own recovery process, provides a rich body of data as well as an opportunity to realize another possible intervention model for the recovering woman. This study could provide the basis for the further development and evaluation of a valuable treatment tool for women.

A limitation of this study is the research variable of only having 12 women subjects. Although the findings reflect a cross section of women in three different recovery years, it is not known whether these findings would be similar with a larger subject population.

**Study Plan**

This study is exploratory, designed to gather information from women through their interaction in a group therapy model. The four major areas of possible issues are explored using a qualitative oriented, group interview format.

The following chapter will discuss in more detail the relevant background information on this issue. Included will be further discussion of the appropriate definitions of alcoholism and other chemical addiction along with definitions of some of the terminology of chemical dependency used throughout this project. Attempts will be made to converge the confusing nomenclature of the addiction field into a few terms that are labels of a more exacting nature. A summary of the varied models of addiction will be provided along with an explanation of the model used throughout this study. Also an explanation of the treatment system and model of addiction that the women subjects underwent will be provided; this will include elaboration on educational, medical, and therapeutic techniques utilized.

Chapter three will provide a review of the research literature as it relates to the chemically dependent woman. Given the limited literature which offers
longitudinal studies of women post treatment, I will discuss the existing research literature which includes physiological, psychological, and social aspects of chemical dependency for women, studies and speculations by other experts in the field of chemical dependency, and treatment outcomes. Along with the research that will be divided into the four major areas of focus, relationships, other dependencies, self awareness, and life roles, some of the bio-medical consequences of chemical dependency in women will be explained.

Chapter four outlines the methodology used in the research plan. This will include a description of the subjects and the instrument with a discussion of the means for data collection and analyzing that was used.

Chapter five presents the findings of this study; the themes (issues) that emerge from the data analysis will be supported by statements made by the women subjects. These themes will be discussed in how they relate to the first three years post inpatient treatment.

The final chapter includes the limitations of this research study and outlines the implications for chemical dependency treatment, social work practice, and future research.
CHAPTER 2: BACKGROUND

The purpose of this chapter is to provide information that furthers understanding of women and addiction. Definitions of alcoholism, addiction, alcohol and drug abuse, and alcohol and drug problems in the general population usually involve a multidimensional measurement of consumption, dependence, and social and personal consequences associated with the chemical use. The interaction among these three sets of partially independent variables is complex and not yet well understood. The nomenclature is confusing and often times misleading. Therefore, attempts to adopt a definitive point of view on addiction has been largely unsuccessful with diversity still existing between the biological, psychological, social, and spiritual factions. To avoid confusion, an overview of chemical dependency with an explanation of the models of addiction is presented here, along with the model of addiction that is applied in this report. Clarification of the terms and definitions that are best suited for this investigation is included as the first section of this chapter.

It is important to offer an explanation of the chemical dependency treatment procedures that the women research subjects underwent. Because each one of these women completed the same residential treatment program, St. Joseph Recovery Center, an elaboration on the educational, medical, and therapeutic procedures utilized would offer a perspective of some of the similarities that these women subjects share.

And, finally, a description of the stages of recovery will be included to put the treatment and other recovery interventions into perspective. Even though the women subjects of this research had been out of treatment and abstinent from post treatment to three years, an understanding of the process of recovery, will help
clarify later findings that illustrate that these women, regardless of their length of abstinence, were also in various stages of recovery.

**Terms and Definitions**
The nomenclature of the chemical dependency field is as confusing as the diversity of the models of addiction. Different points of view about the causes and effects of chemical dependency have resulted in different and often divergent terminology. To avoid confusion, this section will list and define the terms that will be used through this report; the terms reflect the eclectic nature of the public health model. In addition, some of the terminology used by the women in the group therapy sessions that may not be clear to a reader unfamiliar with the jargon of chemical dependency, treatment, and recovery will be defined. The definitions presented are not the most pharmacologically sophisticated but represent the greatest potential for use in this clinically oriented report.

*Abstinence* is abstaining from a drug, other substance, or compulsive behavior.

*ACOA* refers to Adult Children of Alcoholic Parent(s), the adult faction of the COA movement. This term is used by individuals to denote their participation in some aspect of rehabilitation for their dysfunctional family history.

*Addiction* is physiological dependence or need, with its familiar signs of increased tolerance, cellular adaption, and withdrawal symptoms. Addiction is used in place of chemical dependency when a stronger emphasis on the physiologic aspects is needed.
Boundaries are symbolic "fence" systems that have three purposes: 1) to keep people from getting "too close" and abusing us, 2) to keep us from doing the same to others, and 3) to give each person a way to conceptualize a sense of an individual and separate self. Boundary systems are of an internal or external nature.

Chemical Dependency is used to describe a physical and/or psychological "need" or dependency to one or more drugs including alcohol. Psychological dependence centers on the user's needing a drug in order to reach a maximum level of functioning. This is a subjective term and is, as such, difficult to quantify. Malloy (1981) has suggested that the single substance abuse model of alcohol addiction be abandoned and be replaced by a generic model that acknowledges that multiple substance abuse can occur at any time in an alcoholic's life span. Physical dependence indicates that the body has physiological adaptation to chronic use of the substance, with the development of symptoms when the drug is stopped or withdrawn (Schuckit, 1984). The term, chemical dependence will replace the terms alcohol and drug abuse, heavy drinking, and substance abuse. Individuals with chemical dependency are referred to as CDs instead of alcoholic/addicts.

Codependency is defined as a pattern of painful dependence on compulsive behaviors and on approval from others in an attempt to find safety, self-worth, and identity. Originally coined to describe family members of CDs, the term has been increasingly employed to categorize individuals who have difficulty 1) experiencing appropriate levels of self esteem; 2) setting functional boundaries; 3) owning and expressing their own reality; 4) taking care of their adult needs and wants; 5) experiencing and expressing their reality moderately (Mellody, 1989.)
Cross Tolerance  is the physiological phenomenon in which the development of tolerance to one drug of a class of drugs usually indicates tolerance to other drugs of the same class.

Drug of choice  refers to the most preferred chemical of addiction. Individuals categorize this drug as the one they may have had the most problems with and the one they would likely return to if they relapse.

Eating disorders  are included into the category of addictive diseases and are loosely grouped into behaviors which include compulsive overeating, normal overeating, and pathological eating disorders.

Higher Power  is a reference used by Alcoholics Anonymous, other Twelve Step Groups, and treatment programs that incorporate aspects of the American Disease model to form the foundation of a spiritual program of recovery. Chemically dependent individuals are asked to put their egos aside and have faith in a "power greater than self." This power can denote God, or often the love energy that brings people together in a Twelve Step meeting.

Pathological eating disorders  is a broad diagnostic term that encompasses any dysfunctional behavior marked by a pathological relationship with food. Anorexia and bulimia fall into this category and are serious disorders.

Polydrug addiction  is addiction to more than one drug.
Recovery is the validated program that is undergone by the recovering person. This can include treatment, participation in a 12 Step program, professional therapy, and other healthy behaviors that support a dependency-free lifestyle.

Recovering self is a form of selfhood involving a validated program of self-indicators that exercise a regulatory function over other actions of the person, including abstinence. This transsituational self is learned in 12 Step meetings and in treatment. The recovering chemical dependent, often referred to as "recovering alcoholic/addict" in treatment and 12 Step meetings, is an individual who 1) incorporates the identity of a recovering alcoholic/addict into her own self-concept; 2) now becomes a non-drinker and drug user; 3) now calls herself a member of AA, NA, and/or CA.

Relapse is the return to chemical abuse and behaviors by a recovering person. The individual terminates her recovery program and is said to be "in relapse" as she reverts to behaviors and attitudes that were part of her addictions.

Slip is a singular lapse to drug use without the accompanying return to old behaviors and attitudes. The individual never terminates her recovery program.

Sponsor is a recovering and active member of a twelve step group who serves as a mentor and guide for the newer member. One of their principal functions is to support the completion of the twelve steps.

Tolerance means the ability of brain cells to function in the presence of a drug. Acquired tolerance means that cellular changes have occurred as a result of
repeated ingestion of a drug, making the same amount of the drug less effective on the nervous system. Some individuals have an inherent tolerance to certain drugs. This points to a genetic predisposition to addiction. Changes in tolerance are commonly accepted as a sign of chemical dependency.

*Twelve Step Programs* are based on Alcoholics Anonymous; they incorporate the same format and use of the twelve steps and traditions for recovery. Groups have formed with the desire to recover from chemical dependency and other dependencies such as sex, overeating, gambling, and relationships.

**Models of Addiction**

When examining the etiology of chemical dependency, most of the research and data available concerns the drug alcohol. And, although there is a preponderance of research available concerning the origin and disposition of this licit substance, much of it reflects the ongoing disagreements and uncertainty regarding the nature of alcohol problems. Contemporary books confidently ascribe alcoholism to inherent biochemical abnormalities (Milam & Ketchum, 1981), social learning processes (Peele, 1985), family dynamics (Steiner, 1971), sociocultural influences (Cahalan, 1987), and personal choice (Fingarette, 1988). The intervention efforts necessary for the chemical dependency problem are necessarily informed and guided by how one thinks about the problem to be treated.

In this next section some of the alternative models of alcoholism and alcohol problems are described. Awareness of characteristics of each is important because it will be found that treatment programs often combine aspects of all these different models in the delivery of service. Even though these models underscore alcoholism,
many of their features have been easily adapted to other drugs. Therefore, chemical
dependency (CD) and drugs will be used throughout to denote alcohol and drugs
except in cases where model feature relates to alcohol only.

The American Disease model was born through the formation of Alcoholics
Anonymous in 1935. A central assertion of this model is that the disease is
comparable to an allergy to alcohol and other drugs and is seen as arising from a
combination of physical, psychological, and spiritual causes. The principle symptom
is loss of control over drugs, mostly seen as the inability to restrain oneself from
abusing once started. The disease of chemical dependency, in this view, is seen as
irreversible, but possible to arrest through total abstinence from drugs and

This model suggests that moderate drinking is possible for some people
which is appealing to social drinkers, the implication being that only alcoholics are
at risk and nonalcoholics can drink without fear of addiction. The model also
expounded on the position that the CD needed humane treatment not punishment.
The medical profession ultimately adopted the idea of alcoholism as a disease
requiring medical treatment. The inference is that chemical dependency is inherent
in the physical or psychological makeup of the individual.

Intervention procedures in this model contend that people with the chemical
dependency must be identified, informed, and brought to accept their diagnosis
with the willingness to abstain from drugs the rest of their lives, with the exception
of medical directives. Because of their personal experience with the disease,
recovering CDs are seen as the best agents of intervention, and peer support groups
such as Alcoholics, Narcotics, and Cocaine Anonymous provide ongoing resources
for recovery.
The Characterological model emphasizes the origin of chemical dependency is in the abnormalities of personality. Psychoanalytic theorists borrowed from Freud’s notions of psychosexual development to characterize alcoholic personality types (Knight, 1938). Some of the psychodynamic hypotheses have viewed chemical dependency as arising from latent homosexuality, low self-esteem, a need for power and control, or sex-role conflicts. More recently, the application of personality tests has led to groupings by types of abnormal personality traits (Skinner, 1982). The central assumption with this model is that CDs are particular personality types, thus spearheading the search for "the addictive personality." However, attempts to clarify and define this "addictive personality" have failed (Pattison, 1985). Few of these theorists have attempted to tailor their classification systems to the practical needs of the clinicians and researchers; little of the research and information based on this model has been recognized by contemporary researchers as a significant contribution to the treatment of chemical dependency (Babor & Dolinsky, 1988). Preventive interventions using this model focus on bringing about normal psychological development.

The basic principles of the Conditioning model were developed by the proponents of classical or Pavlovian conditioning. A number of different potential incentives for drug abusing have been cited such as tension reduction, escape from rigid social rules, and possible reinforcement from peers. The central premise of this model is that chemical dependency can be treated successfully through methods of aversion conditioning based on Pavlovian concepts of aversive stimuli conditioning of behavior. Thimann (1966) reviewed a hospital program in Massachusetts that employed aversion conditioning. He found that in most hospitals with this type of program, chemical dependency is viewed as a physical/medical problem requiring physical treatment, which in this case included
a "weaning" period to get off the drugs and then a period of aversion conditioning treatment.

The Educational model relies upon education as a tool for prevention of chemical dependency; this model is widely used in school programs to impede the onset of addiction. Education is seen as a secondary prevention tool which includes public education, education of key persons such as medical personnel, social workers, and educators, and development of skills in intervention (Royce, 1981). Implicit in this model is the supposition that drug problems evolve from a lack of accurate knowledge. With the correct knowledge, individuals are presumed to be less likely to abuse drugs and will know the correct behaviors to avoid or change. Chemical dependency professionals and educators knowledgeable in chemical dependency are seen as the change agents in this model.

One of the most widely used models of alcoholism used by treatment programs today is the Biological model, which places strong emphasis on physiological and genetic processes as causes of chemical dependency. A predisposition to addiction is seen in certain individuals that have strong evidence of inherited risk factors as offspring of chemically dependent parent(s). The classical approach to establishing genetic factors utilizing family, twin, and adoption methods has been successfully incorporated in the chemical dependency field with results indicating a great likelihood of important genetic contributors (Schuckit, 1988).

There are some that postulate the evidence of abnormal alcohol metabolism. For example, the enzyme, monoamine oxidase (MAO) is not only said to be low in alcoholics, but there is preliminary evidence that sons of alcoholic parent(s) may also demonstrate at least a trend for lower MAO activity (Schuckit, et al., 1982).
Still others have pointed to the pharmacology of alcohol itself as an explanation of how drinking can lead to alcoholism. The theory of THIQ, a natural opiate-like substance produced in the brain as a byproduct of alcohol metabolism, is seen as supporting the pharmacological addiction of this model. Research has demonstrated that intracerebral administration of THIQ increased ethanol consumption in the rat (Myers & Oblinger, 1977).

Using this model, alcoholics are evaluated for physiological symptoms of tolerance and physical dependency. Physical dependency means that withdrawal symptoms occur from decreasing or ceasing consumption of alcohol (Royce, 1981.) Individuals with alcoholism are seen as having an increased risk for addiction to other drugs, called cross-tolerance. Although much of the biological factors of individual drugs differ, intervention techniques in this model have been adapted for all drug addictions and have combined many aspects of the American Disease model.

The Social Learning model focuses on interactions between the individual and the environment in the forming of patterns of chemical dependency. As the early behavioral assessment research developed in the late 1960s and early 1970s, the impact of specific environmental factors (stress and social interaction were seen as the most common) on consumption rates and patterns of chemical dependency began to be explored. The importance of the modeling of drug behavior by peers has been shown to evoke increased consumption. Nathan and Lisman (1976) concluded from a research review that social interaction facilitates alcohol consumption in most alcoholics and has little or no effect on others.

The social learning model also emphasizes the relevancy of the user's coping skills and cognitive expectancies. Reviews have suggested that an individual's cognitive expectancies concerning the effects of a chemical may exert a greater
influence over abuse and subsequent behavior than the pharmacological effects of
the drug (Donovan & Marlatt, 1980).

Reliance upon a drug to cope with a problem or stressful situation defines the
process of psychological dependence. When healthy coping skills are absent, the
individual may rely upon drugs as a coping strategy. Behavioral clinicians have
developed a variety of social-skills training. A General Systems model approach
has the position that individual behavior is an inherent part of a larger social
system. Actions of problematic drug use cannot be understood without considering
their relationship to other members and levels of the systems to which the
individual belongs. Chemical dependency is seen not as an individual problem but
as an interactive one that affects and is affected by interaction and change at many
systemic levels. This model maintains that a system needs to maintain balance; for
example, if a CD from a family system wants to change, the dysfunction of the
larger system (the family) needs to be addressed. A variety of theorists have
postulated that chemical dependency is a family disease, requiring that the entire
family system be treated along with the CD (Bepko, 1985, Steinglass, 1987,
Wegscheider-Cruse, 1981, and Woltitz, 1983). What becomes clear is that, in the
system organized around drugs, all members of the family or larger system are
essentially drug-affected. Their self-corrective behavior is always generated by
patterns of feedback by the drug-affected individual (Bepko, 1985). From this
perspective, family therapy is seen as the effective intervention for resolving the
tangle of dysfunction created by the chemical dependency.

More recent models of this system's perspective contend that children of
alcoholics manifest identifiable pathology as a result of the dysfunctional family
environment in which they were raised. This pathology gives rise to a pattern of
abnormal needs and behaviors in COAs that makes them subject to unhealthy
relationships and addictive behaviors. Claudia Black (1985) contends that if a child has one chemically dependent parent, she has a 63% chance of marrying and/or becoming a CD herself. Many CDs that have enjoyed success in their ongoing rehabilitation have found themselves needing therapy and peer support to work through their dysfunctional history toward a more adaptive style of living.

The Sociocultural model points to the responsibility of society and subculture in the development of drug patterns and related problems in the individual. For example, the level of per capita alcohol consumption is influenced by the availability of alcoholic beverages. Another important assumption is that the more drugs a society consumes, the more drug problems will be present. Recently, an illustration of the responsibility of the larger environment for the actions of the individual has been implemented--there is increased legal liability of those who serve alcohol for any harm inflicted in a vehicular accident by the drinker who was served. Other important sociocultural factors that are strong determinants of the level of chemical dependency are alienation, level of punishment, and functional importance of drugs within the society.

Interventions from within this model include increased controls on the price and distribution of drugs, more severe legal repercussions that discourage drug-related crimes such as drunken driving, and federal constraints on advertising. Most of the changes are seen as legislative, social policy changes of more appropriate laws.

Evidence can be found in support of each of these aforementioned models, and that each can be also illustrated to be limited in its ability to account for the full extent of drug problems. No one of these models would be adequate as intervention models in the treatment and prevention of chemical dependency. Miller and Hester (1989) offer an integration of aspects of each of these models into a Public Health
model. Within the public health perspective, the presence of a disease (chemical dependency) is a result of the interactions of the agent, host, and environment. The agent is seen as the drug; the host factors can be seen as individual differences that influence susceptibility to the condition; and the environmental factors can be seen as the aspects of the society that promote chemical dependency use and abuse. The major points of this model are presently being implemented in the majority of the CD treatment centers in the United States as the Minnesota Model. The success of the Minnesota Model in motivating the chemically dependent person to achieve and maintain abstinence has been well demonstrated at the clinical level, but there is little in the way of research to substantiate its success.

The American disease, educational, characterological, and biological models all place strong emphasis on the host factors. Emphasis on the environmental factors can be found in the conditioning, social learning, general systems, and sociocultural models. However, the unrestrictive quality of the public health model is its emphasis on all three components. Within the chemical dependency field, a public health perspective contends that alcohol and other mood- and mind-altering drugs are hazardous, placing anyone at risk who uses these substances unwisely. It also acknowledges the individual difference in susceptibility to chemical dependency problems, mediated by factors such as heredity, metabolic rates, and tolerance. And, lastly, this model stresses the importance of environmental factors in the determination of drug related problems, with influences such as the dysfunctional nature of the family system, the nature of role models, the coping behaviors adopted, and the availability of alcohol and drug products. Because of its unrestrictive yet far-reaching design and its incorporation of a variety of alternative strategies, this public health model is the model of addiction perspective used throughout this report.
Another reason for utilizing the public health model perspective is that it most closely describes the characteristics of the residential treatment program the women subjects of this study completed. The St. Joseph Recovery Center incorporates the basic guidelines and philosophy of the Minnesota Model, which is similar to the public health model. The main principals are that drug problems and the individuals who manifest them are diverse, and effective treatment is likely to be successful when the treatment structure is prepared to offer alternatives as well as a variety of promising tools to use in working with different types of chemical dependencies and individuals.

**Treatment Program**

Each of the chemically dependent women subjects of the research study attended the St. Joseph Hospital Recovery Center's residential treatment program as part of their recovery process. Because all of these women were exposed to the same educational, medical, and therapeutic processes, it is important to give a basic description of those processes in order to establish this important commonality that each of the research subjects share.

The Recovery Center offers a basic 21-day program plus any necessary detoxification for the treatment of chemical dependency. Because this program is hospital-based with a staff that includes medical and clinical teams, it is well equipped to provide treatment for men, women, adolescents, the elderly, and to those who have even the most difficult detoxifications, medical complications, and emotional hardships. The specialized services of the multi-disciplinary team is backed up by a broad range of support services from the hospital that are able to
provide any further medical, administrative, and spiritual needs the patient may have.

Treatment is a delicate blending of the Minnesota/Public Health model with the Biological and Family Systems models underscored. One of the most important concerns of women patients are relationships; the support and validation received through the relationship system have much to do with successful outcome. The treatment program recognized the importance of relationships by providing an outpatient treatment program for friends and family of each patient. All members of the patient's family and support system are encouraged to attend the seven days of outpatient family treatment where the treatment of the family system can foster healing as well as providing an understanding of the intergenerational aspects of the disease. Patients, family members, and friends are taught that alcoholism is a disease and learn the addictive properties of all the mind- and mood-altering chemicals. All individual members are encouraged to confront some of their psycho-social roots of dysfunction in order to begin the process of full recovery. Even the minor children of the patients have access to a weekly Children's group; using art, music, and games, these children from ages five to twelve can begin their process of understanding and healthy self-acceptance at their level of cognitive and emotional ability. The patient is seen as having a better chance of maintaining a lifestyle free of chemical dependency when returning to a system that is also working towards functional and healthy interaction.

Each patient establishes an one to one relationship with a staff clinician, along with daily participation in group therapy, workshops, and lectures. Each patient undergoes a thorough assessment period to determine what addictions and dependencies are present, and the treatment issues that need to be addressed. Along with a treatment design that can cater to individual needs, the model is
designed to break through denial, to educate about the physiological components of chemicals and chemical interactions, to motivate the CD to achieve and maintain abstinence, to foster the development of a more healthy self-concept, and to give support to the patient practicing healthy behaviors. The one to one staff/patient relationship fostered at an intimate and meaningful level instills hope to the individual that has arrived in treatment full of guilt, shame, and self-recrimination. The unconditional regard offered helps the patient to see there is someone worthwhile to salvage.

In addition, each patient and family member is encouraged to attend 12 Step programs including Alcoholics Anonymous and Alanon. Every effort is made to match patients with sponsors. With the individual counselor, the patient completes extensive and soul-searching written work based on the first three steps of the 12 Step program. This written work, along with individual and group therapy helps each woman to leave treatment with a clearer awareness of the limiting beliefs and dysfunctional behaviors that have inhibited her ability to cope without chemicals.

The treatment center is a closed area to afford confidentiality to the occupants. There is no caffeine, sugar, or smoking allowed in the treatment center, creating a substance-free environment that helps reduce any mood swings caused by ingestion of chemical substitutes. Patients are allowed to smoke only in a designated area at approved breaks. This is instrumental in helping many to cut down or eliminate nicotine. There are no televisions, radios, or outside reading material allowed, the exception being 12 Step reading material. This helps patients to concentrate on the real issues for being in treatment. Visitors must attend at least three days of the Family Program before being allowed to visit. This helps family members to get to the family program; once there, many find they want to complete the entire sequence.
Many of the women are heads of household with limited resources for financial support; most of the married women must work or be on welfare. The majority have inadequate educational and vocational skills which further limits occupational choices. The program provides vocational and values clarification counseling to assist women to develop a plan to implement changes in this area.

The clinical and medical support that each patient receives in her stay at the Recovery Center is seen as a bridge and a model each one can use in changing from a dysfunctional system to a functional one. Patients are given referrals for further outside support and guidance needed upon discharge from the initial 21 day period. In addition, a continuing care phase of treatment over a 12 week period is provided for patients and family members. It is intended to connect the intensive treatment experience in a meaningful way to each person's daily life at home and in the community.

**The Stages of Recovery**

These phases that follow refer to the stages of recovery which a CD passes through during treatment (Johnson, 1973; Nace, 1987). However, every individual is not the same, so many will not arrive at the Integration Phase during their treatment time. For many CDs it will take several years of physical, behavioral, social, emotional, and spiritual recovery to be finally at the Integration Phase. It is only in this last phase that the therapist can shift the focus from the dynamics of the chemical dependency to the dynamics of the individual.

*The Recognition Phase* begins with the CD's first treatment contact and implies an admission of a problem. The admission can be prompted by outside forces such as the court, family, or employer. Similarly, the patient may internally recognize the
problem after personally assessing health, job, and relationship problems. The chemical dependency professional or other professional with knowledge of disease and treatment needs (physician, EAP representative), should direct all efforts towards helping the CD accept the need for appropriate treatment. This involves active participation with the CD, educating and confronting their disease. The initial admission of a problem with hopefully lead to an admission of needed help.

The Compliance Phase is the difficult phase where the CD superficially recognizes or admits to chemical dependency. This could mean an admission to having a problem to one type of chemical but denial of a problem with another. When the treatment program is complete, or others are not there to encourage a continuation of a program of recovery, the need to deal with the disease is dropped. Tiebout (1953) describes the phenomenon of compliance as a "going along" but without wholehearted acceptance. Tiebout describes compliance as a form of submission wherein the CD acknowledges her condition but does not have a deeper understanding of the implication. When the pain of chemical dependency becomes acute, the CD accepts the need for making a change. As the pain subsides, the need for change subsides.

In this phase, the chemical dependency professional accumulates data that documents the patient's painful loss of control over chemicals. These painful realities are recalled for discussion to serve as an antidote to the denial and minimization. The health professional must work with the family members to help them sustain the effort to stick with their expectations of change in the CD. Members of the family must also be educated and supported to forestall their tendency to deny the seriousness of the disease, and to revert to "wishful thinking" that everything will be all right this time. For the entire family system, including
the CD, confrontations and crises may be necessary to shift from compliance to the next stage, the Acceptance Phase.

*Acceptance Phase* is characterized by the key element of acceptance of powerlessness over the abused chemicals. The CD is now open to reality and does not use the defense of false grandiosity any longer. She is more accepting and recognizes rationalizations and forms of denial as they occur. During this phase, the CD may begin to develop greater tolerance for emotions. Negative emotions such as shame and guilt can now be discussed as part of the therapeutic process. The CD professional is now in a position to form a therapeutic alliance with the patient; the CD is now open to listening and learning about her chemical dependency. It is this therapeutic relationship that can help mobilize a healthy shift in defense.

*Integration Phase* is not necessary to achieve sobriety. However, this is the stage where the CD can be approached psychotherapeutically to address the issues behind the chemical dependency. The CD has now fully accepted her condition and acquired a stable sobriety program. The organic effects of the chemicals have abated to the maximum possible. The CD understands the dynamics of her disease; the therapist may now focus on the individual dynamics. The Integration Phase is free from conflict over chemical dependency. Shame and guilt about being a CD have been replaced with a self-respect rooted in recovery. The rigidity of personality functioning that often characterizes early recovery, is replaced by emerging patience and flexibility. The fears and conflict that may need to be confronted in psychotherapy do not cause the CD to feel fearful of relapse. She knows what to do to stay abstinent; she now wants to know what to do to live.
In summary, therapeutic interventions in the Recognition and Compliance Phases largely focus on confronting denial, assisting the CD to understand and accept that she has a disease, and motivating the CD to participate in an ongoing treatment and Twelve Step programs. The focus is on the dynamics of the disease. As the CD moves to the Acceptance and Integration Phases, the therapeutic focus can shift from the dynamics of the disease, to the dynamics of the individual. The chemical dependency professional must also be prepared to confront any pathological defenses or manifestations of relapse. An understanding of these stages of recovery is useful when looking at the differences in issues experienced by the women subjects who are in various stages of their own recovery process.

CONCLUSION

Chemical dependency is a complex phenomena because of the presence of key areas in which addiction may create problems other than substance abuse. The treatment experience has shown that chemically dependent women and their counselors confront a complexity of issues during the treatment stay. Chemical dependency professionals have experience with some common issues shared between their women patients; these commonalities include relationship and intimacy concerns, the presence of multiple addictions and other dependencies, poor self-image and the absence of adequate coping behaviors and internal motivators to make a change, and role conflict arising from the multiple roles women must undertake.

This study is targeting these four areas of relationships, other dependencies, self-awareness, and roles. Chapter three further explains the research and literature that pertains to these areas. It is understood that aspects of these separate issue
areas do overlap in content and relevancy, as do topics that deal with the human condition. Attempts are made to make distinctions to maintain some clarity between the major issue areas.
CHAPTER 3: LITERATURE REVIEW

Most research reports about the chemically-dependent woman compare her with her male counterpart (Gomberg, 1976). Berner and Kryspin-Exner (1965) believe the issues to be similar enough that similar therapeutic interventions are recommended. Others, this writer among them, believe chemical dependency to be a reasonably different phenomena between the genders; an understanding of the differences in etiology, symptomology, issues, and therapeutic needs is of primary importance in helping the CD woman.

Understanding of some of these aspects of etiology, etc. begins with an explanation of some of the bio-medical components of chemical dependency. Much of the growing body of knowledge regarding chemical dependency in women focuses on the physiological differences in the sexes that affect the progression and outcome of chemical dependency. Some of the bio-medical factors that have a cause and effect relationship with women and chemical dependency are presented here under the subheading Bio-Medical Factors. Although these factors have no direct relationship with the four major areas of research, they make a contribution through the physiological influence on cognitive, behavioral, and emotional states.

As important as the bio-medical factors are to the progression and outcome, chemical dependency professionals are recognizing that treatment cannot focus on just the physiological effects of a chemical on their patient; it is the effects of chemical behavior to which they must address themselves. Consequently, instead of asking why a person abuses a substance, they must try to understand what changes occur for the individual and those around her when substance abuse occurs in certain problematic ways. The behavior of ingesting a psychoactive drug affects and is affected by change and adaptation at many different systemic levels including the
genetic, physiological, psychological, interpersonal, and spiritual. Therefore, it is beneficial to suggest that chemical dependency is both a cause and an effect of dysfunctional systemic changes. Some aspects of women's family of origin, social systems and their impact on sex-role identity and occupation are addressed in this chapter under the subheading **Roles**.

These role and system orientations influence other important aspects of CD women's lives. Research suggests that addiction causes more psychological and self-esteem problems in women; therefore it is important to look at issues that surround these concepts under the subheading **Self-Awareness**. Self-Awareness will be utilized herein as a psychological factor that would indicate problem issues. The influence of chemical dependency on sex-role identity, family systems, and society's expectation of women, has an impact on the relationships that women experience. The effects of chemical dependency and these factors on important relationships of CD women with their primary relationship (male), children, and friends are explored under the subheading **Relationships**.

Although there has been little research to support this viewpoint, it is evident from my experience as a chemical dependency professional in a residential treatment setting, that the woman who presents for treatment with just an addiction to a drug without the complication of compulsive behaviors and possible dependencies on other substances is becoming a rarity. Research does, however, substantiate that women alcoholics tend to use drug substances other than alcohol to a greater extent than do men alcoholics. Women are often evaluated in treatment settings as having multiple drug addictions. Curlee (1970), comparing the same number of male and female alcoholics admitted to a private treatment center, noted that more than twice as many women as men reported use of minor tranquilizers and sedatives. More frequently, women are entering treatment with admitted
polydrug addiction; younger women, in particular, are being treated with a growing familiar pattern of drug addiction—alcohol/marijuana/cocaine. There is also a growing awareness that termination of a preferred addictive drug could signal the emergence of a substitution. With substitution, individuals replace their addictive drug of choice with either another drug or a compulsive activity. Some of this chapter will be devoted to considering some of the complicating factors of multiple drug dependencies along with pharmacological and behavioral substitutions adopted by the chemically-dependent woman under the subheading Other Dependencies.

The subheadings that will be addressed in this chapter can be more clearly understood in the context of an ecological model. By viewing these subheadings in an ecological system, divisions from the micro- to the macrosystem are as follows:

**Microsystem**- This system includes Bio-Medical, Other Dependencies, and psychological factors of Self-Awareness.

**Mesosystem**- This system includes Relationships, and Family of Origin Roles.

** Macrosystem**- This system includes Sex-Role Identity, Society, and Occupational Roles.

**Bio-medical Aspects of Chemical Dependency in Women**

Firstly, to better understand the bio-medical aspects of chemical dependency on women, the CD woman can be viewed as a system. This whole person system is biological in nature and includes the physiological interactions inside the skin that affect cognition, emotions, attitudes, and behavior. Each woman is an individual,
and, as such, chemicals will interact in often unpredictable ways within the organism. Behaviors and attitudes are influenced by chemical ingestion and may take years of recovery to change to healthier ones. Long term and chronic chemical abuse presents a major health concern that has been greatly underestimated (Glenn and Parsons, 1989). For example, alcohol, due to its soluble properties, is able to penetrate every organ in the body and interferes with the functional efficiency of every physiological system. Besides altering brain activity and cognitive processes, recent evidence has shown that prolonged alcohol use affects levels of neurotransmitters, alters cellular membrane structures, and causes destruction of certain nerve pathways. Moreover, alcohol use disrupts intestinal functioning, causes changes in muscle cells, and both directly and indirectly affects hormonal levels. Excessive drinking causes block abnormalities and reduces the efficiency of the immune system, thereby decreasing the capacity of the body to respond to and fight off disease (U.S. Department of Health and Human Services, 1983).

Recent chemical dependency research in the bio-medical area has been primarily gender comparison studies. It would be difficult to refer to the body of literature on physiological factors without referring to both genders. Numerous studies on gender physical differences such as body size, distribution of fat and water, and distribution of enzymes in the liver for metabolization of the chemicals have been documented.

Some studies have centered around the hormonal differences. The periodic hormonal changes associated with the menstrual cycle are an obvious physical difference; however, according to Mello (1980) it is still not known if affective or hormonal changes associated with phases of the menstrual cycle significantly modulate the expression of drinking problems in women. However Mello (1980)
has observed many CD women report that their excessive chemical abuse occurs in attempts to relieve anxiety and depression.

Because cyclic patterns of increased anxiety and depression are often associated with certain menstrual cycle phases, especially the premenstruum, menstruum, and ovulation (Steiner and Carroll, 1977), it is logical to speculate that menstrual cycle phases may be associated with chemical use patterns in some women. Recent clinical studies of active alcoholic women suggest higher frequencies of menstrual disturbances which can consist of heavy menstrual flow, premenstrual discomfort, early menopause, and irregular menstruations (Becker et al., 1989). Many CD women in recovery complain of symptoms of premenstrual syndrome, or PMS, which can include premenstrual discomfort, symptoms of depression, increased craving for the drug of choice or certain foods, blotting, and mood disturbances.

However, research is conflictual concerning any real significant physiological differences between the chemically-dependent genders. Some earlier research suggested that not only are there different health-risk factors associated with chemical usage for men and for women but also certain chemical-related health problems are unique to women. In addition to psychiatric disorders, some information is available concerning sex differences in mortality and morbidity, liver disorders, gynecological disorders, cardiovascular disorders, and disorders of the central nervous system (Wilkinson, 1980). Wilkinson et al. (1969) reported women were more susceptible to the development of liver disease than men. Among women, increased prevalence of both alcoholic hepatitis and liver cirrhosis has been found despite shorter duration of excessive alcohol intake (Krasner et al., 1977).

More recent research that looked at the effect of chemicals on both sexes found that, besides isolated sex differences, there is significant lack of difference
between men and women. Remarkably similar medical and trauma histories and identical drug use and chemical-related symptoms were found in the two sexes. These findings suggest that chemical dependency operates on physical health in similar fashion in men and women, and that any significant items that discriminated between the sexes could be attributable to basic physiological, biochemical, and lifestyle factors that typically vary between men and women regardless of the chemical dependency factor (Glenn, Parsons, & Stevens, 1989).

However, in this study by Glenn et al. (1989) it should be noted that, although the women in this study had been chemical abusers for a considerably shorter time (8.40 years vs. 13.15 years), they still experienced the same number of physical health problems as their male counterparts. Therefore, there is a case for "increased vulnerability" or "lowered resistance to the effects of chemicals" in women to be considered. Piazza, Vrbka, and Yeager (1989) studied this phenomenon of accelerated progression called telescoping, among women who were alcoholic. Women alcoholics were found to report a significantly shorter interval between the age at which they first began experiencing alcohol-related problems and the time they sought treatment than did male alcoholics. The mean interval between first recognition of a problem with drinking and first admission to treatment was found to be 10.36 years, a full 4.35 years shorter than the same interval for the men (14.71 years).

It is quite possible that the severity and rapidity with which alcoholism (chemical dependency) develops in women may work to their advantage. The fact that women abuse chemicals symptomatically for fewer years may indicate a better prognosis due to fewer years of psychosocial problems. However, this advantage would be lost in a treatment model which is primarily designed to treat chemical dependency based on the characteristics of the chemically-dependent male.
It would be important to note that the criteria used to evaluate the symptomatology of the progression in these studies was derived from a model that was developed based on data from an all-male population (Jellinek, 1952). James (1975) found that women respondents reported eight chemical dependency symptoms not mentioned by men, suggesting that the women in these studies could have experienced additional symptoms. If a model of symptomatology based on the chemical dependency of women were used, women may in fact surpass men in the number and severity of symptoms. If this is true, women experience a more severe form of chemical dependency which is expressed over a shorter period of time.

Another important diagnostic tool used by chemical dependency professionals is the American Psychiatric Association criteria for chemical abuse or dependence according to the Diagnostic and Statistical Manual, or the revised DSM-III-R (American Psychiatric Association, 1987). The criteria for DSM-III-R chemical abuse/dependence was developed largely on the basis of clinical and research experience with male patients. There may be experiences more often encountered by women with chemical dependency which are not tagged by the DSM-III-R criteria, such as victimization by rape or battering while intoxicated (Hasin, Grant, & Weinflash, 1988). Use of the present diagnostic criteria along with the frequent use of the Jellinek alcohol progression phases indicates that a unidimensional focus on chemical abuse and dependency may underestimate the severity of addiction-related problems in women. These male-biased assessment guidelines may prevent some women from obtaining treatment due to failure in passing the criteria for insurance coverage. Women's particular problems need to be identified upon admission to treatment through a multidimensional approach by professionals and
then tracked after treatment as important indicators of the relative efficacy of treatment.

For women CDs, another association that appears repeatedly in the literature is the relationship between depression and chemical dependency. It is estimated that between one-quarter and two-thirds of CDs experience symptoms of depression that are severe enough to interfere with functioning (Parker, Parker, Harford, & Farmer, 1987), and that women are more likely to report depressive symptoms than men (Schuckit, 1986). In research to find possible associations between rates of depressive symptomatology across gender groups, it was found that the alcohol dependent women reported levels of depressive symptomatology significantly higher than those of alcohol dependent men, at levels equivalent to those reported by a normative sample of clinically depressed patients (Moos, Cronkite, Billings, & Finney, 1982).

Somatic symptoms along with the feelings of depression, anger, and confusion can be traced to the suspected presence of an affective disorder, which is the presence of clinical unipolar or bipolar depression. These are commonly referred to as major depression and manic depression. Schuckit (1989) found in his research that one in four women alcoholics suffers primarily from affective disorders and secondarily from alcoholism.

The literature indicates that depression in CDs is heterogeneous and can occur before, concurrently, or after the onset of chemical dependency problems (Schuckit, 1986; Weissman & Meyers, 1980). For the vast majority of CDs, the symptoms of depression are caused by the effects of the chemicals on the central nervous system and will abate shortly after periods of heavy use. However, for some CDs, symptoms of depression may represent one of the subtypes of affective disorder, and, as such, these symptoms may be unrelated to chemical consumption.
(Schuckit, 1986). Some depression symptoms seem to persist despite sobriety and irrespective of symptom sequence; symptoms of depression tracked over the course of treatment and recovery have been shown to persist in treated CDs despite a full year of abstinence (McMahon & Davis, 1988).

Studies suggest that chemical use behavior is influenced by the presence of depression. A positive association has been documented between severity of current addiction problems, impairment, and depression (McMahon & Davis, 1986). Both major depression that precedes the onset of chemical dependency and depression that follows the onset of chemical dependency appear to cause more impairment than depression that occurs concurrently with the onset of chemical dependency. Depression that follows the onset of chemical dependency is associated with more social consequences and undesirable life events and has been shown to be highly predictive of suicide attempts and relapse (Hatsukami, Pickens, & Svikis, 1981). However, a diagnosis of major depression in addition to chemical dependency is associated with poorer outcome only for men (Powell, Read, Penick, Miller, & Bingham, 1987); for women, major depression is associated with better outcome in addiction-related measures (Rounsaville, Dolinsky, Babor, & Meyer, 1987).

The social histories of many CD women reveal the the onset of addiction problems is often preceded or accompanied by emotional problems (Schuckit & Morrissey, 1976). But the reluctance of women to seek treatment for chemical dependency and the inability of professionals to properly assess the possible presence of dual disorders, chemical dependency and an affective disorder, prolongs the progression of the chemical dependency and impedes treatment. Depression and affective disorders do play a significant part in addiction problems in women; research findings suggest that nearly every area of a CD woman's life is
affected by symptoms of depression and that the more depressed the woman, the
greater the consequences of her addiction (Turnbull & Gomberg, 1988).

A recovery program for these women should include support and education
but will also require treatment aimed at amelioration of depressive symptoms.
And, because depression is often linked to social withdrawal (Turnbull & Gomberg,
1988), these women are more likely to be isolated and would benefit from group
involvement.

As part of a comprehensive treatment plan, the chemical dependency
professional needs to be proficient at assessment of the symptomatology and special
problems of the woman CD. However, the damage that prolonged chemical abuse
does to every organ of the body makes it clear that a major part of treatment and
later recovery is restoration of the CD to good physical health. Many CDs arrive in
treatment with malnutrition, especially vitamin deficiency (Royce, 1981). A sound
nutritional plan for recovery must include the avoidance of fats, refined sugar, and
too much protein. A badly injured liver cannot handle the amino acids from too
much protein. Once the CD has experienced detoxification and has physically
stabilized, some of the regeneration can begin.

Recreation and exercise must be undertaken with guidelines for interval
training to adapt the body slowly to the new stresses. Education also must be
provided to the CD in treatment and recovery concerning the healthy limits on time
and energies. Many women need to learn good hygiene practices and be
encouraged to take get regular medical and dental check-ups, especially important
because women may be more "illness prone" than men and exhibit an increased
vulnerability to the adverse effects of chemical dependency (Glenn et al., 1989).

Even women who have an extended period of abstinence and recovery find it
difficult to undertake healthy behaviors for self-care. While remembering the Whole
Person model it would be understandable that diet, exercise, adequate coping skills for stress, and medical follow-up all have an impact on the whole being, physically, mentally, emotionally, and spiritually. Some of the women have not made the connection that taking care of their physical well-being has a great deal to do with their moods, attitudes, and enjoyment of life; for example, skipping lunch and only getting six hours of sleep may have something to do with that depressive affect experienced later in the afternoon.

Other Dependencies

The ages of first use and the pattern of chemical intake vary among groups. Genetic factors, natural histories which differ with the immediate environment, and changing views of society all have a great impact on use patterns. It has been hypothesized that desire for a change in mood regardless of the direction of change may account for polydrug use (Mello, 1983). Healthy individuals seek to find the cause of their uncomfortable feelings; chemically-dependent individuals often seek a quick way out of those same feelings. With this in mind, it is possible to make some generalizations about likely patterns of misuse. Schuckit (1984) writes of a pattern of chemical use in Western society that begins with adolescence, a time of emotional upheaval.

In Western Society, youth begin drug experiences with caffeine, nicotine, and alcohol. If they go on to use other substances, the next drug is likely to be marijuana, followed in frequency by one of the hallucinogens, depressants, or stimulants, usually taken on an experimental basis, ingested orally, and with few serious consequences. Individuals who go on to heavier intake may graduate to intravenous drug use, with a progression to opiates.
This information is relevant in that many of the women entering treatment today are polydrug users with early drug experimentation beginning in adolescence. In the United States, there is evidence that women alcoholics tend to use drug substances other than alcohol to a greater extent than do men alcoholics (Gomberg, 1976). Alcohol, marijuana, and cocaine are the most commonly used drugs, and a developmental or stage theory of drug use (Kandel, 1980; O’Donnell & Clayton, 1982) implies that most persons who used other illicit drugs also have used alcohol, marijuana, and possibly cocaine.

For women a common drug that is abused, as well as used as a substitute or in conjunction with alcohol is the benzodiazepines, such as valium, librium, and xanex. One hundred million prescriptions were written for benzodiazepines in 1973 and 70 million prescriptions were written in 1984, with approximately twice as many women as men receiving these prescriptions (Friedel, 1985).

Because benzodiazepines and alcohol are in the same class of sedative hypnotic drugs, cross tolerance is common. Because physicians often look upon a woman’s somatic symptoms as being psychosomatic, a placebo may be prescribed in place of comprehensive history-taking by the physician that could reveal chemical dependency. Women may also seek benzodiazepines for relief of the symptoms of alcohol use and alcoholism. Birnbaum, Taylor, and Parker (1983) in research done with female social drinkers found alcohol use patterns also influenced sober mood states. Alcohol use was significantly related to depression and anger in sober states among 93 female social drinkers. A random sample of female subjects who abstained from alcohol for 6 weeks reported significantly lower depression, anger, and confusion scores than women who maintained their alcohol intake. It can be speculated that women with alcoholism would reveal even more pronounced symptomology.
It is important for clinicians to assess their woman client for a possible dual disorder that she may be using chemicals to mask. Typically, the women in this subgroup have a history of treatment for depression or have taken amphetamines to lose weight (Joyce, 1989). Women could be abusing chemicals to counteract the negative feeling state due to an affective disorder and the secondary effects of a pathological eating disorder. However the depression, anxiety, suicidal ideation, and medical complications of a pathological eating disorder could also be the primary contributor to the presence of a chemical dependency.

Societal attitudes and norms regarding women and body image with the often unrealistic images of what women should look like, can cause many women to use drugs for weight control. Females who report that they use cocaine and other stimulants such as caffeine and amphetamines for weight control may have a history of an eating disorder or pathological eating disorder, both of which will complicate the clinical picture. They may be reluctant to quit the drugs of choice for fear of gaining weight. And, during recovery, these women are at a higher risk for relapse as they see themselves gain weight. For women with eating disorders that present for treatment, a treatment plan must be initiated that will address both the chemical dependency and the eating disorder.

An eating disorder or pathological eating disorder doesn't need to be present for the recovering woman to have problems with food. Hudson and Williams' (1981) research study of 100 women and men, revealed that a statistically significant number of the women ate as a method of coping with anxiety, frustration, and confusion. Of the sample, 25% had pleasant feelings after eating while 33% reported negative feelings of guilt and anger. Among 280 obese women, the antecedent characteristics of binge eating reported most regularly were feelings of anxiety, frustration, and depression (Loro & Orleans, 1981). Alcohol is perceived to
be an anxiety-reducing agent. During periods of anxiety, depression, and frustration, recovering alcoholics with or without an eating disorder may substitute the agent food for forbidden alcohol or other illicit substances.

The substitution of other drugs or compulsive behaviors for the drug of choice may be linked to a desired chemical affect. For example, some cocaine quitters use caffeine excessively during their efforts to maintain cocaine abstinence. Caffeine mimics the sought-after stimulation that cocaine once provided them. Or compulsive overworking and procrastination may be used to stimulate the feeling of "speediness" that the addict craves, partly through a build-up of adrenaline from the sudden over activity. Compulsive shoppers and gamblers are seeking a feeling of reward and satiation. Also there may be an increased excitability from doing something forbidden and in secret. Increased pursuit and obsession with sex has caused some people to label themselves "sex addicts." The pursuit of the "high" is a familiar one to addicts.

Some recent success has been seen for individuals with dependencies through the administration of the anti-depressant fluoxetine. Prozac, as it is known to the public, helps increase the amount of serotonin, a neurotransmitter in the brain. Serotonin produces sensations of satiety (Seligmann & Springen, 1990) and is in the family of neurotransmitters that afford a calming effect on the brain activity. Individuals with a deficiency of serotonin may seek chemicals and other dependencies to achieve the same effect as serotonin. After a period of time taking prozac, some have found relief from compulsive-obsessive disorders, old defeating dependencies, and eating disorders. In laboratory tests, prozac, which specifically acts on serotonin reuptake blocking activity, was administered to alcoholic subjects. These subjects, in turn, had free access to alcohol 12 hours a day for a period of 28
days. The subjects who received prozac instead of a placebo, tended to consume less alcohol than control subjects (Li, 1988).

Until recently, little research and treatment concerns have focused on the importance of staying off a drug once the CD has stopped. Relapse is a serious problem for those with chemical dependencies. It has become almost a truism to assert this. Nevertheless, relapse remains a poorly researched area (Gossop, Green, Phillips, & Bradley, 1989). Marlatt (1985), an expert in relapse prevention, has shown that intrapersonal negative affective states present the greatest risk to prolonged abstinence. Uncomfortable feeling states such as depression and rage put the quitter at a higher risk to substitute one compulsive behavior pattern or drug for another. The CD may revert to familiar coping behaviors while under stress or fearful experiences. Individuals who are attempting to manage negative physical states such as chronic pain syndrome are also at risk for substitution and relapse. Other intrapersonal events can trigger the relapse and substitution episodes including enhancement of positive emotional states, surrender to craving, and testing personal control.

Interpersonal factors including coping with conflict, managing social pressure, and communicating wants and needs to others can be determinants of relapse. As internal and external pressures mount from these and other factors, individuals attempting to maintain abstinence without a healthy self concept and adequate coping skills, usually turn to alternate forms of "pressure release." Chemical substitutions (food for tobacco, coffee for alcohol, and alcohol for heroin) have been reported by tobacco (Stall & Biernacki, 1986), alcohol (Vaillant, 1982), and opiate quitters (Waldorf, 1983.) This chemical substitution can become dangerous and excessive and lead to a new chemical addiction as well as possible relapse into old addiction patterns. For example, many cocaine addicts indicate they would not
have gone on a cocaine binge if they had not begun drinking alcohol. Alcohol appeared to lower their inhibitions and stimulated their desire for cocaine.

Some professionals, particularly in the 1980s, are linking addictions and dependencies to an outgrowth of the core symptoms of codependency (Cermak, 1986; Mellody, 1989). Dr. Tinnen Cermak (1986) sees codependency as a setup for the development of chemical dependency. The codependent's defective coping response to threats by denying that they exist makes the use of mood-altering chemicals the logical next step. The denial is necessary to avoid being overwhelmed by feelings stemming from the threat, and chemical abuse serves as a biochemical "booster" for the denial. Cermak (1986) states that "substance abuse is consistent with the personality structure of the codependent." Pia Mellody (1989) calls dependencies the addictive process which is defined as any process that relieves intolerable reality. Both agree that once the chemical dependency is stopped, the codependency remains, and, if untreated, acts as a barrier to long-term recovery.

John Bradshaw in his book Healing the Shame that Binds You (1988), places compulsive behaviors and addictions and addictive behaviors in two separate categories based on control and release. He sees individuals trying to maintain control by attempting to behave in these rigid and compulsive ways, only to lose control and experience the "release" which is a reversion to their addictions and addictive behaviors. The release cycle will be maintained until such time as the individuals can regain control, thus moving cyclically from release to control. Both the control and the release are triggers for each other. The lists are as follows:
Bradshaw sees these control and release processes as attempts by individuals to alter intolerable pain, or the intolerable reality as Mellody calls it (Mellody, 1989). Codependency professionals believe that dysfunctional, less-than-nurturing abusive family systems create children who become codependent adults. What follows is an explanation of possible roles that a chemically-dependent woman may have experienced in her family of origin. In both roles the control-release mechanism is illustrated through the control behaviors and then the release through the use of chemicals.

**ROLES**

This section describes some of the different roles and role conflict experienced by CD women. An understanding of women's roles within systems of dysfunction and addiction is provided and includes explanations of aspects of sex-
role identity, roles learned in the family system, society's expectation of women's roles, and occupational roles.

**Family of Origin Roles**

When looking at the system of addiction, some of the aspects of the general systems model are applied, which includes the family of origin system. The most definite life event which could relate to the development of chemical dependency is the existence of a biological parent with the same problem (Vaillant, 1983). During my professional experience in chemical dependency treatment, it has become a rarity to find a chemically-dependent woman who did not have at least one chemically-dependent parent and/or grandparent.

This next section will include descriptions of some of the effects on women's behavior and self-concept of growing-up in a dysfunctional family system. However, a definitional scheme that defines chemical dependency solely in terms of disrupted behavioral functioning proves to be shortsighted. In at least one area of critical importance to family life, the transmission of chemical dependency across the generations, a series of adoption and twin studies has suggested that alcoholism, in particular, has a genetic predisposition, and that genetic factor is relevant for those types of chemical dependency associated with physical dependence (Goodwin, 1983).

The genetic factor may be present, but much is still not explained by genetic studies. Impediments of a dysfunctional family system on the woman's development can also be a causal factor in generation of that disease. Work by Rice, Cloniger, and Reich (1978) at the Washington University School of Medicine in St. Louis are examples of an epidemiological approach to chemical dependency that espouses just such a multifactorial model of inheritance that attempts to clarify the interaction between genetic and environmental contributions. They postulated
three types of models: 1) the polygenetic, which does not take into account the cultural influences on transmission; 2) the cultural, which does not consider the genetic contributors; and 3) the multifactorial, which encompasses the possibility of both genetic and cultural transmission (Rice et al., 1978).

From a multifactorial model of inheritance perspective\(^1\), this increased transmission is most likely due to a combination of genetic and cultural factors. Many researchers find this model of great importance for the potential direction of further research on chemical dependency as is clear in the following quote: "Current etiological theories must therefore take into account both genetic and nongenetic factors in alcoholism. Indeed, both types of factors are so closely intertwined that an understanding of one cannot proceed without an understanding of the other" (Reich, Cloninger, Lewis, & Rice, 1981).

An example of this multifactorial model would be the daughter with an alcoholic parent (predisposition) who also experiences traumatic and dysfunctional family-of-origin issues. This woman has a greater chance of using chemicals to cope with her stress and negative feelings; when she does, she may already experience inherent tolerance and, thus, addiction.

The woman who becomes chemically-dependent may have experienced one of several possible roles in her family of origin. Either she was an overresponsible daughter who assumed an emotional and functional caretaking role with other family members, or she functioned in a underresponsible fashion while one or both of her parents were overresponsible for her (Bepko, 1985). Another possible role from the dysfunctional family system is seen as the deviant thrill-seeker; this

\(^1\)This model was not included in the section Models of Addiction for it is best used in this section to illustrate the connection between the genetic factors and aspects of the General Systems model whose psychosocial implications are more thoroughly described here.
daughter functions as the one who takes the blame for the dysfunctional atmosphere.

For the woman who was overresponsible, drugs functioned as a release from overfocus on others. Substance abuse including drugs and food may have become a mechanism for self-gratification and could be seen as an attempt to meet personal needs that were never adequately responded to by the parents. This woman may have used drugs to permit underresponsible behavior, to express anger, and to provide an outlet for sexuality in the face of the fear of intimacy. This woman represents the characteristics of codependency; she may experience herself as unimportant except in the service of other people's needs. She is bound to others in this form of dependency which does not permit her to establish a clear sense of herself.

During recovery, this overresponsible woman reverts back to her overresponsible mode of functioning. She feels intense shame about her chemical dependency and may attempt to make up for it by becoming a perfect wife, mother, and twelve step member. This overperfection and focus on others can set the stage for relapse and substitution. Many women in recovery become aware of their codependency and see their inability to formulate a clear sense of self and healthy relationships as problems. Some women elect to maintain abstinence from sexual relationships in order to focus on formulating a healthy relationship with self.

The second category of potential family-of-origin patterns affecting the chemically-dependent woman involves parents who may have been both functionally and emotionally overresponsible for their daughter. Her chemical dependency has helped her avoid issues of dependency versus autonomy which could never be adequately resolved in her dependent role. Also, because she was singled out and defined as "special", she is angry that in adult life she is not viewed
as such and is expected to function for herself. On the other hand, she experiences herself as incompetent to deal responsibly with her life; therefore, on a deeper level, she doesn't experience herself as being of value. Because overresponsible parental behavior usually reflects parents' need to enhance their own feelings about their selves, this "special" child's real needs may have been neglected. Chemical abuse then provides her with an outlet for her rage, an illusion of independence, and a solution for the anxiety of conflicting internal messages about self stemming from her parents' behavior.

In recovery, these women are seen as tending to be predominantly underresponsible emotionally, and they continue to look to others to meet their needs, feeling angry and vindictive when they don't get the response they expect. They tend to be demanding and seemingly needy of attention and are frequently in a state of chronic crisis in their emotional relationships with spouse, children, and employers. They often plead directly or indirectly for help but often do not take the help. Their inability to assume responsibility and their tendency to maintain relationships that are highly conflicted and crisis-oriented, increase their danger for relapse and substitution.

The third category of potential family-of-origin patterns affecting the CD woman is the deviant thrill-seeker. These women report of themselves that they were disciplinary problems in school, preferred to handle boredom by "stirring up some excitement," had involved themselves in dangerous activities just "for the thrill of it," had engaged in "unusual sex practices," had had "trouble with the law," did many things that they later regretted, often felt that they had done something evil and wrong, and, in general, that they had "not lived the right kind of life." (MacAndrew, 1987).
Within the operating family system, this deviant daughter is seen as the cause of all the problems. She often finds herself alienated from family activities and will find a new "family" in other misfit peers. Even though she doesn't appear to be responsible, she has assumed great responsibility as the scapegoat for a parent or both parents' own unhealthy behaviors. She enables the system not to have to face the reality that the parent(s) can not really meet the physical, emotional, and spiritual needs of the children. That may be too painful to admit; the deviant thrill-seeker sacrifices her individual needs for love and acceptance in order to benefit the family illusion.

In recovery, these women continue some of their "thrill-seeking" behavior, often stirring up arguments to have an excuse to express their own internal anger and anxiety. Their own anxiety in the face of confusion and hostility causes them to intercede into situations that are none of their business. There may be great difficulty in gaining their acceptance to stop socializing with their alternate "family" which could consist of rebellious factions such as street gangs, punkers, skinheads, or devil-worshippers. They have been attracted to these groups because of the danger and thrill, and because they were finally accepted as an important member by a group of peers. Recovery would be very difficult because of the importance that drugs play within the social system of these groups.

In addition, recovery may be impeded by this woman's internal feeling that she doesn't deserve recovery. Even though the external behaviors may be defiant, arrogant, and "I don't care" in appearance, the internal self-validation is one of remorseful intrapunitiveness. It is that feeling of being evil and no good that must be worked with in the recovery process, because continuing patterns of deviant behavior will reoccur as self-defeating and sabotaging actions that externalize the poor internal self-concept. Chemical abuse affords her a means for this self-defeat, a
trigger for her impulsiveness and need for "reward," an outlet for her rage at being rejected, and a buffer for the internal pain and self-rejection that she feels.

**Sex-Role Identity**

The theme of *Sex-Role Identity* occurs frequently in the literature on female chemical dependency (Gomberg, 1976). Wilsnack (1972) uses terms such as "role confusion," "masculine identification," and "inadequate adjustment to the adult female role" to describe this subject. Sex-role is meant here to suggest a set of feelings and behavior assumed to be characteristic of an individual based on broadly stereotyped generalizations that are generally accepted by society as normative given the individual's gender. This is referring to sets of learned behaviors and attitudes as opposed to those qualities in which one knows oneself to be male or female.

Sex-role confusion originates in the family of origin; dysfunctional family patterns and social context skew sex-role development in the CD woman. The classic characteristics of the codependent are seen as aspects of the feminine sex-role identity. Typically, these women function as helpmates, nurturers, and mothers. Aspects of the overresponsible and underresponsible daughter roles can be applied to this sex role.

The conflict between the feminine sex-role identity and chemical dependency leads these women to take greater pains to conceal use, to use chemicals under the protection of a male partner, to limit use to occasions that do not conflict with role obligations, and to make attempts to behave in a "feminine" manner even when under the influence of drugs (Robbins, 1989).

Inordinate anger and excessive attempts at control are frequent results of sex-role socialization conflicts. Their anger comes to be expressed in more appropriately feminine ways such as somatic complaints, hysterical symptoms,
eating disorders, shopping sprees, and gossiping. At worst, the CD woman becomes depressed. Anger, when expressed, will tend to be inappropriate to the situation; many depressed and repressed wives take their anger out by physically and verbally abusing their children. However, chemicals permit either repression or expression of undesirable feelings. It lowers inhibitions and allows the woman, while under the influence, to express anger, aggressiveness, and the dislike of her feminine role. Or when chemicals allow the woman to suppress these same feelings, she avoids having to acknowledge the "masculine" feelings.

While the feminine sex-role is characterized by an internalization of distress, the masculine sex-role is more outwardly directed. Women who take direct action to achieve goals are said to have a masculine sex-role identity (Joyce, 1989). Aspects of the overresponsible daughter role apply here, especially if the daughter was the star achiever and worked hard at demonstrating that everyone in the family was okay. These women purposely set goals outside of the feminine sex-role identity and are seen as more assertive and able to express anger more easily than their counterparts.

The deviant thrill-seeker role from the family of origin system is another aspect of the masculine sex-role; however, instead of being viewed by society as a valuable achiever, this role is seen as antisocial. Chemical use is viewed as a masculine activity; individuals under the influence can reinforce their masculine qualities of assertiveness, independence, personal power, and expressions of anger. The antisocial behaviors of the deviant thrill-seeker woman reflect her attempts to disregard traditional femininity. Adolescents, as a group, appear to be least committed to traditional sex roles, and females of this group use chemical abuse to rebel against the traditional role orientations (Bepko, 1985). Because this deviant masculine role will not make attempts to conceal their chemical abuse, women in
this role will have more social and behavioral problems than the feminine sex-role. Their chemical dependency will be associated with more job loss, accidents, interpersonal violence, and arrest.

For lesbian women, the overtness of homosexual orientation limits access to more mainstream social roles, and may indicate acceptance of this masculine and deviant identity too (McKirnan & Peterson, 1989). Lesbian women typically enter the work force, assume economic and social independence, and engage in other "out of role" behaviors (Marmor, 1980). Few homosexual women enter traditional marriages or childbearing roles as they age (Bell & Weinberg, 1978), which are more characteristic of a feminine sex-role identity.

These conflicts regarding sex role behavior cannot be separated from the patterns of over- and underresponsibility, and deviant thrill-seeking that emerge in the family system and are seen in later psychosocial and intrapsychic problems. One of the most harmful consequences of this confusion is the inability by the woman to acknowledge or act on feelings that run counter to traditional sex role expectations.

This can, at least, partly explain the difficulty the feminine sex-role woman has with expressing anger, acting assertively to get needs and wants met, being able to set healthy boundaries to avoid abuse, and choosing healthy intra- and interactions that foster self-esteem. For the masculine sex-role woman, there is difficulty with expressing any feeling or need that may spell weakness or powerlessness, greater difficulty with intimacy, an avoidance of self-nurturing activities, an inability to set limits on work, and the lack of friendships and social interactions.
Society's Roles

Our culture's greater disapproval of excessive drinking and drug use among women than among men has been documented by many studies. Women's experience of addiction is markedly different from men, and the response of the world around them is very different as well. Earlier studies reveal a harsh stigma attached to female chemical abuse that shaped the entire experience of the CD woman, and made is different—in many ways more painful and obliterating—than that of the male CD (Sandmaier, 1980). A survey of attitudes toward alcohol use and abuse among four hundred women and men of varying socioeconomic classes in the United States showed that people of both sexes and all social classes believed it was "worse" for a woman to be drunk than a man (Lawrence & Maxwell, 1962). A study conducted a decade later by Sterne and Pittman (1972) of drinking attitudes among the primarily black residents of a low-income housing project disclosed that half of the men and three-fourths of the women thought it was acceptable for a man to be drunk. However, only slightly more than a quarter of both sexes would tolerate a drunk woman.

Women, by nature of the stigma, are often protected in family systems longer than men. By the time their chemical dependency is acknowledged by their family, they are often in more advanced stages of deterioration. Within the family, the CD woman is viewed as having abandoned her society role of virtuous wife and mother. These taboos against drunk and drugged women seem rooted in two focal points, female sexual virtue and nurturant role obligations (Gomberg, 1982). The mother with nurturant role obligations is seen as needing to be more consistently sober than do the male sex roles. Child, Barry, and Bacon (1965) found that a man could neglect his job for a day, but that a woman's temporary incapacity is far more threatening because it would mean neglect of the child. For years the mental health
profession has maintained that the "bad mother" is at the root of the psychic ills in all of us. Men's drinking and drug use could be more tolerated, just so it doesn't interfere with work performance. Beer advertisements depict that it is desirable to socialize with alcohol after a hard day's work; women are seen in these ads serving but rarely drinking themselves.

Being under the influence of chemicals is also disapproved for women because it could result in a disinhibition of sexual behavior, or the ability to fend off sexual advances would be greatly impaired. Drug addiction is more stigmatizing for women because the practice is associated with prostitution (Inciardi, 1986). It follows that the threat which chemical abuse poses to the women's nurturant and virtuous role in society not only shapes society norms concerning male and female alcohol and drug use but also directs men's and women's internalization of the norms and their subsequent role enactments related to chemical use.

Homosexual communities often cite a high proportion of social or recreational settings that involve alcohol and drugs (Ziebold & Mongeon, 1982). Bars or similar settings have traditionally been an important social focus in the homosexual culture, due to discrimination in other more "mainstream" social settings. Therefore, chemical use is more out in the open and acceptable in the gay community; there is a less inter-community stigma for lesbian women to use chemicals in public. Gay bars have traditionally functioned as havens where people can be explicitly homosexual and not suffer stigmatization or exclusion (Achilles, 1967). This strong reliance on bars as a culturally prescribed setting for social interaction would create vulnerability to chemical dependency for the homosexual population. This vulnerability created by the cultural importance of bars may be exacerbated by the stress many homosexuals feel as stigmatized members of a sexual minority (McKirnan & Peterson, 1988).
Occupational Roles

Interest in studying employment and occupation as an issue for the chemically-dependent woman was stimulated initially by the observation that, among CD women in treatment, there existed a substantial number with work-related problems such as low self-esteem, role confusion, role overload, and fewer employable skills and choices for employment than men. One major difference between males and females is in terms of occupation; unlike males, there is a significant percentage of females whose principal role is caretaking of others (Beckman, 1984). Furthermore, employed women experience different demands and stresses than their male counterparts in terms of role conflict, occupational isolation and discrimination, and role overload (Levine, 1980). These women confront a future with fewer financial resources to support a much needed rehabilitation period while maintaining a family. These added stresses can increase a woman's vulnerability to relapse.

The literature supports a correlation between employment and chemical dependency. Studies have shown that alcohol consumption and alcohol-related problems among women has increased co-ordinately with the increase of the number of women entering the labor force (Shaw, 1980). Recent research completed with women subjects and alcohol in North America reveal that both regular drinking and alcohol-related problems are more common with employed than unemployed women (Ferrence, 1984).

There are a number of possible reasons for this increase among women. One of the most obvious is that employment tends to produce both the money to buy alcohol and other drugs and the time and opportunity for use and abuse. Another reason may be that as women increasingly occupy traditional male roles, their chemical use takes on the more masculine sex role stereotypical pattern. Women in
the labor force may feel pressured to "drink like the boys" (Gomberg & Lisansky, 1984). And employed women are more likely to experience stress arising from role conflict when they deviate from stereotypical sex role expectations (Johnson, 1982). The more public behaviors of the masculine sex-role pattern for women could result in more symptoms of social disruption. Women may be drinking more in bars and experiencing more legal problems such as driving while intoxicated (DWI) charges. Women may be experiencing an increase of stress due to role overload; employed women are more likely to undergo the pressure of role overload because of engaging in multiple roles of worker, mother, and wife (Keil, 1978). Studies have illustrated that stress appears to be more closely associated with the onset of chemical dependency in women than in men (Beckman, 1980; Corrigan, 1974). It is hypothesized that the stress arising from role overload can contribute to chemical dependency in women.

Research has also indicated that stress resulting from role deprivation is also significant. Dritschel and Pettinati (1989) in a study they conducted to determine whether occupational class is related to the severity of problems associated with alcohol abuse in females found that significantly more homemakers than workers reported wanting a job change. These homemakers (64% homemakers vs 22% workers) felt that such a change would result in improvement outcomes. It was found that common occupation-related stresses reported by the homemakers were feelings of boredom and loneliness, and the subjects thought a change in occupation would alleviate these feelings. In another study conducted by Wilsnack and Cheloha (1985), role deprivation and not role overload was associated with more severe problems with chemical use and abuse.

Another possible explanation for the increase could be due to public exposure of a possible chemical dependency problem. Women in the workplace are
not able to hide their addictions as readily as unemployed women and homemakers. Even if a woman is abusing chemicals only at home, the deteriorative effects can tell in diminished work performance, attitude, and physical appearance. Interventions by employers are becoming effective tools in getting CD women to treatment sooner.

And, lastly, a possible causal factor contributing to chemical dependency in women can arise from the working woman's conflict between roles. This reason draws heavily from psychological work which claims that many women who abuse chemicals experience uncertainty and conflict both in terms of adequacy feelings in performing traditional feminine roles and in terms of their perceptions of their sexual identities (Shaw, 1980). This role obligation could be generalized to the modern work role (Robbin, 1989). Beckman and Kocel (1982) suggested that CD women feel guilty that their relationship with their children is suffering because of their addiction, and this problem is particularly acute in working CD women. It is tempting to speculate that the higher rate of chemical dependency among employed women is caused by a variable such as role conflict; however, the conflict between the demands of employment and non-occupational roles is only one aspect of a complex picture.

Whether or not these "reasons" for increased chemical dependency emerge in any situation depends partly on the quality of the occupational and non-occupational environments. For the woman at home, the spouse's attitude and arrangements for child care are important influences, and for the woman on the job, work relationships and scheduled work hours are considerations. In addition, role overload and conflict, especially, are less likely to occur in the case of a single woman without children than it is in the case of a married woman with children.
Employment can act as a positive for women, particularly those in a dysfunctional home environment. A job may provide a haven from domestic discord or can provide a substitute for what is lacking in the domestic environment, be it money or social support. Employment can furnish women with opportunities to create alternative role identities and sources of self-value; therefore, protecting some women from developing the depression and low self-esteem stemming from discord at home (Brown & Harris, 1978).

But what about the unemployed women that need to work not just for "pin money," but to support self and family? For the more than eight million women who are heads of households the unemployment rate is nine percent (U. S. Department of Labor, 1978). Many of these women-headed families live at or below the poverty level. The pressures of economic deprivation and failure to be an adequate nurturer for the family can help create the psychosocial environment for chemical abuse. Many chemically-dependent women who began their drug use in adolescence, lack adequate job skills. And most that do work are still slotted into low-status, repetitive "pink collar" jobs that offer little challenge (Sandmaier, 1980). A typical job for a woman is waiter (91% of waiters are women (Howe, 1977)). Waiter jobs that expose a woman to alcohol such as cocktail waitress can increase opportunities to drink.

The shifting of the stereotypical sex roles as caused many women to want to define themselves, at least partially, in terms of a career; increasingly they are likely to respond to unemployment and low-status employment with a sense of failure and inadequacy. And even though there have been a small percentage of women who have succeeded in a male-dominated job world, relatively few women are able to break out of their feminine sex role identities on the job. Many women find themselves taking care of men at work just as they learned to do so in their family...
of origin. And, if they try to compete with their male counterparts, they may have to work twice as hard as the men to prove their competence. Their feminine training in passivity and dependence makes them less prepared to handle the politics and overtly hostile opposition to female participation in the workplace.

Gomberg (1976) suggested that one of the aspects of social support systems of CD women that require improvement is vocational training and employment counseling. Schuckit (1978) asserted that any hypothesized sex differences in treatment needs should include a common sense appreciation of CD women's economic and occupational positions. Women are experiencing a redefinition of their sex-role identities with resulting conflicts arising from their increasing need to define themselves in terms of both feminine and masculine traits. However, few women arrive in treatment with the internal capabilities to adequately determine that definition, and they do not have a command of the external skills needed to actualize this definition in an appropriate occupational role.

There is no doubt that addiction can result in an increase in occupational problems, as well as an increase in occupational problems can influence the severity of the problem. However, the complex relationship that exists between chemical dependency and occupational roles would need further definition. Some of these occupational role problems are confronted and solved during the treatment process; however many of these issues including definition and direction are confronted during the recovery process when the CD woman has regained enough health and positive self-concept to handle them.
SELF AWARENESS

Research provides some support for the hypothesis that chemical dependency creates more psychological problems among women and social and behavioral problems in men. Experimental evidence shows that women experience declines in self-esteem after social drinking while men's self-esteem enjoys a slight increase (Konovsky & Wilsnack, 1982). It is felt that women's psychological vulnerability derives more from internalized society role norms rather than from the physiological effects of the chemicals themselves.

Women's internalization of society's disapproval and their own failure at maintaining the feminine ideal can lead to greater shame, guilt, and depression regarding their chemical dependency (Beckman, 1978; Knupker, 1982). Therefore, women may take greater pains to conceal their substance abuse. Men, on the other hand, display their substance abuse more public, using it for an occasion to be more aggressive and risk-taking. Because of this more public display, men are expected to suffer more adverse social consequences. Chemical dependency is associated with accidents, job losses, arrest, and violence more often among men than among women (Hser, Anglin, & Booth, 1987).

There is also a positive association between low self-esteem and earlier onset of chemical use and loss of control (Turnbull & Gomberg, 1988). Longstanding difficulties with chemicals would negatively influence self-worth and perception; a poor self-image could prompt earlier chemical use to deal with inadequacy and the associated painful effect. Research has not clearly designated which of these possibilities is true; however low self-esteem must be considered as an ongoing part of the addiction disorder, from onset forward.

Self-awareness in the context of this report, based on group therapy interactions between women in recovery, is better understood when looking at the
perceptions of self and self in the world that the three different family of origin roles assume. For the woman who functions in the overresponsible role, taking care of others on an emotional or functional level is the only way that the experience of self will be adequate and worthwhile. However, the dilemma is intensified by the additional expectation that self will need to accomplish this caretaking with perfection. Since the overresponsible woman can never be successful at this impossible task, she is plagued by internal feelings of self-doubt, guilt, shame, and inadequacy.

In a group therapy situation, this role will focus on others; any tendency towards self-focus will be denied, resisted, or experienced with tremendous anxiety (Bepko, 1985). She is not capable of being self-responsible; she is dependent on meeting the needs of others for a positive sense of self. Anger must be denied at all costs, because to experience it would mean acknowledgement that, in reality, personal needs are not being met through caretaking behavior. With women group therapy members who are overresponsible, the group therapist encourages personal reflections, educates on the establishment of internal and external boundaries, and enables these members to become aware when they are overfocusing on others to exclusion of self.

For the woman in the underresponsible role, there is an illusory feeling of specialness; this role person needs to be constantly focused on and taken care of by individuals in the overresponsible and/or authority position. She has learned to be incompetent and helpless as a means to get support to deal with many aspects of her life; this creates tremendous feelings of anxiety, inadequacy, low self-esteem, and worthlessness because of the need to be dependent. This underresponsible role is not competent to be self-responsible because of this dependency on others for a sense of self.
In a group therapy situation, women members with this underresponsible role will try to monopolize the group's attention because of their need to be "center of the universe." They will constantly demand to be responded to, taken care of, and given to while gradually experiencing a building of anger at being told what to do, how to do it, and at having it done. They will look to the therapist to meet their needs and do it for them; the therapist must be aware of not falling into this dependency trap. The therapist needs to understand that these women want to be self-responsible. However, functioning for self would rob them of their entitlement to be supported by others and would cause great anxiety about failure. The therapist must not function for these individuals. Support is needed in the form of education about self-responsible behaviors, and feedback given about present reality. These women need encouragement to feel, acknowledge their anxiety, and take action.

In the third family of origin role, the deviant thrill-seeker, there is an illusory feeling of being special, but this specialness is seen as negative and unacceptable by society's standards. Even though the external facade may be one of casual disregard or flippancy, women in this role internally feel the same degree of inadequacy, low self-esteem, worthlessness, and anxiety as the other roles. However, unlike the over- and underresponsible roles, the deviant thrill-seeker openly expresses anger and defiance. It is the hurt and pain of rejection that are suppressed. There is an unavoidable need to take the blame; although this role cannot be self-responsible, they are dependent on assuming responsibility for the negative aspects of interaction.

In the group therapy situation, women in this role will resist self-focus to avoid a possible display of their vulnerable self behind the facade. They may be lively and creative contributors in a group situation, often regaling others with
stories of their disreputable past; however, they don't want to show their pain, hurt, and need for others' support. The deviant thrill-seekers will get bored easily and will try to instill some excitement in the interactions. They will often act as the scapegoat, rescuing others who are perceived as being in distress by drawing the focus of the therapist to themselves. The therapist needs to be aware of these aspects of the deviant thrill-seeker. More than anything else, these women need acceptance and validation; they are encouraged to not rescue and to share their internal vulnerable feelings. This is a slow process, but each time they do expose internal vulnerability and are supported, external and internal trust builds.

In the group therapy experience, the therapist must consider the perspective of each individual woman as well as the dynamics of each role distinction. In addition, aspects of a whole group comprised of chemically-dependent women is another variable to be considered. Brown and Yalom (1977) found that CDs are inordinately guarded; they often survey the therapy group for signs of disturbance. This pattern of hypervigilance is continued outside of the group and has roots in dysfunctional childhood. Hafner and Fakouri (1988) reported that CD women perceived significantly more fear and anxiety provoking or threatening situations than "normal" women. This data suggests that CD women see threats to their security everywhere; they view their world as an unfriendly and dangerous place that is made up of people who should be kept at a distance.

Hafner et al. (1988) also found that CD women showed a significantly higher score on passivity in the active-passive cluster than the non-CD women. On the basis of this data, CD women are acted upon rather than act. Therefore, CD women in group therapy, because of their passivity, are more likely to place the burden of responsibility for their therapy progress on the therapist (Mosak, 1965). To
counteract this passivity, the therapist must make their behavior apparent to them and encourage them to take active responsibility for what happens to them.

Most studies report that CDs are externally controlled rather than internally controlled (Stafford, 1980). This would make sense in light of what is understood about codependency and the effects of the dysfunctional family of origin and society's expectations on women's roles. These roles are adaptations to an environment that would not support healthy development of a self. The need to control would be a response to the internal feelings of anxiety, mistrust, and alienation that these CD women constantly feel.

Issues of low self-esteem, poor self-concept, mistrust, need to control, inability to be self-responsible, and passivity by these women in their different roles in the group therapy experience will be further reflected in the later Findings and Discussion chapter. These special characteristics that may make this group of CD women unique are important when gaining an understanding of the research results.

RELATIONSHIPS

Primary Relationship

The learned behavior and attitudes of the sex-role identity that originate in the family system extend to the primary relationship and creation of a new family for the chemically-dependent woman. Women leave their family systems and often marry men who are also chemically-dependent. The self-identification roles learned with their primary relationship with their chemically-dependent parent(s), could be most easily duplicated within their primary spousal relationship. Women have
been socially conditioned to be the nurturants, and, when this is combined with an overresponsible role, marriage to a spouse that is dependent because of his own addiction, can be easily understood.

In relationship, women are taught to over function for their mate; men are taught that someone else is to be responsible for them, and, thus, they underfunction for self (Bepko, 1985). Women also are taught to be economically dependent on their spouses, yet, at the same time, assume the entire responsibility for the emotional and physical well-being of the family. Women learn not to directly ask for needs to be met from their husbands because that would be "nagging." Needs and decisions are gained covertly through the use of emotional "blackmail" or "feminine wiles."

Women's chemical abuse is more likely than men's chemical abuse to occur in conjunction with an chemical abuse mate (Gomberg, 1979; Hser et al., 1987; Prather & Fidell, 1978; Rosenbaum, 1981). In a study conducted by Kandel (1984) examining the effects of social influence on drug use, it was found that for young women, current drug consumption patterns were best predicted by drug use of spouses or friends. It can be assumed that some of the environmental factors for these results stem from the codependent and dysfunctional role issues.

In a chemically-dependent marriage, studies of self-reported perceptions of each other by the partners indicate that the CD women are self-deprecatory in relation to their spouse (Feuerlein & Busch, 1975). Increasing use of chemicals renders the female CD more depressed and more guilty than her spouse who, instead, regresses to immature behavior patterns (Tamerin, Tolor, & Harrington, 1976). The bulk of the literature on chemically- dependent marriages consistently points to a more difficult marriage in the case of the female as compared to the male CD (Perodeau, 1984).
However, alcoholic men associated their spouse's heavy drinking with a more positive outlook of the overall relationship (Perideau and Kohn, 1989). Men like their wives to drink with them; it may be that a heavy-drinking wife will also become a drinking partner instead of a nagging teetotaler in order to avoid one fewer source of marital stress. And, CD women who are attempting to maintain abstinence have a high degree of relapse when they have a close relationship with a man who is actively abusing chemicals.

An explanation of why alcoholic men have a more positive outlook about spousal drinking could come from research conducted by Perodeau and Kohn (1989) with couples where both were chemically-dependent. They found that the CD female is likely to have taken more steps to end her union than her spouse has; whereas the CD male is likely to have taken fewer steps than his wife has. Married CD women are more guilty and depressed about the impact their addiction has on the family unit, and they are more likely to link marital factors to their own chemical abuse. In contrast, married CD males have been described as immature, responsibility-avoiding individuals, unlikely to openly associate their chemical abuse with their family problems. CD husbands appear unable or unwilling to present a realistic picture of the impact of their addictive behavior on their marriages.

But even when women leave one relationship, they often will soon find themselves in another one. For women with the feminine sex-role identity, their femininity is defined through attachment; thus their identity is threatened by separation (Gilligan, 1982). For the women who more define themselves through the masculine sex role, separation is not as much an issue as intimacy. Even though each sex role would have a great number of problems inherent within their relationships, the woman with the feminine sex role identity would be in
relationship no matter what the costs. This may mean jumping from relationship to relationship or remaining in a seemingly intolerable relationship situation.

**Parenting**

Much research has been conducted on the effects of alcohol and drugs on the offspring (Lex, 1985; Jones & Smith, 1973; Rosett, 1980; and Jones, Smith, Streissguth, & Myrianthopoulos, 1974). And, as has been cited already, much research has been conducted on the psychological effects on children of chemically-dependent parent(s). However, little research has focused on CD women's painful acknowledgment of their maternal role performance deficits. There is the possibility that a CD woman will admit to any addiction-related consequences except those related to her children. This angle is supported by early work that suggest that CD women have a strong identification with the maternal role (Wilsnack, 1972).

Bepko (1985) relates four characteristics of actively CD parents as follows: 1) they are unable to nurture appropriately; 2) they are unable to set limits without being angry; 3) they are inconsistent in their expectations of the child; and 4) they are driven by a need to have the child's approval—in effect, to have the child parent them. According to O'Gorman and Oliver-Diaz (1987) this style of parenting shifts between wet and dry states in the family. During the wet, or actively abusing, state, parenting may be abdicated entirely. The CD may leave the children to do whatever they want. In the dry or sober phase, parenting may become more perfectionistic and rigid. If in the wet period the parent abdicated parenting; in the dry period there was an attempt to reassert authority.

Frequently, CD mothers have no clear understanding or experience of themselves as responsible for parenting; they do not have the clear sense that a healthy parenting role requires them to treat their children as other than peers or
surrogate parents. Without these appropriate roles established, children do not experience themselves as children, and, therefore, they miss the important developmental stages necessary to formulate a clear sense of self.

Chemically-dependent women in early recovery, generally do not acknowledge the pain they have caused their children. During the treatment phase, they express their desire to "hurry home and be a perfect mother." Observations of parent and child interactions during this phase show mothers who seem confused about parenting and fluctuate between the behavior extremes of the wet and dry states. One minute they are overindulgent and tolerant with their children; the next minute, they are rigid and stern. These women are extremely anxious to see demonstrations that their children still love them; yet they appear easily overwhelmed and stressed by the weekly interactions with their children. They are desiring their children to fulfill their needs for reassurance and validation; they seem lost in being able to adequately fulfill their children's needs.

For women in early recovery it seems unlikely that they are capable of seeing beyond their own needs for role validation. It would not be until they begin the integration phase and learn self-responsibility that they could more naturally behave in a healthy way with their spouses and children. However, there is education and parenting guidelines that can be presented to these women at an early recovery stage that are in line with the whole family system in recovery thrust of most quality treatment programs. And CD mothers want to be healthy parents; they are just not able without education, time to heal, and support.

Friendship

Women affirm and empower each other through the sharing of their similarities, different points of views of the world, and ways of coping. Sanford and Donovan (1985) write the following:
Strength can be gained by sharing common life experiences. Without much or any previous interaction, two women can jump into a conversation together, sharing both the feelings of loneliness and the freedom of being single, or perhaps the dreariness and joys of motherhood, or the feelings of competence and sacrifice engendered in a career.

Many CD women talk of never experiencing a close female friend. Feelings of shame and worthlessness, inability to share feelings and ask for needs to be met, inadequate boundaries, and an internal concept that people cannot be trusted are barriers that prevent CD women from experiencing friendship. Other inhibitions include society's negative stereotypes about female friendships which pressure women to devalue these connections; the most common negative idea is that "women can't be trusted because they will steal your man."

Not much has been written about the effects of chemical dependency on friendship. However, when looking at the impact that Alcoholics Anonymous, the most successful recovery tool for sobriety, has on chemical dependency, it may relate to its social support rule (Vaillant, 1983). AA defines itself as a "fellowship," as well as offering a program of recovery. For many recovering women, the people they met in their AA meetings may be the first friendships they have experienced since before their addiction began.

For many CD women in AA, their first female friend is their sponsor. They see their sponsor as a mentor, someone to emulate. The sponsor, depending on the progress in recovery she has made, teaches her sponsoree how to live free of addictions and substitutions. This relationship is encouraged as an important tool for recovery success. It sanctions women to acknowledge their vulnerability;
women are encouraged to ask for help and receive the support so freely given in the AA fellowship.

CONCLUSION

In working with chemical dependency systems, many clinicians including Claudia Black (1981) and Sharon Wegscheider-Cruse (1981) have identified these and other general characteristics common to women in the dysfunctional system generated from chemical dependency. The family of origin roles are seen as similar to the cultural roles women assume as products of a dysfunctional society system. The behavior of women in response to these systems tend to assume somewhat predictable and rigid patterns of behavior. Change involves helping these women to replace rigidity and dysfunctional roles with a more realistic assessment of their own capabilities and with the ability to discriminate real threat in the environment from feared threat. The creation of healthy internal and external boundaries and the learning of appropriate forms of assertiveness and expressions of anger become important ingredients in this change.

For the chemical dependency clinician, it is therapeutically sound to have knowledge of the different systems found in the field of chemical dependency. Research has speculated about the causes and effects of chemical dependency on females. However, to be effective, the CD professional must have knowledge of the impact the systems, role expectations, self-concept, and chemicals have on their women clients' after abstinence. For treatment to be a successful intervention tool, it must also provide education, medical support, psychotherapy, and social interaction tools through this complexity of bio-psycho-social-spiritual parts; the
knowledge needed for successful intervention must be acquired from throughout the recovery process.

After all, the women subjects in this report only began their recovery process when they achieved abstinence and underwent the inpatient program at St. Joseph Recovery Center. Their real work started when they had to leave the protection of treatment and stay clean and sober in the real world.

Rationale for Selection of Issues

The next chapter describes the design and methods used to research this neglected area of post inpatient treatment for chemically-dependent women. There are four factors that support the rationale for this research. First, women dealing with the often difficult journey of behavior change and abstinence would benefit from the information and education they could receive about what issues they may experience during their first years of recovery. Second, there is a need for research that addresses the special needs of CD women in order to create more comprehensive women-specified treatment and support systems. Third, active and recovering CD women and their families impact the social service system which needs changes to more effectively meet their better defined requirements. Lastly, there is a large audience for this research. CD women, women from a dysfunctional system, women with other dependencies, social service organizations, private therapists, treatment programs, chemical dependency counselors, other researchers, and women and men who want to understand CD women better.
CHAPTER 4: METHODOLOGY

RESEARCH DESIGN

The purpose of this study is to identify some of the issues and concerns that women experience during their first three years of recovery process after completion of inpatient treatment for chemical dependency. The nature of the present study is exploratory, using the broad focus of the qualitative research method. This openness of design is well adapted to the subject matters of women, recovery, and chemical dependency for it would be very difficult to conceptualize these subjects under the limits and restrictions of a quantitative research design. This design approach allows for the emergence of new variables and directions; these new ideas are useful in understanding the chemical dependency and women question.

The recovering CD women subjects, all past graduates of the St. Joseph Recovery Program, participated in a sixteen week group therapy format. In addition, each woman was individually interviewed for one and a half hours. Data obtained from the group sessions was treated as group interview data in the analysis; the information from the individual interviews was used to substantiate or dispute the data findings of the group sessions. Women were chosen for the group partly based on length of recovery since completion of inpatient treatment at St. Joseph Recovery Center in Bellingham. The twelve original participants were distributed between first, second, and third years post-treatment. It was felt this distribution would afford a greater wealth of data. This distribution along with the multiple sessions increases the comparability of the analysis.

The group therapy model was chosen because it would allow the women to speak on a wider range of pertinent issues and topics. Multiple sessions afforded
the women the opportunity to voice their opinions; it also helped the trust building process so to encourage more indepth sharing. Group therapy strategies are effective in clarifying the issues and problems as well as reframing these problems and issues presented into a systems perspective (Okun, 1984). The interaction of the women as a "system" created an atmosphere that could reveal more observable examples from the four major areas of inquiry, relationships, roles, self awareness and other dependencies.

The group therapy model was also chosen because of the clinical value it affords the participants. As a chemical dependency professional who has a special interest with CD women, there was concern for quality in the interactional and therapeutic experience of the participants. A major point about working with adults is to help them mobilize and utilize whatever resources are available to them; these can come from themselves, and from peers, professionals, and institutions. It was felt that this process could support the fostering of new ideas, awareness, and potential styles of living that could enrich all involved. In addition, the women would be returning to a familiar place that is remembered by most as having been instrumental in them achieving abstinence. All of the participants shared the same experiences of chemical dependency and treatment program participation; this common association could encourage the women to interact in the group sessions more quickly.

Yalom (1975) identified some of the curative factors of groups. One of the factors is the development of basic social skills. Many CD women either never learned basic social skills, or they have lost them during the period of active addiction. For these women, the group represents an opportunity for accurate interpersonal feedback. It is apparent that the more senior members of the group, those with the longest periods of recovery, have acquired more sophisticated social
skills. These women can be offered as models of healthy behavior for the newer women in recovery.

Another important factor of the group therapy process is group cohesiveness. This includes the source of stability that one experiences from being a part of a group that fosters "oneness". This cohesiveness generates the willingness to take risks. Risking involves opening oneself to others, being vulnerable, and actively doing in a group that which is necessary to change (Corey and Corey, 1977).

The research design and implementation is timely for the group site, St. Joseph Recovery Center. As head of the Women's Program which is part of this coed treatment facility, there is some latitude to introduce innovations in this program, which is still in its developmental infancy. With a wealth of research subjects, all past graduates of this program which goes back over three years, the design of this research affords quality for the researcher, the participants, and the institution involved, as well as providing information in an area that is sorely neglected by researchers.

**Study Population**

A sample of chemically dependent women, between the ages of 23 and 42 participated in the study. The women were divided into groups based on length of time after treatment completion. Treatment to one year duration, one to two years duration, and two to three years duration were designated as first, second, and third year groups. For all but one of these women who had a relapse on alcohol at one and a half years, lengths of continuous abstinence fell into these same year ranges. Of the twelve who originally started the group, three dropped out. One
attended only one meeting, one attended two, and one dropped out after five meetings due to employment conflicts. However, in order to accurately describe the study population that began the group, characteristics of all twelve original members are provided in Table I.

<table>
<thead>
<tr>
<th>TABLE I</th>
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<tr>
<td>Characteristics of the Sample</td>
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<tr>
<td>12 SUBJECTS</td>
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<th>Age Ranges</th>
<th>23-42</th>
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<tbody>
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<td>Currently Married</td>
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<tr>
<td>Never Been Married</td>
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<tr>
<td>Separated</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
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<tr>
<td>Children</td>
<td>9</td>
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<tr>
<td>Employed</td>
<td>7</td>
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<tr>
<td>In School</td>
<td>2</td>
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<tr>
<td>First Year Post Treatment</td>
<td>4</td>
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<tr>
<td>Second Year Post Treatment</td>
<td>5</td>
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<tr>
<td>Third Year Post Treatment</td>
<td>3</td>
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<tr>
<td>Current Relationship/Marriage with Active CD</td>
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</tr>
<tr>
<td>Current Relationship/Marriage with Recovering CD</td>
<td>5</td>
</tr>
<tr>
<td>Means of Support for Recovery--12 Step Groups</td>
<td>11</td>
</tr>
<tr>
<td>Therapy</td>
<td>2</td>
</tr>
<tr>
<td>Religion</td>
<td>2</td>
</tr>
<tr>
<td>Identifies Self as Having Multiple Dependencies</td>
<td>12</td>
</tr>
</tbody>
</table>
Sample Selection

The treatment staff of the St. Joseph Recovery Center lent their support and valuable input to this project. However, in order to conduct research with the hospital system using the confidential records of all past female CD women who have completed the program, it was necessary to obtain clearance from the Administrative office. Clearance was obtained after furnishing Administration with an outline of the prospective research.

Through medical records data, a list of all the women that attended St. Joseph Recovery was obtained. From that list, only the names of women who had completed the 21 day inpatient and the 12 weeks of aftercare were extracted; the list was shortened to 48 names. Those 48 women were sent a letter of information which included group structure and purpose along with qualifications for participation. Telephone contact times were also provided. The information letter is reproduced as Appendix "A".

From the 48 women who were initially contacted by letter, 20 responded by telephone. In order to qualify for the group each CD woman had to meet the following criteria: each woman is currently maintaining abstinence from alcohol and drugs, (exceptions made for medications that are not mind or mood altering); each is actively participating in some form of outside support whether it be a 12 Step group, individual therapy, or church support group; and selection of the women was determined by a fair distribution between the three separate recovery year categories. Each of the women responded to a telephone prescreening interview to determine eligibility and to obtain some basic information germane to the research. The prescreening interview guide is reproduced as Appendix "B". Upon determining eligibility, all women that were accepted into the program were given some basic information about group participation along with an explanation
of the group structure. In addition, each was requested to commit to the entire 16 weeks.

The only difficulties encountered in this selection procedure were obtaining a reasonable number complement for the three groupings and having to refuse some respondents because of an overabundance of their year category. Far more first and second year women applied than third year. It was only after an additional telephone contact was made to several third year women, that a reasonable distribution was obtained.

Data Collection

The 16 group therapy sessions conducted weekly over a four month period formed the basis for the main source of data collection for this study. Data obtained from these sessions was substantiated and reinforced by individual interviews, group summary forms completed after each group session, and field notes written by the group recorder during each meeting. In weekly discussion sessions between the two group leaders, notes were taken on any identifiable themes or issues that were observed in the preceding week's group.

The significant data collection technique that was utilized in this report was the group therapy format conducted weekly. Each group was two hours in length with a 15 minute break at the one hour mark. Each group session was audio taped in its entirety. All the tapes were later transcribed with each speaker identified for later comparison among the three groupings. An example of a transcription is provided as Appendix "E".

The group was facilitated by two group leaders, myself, and Ruth Greene, ACSW, who acted as onsite supervisor for the clinical portion of this project. In
addition, a group recorder, Margaret Curry, was present to maintain a written record of the proceedings. Having this clinical and record keeping support enabled the researcher to concentrate on guiding the therapeutic process. Although data collection was crucial, the clinical aspects of the group interaction were of primary importance. Ray (1958) is quoted as saying the following: "it also becomes apparent that to understand an individual fully, he must be viewed in his social interaction with others. Conversely, full understanding of group process requires depth understanding of the dynamics of the individual as well as the group as a whole." Being able to freely observe the group as a whole entity assisted the internal formulation of themes and issues as they emerged in different guises through the sharing process.

The discussion followed no set format and by nature was not predetermined. The group leaders endeavored to maintain background positions to minimize bias to the material and to motivate the women to interact with each other. When the group leaders did intervene it was in the form of pertinent information or of therapeutic necessity to move the group process forward. This leadership structure helped facilitate a flexibility in the discussion as well as enabling communication to become of a more intimate nature as the group interaction encouraged trust and commonality.

Group summary forms (a sample is provided as Appendix "C") were completed by the researcher after the completion of each group session. The forms outlined the main issues that seemed to be raised that week; special attention was given to categorizing material under the four main areas of interest. In order to expedite the coding process later, attempts were made to connect the speaker with the speculated themes and issues. These forms provided a way of managing the large amount of data generated in the groups. Therefore, the speculations that
emerged from this distillation of information provided later direction in the data analysis portion.

The group recorder was present to observe and maintain research field notes. The group recorder had little interaction with the rest of the group in order to remain impartial and removed. These notes included summaries of the different conversations and interaction with corresponding identifications. Attempts were made by the recorder to categorize the material into the four main issue categories. However, this was not always easily accomplished. These notes serve as indicators to the outlined contents of each audio taped session. They also provide another point of view on possible themes and pertinent information.

Each CD woman participated in an individual interview with the researcher. Each interview was audio taped and followed a format which is provided as Appendix "D". As can be seen from the agenda, the interview served a dual purpose of obtaining pertinent research information and supporting the therapeutic process. The interview questions were designed to afford each individual an opportunity to express her opinions freely. The format was in the form of open-ended questions that were partially developed to define the major issue areas. However, the interviewees were given the flexibility of questions that allowed a range of issues to be discussed. The results of these interviews has been used to test the reliability of the data analysis of the group sessions. Special note is made of reoccurring themes and information that appears to be of importance to the interviewees. Many of the women felt more comfortable in an one-on-one situation and, therefore could be more candid. The researcher has remained flexible to utilize information gathered from all sources as checks and balances for reliability.
Strengths and Limitations of the Group Therapy Process

The use of a model for data collection that serves a dual purpose of therapeutic and research orientation has some strengths and weaknesses. Included in this section are some observations on some of these strengths and weaknesses. Speculation can not adequately be made of the origin and causes of these aspects, due to the complexity of the numerous variables inherent in the design.

All of the women participants have been exposed to the meeting format of the 12 Step groups; all but one of these women are very active members of these groups. In the beginning, the group interaction took on characteristics of that format. The predominant feature was that women would share individually with no feedback or interaction resulting, as is encouraged in the 12 step groups (no side talk allowed!). Much modeling of appropriate response by the group leaders was needed before the women implemented this practice on their own accord.

All participants had a past association with the Treatment Center and the researcher. Expectations based on these associations prevented any initial impulsiveness. Group therapy in the treatment setting is very structured and dominated by the modeling, education, and direction provided by the counselor. Patients are "spoon fed" the pertinent information. Many of the women came to the group therapy experience expecting the same. Because of this, some waited for help or continually demanded it. Change to self-motivation and peer influenced reaction came only after weeks of disappointment and hesitancy.

Some group members dominated the group time. The overresponsible role women attempted to take care of other members especially with overstated advice. An underresponsible member constantly demanded support and input. And several
women would "rescue" the group from uncomfortable emotions by defocusing the attention from the issue at hand.

One of the group participants had been given permission to miss the first several group meetings due to a prior conflict. Because this woman entered the group later, she was treated as an "outsider" for a number of groups and was a focus of some disunity within the group. However, this situation later became the catalyst for cohesion.

All of the women expressed satisfaction with having participated. And, when asked if they would choose to continue if possible, all but one were affirmative. In the individual interviews, everyone was able to articulate their important issues. It was noted that many of those issues had changed or expanded from the initial telephone screening.

All of the women talked of not having quality relationships with other women. The interaction of this group of women afforded them opportunities to experience the similarities and differences between them. Even though 16 weeks had appeared to be a lengthy time period, it was actually just enough time for the women to begin to take risks with their vulnerability. It was felt, as one woman shared, "as a loss that the group was terminated just as it had gotten started."

Data Analysis

The transcripts contained an abundant wealth of data. In the initial stages of analysis, I went through the transcripts line by line to code the data for different ideas and impressions. These ideas were written in the margins. During this portion of the coding I also wrote theoretical memos to organize insights generated by the data, and to allow me some sense of direction in my inquiry.
After reviewing the initial coding, all codes were sorted through in order to develop a system of properties and categories. Where I could, sentences or a group with a common subject linking them would also be coded for one of the four original core categories. The transcripts were then cut and filed in separate manila folders according to the four core categories. An additional folder was provided for any data that did not fall under the existing core categories. Each transcript segment was identified by speaker, date of session, audio tape side, and page number of transcription so that cross referencing to the master copy could be made.

An analysis of each of the separate files began. In this stage of analysis, the larger core categories were refined into separate issues. Then these issues were combined to from categories. Glaser and Strauss (1967) has this to say about this categorization method in the following:

From the comparison of indicator to indicator the analyst is forced into confronting similarities, differences, and degrees of consistency of meaning between indicators which generate an underlying uniformity which in turn resulted in a coded category and the beginning of properties of it.

For example, under Self-Awareness, one of the four core categories, there were 24 separate codes or issues. These codes were then grouped into three separate categories. These three categories of issues are: Esteem, Empowerment, and Avoidance Issues. After completion of the data analysis in each folder, a separate listing divided into columns for first, second, and third year women was made of each of the categories. Then what each woman said about that particular issue was recorded under the appropriate column. This enabled the researcher to better compare and contrast the data between women's groupings for the chapter on Findings.
Because of the nature of the responses, of the four original general areas of inquiry, Relationships, Work, Self-Awareness, and Other Addictions, Work was changed to a broader category, Roles. Other Addictions was changed to read Other Dependencies. Also, it became necessary to add a fifth area of Other to categorize data that did not fall into the first four. An example of the coding schedule is reproduced as Appendix "F".

In the next chapter, which presents the Findings, the relation between the categories, the issues they represent, and the comparisons between the different women's experiences will be discussed. Quotes are used throughout to bring the experiences of these women to life.

**A Qualitative Approach**

Chemical dependency and social service professionals recognize the need for research on women and chemical dependency. And much of the intervention methods used to treat CD women have been based on research results obtained from male-dominated research. The preponderance of research that does exist battles the importance of finding out the causes and origin of chemical dependency, with less concerns about discovering the effects, principally after abstinence has been achieved.

As Schatzman and Strauss (1966) have found, most social worlds seem to dissolve, when attempts are made to analyze them into a number of sub-worlds. Segmentation creates difficulties for analysis because these social worlds are marked by tremendous fluidity. But these difficulties enhance this qualitative endeavor by insuring a focus on process. This perspective fits well within the construct of the coordination of human activities through groups.
The qualitative approach lends itself well to allowing the researcher to move beyond classification with rigid boundaries into the social world area in an attempt to distinguish the fluidity and changeability of human behavior. Blumer (1966) illustrated the difference between physical and social science as the difference between "definitive concepts" and "sensitizing concepts". "......sensitizing concepts merely suggest directions along which to look" (Blumer, 1966).

Even though it is important to designate chemical dependency as the intersection of boundaries between the physical and social worlds, the research design of groups used in this report best illustrates the intersections of boundaries of the social sub-worlds of human behavior. The individuals within these "worlds" achieve ".....a commonality of perspective with others by learning and developing together the symbols by which aspects of the world are designated" (Wiener, 1981).

It then makes sense that the research that is attempting to gain an accurate perspective of this "world" of chemical dependency and women would depend on the participants' own stories and insights in the construct of unstructured group interviews. Qualitative research allows for flexibility of the boundaries to allow the women participants to freely express their issues. When the purpose of research is not to test a hypothesis but rather to discover themes grounded in data, the intent is to achieve a larger theoretical perspective. It is helpful that this method minimizes the researcher's unavoidable interference in the data analysis.

Even though the qualitative methodology is the obvious choice for this study, there are drawbacks. This method produces tremendous amounts of data, and the processes to reduce the data to a reasonable size take extensive time. Choices to limit the scope of perspective had to be decided by the researcher; the resulting data, to be manageable, had to be reduced to accommodate the design.
Although careful attention has been paid to choose areas of inquiry that are substantiated by past research, it is not certain if another researcher would target the same areas. The reliability of this research depends on an accurate determination between what is recorded and what actually happened. Much depends on the researcher's ability to understand and analyze the data. Because the goal includes the achievement of a larger theoretical perspective, it is also beneficial to have a holistic understanding of the physical and social worlds of the subject matter.
CHAPTER 5: THE FINDINGS

In this study women in various stages of recovery have shared about their problems and experience adapting to life without chemicals. Some have maintained long periods of abstinence, while others still struggle with relapse. The divisions of first, second, and third year women do not maintain a predictable delineation for three separate stages of recovery. For instance, all of the first year women were concerned with relapse; the third year women were not concerned. It was the second year women who were mixed on this issue. All the women in the group identify themselves with having additional dependencies that they are struggling to resolve but the importance placed on resolution is diverse. There were many issues that underscored the importance of relationships in women's lives. Some of these issues overlapped with women's confusion over identity and self-awareness. Some of the information shared could conceivably belong in any of the core categories of Relationships, Self-Awareness, or Roles.

In order to present the most comprehensive view of issues that are faced by these women, the principal categories found under the general core categories of Relationships, Self-Awareness, Roles, Other Addictions, and Other (for those issues not belonging to the first four categories) will be discussed utilizing specific examples where appropriate. Where it has been clearly defined, changes in behavior concerning an issue will be included, particularly if a woman indicates that the change came during her participation in the group. The information from the three groupings of women will be compared. The speakers will be identified as WM-I, WM-II, and WM-III for first, second, and third year. The numbers after the quotes indicate the interview date, sequence, and the page number where the quote was
derived. For example, (WM-I 3/6B-7) indicates the quote came from a first year woman from the group session of March 6th, side B on the audio tape, page seven of the transcription.

RELATIONSHIPS

Trust Issues

Trust is defined in the dictionary as "firm reliance in the honesty, dependability, strength, or character of someone or something" (1984). Many factors influence the development of trust and mistrust. An individual's childhood environment, a history of abuse, the experience of traumatic events, and self-perception based on experience all impact upon the state of one's trust in self and the world. Research has shown that CD women perceived significantly more fear and anxiety provoking situations than non-CD women. Chemical dependency has a chaotic affect on behavior and perception; therefore, a CD's experience leaves individuals with a precarious reliance on all aspects of security.

All of the women subjects expressed problems with trust, although in varying aspects. Women from each of the three groups talked about feeling different, and that this separateness contributed to a feeling of mistrust. This quote is from a second-year woman who is talking about people who judge her negatively for her chemical dependency.
Some of this tends to set you apart, because people tend to judge harshly. I can make myself look bad without help of somebody else. When they do it, it sure pisses me off, especially from people like that. I want to tell them, if they feel uncomfortable with me, they can just leave. I want to be accepted. I would like to think that I could fit into any social group of any social status. But I know I don't. I usually screw it up before I even get into it. (WM-II 2/20 B-3)

For many individuals in the first several years of recovery, there exists a "them and us" mentality. People who are not alcoholics or addicts are referred to as "normies". Most of the women spoke of repeated attempts to gain a sense of belonging to this group.

All these people (in her choral group) are so terribly normal. Real normal. I never thought I would fit in. I think I was still drinking when I first got into this group. ......There still are some fears. (WM-I 12/12 B-2)

Some of this sense of separateness from the rest of society derived from not sharing a history of experience that would be in common with the "normies." A situation as seemingly uneventful as a Tupperware party was impactful on this third-year woman.

Somewhere along the line, I needed to feel that I fit in there somewhere. My path started over two years ago (with recovery). I have had a lot of paths, but the experiences I have had that I can talk at a Tupperware party about started two years ago. (WM-III 2/5 A-1)

However, even within the group where there was the common thread of all sharing chemical dependency and attempts to maintain abstinence, there was still the need to find commonalities to build trust.
I can't really think of anything that would keep my distance except that I haven't found, you know, like a common ground of things for us to talk about. But that is all right. I wouldn't know what to talk to you about, except for our AA issues. (WM-II 1/23 A-3)

These women have trouble trusting and communicating honestly with other women. This may stem partly from social conditioning that precludes women to be in competition with each other for male attention, and to be preoccupied with male relationships. Research has shown that women more readily abuse alcohol and drugs in the presence of a male partner. CD women may not have had the opportunity to experience a healthy, adult relationship with another woman. Additionally, there may be transference issues, projection of one's own mistrust of self.

And like the rest of these gals too, being able to communicate with a woman has always been difficult. I mean, I can talk to any man, but it is hard for me to open up to a woman. And I think this is a terrific opportunity to try to do that. (WM-I 11/21 A-3)

I'm real grateful to be here, and I'm real grateful that we are all women today, because it took me a year and a half before I got involved with a women's group. And tonight, right now, I'm sitting in this women's group. And it is real strange. I'm learning how to communicate with women and enjoying it. And not in a way that has to be slanderous against men either. (WM-II 11/21 A-2)

Several women talked of building a trusting woman relationship first with their sponsor. This may be the first more healthy female relationship experienced in recovery. Because the woman sponsor, in some instances, is seen as a mentor or wise mother, this relationship could be viewed as reparenting; the recovering
woman receives healthy guidance on ways to cope with life without abusing chemicals from a concerned "mother" who has taken the same but earlier journey.

It's always been a risk to admit my fears. And with my sponsor I've been able to.......... I feel comfortable with her admitting my fears no matter how stupid they are. Whether they are real fears or whether they are not. (WM-II 11/21 B-2)

Social Competency Issues

Reviewing the chemical abuse history of the study subjects reveals that all began chemical use in adolescence. This important developmental period where skills of social interaction are refined, was experienced often times under the influence of mind altering substances. All three groupings of women experienced features of social incompetency. However there are some interesting contrasts.

The women in their first year of recovery did not have much to say on this subject. This could possibly be due to their lack of new social experience. One of these women was in the Compliance Phase of recovery, where she was seeing her program as a struggle with authority. The majority of the first year women were in early Acceptance Phase. For these women, in order to prevent relapse, they must avoid social situations that including alcohol and drug use. Feelings of boredom because of perceived limited social activity choices are common in the first year. One of the first- year women expressed her conflictual thoughts when confronted with concern from other group members about serving alcohol at her impending wedding. It reflects the limited sense of choice and personal power that these
women in early recovery must feel. It also demonstrates how close they still are to their next drink.

Well, my fiance hadn't quit drinking when we made all the arrangements. Plus we are having it in the afternoon because the evening wasn't available. Plus all of my fiance's family drinks, and all my relatives up in Canada all drink. A lot of my friends all do. (WM-1 3/6 A-2)

By the second year of abstinence, women that have been regularly attending AA meetings, appear to have expanded their social interactions within that organization. Whereas the first-year women, for the most part, limited their AA interactions just to meetings, these second-year women have developed more of a social network. However, there is not yet a sense of social mastery, and the women are still socializing predominantly with others in recovery. There may still be some fear about socializing around drinking as might be found with the "normies." Also there may be a need to remain immersed in the AA experience as part of the Acceptance phase of their recovery program.

We are going to Seaside for the AA convention with some friends of ours next month. There are some friends that we invited to ride with us, and I am finding myself being very careful to lay out plans, especially financial wise, because I don't want to foot the bill. I am working it with my sponsor o have her critique it to make sure I am doing it in a healthy way, because sometimes I don't know how to do that. (WM-II 3/13 B-4)

My sponsor called me and told me that she would like to cultivate friendships with other couples, and that (husband) and I were her first choice. I was flattered but very scared. I am afraid that if she knows who I am, she won't like me. (WM-II 1/16 A-3)
Women in their third year of recovery appeared to be conceptualizing a more well-defined sense of self in their social world. They could be seen as experiencing the Integration Phase. They are not afraid of relapse and are more willing to take some social risks. They have more awareness about the dynamics of their social interactions, positive and negative, as this third-year woman explains when talking about her need to impress others.

Why do I think I have to impress people that have no bearing on my life? ........All that energy I expend trying to impress people that either don't matter or that I want to get close to. There are three ways to look at people; there is professional, as intimate and close friends, and the people that don't really matter. (WM-III 2/27 A-1)

Social interaction through participation in the weekly sessions enabled all the women to learn some communication skills. In the beginning everyone was careful not to say or do anything that might generate criticism in return. It was the third-year women who interacted in a more risky and vulnerable way. Two of these women had a conflict that was discussed the following week by them.

"This sounds so sick and so juvenile, but this is it. You put me on the spot in front of all these people, so you are not worthy of being my friend anyway. That is honest; that is real."

"That happened last week. Don't you feel better now, like f___ you?"

"Yea I do. I feel better. But that is why."

"I feel better about you too."

"I did want your approval before then, so that was like a one upper, and now it is like more even because I don't care as much." (WM-III 2/27 A-4)
During the last group session where women were asked to share what they had learned, one of these same third-year women said the following:

I am grateful to ____ for teaching me that I don't have to have everybody like me. And that was just—that was such a cool thing. I mean, I know it doesn't seem like a cool thing, but it does. (WM-III 3/13 A-3)

**Boundary Issues**

All the subject participants expressed concerns about boundary issues both within the context of the group and in their personal and professional lives. Most of the women had learned about boundaries through the recovery community's interest in codependency. However, several of the first year women needed explanations of the concept (definition is provided in Background chapter.)

A first-year woman talked of the experience of having an underdeveloped sense of boundaries between herself and others. Her fear of engulfment indicates problems with autonomy.

I think there is a part of me that I feel is separate. I think there is a part of me that wants to be separate. A I think it is that sense of feeling like I could be swallowed-up. It gives me a hard time in relationships as far as.......What relationships?! But if I had some it is that fear of getting swallowed-up and losing my identity. (WM-I 3/13 B-5)

She went on to talk about her need to find herself and the difficulty she had doing that in relationship. Her solution has been to "shut people out."
A common theme between all groupings is feeling responsible for other's feelings. It is not surprising that most of these women express this responsibility for it is a characteristic of the feminine sex-role identity. However, the women reacted to this responsibility in different ways. During one of the group sessions, a woman became very hurt and sad about her sense of alienation; she began to cry and shake. During her crying, only the therapist responded. The next week, several of the women had similar comments about their reaction.

This is the most important thing I learned last week, my reaction to her pain. Because I am supposed to be going to be a counselor, and my body language was like 'whoa', and how much I avoid other people's feelings. And how much I distance myself. (WM-III 2/6/B-5)

Whereas this woman was surprised by her frozen reaction because she had the idea she shouldn't because she wanted to confront people's feelings as a profession, a first-year woman without such aspirations talked of becoming overwhelmed by other people's issues. She too must feel a level of responsibility at least to provide advice or concern.

And everybody has to deal with their own issues, and sometimes I just get to the point where I feel like I don't have time for everybody else's problems. So I want to shut stuff out. (WM-I 1/23 A-l)

A second-year woman talked to another participant about why she keeps her distance. She felt a need to help this individual to express more joy, but she knows this would be intrusive. Therefore, she creates a barrier instead of a boundary.
And it's hard for me to sit across from you and sort of feel, you know. I watch when you laugh and when you smile. It's like it cuts right off. And so I feel like I want to help you let it out. And so I feel I want to keep my distance from that, in case I step on your toes. (WM-II 1/23 A-3)

As the therapist in this group, it was difficult to intervene on the passivity displayed by the participants. Women were fearful of criticism, engulfment, hurting others, and resulting feelings of shame and remorse. However, it was the third year women that showed the most boundary related change during the group period. None of the first-year women showed any significant change. In fact, one of the first-year women consistently asked for advice concerning a job related situation but never acted to change that situation (aspects of the underresponsible role.)

The second-year women appeared more aware about the concept of boundaries and made reference to life situations where they could see application.

If we spend a lot of time together, and we don't always get along because she is a blunt woman; that is OK. I am not going to change for anyone. I know it is about acceptance. I would be really happy if it worked out, but, if it didn't, that is OK too. (WM-II 1/16 A-3)

The group of third-year women acted out the formulation of boundaries in the group sessions. Some of the changes observed and voiced by these women included risk-taking with honest communication, increased awareness about chosen responsibility based on reality, and ability to separate self from reactions of family members. This came from a third- year woman after she had been honest about her criticism toward another group member.
Now I am not afraid to look her in the eye, and I am not wanting to avoid her. Whereas last week I felt that way. It was how I felt about how I was handling it. I was creating a barrier, not a boundary. (WM-III 2/20 B-5)

Another third-year woman took what she had learned in the group and applied it to a situation where she needed to be honest with an outside friend.

I told her how I felt, and she started to cry. And normally I would have backed-up and said "I'm sorry." But I kept on, and I said "I want you to understand why I feel like this." I almost cried and let the whole thing go. How could I be so horrible? How could I hurt her feelings and do those things to her? I thought about it enough; I had rehearsed it enough. But I almost stopped. (WM-III 12/12 B-3)

It was observed that the third-year women had acquired enough autonomy and sense of self to enable them to be more actively definitive about boundaries. Having a well defined sense of boundaries makes possible the kind of honest interaction that fosters trust and internal security.

**Control Issues**

The negative effects of society's expectations and the dysfunctional family of origin on women's roles necessitate adaptations to environments that cannot support healthy development of self. The need to control is a maladaptive response to the internal feelings of mistrust, alienation, anxiety, and shame that CD women constantly feel. This control can be seen as attempts to manipulate, the need to be in charge, but most especially in this context, is seen as a sense of responsibility in
relationship. There were no comments on control from the first-year women; several of the second- and third-year women talked of control.

A third-year woman spoke of the responsibility she felt in her marriage while she was still drinking. This comment reflects the shame she felt for her addiction, and the denial she experienced in order to maintain her illusion of security and propriety.

There were some problems in the relationship, but I thought that I was the one that drinks; I am the one that does this and that. He goes out and has a girl friend........It was my fault that we didn't have what we should have had. It was my fault, and I deserved what I was getting.......He was so wonderful, and so what about these couple of things.......And the only thing wrong with it was me; I was the bad guy. Even what I thought was security—a place to live, and a person to live with, and a family, all of those things were security. (WM-III 1/9 A-2)

People in the program of AA talk about "getting far enough away from their addiction to be able to see it." This woman talked of "getting far enough away from her husband to begin to see what was real" (WM-III 1/9 B-7). She felt she would have not been able to break through her denial and let go of control if she had not been in recovery.

This theme of feeling responsible for the relationship is intertwined into the feminine sex-role identity. Women are responsible for the emotional and physical well-being of the relationship; if there is something dysfunctional, the woman needs to correct it or adapt to it. This responsibility does not apply just to relationships with the opposite sex. This second-year woman explained this dilemma she had with her friend stealing at work.
This was something that was so stupid; something that I really hated about her. We would go to work, and this would just irritate me, and it irritated me the whole time we hung around. But I have never said anything to her about it. I don't even know why I can't say this; it wasn't even me. It was her that did it. It is real petty. (WM-II 1/9 B-7)

A second-year woman saw how her control issues interfered with her male relationships and helped her to avoid awareness of self. It is reflective in part to the anxiety she must have felt as the relationship became more familiar over time. She used the distraction of obsessive thinking to cope with her increasing feelings of anxiety.

And I find myself doing that now in a relationship; I will fix them. I will look at them as being all right for awhile. Then I will say, "Hum, what can we change?" And I will start thinking about things I don't like about them; things I want to change. And it is always in my mind; if I live with them long enough and I do this or I do that, I can change them. And I know that is my own recovery bullshit. (WM-II 1/9A-1)

**Friendship Issues**

Having a close female friend is an experience that is new and frightening for CD women. As has been already discussed, inadequate boundaries, a concept that women cannot be trusted particularly because they will try to steal your man, a tendency to take responsibility for another's actions, and confusion about what is socially acceptable, all contribute to the inability to make connections.
For all the women in the group, fear was the common denominator when talking about friendship, especially with another woman. As a group, the first-year women spoke of their fear in generalities. This would suggest that they as yet do little risking and are still overly invested in protection.

Well, I still don't do groups well. And women's groups are still hard, so I guess that is something I need to work on. .............And maybe it is the fear of just not wanting to get close to people. I can get close to people, but, no, I can't get close to people. (WM-I 3/13 B-5)

As a group, the second-year women talked more openly about their confusion, fear, and attempts at friendship. However, none of them were taking an assertive role in acquiring a friendship. Some of these women acknowledged their need for a friend, but they viewed the efforts as disconcerting and complicated. This illustrates the difficulty experienced in doing the work of relationships such as honest and responsible communication, commitment, play, and support.

About a week ago, a lady at a meeting, we kind of befriended each other. We have gone over lots together. And I am getting afraid of the friendship........I am afraid of getting close to someone; I guess because I feel it is going to end or something. But I guess I want to keep the friendship. It is really scary, but I want to try it because I haven't had that for awhile. (WM-II 1/16 A-2)

I rather have him than nobody. Because that is kind of how we became friends. He could sense that I was real lonely and that I had nobody to pal around with. I may never have said this before, but I am really lonely. I don't want to go through this little journey of sobriety by myself........It was real scary for me to say that in a meeting, and no one ever came up and said, "Let's go do something." (WM-II 1/9 B-8)
For the majority of women in second year, their first experience of female friendship is their sponsor. They see their sponsor as the person who teaches them how to be healthy. The honesty and integrity that the program of Alcoholics Anonymous demands, along with instructions to get a sponsor already a part of the recovery structure, create the foundation for this first time try.

I have a tendency to get just male friends, but this year I have forced myself to get a sponsor. And getting to know her and letting myself be open enough to not feel any of the old stuff has been hard. (WM-II 11/21 A-4)

I notice that the last few times I called my sponsor, she shares a lot more with me than when I first started calling. When she feels down about her relationship and what is going on in her marriage, I can help. (WM-II 1/16 A-4)

The third-year women appeared to have more certainty about their friendships, positive or negative. Although there was still fear present, it was a fear that had dimensions that the women understood. There was less self-recrimination for awarenesses of shortcomings and vulnerabilities.

I don't know how to have a relationship or how to have friends. ......I am looking at that, and Oh, I get it! It is not that I don't want to have friends or that I am a cold person like I think I am; it is just HARD WORK. And there is some stuff that I don't know how to do because I have never allowed myself to do it. (WM-III 2/20 B-5)
Last week when ____ talked about not having anyone to talk to, I was more than willing to give my phone number. I know everybody is saying, "Yea, right, sure." But I knew I was safe to do that. I knew you wouldn't call. And it was safe to visit you while you were in the hospital, but not after you got home. If you called me or we visited, that might mean that we would have to be friends and that would be really horrible. (WM-III 1/16 A-1)

Only one woman in the group, a third-year woman, expressed that she had wonderful women friends. However, this woman goes on to enumerate about the difficulty that she experiences with male relationships.

Lastly, there was some mention made of two important aspects of friendship and recovery. A third-year woman talked about the loss of her old girlfriend in the first year of her recovery. "This was the woman I use to drink with. I had to leave her behind" (WM-III 2/5 A-1). Although that is a loss that some women experience, many of them confront the harder task of leaving a male relationship behind. As will be seen in the next section, that is a much more difficult undertaking for the CD woman. The other aspect is one of relapse by a friend in recovery. Relapse is a real and present threat, and, as confusing as boundaries are, women experience difficulty with limits on responsibility and loyalty.

This person is just getting back into recovery; she relapsed. Sometimes I feel like a support for her, but sometimes I feel like I am doing it too much. That is scary because I just want to be there as a friend. But sometimes it feels like I am doing all the work; I don't feel like I am getting a lot back. (WM-II 1/16 A-2)
Male Relationship Issues

As the literature suggests, CD women are, for the most part, involved in relationships with men who are also chemically-dependent. Women have been socially conditioned to be the nurturers; therefore, relationships with men, who are made dependent at least in part by their addictions, can be realized. Of the group of twelve women, nine were at present involved with chemically-dependent men; however, some of those men were also in recovery. Of the remaining three, one first-year woman was homosexual, another first-year woman was obtaining a divorce from her non-CD husband, and a second-year woman continued to be married to a non-CD man.

Five women had instigated divorce proceedings with their husbands during their first year in recovery. Both a first- and a second-year woman had relapsed at least in part because of the loss of their sense of identity when confronted with the changes brought on by divorce.

I didn't have any validation. The family unit did exactly as the wheels of treatment showed. One wheel would spin this way, and all the rest were going off in other directions. And right before one of the court hearings, I decided that it would be best to go down to Mexico and not get lost in the potshots. Well, now I realize that it was a geographical escape and an ideal situation for relapse. I set myself up for this pretty well. (WM-II 11/21 A-1)

Because women's chemical abuse is much more likely than men's chemical abuse to take place in conjunction with a CD mate, the success of continued abstinence is greatly influenced by the woman's willingness to change her relationship situation. Women's codependent and dysfunctional role issues often
prevent them from making healthy choices for recovery. Women, especially those with the feminine sex-role identity, can rationalize, minimize, and ignore in order to justify continuing in an unhealthy relationship. It is better than no relationship at all. One first year woman, who relapsed during the period that the group sessions were underway, talked about how she handled her CD husband and his drinking. Her denial is apparent in that she later relapsed in conjunction with one of his drinking episodes.

Last Tuesday night he came home drunk. He was going to have a drink and then get something to eat, and his work schedule had been changed. But he came home, and he was real drunk. He just came home and and sat and grumbled. He wanted to pick a fight, but what he does doesn't control my emotions. (WM-I 3/6 A-5)

A second-year woman talked about her struggles with attempting detachment from her recently divorced husband and his addictions.

I see myself going through periods of being very frustrated. I saw his grass pipe in the car, and I really resented that. How dare he gets to go through all this stuff (the divorce) and doesn't have to feel these feelings. I hate these feelings. (WM-II 11/21 A-2)

The feminine sex-role identity motivates a woman to be in a relationship no matter what the consequences. A first-year woman was planning her impending wedding to a man who was an active alcoholic. She voiced her fears that this may be her only chance to get married, and she didn't want to wait until it was too late to have a family. Although she was herself involved in a recovery program and knew first hand how hard it is to stay abstinent, she didn't voice any concern over how his
drinking could affect her sobriety. Her fiance had stopped drinking but had not chosen to participate in any recovery efforts.

He has been hinting that at the bachelor party and the wedding he might drink. Well, it looks like he can live without it. All he has to do is keep his mouth shut. (WM-I 3/6 A-1)

Most of the women in the group expressed their concerns with her marriage. Many felt anxious and reflected on their own past experience.

Your upcoming marriage and some of the feelings you've shared remind me a whole lot of the way that I have felt in the things I have gone through. And, so that brings the old, negative reruns in my head that I don't like to look at. (WM-II 1/23 B-2)

I feel like you are living in a kind of la-la denial land about marriage and issues that are important, and it scares me to death. And I guess it's frustrating for me to see you not want to address it, you know, the reality. (WM-II 1/23 A-4)

The second- and third-year women had more experiences of trying to maintain sobriety with an active CD relationship. One third-year woman talked about the painful dawning of reality that she had experienced with her husband. Her dilemma was made even harder by her voiced need for validation as a married person.
And I thought, why do this? There will never be anyone who wants you or will marry you. Here was this situation where he is still drinking and using; he didn't know if he loved me or not. He didn't know if he wanted to be a dad or not. .......I could go back to him and the drinking and the drugging, but he had a girl friend. He wasn't sure how he felt about me. (WM-III 1/9 A-4)

However, this same woman talked of the resolution she obtained in her third year. During the time between experiencing the grief of divorce and achieving acceptance, she had learned a great deal about herself in relationship.

At nine months we were getting a divorce. And for two years after that I held on to him and my failure. I tried to kill myself and all that old familiar story. And for two years I only dated twice. I thought this guy was wonderful, and I was going to keep this marriage together...........The reality is that it wasn't the perfect relationship. It wasn't what I thought. I wasn't the failure in it. Now I look at it as it was him, and it was me. We have different lifestyles, and it is really OK. (WM-III 1/9 A-3 and 5)

Having difficulty in relationship didn't seem to change between the three separate years of recovery. However, the second- and third-year women appeared to be more aware of the dysfunctional nature of their situation. Several women talked of having relationships with active CD men that they began after they were in recovery. One third-year woman talked about the men she seemed to attract. She had originally had a rule to only date men who had at least one year of abstinence. She had since dropped her criteria.
Young men in the program (AA) real go after me. I always pick the sick ones. Why am I attracted to him? Why does he make me melt? And he is a little boy. Taking care of him is normal. There is always something that makes me keep my distance. (WM-III 3/13 B-5)

Another third-year woman has an ongoing relationship with her ex-husband whom she divorced in the first year of recovery. Even though they are both abstinent, he has been verbally abusive to her. She still is attracted to him out of the illusion that she will be taken care of by him. This can be compared to the fairy tale of "Snow White and the Seven Dwarfs." Snow White takes care of seven little men, all with different defects, until the handsome Prince comes to awaken her. The illusion of the rescuer who awaken all the potential in the woman with his kiss is a common myth in society, but it is not based on reality. Women may remain in an abusive relationship because of this illusion, but all too many of them are being abused. And, because of their role identity, they are likely to be the principal caretaker and nurturer in the relationship.

In the group many were aware of their problems with codependency, which could be seen as a consequence of female socialization. However, several women had a sense of themselves independent of their typical sex-role identity. These women appeared to have more of a choice in their relationships.

In talking about willingness, especially willingness in the program, I realized, actually before my husband came to treatment, that I am willing to give him up. If it has to be, it has to be. And it is that willingness that I try to keep intact with that really helps me alot. It helps me to know I am doing my program. And the kids would be all right if their Dad and I split. (WM-II 1/30 A-1)
It would be important to remember the masculine sex-role identity; women who identified more with this role would be having difficulty having and maintaining a relationship due to their fear of intimacy. Four of the women in the group had more of this role identity. For the lesbian member, it was particularly difficult to feel a connection with the other members. She talked of difficulty in relating to the group when the major topic is usually male relationships. Throughout the course of the sessions, she was the least involved, but when she talked she honestly expressed her fear and sense of alienation. "I just don't want to get close to people. I guess what I have is a fear of intimacy" (WM-I 3/13 B-5).

A second-year woman with this sex-role identity talked about how easy it was to express anger. "It was the shame that I felt afterwards that was so hard" (WM-II 1/9 B-4). This woman had a history of being a deviant thrill-seeker. Another second-year woman talked of having relationships that usually lasted only three months, reflecting her fear of intimacy. She would find something wrong with whomever she was with and move on. However, during the group therapy sessions, she was able to see a different point of view on relationships.

That is what I am discovering in the relationship that I am in right now. He doesn't have to be alike. I always thought you were supposed to find someone who has everything in common with you, and then you will be OK. (WM-II 2/5 B-4)

When a relationship ends there is a grieving period. Any change brings about a time of reexamination of identity and the formulation of an identity independent of the one in partnership. Use of drugs and alcohol to blunt feelings caused some sober women to experience delayed feelings of relationship losses they
had experienced while using. One woman, who was undergoing a divorce was aware of feeling the loss of another relationship years ago.

I am going through a personal experience where someone very close to me died eight years ago. And I never went through the grief. I went into treatment, and am now going through this divorce. A lot of the issues that I thought were divorce-related haven't been. It is now like I've gone into a grieving period and allowed myself that for the first time. (WM-II 12/12 A-1)

The recovery process is seen as a form of grief and loss wherein an individual can gain a new identity independent of their addictions by letting go of old behaviors, beliefs, and attitudes. For these women there was shame and remorse about using to cope with the loss of loved ones, even though that may have been the only coping skill available. As part of their recovery process, there was a need to return to the memories and acknowledge the loss.

My dad, my grandfather, and my grandmother all died while I was still abusing drugs and alcohol. And it was like, oh well, they are gone. There is no reason left to live. Everybody who mattered to me is gone. I went through the grief process after I got out of treatment. (WM-III 12/12 A-3)

**Summary of Relationships**

All of the group members experienced mistrust about the world around them, particularly the feeling of separation that they had little in common with "normies." Length of recovery brought with it a broadening of sobriety experience
and with it an expansion of social competency. The first-year women were fearful to socialize for that could mean relapse, and the first social interactions experienced by most appear to evolve through the Twelve Step Program.

Boundary issues were an important topic of sessions. The distinctions between the three groupings revealed that the first-year women lacked a sense of autonomy, the second-year women were confused but more aware of their issues especially concerning responsibility for others. The third-year women took most risks, showing a more developed ability to protect self while interrelating.

Second- and third-year women had become more aware of dimensions of their feminine sex-role identities. They spoke of behaving overresponsibly for others and attempting to control and manipulate. First-year women still lack the self-awareness to observe their own behaviors clearly.

All the women express a sense of fearfulness concerning friendships with other women. The guidelines of AA enable these women to form their first relationship with another woman, their sponsor. Third year women understand their fear better and take a more active role in acquiring friends. The second and third year women also speak of the loss of old CD friends and the relapse of friends.

All the women relate relationship problems with men. The only exception was the lesbian participant who did not feel safe to talk about her sexuality in group. There seemed to be few distinctions concerning issues between the three years. However, the first-year women had more denial about the dangers of associating with an active CD male relationship than the other two groupings. The second- and third-year women had more experiences to relate about past mistakes. A common theme was the desire to be taken care of or rescued. This is seen as a common myth of the feminine sex-role identity. Women with this role appeared to need to be in a male relationship no matter what they may have to tolerate.
The second- and third-year women expressed their awareness of delayed grief. There was a feeling of shame about abusing alcohol and drugs during the original losses, but there was a feeling of coming full circle when they gave themselves permission to grieve in sobriety.
SELF-AWARENESS

Esteem Issues

It was surmised by this researcher that there would be indications of low self esteem among the women subjects. However, it was unknown what elements pertaining to esteem would surface. Society's role expectation and the stigma of being a chemically-dependent woman both have great impacts on these women's self images. As part of esteem issues, components of alcoholic/addict image, shame, wreakage of the past, confusion, spirituality, learning to have fun, and acceptance will be presented.

It was found that all three groups had identity effects from being addict/alcoholics. There was no real pattern to the comments made between the groups. The determining variable was how much self-respect and acceptance each woman had gained as part of her recovery program. One particular first-year woman had many angry, self-recriminating statements to make about her addictions. From the number and intensity of her comments, it could be speculated that she was very ashamed about her past and had, either not experienced many positives to redeem a sense of acceptance, or her expectations were too high for what she needed to accomplish to be forgiven for her past.

I feel like a real f__-up. You know, I had my kid taken away from me because I was a drug addict. I am really down on myself. And I can't be a nurse because I was a drug addict. I'm a convicted felon; I am wanted in _____. I have to do two to five in the penitentiary. (WM-I 1/16 B-1)
This same woman talks another time about always feeling like the bad guy. She sees herself as the one bad seed in her family; because she cannot determine any trauma or adverse condition that could have caused her to seek drugs, it must be because there is something wrong with her.

And that is another thing with doing drugs and drinking all the time, you are so used to being the bad guy. You walk in and say, "I'm guilty," from the jump before anyone says a word. I have guilty written all over my face. I am so used to being in the wrong. Sometimes it is an insecure feeling to be too good, you know. Does anyone of you get that feeling where you don't break the law; you don't do anything bad? You don't drink. You don't drug? It's a strange feeling. Maybe not insecure. It just feels like you have nothing to hide. (WM-I 2/6 A-2)

A third-year woman speaks of that same sense of feeling bad and different. However, she is disappointed in herself for having this reaction. There is also anger at being labelled an alcoholic/addict and the quick assumptions others may make when they hear her label. This illustrates that for many CD women, this label is a stigma.

I have gone through something like this a few times. The thing that bothers me about people finding out that I am an alcoholic/addict is that my first reaction is that I am always ashamed. Now they know. Now I am in a box, and I can't get out. I am really disappointed in most of this s____. (WM-III 2/5 A-3)

This stigma and fear about society's condemnation is not without some basis in truth. Reality is that society still has harsh opinions about the woman alcoholic/addict. Another third-year woman had a sense of perspective that enabled her to put her past in a more acceptable light.
Didn't you have to get used to that part of your life where you wondered how you were going to cover your bad checks, or wondering what you did the night before? And now you don't have to worry about what you might have said or did or what you wrote. (WM-III 2/6 A-3)

The second-year women appeared to be more concerned with actual events where their alcoholic/addict status may have an impact. One woman related a family holiday where her secret was revealed.

At Thanksgiving with my Grandma, they were going to have wine. And she looked at me and said, "Is that OK?" And then it was OK; I said it was fine. So my big secret about being an alcoholic was broken. What happened after that was that a cousin of mine started talking about his brother who had just gone through treatment. All of this stuff started coming out. Somebody always ends up gaining from this honesty. (WM-II 2/5 A-2)

Another second-year woman argued that she was grateful to find out that she was an alcoholic. Finding out in treatment that she had a disease instead of being immoral, helped to to view herself as sick not bad. She was also relieved that there was a solution for this disease.

So, everyone had an opinion about the alcoholic/addict image. However, some of the women had come to terms with their past and were not adversely affected by it in the present. Other women still needed to do more resolution. This resolution came in part from individual experiences that helped foster a change in attitude, and these changes just take time.

A closely related issue to self-image is the feeling of shame. Shame can be defined as a failure of being; falling short of goals; of whole self (Potter-Efron, 1988). Research shows that women internalize society's disapproval of their failure to
to maintain the feminine ideal and that this failure creates feelings of inadequacy, shame, and depression. All three groups of women made comments that could be defined as containing evidence of shame. The first-year women made generalized comments that didn't necessarily reflect self-understanding. However, it was the second- and third-year women that could label the emotion they were feeling as shame.

The last time I had one side removed (an ovary), I didn't know how much of that was because I wanted to get high. OK, this was the way it was. My doctor kept telling me and telling me to do it, but there is some part of me that feels ashamed, like I went in and did it to get loaded. (WM-III 2/6 B-8)

A second-year woman mentioned on several different occasions that she feels "her separateness comes from a sick place in me" (WM-II 12/19 A-5). She also says that "my little trip is that I might be weird or something" (WM-II 2/27 B-7). For this woman, shame doesn't seem to dictate her responses, but there is the lingering doubt about her validity as a person.

Another second-year woman, however, reacted frequently to feelings of inadequacy. This was her response to getting feedback from another woman in the group. "It was scary. I thought she wouldn't have anything positive to say. It tends to invalidate me" (WM-II 1/23 A-1). Over recovery time, there seems to be an increase in the awareness of shame as a feeling, but how shame manifests in the behaviors and reactions depends on the individual.

Closely related to shame and image as alcoholic/addict was the reality of dealing with the past. The past was seen as confronting the insanity of past behaviors which happened under the influence of mind-altering substances. In the AA program it is referred to as "dealing with the wreakage of the past." All three
groups of women talked about confronting this issue. However there were some differences in the levels of responsibility between the groups. Those women more recently abstinent, took little responsibility for their past actions. Bad things seemed to happen to them with no control. The second-year women were more aware of the insanity of past actions. However, although there was an increased sense of personal responsibility, there was not a sense that they had resolved the issues. They were still feeling ashamed for the actions. The third-year women appeared more resolved about the past. The past, as a whole, was not so scary and overwhelming for they had created a pathway through it.

A first-year woman talked about recently learning that the Federal Government is pursuing her for welfare fraud. She expressed anger about now finally being clean and sober; she cannot understand why bad things are happening to her when she is being so good. There was at yet no acceptance of consequences of her behavior.

Going to jail is not one of my parts now. That was my past life, and I am having a real hard time dealing with the fact that it may happen now that I am a nice person. I know you are suppose to take responsibility for all your actions, but I feel it is a real injustice. You know, it is not right. (WM-I 2/6 A-1)

On the other hand, a third-year woman had this to say about the wreakage of the past.
It takes a long time to get over the wreakage of the past. I am over two and a half years sober, and I am still dealing with past stuff. And it is just one day at a time. You know they say not to get stressed. It is impossible not to get stressed. I think you need to figure out how to deal with it, how to work with it step by step. (WM-III 2/6 A-1)

Both the first- and second-year women had feelings of confusion and self-doubt. The presence of confusion is not necessarily negative for it can be an indication of change. However, here there were elements of being more easily perplexed, a possible result of poor definition of self. The self-concept and personal understanding of reality can both be confused when trying to gain the approval of everyone as this second-year woman tried to do.

You know, it's confusion, and I'm not real clear where to go with that, or what to do with it, because I can't figure out what aspect it is that I'm supposed to be working on......So I'm considering trying to pass by the things that I've worked damn hard for. And so now I'm feeling resentment. (WM-II 2/20 B-1)

Clarity was seen as having control. And for women who experienced anxiety, clarity and understanding was what they wanted. There is a slogan in Alcoholics Anonymous that says "Don't try to figure it all out." This saying is an answer to all the confusion that someone in early sobriety experiences. A first-year woman who relapsed during the group time period, talks about what she did to get back on the recovery path. It is noted that she didn't relate actions like going to meetings and talking to sponsors which would have certainly helped. What she wanted was to figure it out.
It was just sheer terror. I have been carrying this journal around with me and just writing like crazy. And I am talking to myself and going back and forth. And I am having a debate class with myself. I will write it all down. Write-write-write. (WM-I 1/16 B-1)

Another first-year woman talked about not participating much in the group and feeling overwhelmed most of the time. She later surmised that she hadn't been emotionally ready to experience a therapy group, and that more time in recovery would have helped. This could signify that women in their first year of recovery are not ready for therapy, and that what they need instead is more structure, direction, and support.

I think real hard about it, and I talk to my therapist about it. I don't know if it is that I am just not far along as yet. I don't know. I don't know if it is just that I am not that far down my path of recovery that I can do it. (WM-I 3/13 B-6)

Spirituality is an important aspect of the Twelve Step Programs. However, only two women mentioned it as something that they were confronting. A first-year woman, one who had earlier talked of not being ready for the group experience talks about her next step in recovery. This step may be seen as her attempts to gain clarity and direction through a clearer understanding of herself and herself in the world.

My next step in recovery is to do some spiritual stuff. Well, the first thing is that I say, "Well, I am going to go off and do these camping trips by myself." There is the sense that I am getting to like myself now where I want to do stuff by myself. But then I have always kind of done stuff by myself. But I never enjoyed it because I was always drinking. (WM-I 3/13 B-6)
Another side to spirituality is religion. A second-year woman talked about returning to church after over a year absence only to find the experience really weird. She is questioning whether she should return; she doesn't yet feel like she belongs. It was surprising not to have more spiritual content in the group because it is mentioned so frequently in AA meetings and literature as the cornerstone of sobriety.

Two of the women mentioned wanting to have more fun. Learning to enjoy life without the familiar catalysts of drugs and alcohol is a difficult task; they suffer from what can be described as a "pleasure deficit." Also, being able to take care of one's own needs takes an element of self-esteem to accomplish. They often have trouble letting go and having fun. One second-year woman was going to join a softball league after a six year hiatus. A first-year woman talked of just learning how to have fun. Because of so little reference to fun, most of the women were caught-up in the hard work of recovery and didn't appear to be having much fun as yet.

Acceptance was seen as a solution to issues for all three groups. Acceptance is written about in the AA Big Book as "the answer to all my problems today" (Alcoholics Anonymous, 1976). A third-year woman talks about how she uses the concept of acceptance to help her deal with shame.

I try and validate myself that that is just the way it is, and I am not going to change it. I don't have the power over someone else. There is no way to go back and change, and this is OK. There are the simple things to remember. Just validate me and be happy with who I am. I say that stuff to myself. This is just the way it is. I am an alcoholic, and I screw-up. I got alot of neat things inside of me. (WM-III 2/5 A-3)
Empowerment Issues

Empowerment is a term closely related to personal power. It basically refers to the politics of a relationship and follows the gaining or giving-up of self through the dynamics of the relationship. It is also closely related to the issue of control. However, one of the differences is that control deals more with the interactional attempts to control self or others; power is more defined by the composition of the larger social, family, and ethnic systems. For women with the traditional feminine role identity, admissions of being controlling or manipulative are acceptable; however, admissions of wanting power for themselves are unacceptable. Men in the traditional social role resent being called manipulative or controlling but enjoy the perception of wanting or taking power. However, when drinking, many women talked of feeling more powerful than when sober. And men talk more of feeling powerless while drinking, and it may be one indirect way for them to give up power.

In this context of self-awareness, empowerment is the term that encompasses different aspects of the larger political system of relationship with self and others. Although aspects of this category could be also included in the Relationship category, division has been made between direct references to relationships and women's references that pertain to self and self in the world. Therefore, issues of control, assertiveness, the desire for structure, and awareness of choices will be discussed as part of empowerment issues.

One needs a sense of control in order to let go of control. An individual needs to have a sense of a "space" around her, the comfort level within that space, and be able to communicate that to others. There needs to be a sense of identity and an intuitive knowing about what she is about, where she ends and where the rest of
the world begins. When an individual has good internal boundaries, she knows that her good feelings will come from her own behaviors. These internal boundaries are regulators of one's own self-respect and integrity, and, when present, it is said that the individual's locus of control is internal and self-regulated, not external and other-regulated.

All the women in the group experienced and expressed concerns pertaining to control. Both the first- and second-year women talked about the need to "look good" to others. Creation of a false self that radiates socially acceptable characteristics is a typical defense of the chemically-dependent individual. This false self is a disguise for the real self which is defective (shame), and it is also a cover for the alcohol and drug abuse. A second year woman voiced it like this.

You know, everybody has problems, but they are probably thinking the same thing you are. "I really need to look good." They talk about this or that, but they are all trying to be in control. They are all trying to look good on the outside. Don't talk about that stuff like sleeping around on our husbands and getting drunk in the car. They are not going to talk about those things. (WM-II 2/5 A-2)

A first-year woman talked about some of the changes she had experienced while participating in the group. There is direct reference to her need to project a "perfect image."

Everything in my life has always had to be completely thought out. Now I've looked here, and it has just been OK to not know. It has been OK to be wrong. It has been OK to be not striving to be the perfect image of what I think I am supposed to project. (WM-I 3/13 A-1)
The need to be in control was clearly manifested in the first year women as the need for clarity and a definition of what behaviors help counteract anxiety and the feeling of helplessness.

I would like to be able to intuitively know what is best for me without getting into control. I will still have times where I will hit that peak and try to control it. I hit this bottom after I peaked out. I say, "I told myself the last time that I wasn't going to try to figure it out." Then boom, it happened again..........But I cried a lot about it, and then I tried to surrender. "OK, so you didn't figure it out. It is OK. Let it go and just keep on going." And, yet, I am going to try to figure it out again. (WM-I 3/13 B-8)

Another way to cope with the helplessness and out of control feelings is to blame it on others. This is a reaction of the underresponsible woman type who isn't aware that her own behaviors dictate how she feels. A first-year woman responded, defensively, to confrontations from others in the group. "It felt like someone was pushing my buttons. For me, I thought I was busting my buns to do the best job I can. I am trying as hard as I can. (WM-I 1/30 B-2).

The majority of the second-year women were concerned about authority figures. There were comments made about how the group therapists could "see right through me."

I felt Melinda had super powers and could see into the back of my head. I was fearful. I thought, "Oh, she can see all those words back there." (WM-II 11/21 B-2)

I feel, like what you just shared about Melinda being able to see right through you, I feel both Ruth and Melinda can see right through me for things that I don't even know about myself. (WM-II 11/21 B-2)
At least with authority figures, the locus of control appears to be on the outside. These women feel exposed and vulnerable towards the individuals that appear to have the power. The position of power could be seen as a masculine role place, and it is the obligation of the feminine role to acquiesce.

The third year women appear to be applying their growing sense of autonomy to their relationships. In more and more instances, they were reacting from an internal locus of control. This third-year woman talks about her attempts to change the dynamics of her relationship with her sister.

Finally, I just stuck with it. I think she lost her control of me too. And that is why she felt real bad, because she couldn't control me anymore. And it was hard. It took me a long time to be separate from her to realize I was letting her do those things........I was just taking what she told me to think and thinking it. (WM-III 2/20 A-2 & 3)

All of the first-year women wanted more structure, both as part of the group organization and as part of their lives. A first-year woman asked directly for it from the therapist running the group. "I want direction. I want Melinda to have something planned (WM-I 11/28 B-3). Another first-year woman summarized her experience of the unstructured therapy group.

I also liked the fact that it wasn't real structured, and it was kind of... that's real scary. That's very scary. So, we didn't make great leaps and bounds a lot of times because we were just kind of floundering around........You kind of want to be told what to do, because that is the way it usually is in treatment. (WM-I 3/13 A-2)

This woman made a point about the rigidly structured treatment program that they all completed. Unfortunately for most CDs, their opportunity to learn the
most about their addictions comes when they have just stopped using drugs and alcohol; therefore, they are too cognitively and physically deficient to conceptualize the information given. Treatment needs to be highly structured, for people in early recovery experience abnormally high levels of anxiety and confusion. The rigid structure enables them to feel secure. That anxiety apparently continues into the first year of abstinence. "That is part of my next step. I really don't know what my next step is. I really don't. I feel the need to cook something up, but I really don't know what it is" (WM-1 3/13 B-8).

Issues of assertiveness were most apparent in the interactions between group participants. The initial two group sessions were discussions of how the women wanted the sessions to be structured. In these sessions, two of the first year women and one of the third-year women did little to no talking as part of the negotiations. As later happened, one of these first-year women and the third-year woman dropped out of the group. Both related later that they had been extremely intimidated by the group format.

It was this therapist's observation that the women in the group tried extremely hard not to offend anyone else. They initially avoided speaking directly to each other on any subject that might generate disagreement. This is common in any new group. However, the women remained passive until some structured activities were generated by the therapist leaders. Responses to doing one of these exercises, where each woman had to tell every other woman what it was about her that was attractive and what it was that was repellent, were varied.

Because I usually do it the other way. I always will go with what everybody else thinks, instead of what I want. A lot of times I just don't know what I want, so it's been a good experience for me. (WM-I 1/16 A-6)
Oh God, I want to get it over with. It's a major risk because I don't know what I'm going to say to anybody. (WM-II 1/23 A-3)

And, I learned from the feedback that I gave how good it felt. It felt really good, and the things I said were real sincere. And how much easier it was to say it than I had suspected. I expected it to be really hard. (WM-III 2/6 B-5)

Some of the second- and third-year women demonstrated the capability to be more assertive in the group. Some of these women were also more identified with the masculine sex-role identity, wherein assertiveness might be more readily demonstrated. However there still remained differences in how conflicts were experienced and resolved within those groups. The first-year women avoided conflict as much as possible. As recovery time increased, the ways that conflicts were confronted and resolved improved. A third-year woman spoke about how she assertively adapted to recovery.

I make myself have to do the stuff. I still have to do that kind of stuff......I had to make myself call, go to meetings, and put myself into situations where I had to. That was the best thing for me; just get in there and really give it a try. (WM-III 1/16 A-1)

Comparing information between the three groups on the issue of choice revealed that the longer the recovery time, the greater the sense of choice. Chemical dependency robbed individuals of the freedom of choice. There may have been the illusion of being free, but the physical and psychological need for their drug was their only avenue of response. Part of the emergence of choices is the clarity of mind that increases over sobriety time.
In the first year of recovery, the most important choice is to decide daily to stay abstinent. All other choices emerge from that one principle. This is what a third-year woman had to say about her choices in her first year. Her success is partly due to prioritizing this important choice.

My choice was to live with my sister who is a practicing alcoholic, live in the street, or go live with him. The only thing I could think of was what was the most important. And the only thing I could come up with was that I wanted to be sober and clean. (WM-III 1/9 A-4)

A first-year woman has an issue of living with a progressive and fatal disease that was caused by her addiction to drugs. However, she was unprepared for the fact that her disease was not progressing the way the textbooks and physicians had prescribed. She had to face the fact that she may live.

And a lot of issues go with that. I was kind of all prepared not to live, so I kind of prepared myself for all this book stuff. And, instead I am getting better. So a lot goes along with that. You got what you asked for. Now, what are you going to do? Be careful what you ask for; you just might get it. (WM-I 3/13 A-1)

First-year women relied more on AA slogans and other sayings to remind them of their choices. These phases appeared to act as guideposts especially when they were confused and anxious. Phases such as "this too shall pass" (WM-I 3/13 A-5) and "it ain't Cook County Jail" (WM-I 2/6 A-3) were used as coping agents for periods of stress.

Choice also appears to spring from a growing sense of responsibility and personal power. All three groups of women were able to learn through experience
that they had a choice of attitude and perspective, mainly when they were able to see an alternate point of view.

Something I have learned about myself is that, if you want to change, you have to have an open mind, even if it hurts to hear it from other people. (WM-I 3/13 A-5)

It is reality. It comes back to starting to find out that I don't have to like everybody. And some of these people that I thought I have got to like, I gave them a lot of time and put them on a pedestal. Then they would fall off, and I would get pissed-off at them. But now I am starting to say, "Gee, if I had not put them there, they would not have fallen off." That is my responsibility, not theirs'. (WM-II 1/9 B-6)

People keep calling me and asking me to come work for them.....And they are little jobs. But still there is something about being able to say "no" now. I don't have to take these jobs. I don't have to say "yes" to those people just so they will like me. I can say "no." And if they still like me, that is OK. And if they don't, who cares? (WM-III 3/13 A-3)

**Avoidance Issues**

In early recovery, women need to be taught ways to cope with stress, pain, and anger. In the CD woman, healthy response to stressful situations has been dulled and distorted by the use of alcohol and drugs as substitute coping mechanisms. When these agents are removed, feelings are once more experienced; however, women are often not equipped to handle them. Alcohol and drugs not only mask unwanted emotions, they enable normally repressed emotions to be
expressed. Anger, an emotion that the socialized feminine role is taught is not "ladylike," can be expressed when intoxicated or high. For the woman with the masculine sex-role identity, sexual expression can be openly and aggressively expressed while intoxicated.

The influences of the dysfunctional family of origin and socialization have distorted natural and healthy expression of feeling that runs counter to sex-role expectations; therefore, it was found that many of these women, in recovery, were fearful of their feelings, real or imagined. The mistrust of self and others, the internalized shame, the repressed rage from past abuse and neglect, and the grief of losses not yet expressed all serve to keep women intimidated by their own internal affect.

All three groups of women expressed fears about life situations and their reactions to them. All three groups were incongruent with affect. What they were feeling inside was not openly expressed. This inconsistency may have originated in an environment where it was safer to mask inappropriate emotions. The women were not always aware of this discrepancy. This was an interchange between the therapist and a first-year woman which occurred after she had completed a difficult group assignment.

Therapist: "How do you feel?"
Woman: "Oh, that was real awful. Yeah, real awful."
Therapist: "But you are smiling."
Woman: "I know I am. Well, that is because I am in shock. That was really tough."
Therapist: "Well, there is another clue to other people. When you have a frozen smile on your face, it may mean you are feeling shock." (WM-I 1/23 A-2)
For the first-year women, negative emotions were usually avoided. Feelings such as anger, grief, hurt, shame, and fear could become out of control and lead to relapse. This woman was amazed that she didn't experience craving.

I'm still feeling things that I don't want to feel. But it is amazing because Sunday through today has just been hell. I have spent more time crying in the last three days than I have in the last ten years. But, in all that time, I never wanted a drink. I didn't even think about it. And that is a really good feeling. (WM-I 11/21 A-4)

The first-year women were also not certain of the cause of their feelings. Feelings have long been avoided with chemicals. Confusion and anxiety can be generated when there is little sense of personal control and understanding.

I like to laugh. That is what I am into right now. And I don't know if it is because I am uncomfortable about talking about my feelings. I am in this mood where I kind of want to laugh and have fun. I am really confused. (WM-I 3/13 B-7)

This confusion and anxiety extends towards others also. Women have been socially conditioned to be emotionally responsible for others.

I am so embarrassed when someone cries in a group setting. I don't know what to do, so I just sit there until it is over. And, when is it appropriate to respond? I remember when _____ got so upset (in a group session). I remember how inappropriate I was. I am terrified when people cry......I guess I was never taught how to deal with it. No one in my family ever cried. (WM-I 3/13 A-1)

Whereas the first-year women lack a sense of personal awareness and understanding about their feelings, the second-year women are more conscious of
their feelings. This consciousness has more to do with patterns of responses instead of the causes. For example, several of the women in this group were aware of numbing of feeling when confronted with an uncomfortable situation. This psychic numbing may have it is origins in a dysfunctional childhood.

I am really selective about what I'll take in. And I have been tuning out that way for a long time. When we went around and everybody said things, I went home and couldn't remember any of it. I chose not to remember even the good stuff. I don't like that. I guess in my recovery that is something that I'd like to change because I have noticed that in just this year of being sober. (WM-II 3/13 B-1)

This numbing can also take the form of delayed feelings or detachment. Most of the women in this group were aware of experiencing their emotional reaction to a situation much later. "I want to know how to have those feelings sooner instead of later. And I want to be able to understand what they are when I have them" (WM-II 11/21 A-4). Another woman spoke about her detachment being a defense response. "I want to learn not to be so defensive. I can detach almost to the point where it is not good for me, where I am not feeling what is going on. I want to learn how to feel what I am saying, not just state the facts" (WM-II 11/21 B-1).

Another reaction was to change feelings to match another person's feelings. This is seen as a result of ineffective emotional boundaries. Without adequate boundaries, a woman may overly react to outside emotional stimulus further confusing herself.
I am learning to stay in what I feel and not cling to what someone else feels. In the past, it has been like "Whatever you felt, that is what I felt too." That is real sick. And what I know about that was that it was a survival technique that helped me get through my life until now. (WM-II 3/13 B-3)

Women wanted permission to experience their emotions. Having authority figures tell them it was acceptable to express honest emotions appeared to counteract to some degree their own internal negative and unsupportive dialogue. "I wish I had known then what I know now about myself. About crying all day, I wish I had known that I was allowed to do that, that it was all right to give myself permission to feel those feelings" (WM-II 12/12 A-2).

The women in their second year were also interested in the origins of their patterns of emotional response. However, they were viewing these origins in a detached and impersonal way, obviously not emotionally ready to experience the pain connected with these memories.

It is like when we were kids. There was that insanity where we say everything as fine and OK, and then one day something happens. It is just about the biggest thing on earth. And then we just go back to normal saying, "Was it really that big a deal?" (WM-II 1/9 A-1)

There were not many distinctions between the second- and third-year women. However, the third-year women were more willing to take some risks in group to gain understanding of their feelings. The second-year women wanted more to talk about their feelings; the third-year women were slightly more willing to confront negative emotions and conflicts in group. "I learned that it seems that we learn the most from people we have the conflicts with. Sharing these emotions is better than living our lives in emotional isolation" (WM-III 3/13 B-3).
However, the third-year women shared some of the same fears and defenses as the first- and second-year women.

Something I learned about myself is about the crying and the anger. It was about being around that much emotion and how much I have shut myself off. My first impulse when somebody is crying is I want to go up and hold that person. I just want to hug and say, "Wait. Stop. Don't show your feelings." .......As long as everybody isn't getting along, I feel uncomfortable. (WM-III 3/13 A-3)

I learned the other night that there are a lot of feelings that I don't deal with. I just kind of have a little thing that goes, "OK, here they come." And I don't even know really what they are. I just know there is stuff I don't deal with and haven't. I just let it slide off my back. I have a lot of recovering here to do. (WM-III 3/13 B-2)

Therefore, all three groups of women have many of the same reactions to emotional and stressful situations. However, as recovery time increases, so does awareness and the acquisition of coping skills and empowerment to manage resolution.

Someone said to me this week, "You know, people who have not had this disease aren't happy. But they can look happy." I want more than that. I don't want to be one of those people who wasn't happy but looked like it. I want to deal with my feelings, not just look happy to fit in. (WM-III 2/5 A-1)
Summary of Self-Awareness

All three groups of women experienced the stigma of being alcoholics/addicts. However, the influence of this stigma varied among individual women. The second- and third-year women were more conscious of experiencing shame about their past. The first-year women had not gained enough of an objective perspective to label this emotion. The acquisition of an objective perspective over recovery time extended to how each group handled the "wreakage of their past." A sense of responsibility and resolution of the past increases with time in recovery.

Confusion about reality and sense of personal identity created anxiety for first- and second-year women. The lack of structure and the confrontive nature of the therapy group made it difficult for the first-year women to participate. It is felt that they are not ready to participate in a therapy group; structure, direction, coping skills, and validation are important prerequisites in the first year.

It was surprising that there was little mention of spirituality, although it is an important part of the Twelve Step philosophy. Also there was little talk about wanting to have fun. Individuals in early recovery experience a "pleasure deficit." It may be some time before these women experience any extended period of joy and happiness.

Acceptance was a concept used to cope with everyday conflicts and stresses. It was used as a solution by all three groups. However, there is a sense that the greater the time in recovery, the more acceptance means true surrender not just resignation.

Women are not socialized to acknowledge desiring power; however, it is deemed acceptable to be controlling and manipulative. All the women had control
issues. However, the third-year women appeared to have a greater sense of autonomy; they responded with an internal and self-regulated locus of control. The first- and second-year women seemed to react with an external and other-regulated locus of control. Both first- and second-year women projected a "false self"; the second-year women had problems with authority figures.

Along with this need to feel in control, the first-year women wanted and needed more structure and avoided conflict at all costs. The group as a whole was more passive, although assertiveness was more apparent with women who had more recovery time. A sense of choice also increased over time. First-year women needed to rely more on slogans and sayings to remind them of their choices. The second- and third-year women experienced a growing sense of choice over a continuum, which springs from an understanding of responsibility and personal power.

Lastly, all three groups of women experienced fears about their emotions. This fear was manifested in different defense and avoidance behaviors. The first-year women were fearful of relapse so avoided feelings as a safety measure. The second- and third-year women were more conscious of their defenses. However, it was the third-year women who expressed the most willingness to confront conflicts and negative emotions in the group.
Sex-Role Identity Issues

Women with the feminine sex-role identity have been socialized to be the emotional and physical caretakers of others. The feminine ideal doesn't drink excessively and doesn't abuse drugs. There is no angry loss of control and no sexual misconduct. Women with this identity have difficulty expressing needs and wants, avoiding abusive situations, and choosing relationships and situations that foster a greater sense of self-esteem.

Women with the masculine sex-role identity are attempting to break loose from society's stereotypical expectations. However, this rebellion doesn't always lead to positive results. Women with this identity tend to avoid the intimacy of relationships; overwork; have difficulty with expression of vulnerability; have more socially unacceptable consequences of their addictions; and lack friendships.

Conflicts regarding sex-role behavior cannot be separated from the patterns of behavior that emerged from the family system. The over- and underresponsible and deviant thrill-seeking roles that emerge are later observed in women's behaviors and attitudes and disclose psychosocial and intrapsychic problems.

Women from all the groups shared about conflicts with their sex-role identities; however, the content of the second- and third-year women revealed that they had some understanding about their struggle. This third-year woman talked about her marriage which has since ended in divorce.
We were on the way to the church, and I said, "You really shouldn't do this." And I really meant that, but it was like a joke. But what about the church and all the stuff that has been arranged? When will I ever get married? When will I ever have kids? If I don't do this now, then it may never happen. I will be incomplete. (WM-III 1/9A-3)

This myth of the feminine sex-role identity follows the idea that the way to feel fulfilled and worthwhile is in relationship. It is the myth of "love-home-kids." A first-year woman had the same need to be married. She discussed the impending marriage with an active CD man with the rest of the group. Although the group had many objections because of their fears she would relapse, this woman saw most of feedback as unsupportive. "Well, you are all putting a downer on my wedding. God, I try to bring up nice things. It makes me feel like s____" (WM-I 3/6 A-4). She was not conscious of any conflict that could have a negative outcome. She was consumed by her myth.

A second-year woman shares about her conflict between the extremes of feeling suffocated with the relationship or feeling abandoned without it.

Either I get suffocated because they feel that way about me or visa versa. Then I have to get over that abandonment feeling. I want to go do something with somebody else, but I should be with them so they won't leave me. So I do stuff with them that I don't even like because I should be with them. (WM-II 2/5 B-4)

This is another myth which has been discussed before. It is the myth of "finding a man to take care of me." It is necessary to subordinate one's own needs and wants for the man's so that the relationship will remain intact. In reality, just the reverse of "being taken care" of has often happened. A third-year woman, who has achieved a great deal of success during her recovery, has also continued to drift
in and out of unhealthy relationships with men who are inappropriate for her. However, she somehow feels incomplete without some relationship. "Maybe this is wrong, but I saw for me that I am always looking for a man to depend upon. I need him to fulfill a certain role in my life" (WM-III 12/12 A-1).

Another second-year woman who has more of a masculine sex-role identity has a continuing struggle with herself. Often in the group she has voiced her conflict over feminine versus masculine sex-role behaviors. Even though she is more comfortable with the masculine, she feels society's pressure to conform to a feminine image.

I am having this identity thing. Do I want to be this prime and proper lady, or do I just want to be me? This is the way have always been. This is one of those things where I say, "I know I have the power to change things, but I am trying to figure out what I want to be." I feel like I am pretty happy the way I am, even though I am crass and vulgar at times. (WM-II 1/16 A-4)

Aspects of the different roles of over- and underresponsible, and deviant thrill-seeker were apparent from the group. A good example of the overresponsible role came from a second-year woman.

When I husband had his accident, my mind went onto automatic. At that time, it was his survival. His mom was sitting there crying; this wasn't the time. Once he was OK and going to be alive, then I could sit there and cry, but not until then. I waited until ten days after he came home from the hospital, and then we were watching this stupid movie and I fell apart. (WM-II 1/16 A-4)

A first-year woman was the obvious presence of the underresponsible role. Throughout the group sessions, she would attempt to dominate the group with
demands for instruction, direction from the therapists, and help with her problems at work. Because she was not responded to as she would have wished, during the last several sessions, she was quiet.

Therapist: "I think you need a dose of reality."

Woman: "And you just gave it to me, didn't you? Thanks a lot. You guys don't have any faith at all. Every single time. Really, I get tired of it." (WM-I 3/6 A-4)

An example of the deviant thrill-seeker comes from a third-year woman who is attempting to change her self-image from the scapegoat to the overresponsible role, the switch from under- to overcompensation. She puts a great deal of energy into accommodating her friends and being a success in recovery and in her work. This was her reaction to a conflict that happened in the group. It illustrates her internal feeling still has elements of the deviant thrill-seeker. However, it clearly shows how she is aware of a choice and knows she can change by choosing her reaction.

My original reaction is f____ them. I don't need them. I am not going to let them win. So, I came back. It is that thing between depression and anger. I rather be angry than depressed. I could explain and put my tail between my legs and be real pathetic and apologetic. But I didn't do anything. I must of been misunderstood. I always come at things like I did something wrong. I got to change what I do. (WM-III 2/27 A-1)
Family Issues

Women from all three groups discussed concerns they had with family issues. Three of the women did not have children; of the remaining nine, only five made mention about them. There was an absence of discussion of how their behavior while using drugs and alcohol had affected their children. The exclusion may have something to do with women's deep shame about neglecting their most important role—mothering. The reality is that their addictions had adverse effects on their offspring but are too painful to accept. Two of the first-year women made some reference about their children. One woman shared in the context of hope that she will become able to be more of a mother to her daughter. Because of her addictions, the grandmother has raised the daughter in another state. "There are some real possibilities that I am going to actually start putting some time and energy into trying to be ______'s mother" (WM-I 3/13 A-1). This woman is not emotionally ready to deal with her pain over abandoning her daughter and the grief of all the lost years without her.

Another first-year mother talked about sharing a common disease with her daughter. There is still a feeling of emotional detachment, that the issue is kept at arm's length.

I have a daughter at home who is going to celebrate two years (sobriety) on December first. Her mother will have 90 days on December first. We kind of joke about it. ___ went through her treatment at St. Joseph's Recovery Center also. And she is one of the issues I am dealing with at this time. (WM-I 11/21 A-3)
Among the second-year women, three out of the five talked on occasion about their children. Only one of the women, in fact the only one in the entire group, talked about how her behavior may be hurting her child.

This Sunday was really hard for me. I slapped my daughter in the face for the first time. I want to deal with this guilt in here and hang on to that, so I don't do it again. And I want to learn to take care of myself so I don't hit that point where I break and lose it. I don't know, but I am sure other women are the same way. (WM-II 11/21 A-4)

No other women admitted to the same or similar problem during the group sessions. Another second-year woman made several references to how her teenage son has a lot of problems. She appears afraid of "his pent-up feelings" and helpless about what action to take. She relates that he has the problem, not her. "I'm not doing well right now. My son left for awhile because he doesn't know how to function. I had to detach from that" (WM-II 11/21 A-2). If she is feeling guilty and helpless, she is either not aware of it or she is fearful to admit it.

Although two of the three third-year women had children, most of these children were grown and no longer lived at home. One woman did have a retarded adolescent daughter living with her; she made no mention of her or any related problems with the group.

Of the women who did not talk about their children at all, two of them, both second-year women, did talk about issues they had with their original family. One woman talked about how she is influenced by her family of origin.
I don't want to have to feel so none of my family would see me feel. My family doesn't feel. I get the happy look even when I don't feel like it. In treatment I did this so I wouldn't have to cry. I am afraid to cry. (WM-II 12/12 B-1)

Recovery means not just abstinence but dealing with the past. This woman is more aware of the intergenerational influence on her affect. She doesn't, as yet, see a way through it. It makes sense that these women, in early recovery, would still be experiencing their world mostly in reactionary terms. They are at present not emotionally equipped to handle the stresses of the emotional baggage of the past they will have to deal with eventually. They also lack the insight and detachment necessary to see and accept their responsibility for how their addictions have effected the people they love.

Of the women without children, one first-year and one third-year woman talked about problems within their family of origin. A first-year woman, who in group has been reacting in an unresponsible manner, shared about rescuing her brother from Gramps.

Everyone is afraid of Gramps. They're going to get cut out of the will or something. He called up and yelled at my little brother because the wedding invitation didn't have my dad's name on it. No one said anything about the wedding invitation to me. I called Gramps up and told him what I really thought of him. (WM-I 2/20 A-4)

This is an instance where this woman has real problems taking assertive responsibility for her own recovery; however, she found no trouble emotionally rescuing her younger brother. This may be due to her placement in the sibling order. She may have been conditioned to be responsible for him. Frequently, female children are socially adapted to be emotionally responsible for males.
A third-year woman appears to have more awareness about some of the dynamics within her family. She is also able to experience some of the feelings associated with trying to make a change. She doesn't, at yet, see the bigger picture of the boundary fusion in her family relationships, particularly in the triangle relationship between her sister, her mother, and herself. Even though it is difficult for her to make behavior changes, she is making attempts.

My sister doesn't talk to mom about me. When it is time to talk about it, it is really hard to come to terms and talk about it to that person. It is hard not to just call Mom and talk about everyone else in the family. Boy, I have heard some stuff from Mom. (WM-III 2/20 A-3)

The surprising lack of reference to family issues illustrates that women in early recovery are not emotionally ready to resolve issues of the past, especially concerning the important core issues of family and children. It may be some time before a CD woman can confront the pain and remorse she feels for how her addictions have adversely affected the people she loves. And it may be just as long or longer before she can resolve the unhealthy attitudes and behaviors learned in a dysfunctional childhood.

**Work Issues**

There is a shifting in the stereotypical sex roles and this is causing women to want to define themselves increasingly in terms of a career. It used to be that "housewife" was the normative title; however, unemployed or underemployed women are now feeling a sense of failure and inadequacy at their lack of additional
career titles. Expectations were that the research would reveal aspects of this conflict in identity.

Three of the women did talk about their sense of inadequacy because of unemployment or underemployment. One first-year woman revealed that she felt separate from the rest of the group because she was not employed. Although she was experiencing a debilitating disease that prevented employment, she still felt ashamed about her idleness. Her shame was exacerbated by having lost her nursing license due to drug violations and having been a prostitute to support her drug habit. In other words, she experienced the stereotypical extreme of the stigmatization of CD women.

A second-year woman felt ashamed because she was underemployed. Another second-year woman, who was a housewife, shared about her inner conflict with not having a career.

You have a career, and you are doing so good. I'm not to that point yet, and I am jealous of you. I have to remind myself that the way I have it is the way that it needs to be for right now. (WM-II 1/23 B-2)

Members of all three groups made reference to conflicts in their careers. However, there was a difference between the years concerning the proximity to the problem, and there was a difference in frequency of comment. All of the employed first-year women talked frequently about problems they were encountering in their place of employment. These frequent mentions pertained more to specific situations with specific groups of fellow employees. For example, a first-year woman talks about working overtime without pay.
It is just not fair. At work I had to just finally get rude. I said to my supervisor, "If I am not going to get paid for overtime, I am leaving at 4:30 PM." And, when I talked with my boss, she said, "Well, that doesn't sound like you are working it out with your supervisor." (WM-I 1/9 A-2)

Another first-year woman has a particular problem with discrimination from her fellow employees not shared by the others. She talks about her homosexuality and her job. No one at work knows she is a lesbian.

The hard part about it is that I am not that open about it. I don't want to show people my pain. I work with people who talk about queers, faggots, and AIDS. I just sit by. They are talking about people like me. I feel bad because I don't stand-up. Then I think of what is more important, my job or what people think? (WM-I 1/30 A-2)

Another important factor to consider about her place of employment is that she is part of a male-dominated career and work force. Women in these situations where most of their fellow workers are men have additional conflicts between their feminine and masculine sex-role orientations, as well as with the clash of competition between genders in a male-dominated profession. A second-year woman discusses her conflicts working in the fish industry. She doesn't always find it easy to be one of the guys.

A lot of this has come up in the last week where I work. The guys I work with are pretty crude, and they are pretty rude. I don't mind. I think it is funny and join right in. But one of the guys said something really bad, and I said, "I can't believe you said that." And he said, "But, I am a man." And I said, "So what?" (WM-II 1/16 A-3)
Two other women made comments about struggles with their careers. A second-year woman made brief reference to her attempts to balance her work and her recovery program. Even though there must be stress inherent in maintaining the different role obligations of home, career, and recovery, there is only this brief mention. A third-year woman was aware of how her need to please people, a feminine sex-role quality, interferes with her school career decisions.

I guess what it comes down to is letting myself be me. If I want to go for my Ph.D. in Women's Studies which I think I might want to do, then screw them! I mean screw even my kid. It is always weighing everybody else and then weighing me. NO. I can consider other people's feelings, but mine are the most important, and they outweigh everybody else's. (WM-III 3/13 A-4)

Although specific job-related problems will always be present no matter what year of recovery one is in, it is interesting that the first-year women made frequent mention of specific problems, whereas the other two groups made few comments. One indication of this discrepancy may be that the first-year women are seeking more assistance and support with their work issues; certainly one of them was constantly looking for a "fix-it" resolution from the group. Also, the first-year women may, because of their vulnerability to stress with few coping skills, be experiencing more conflicts through their associations. And work is where they are forced to associate eight hours a day. The other two groups were just sharing about their experience not necessarily seeking answers to a dilemma. The contrast between the first- and third-year women was most apparent. The first-year women are in their problems, whereas the third-year women have an overview of their awareness and steps for resolution.
Summary of Roles

There were conflicts that women from all three groups experienced concerning their sex-role identities. Some myths were reflected in sharings from some of the participants. These myths of "love-home-kids" and "I need a man to take care of me" both expound the socialized feminine role and serve to make women feel dissatisfied and incomplete when without the myth. When they do obtain the ingredients of the myth, they are left confused and self-repentent because it is nothing like the expectation.

Aspects of the over- and underresponsible, and deviant thrill-seeker roles were apparent in the behaviors and sharings of the different women. It was interesting to observe that women assumed specific roles and responsibilities in this group "family;" the assumption is that these group reactions were often similar to the role behaviors they assumed in their family of origin. These similarities would be most apparent when there was stress produced between members.

There was little mention of family issues, particularly those relating to mothering. It is apparent that women are not emotionally ready to handle the shame and remorse they feel from abandonment of their role obligations due to their addictions. There was some mention made of family of origin issues. As recovery time increases, so does the awareness of the dynamics of family interaction. Also an understanding of the choices for change also increases over time.

First-year women made frequent reference to specific work-related problems and appeared to want some guidance and support from the group to fix them. Both first- and second-year women had struggles in and between sex-role identities
while working in a male-dominated job. Several first- and second-year women felt inadequacy over being un- or underemployed. The sharing of a third-year woman showed her to have more awareness of the dynamics of her work conflict and the steps needed to resolve it.
OTHER DEPENDENCIES

**Codependency**

Codependency is a pattern of painful dependence on compulsive behaviors and on approval from others in an attempt to find safety, self-worth, and identity (Mellody, 1989). Members of all three groups of women shared about different compulsive behaviors they were experiencing in recovery, and all women displayed codependent behaviors. However, only second-year women talked specifically about traits of codependency. For example, a second-year woman shares with another member of the group about her own codependency. "When I came over and talked with you last week in group, it was because of my old codependent nature. I wanted you to like me" (WM-II 2/20 B-1). Another second-year woman discussed her next step in recovery. "I am just about finished with *Codependent No More*, and I knew without a shadow of a doubt that I was codependent. I want to begin to get recovery for that" (WM-II 3/13 B-3).

Codependency happens to be a hot topic in the recovery circles. However, the traits of codependency are very similar to the traits learned as part of the feminine role expectations. Therefore, women experience the additional shame of negating traits they were taught to have. Just as they have been shown to label the behaviors that relate to their chemical dependency, they are also learning to label codependent traits. However, there is a tendency on the part of the women to label without completely understanding the concept. Codependency can be another way women feel labelled and wrong.
How do you get rid of that? I'm trying to catch myself doing that. There is some codependency in here, because one of the people that said that to me was somebody I am really close to. So I was starting to think that I had one of these belief systems where I said, "Oh! That is totally sick." That is not the way I want to be. I couldn't be comfortable with the fact that they could have their beliefs, and I could have mine. (WM-II 11/21 B-4)

This woman does have difficulty with boundaries; when someone disagrees with her, she takes it personally. However, this reaction could be caused by several different factors. Choosing which cause would depend on the orientation; it is important that these women learn to not so quickly judge their own behavior as dysfunctional and wrong.

Six of the members indicated that they had been to Alanon, the twelve step organization originally formed as support for family members of the alcoholic. Until the recent creation of Codependents Anonymous, this was the meeting where codependency could be talked about. However, because most of these women were or had previously been involved with CD men, it would be difficult to surmise that they were motivated to attend for their codependency issues only.

Other Dependencies

Members of all three groups discussed other addictions or compulsive behaviors that they were experiencing. However, besides those with codependency, only four women talked about other dependencies. A first- year
woman mentioned having trouble with sugar. She appears to be just as compulsive and unconscious about sugar consumption as she must have been with alcohol.

When I get to work, the first thing I have is a giant doughnut. I say, "Oh, no. I am not suppose to eat that." Then someone else says, "Oh, there is cake and ice cream over there for so-in-so's birthday. Then I go over there and get cake and ice cream. Then it dawns on me that I have eaten a ton of sugar." (WM-I 3/6 A-7)

Before research showed that proper diet was essential to successful recovery, AA used to advise people to eat sugar when experiencing a craving for alcohol. Sugar temporarily helped by elevating mood and energy through increased blood sugar, just like the sugars in alcohol would do; however, later there would be a sudden dip in blood sugar causing sleepiness and depression. Therefore, it has been shown that a diet free of refined sugar is important.

A first-year and a second-year woman talk about their attempts to stop smoking. Several more women smoke but made no reference to it in group. Both women were frustrated about their attempts. "I am trying to quit smoking, but I am stealing and sneaking cigarettes all the time. Today I have had cravings to smoke and drink all day" (WM-I 1/9 A-3). The second-year woman was limiting herself to six cigarettes a day and had a clonodine patch to control craving.

A second-year woman talked about a sexual addiction. She relates to it in the same way that she related to her chemical addictions.

I try to have abstinence around sleep with men. I had 28 days and then had a slip, sleeping with a friend. I felt all those old, yucky feelings. I wasn't able to communicate my feelings of anger to the friend; I was sarcastic and real casual instead. So I am attempting to do the 12 Steps around my sexual addiction. (WM-II 12/20 B-3)
Except for this woman's reference to her sexual addiction, there was no mention of sexual issues. Active addictions to alcohol and drugs create chaos in sexual functioning. However, rarely is any dysfunction talked about in a treatment program, and, at least in this group, nothing was said. There is still a taboo about discussing sexual matters. However, in the chemical dependency field there is starting to be dialogue about the importance of healthy sexuality in recovery.

A third-year woman was conscious of how her obsessive thought patterns create a physiological response in her much like the "high" of drugs. Although obsessing is a frequent complaint of individuals in recovery, this is the only direct reference to the problem. It reflects an understanding of how this behavior interferes in her life.

It was a beautiful day, but all the way there and back, I was obsessing about how I needed to go to Jamaica. How I could get the money, and it ruined one of those first beautiful days we had last week. That was a fix because I don't need to go to Jamaica. In the here and now trying to manipulate money, other people, and lives so I could do this thing I wanted to do, is like getting drugs. It had that feel. (WM-III 3/6 B-7)

Because so little was said in group about other dependencies, addictions, and compulsive behaviors, it would be interesting to see what the women had to say in individual interview. One of the questions was "In the area of other dependencies, what do you identify as issues for you?" This is the additional information that had not been alluded to in the group sessions. The dependencies are listed by year of the speaker, and the numbers indicate how many women in that group indicated a problem with that dependency.
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<td>Cleaning house-1</td>
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Although the information found in the individual interview was only utilized to substantiate the coding process, it is used here to clearly show that women in recovery are contending with some additional dependencies, many of which fall into the norm of expected issues for women based on the research.

**Summary of Other Dependencies**

All the women in the group experienced different symptoms of codependency. However, it was the second-year women who labelled it as a problem. Even though some of the debilitating characteristics of codependency need to be confronted and overcome in recovery, it is important that women do not use codependency as another shameful label of how "sick" they are.

All the women experienced at least one or more compulsive behaviors or addictions that they would like to change. However, few actually mentioned them as issues during the group session.
OTHER

Relapse

This core category was reserved for information that did not fall into any of the other four core categories. Relapse was an important issue for the first and second year women. The third-year women made no mention of relapse as a concern for them. This could possibly indicate that the third-year women know what they need to do to stay abstinent and are no longer intimidated by the possibility.

The first-year women made frequent reference to relapse as a concern. In particular, a first-year woman relapsed while the sessions were still in progress. Soon before the relapse, she talked in group about her dream of shooting-up heroin. However, she did relapse on alcohol. The relapse policy that had been decided by all the group members was that a member who relapses needs to return to group and talk about that relapse. The feeling was of wanting to support that person back into recovery. This same first-year woman had this to say about her relapse after she returned to the group.

I could feel the warning in my feet; I knew what was coming. And I hit the wall anyway. When you feel the warning shock you are suppose to stop. This is just the real common, how to stay alive, basic kind of things. I know it is the disease, but that doesn't help a helluva lot. (WM-I 1/16 B-1)

Another first-year woman shared about having cravings. "I thought about relapse all week. I am the one that is most worried about it or something" (WM-I
However, as of this writing, she reports having remained in recovery and abstinent.

Most of the second-year sharings were concerns for possible dangers other members may have to confront; women would relate their own past experiences that proved disastrous. They were keenly aware of chances for relapse, as they must still be hypervigilant about it in their own recovery program.

If he is drinking and you are going to get on a plane and fly away, there will be someone from AA there when you get there. It will be your choice whether you will call AA. If your husband is drunk and you are on the plane and they come around with a cart full of alcohol, you are in trouble. That was how I drank the first time after four months. (WM-II 3/6 A-4)

One of the second-year women gave some clues about her relapse which did occur three months after the group sessions were completed. In one session, she talked about how she drank nonalcoholic wine and that her behavior changed when she drank it. Her sponsor had told her to change her AA birthday to when she stopped drinking even the nonalcoholic wine. In another session, she talked about ordering a drink and not drinking it. These were both indications of problems yet to come. A third-year woman later expressed, to the researcher, concern for this woman.

Depression

A first-year and a third-year woman made some reference to being depressed. Research has shown that many CDs experience depression, and it can
occur before, concurrently, or after the onset of addiction problems. Some symptoms of depression abate after the initial detoxification and physiological stabilization from withdrawal has occurred. However, for some women, symptoms of depression persist or reoccur intermittently throughout recovery. This third year woman talks about her depression.

I can't bear to live this way any longer; I almost quit school last week. I didn't know what was wrong with me; all I knew was that I didn't want to leave the house. I didn't want to talk to anybody. I didn't go to school. I couldn't figure out why I was going to school. This didn't make sense at that time. I'm a basket case. (WM-III 2/6 B-7)

This same woman and another second-year woman talked about suffering from pre-menstrual syndrome, or PMS. For the third-year woman, PMS and her depression are interrelated. "I had a really bad week last weekend. I have PMS pretty bad, and I get real depressed. I kept feeling I had PMS, but my period wasn't due" (WM-III 2/6 B-6). For the second-year woman, she talks about the opportunity to share her feelings about her PMS to the group.

I am glad this is a women's group so maybe I can get some feedback about things like PMS. It happens every month. Right at this certain point I get all these feelings, and I'm not prepared for it. It is really scary. (WM-II 11/21 A-4)
Summary of Other

For women in the first year of recovery, relapse is a real and present danger. All situations outside of the basic routine of home, work, and meetings must be analyzed carefully for potential dangers. The first-year women appear to still have blind spots of denial and need the guidance of others who have experienced the same thing to show them the pitfalls.

For the women in their second year post-treatment, relapse is still a conscious danger. However, they are, for the most part, able to see the potential dangers in a situation. They know themselves and their probable reactions better than the first-year women. There is still the danger of relapse, as the example of the second-year woman who hinted at her impending relapse has shown.

The third-year women are not fearful of relapse. They don't get as emotionally charged when hearing about others in the group who may be in potential danger. It is noted, though, that the women in this research were all active in a recovery program. Another control group of women, who were abstinent but not participating in a recovery program, may reveal different results.

For many women in recovery, their continued success is made more difficult by the painful feelings resulting from depression or depression aggravated or caused by PMS.
CHAPTER 6: CONCLUSIONS AND IMPLICATIONS

The intent of this study has been to identify the issues chemically-dependent women confront in recovery. Analysis of the data, obtained from group therapy sessions, generated a wealth of information that was, in turn, coded into five core categories. The division of first-, second-, and third- year women provided the conceptual framework from which the data in the core categories could be compared and contrasted. The findings suggest that there are differences in perception and behavior between the three groupings with, among other things, adaptability, coping, self-esteem, and autonomy increasing over recovery time.

Research has shown that many of the issues identified in this study are present in CD women. However, little research has been conducted on CD-women post treatment; therefore, this present data adds to the identification and understanding of what CD-women confront after they stop using drugs and alcohol. Their sharings about their feelings, relapses, self-image, relationships, and attempts to cope with stress could contribute significantly to the expansion of our understanding about what constitutes successful intervention and treatment. This may result in better services and support for the chemically-dependent woman in our society.

This study separated the women subjects into three distinct groups based on length of recovery time after inpatient treatment. Service and support needs are directly related to these groups and to the characteristics of the specific issues experienced by members of each group. This chapter will follow a format of the three groupings with a discussion of the major issues found in the five core
categories which are germane to each group. The conclusions and implications are discussed under the headings of First-, Second-, and Third-Year Women.

FIRST-YEAR WOMEN

Relationships

Women in their first year post inpatient treatment are preoccupied with the dangers of relapse. Their attempts to avoid familiar situations where they used to drink or use drugs leaves them with few social choices. They no longer want to belong to the social circle of alcoholics/addicts, yet they feel separate from the world of everyone who is not. This first year includes their early attempts at experiencing "normie" activities to gain a new perspective of self-identity.

The habitual abuse of alcohol and drugs inhibits a realistic awareness of self and self-in-the-world. This confusion and unsteadiness can make the world appear as a frightening place. The resulting distortion of perception and emotions make these women continue to mistrust self and others. These women report mistrust and avoidance of relationships with other women. The effects of social conditioning, projection of self-image, and the conflict created by competition between women over male relationships are some of the causes that left the CD-woman avoiding friendships.

A recovering CD-woman's first exposure to a healthy female relationship may be the one with her AA sponsor. Alcoholics Anonymous has structured this mentor/student association to help those in early recovery receive the guidance needed to work the twelve steps.
One of the most difficult relationships for a CD-woman to avoid is an unhealthy relationship with an active CD-man. Many women in early recovery are attempting to live with men who endangered their sobriety. What makes it more difficult is that these women experienced denial about how dangerous their romantic associations may be.

**Self-Awareness**

Painful experiences in the life of the chemically-dependent woman leaves her in early recovery with low self-esteem. The women in their first year express that aspects of this low esteem are generated partly by society's stigmatization of women and addiction. They express internalized shame about past behaviors, although they are not aware that is what they are feeling. A negative self-image and the need to hide the chemically-dependent behavior while actively using helped create a false image of self. This "need to look good" is the false facade of the internal reality of shame and guilt.

These women are aware of the wreakage of their past and know much of the philosophy of the Twelve Step program is to resolve the past. However, these women are still taking little responsibility for past action so are not ready to confront it. They do attempt to use the concept of acceptance to cope with the stresses of everyday living and negative reactions exacerbated by internalized shame. However, at this stage of recovery, acceptance is an ideal not often achieved.

Some of the physiological responses from alcohol and drug abuse are anxiety and confusion. The women in early recovery experience this confusion and anxiety;
their reaction is to attempt to gain control by gaining clarity. Stressful situations influence this lack of clarity and direction. They depended more on AA slogans and positive sayings to keep them on the path of recovery. In the group therapy sessions, these first year women asked for structure, for the therapists to specifically direct the proceedings.

Achieving a sense of control over emotions and actions is very important for these women. However, their locus of control is externalized. They experience life by reacting more than interacting. They have difficulty accepting responsibility for past and present actions; they are more likely to blame others. Their lack of awareness and direction also inhibits their sense of choice in situations. Their anxiety and helplessness increased because of this limiting awareness of choices.

Conflict is avoided at any cost. These women are not emotionally or mentally prepared to confront conflict without feeling overwhelmed and fearful of relapse. They are also very fearful of theirs and other people's emotions, particularly negative emotions. They do not have a sense of what caused the feelings which made it more uncomfortable. Often their internal affect and external expression are incongruent. This is partly the case because women have been socially conditioned to take care of others' feelings, not their own.

Although treatment and Twelve Step programs emphasize the importance of spirituality, there was little mention of it during the group sessions. If it is true that women in early recovery feel lost with a poor self-image and fear of the world, a strong faith in a power greater than self could offer some of the stability and security these women need.
Roles

The feminine sex-role identity created conflicts for all three groups of CD women. For those with this identity, the myths around the importance of marriage and having a man to take care of them is strong. The first-year women lack awareness of how this feminine role may clash with the healthier choices that would be based more closely to what they really want.

The same was true for those first-year women with more of the masculine sex-role identity. Their conflicts are compounded by a lack of awareness of the causes.

One of the first-year women was a lesbian. Because of her different sexual orientation, she expressed more feelings of alienation and separateness not just with "normies" but with the women in the group. Her sexual-role preference seemed to have significant influence on the issues she shared.

The first-year women are not emotionally ready to experience the pain and remorse of neglecting their roles as family caretaker and mother while they were active CDs. There was little mention of family and children issues; the detachment these women experience is a defense against being overwhelmed by feeling.

These women made the most frequent mention of problems they were experiencing at work. Some of these problems were due to working in a male-dominated profession. The frequent mention indicates that these women want more support and problem-solving from others because they still lack this capability themselves. The women that were not employed or underemployed expressed shame about it. This follows the image of women in today's society; they need to be homemakers, mothers, and have a career to have worth and acceptance.
Other Dependencies

All of the first year women are aware of other dependencies that they needed to address. However, because their greatest concern was to remain abstinent from alcohol and drugs, there is little emphasis on any additional behavior changes needed.

Implications

First-year women are not ready for individual or group therapy. They frequently have other traumas from the past that complicate the clinical picture; however, remaining abstinent and working a program of recovery is the priority. These women need stabilization. Professionals can offer them structure and direction in establishing a program that needs to include the following components:
- Physical diet and exercise program
- Establishment of appropriate support systems
- Stress reduction techniques
- Healthy women role models
- Assessment for dual disorders and possible need for medication
- Monitoring of structured program created by professional and client
- Memory reframing
- Coping skills
- Assessment for presence of other dependencies
- Parenting skills
- Vocational training
Inquiries made about possible chemical dependency in family members
Family receive education and support
Resources and access to other social service support systems
Support groups for special populations

Consideration must be made for the difference in needs between the sex-role identities. For example, women with the feminine sex-role identity may need more support with the establishment of healthy rules against abuse, time management for role obligations, healthy expression of anger, and clarification of needs and wants. Those with a masculine sex-role identity would need stress management, facilitation with sharing and acknowledgment of feelings, assignments for leisure time activities, and assertiveness training in regards to personal relationships.

There are many of these necessary components that a social worker could provide. The most important contribution social work can make is to advocate change in the present structure of provider treatment. Treatment has been designed for the male patient and is based on research on CD-men. The issues these women identified as present in their recovery existed while they were still in their addictions. Additional treatment must be created that would address these issues.

Education about the different issues women confront and what they need from professionals in early recovery will also be important for social workers in social service agencies. Women are often the sole parents of minor children, and, because of their frequent lack of vocational training and education, they are limited to minimum-wage jobs. These families access social service agencies; this is often where they would come into contact with professionals. Their attempts at recovery would be supported more strongly by professionals who understand the situation and know what is needed.
SECOND-YEAR WOMEN

Relationships

Just like the first-year women, second-year women experience mistrust and separation from others. However, these women enjoy an increase in awareness and understanding of self. They have had more time to heal physically, emotionally, mentally, and spiritually from their chemical dependency. Therefore, they do not experience the same level of cognitive confusion. They see some boundaries between themselves and others; these women are able to take some responsibility for their relationships.

Social competency has increased from feeling fearful to do anything social to socializing within recovery circles. These women have experienced a woman sponsor and are learning how to maintain a friendship within that relationship. They are still mistrustful of other women, but they recognize, because they are more aware of what their needs are, the need to change. They are gaining experience with "normies." They still feel a division between themselves and others like them and the rest of the world.

The second-year women have problems and preoccupation with male relationships. However, they have acquired more experience and understanding from past mistakes; therefore, they are able to see more clearly some of the dangers and pitfalls of associating with an active CD-man.

These women are becoming cognizant of the presence of grief from losses undergone while still abusing alcohol and drugs. Although they have not for the
most part experienced the associated feelings, they do acknowledge the shame they felt for using alcohol and drugs throughout those painful losses.

**Self-Awareness**

The second-year women also feel stigmatized by their image as alcoholics/addicts. To what degree they feel ashamed and lack self-acceptance depends on the individual. They have had more opportunities to undergo healthier activities, behaviors, and resulting responses. They are building a foundation of self-esteem based on the new image they are developing in recovery.

They acknowledge the shame they feel for the wreakage of the past. Although they often do not know the realistic parameters of responsibility, unlike the first-year women, they do take more responsibility for their actions, particularly those of the past. Confusion is still present, and control is still desired. These women are still easily overwhelmed by feelings, but have less fear about personal relapse than the first-year women have. Acceptance is a concept that provides some solution for their problems. They more actively use it to cope with everyday stresses.

There is still the presence of the false image of "the need to look good." They are concerned about this need to hide their shame and addictions. They are becoming aware that there is a way through this to self-acceptance, so they have hope. They are adversely affected by those in authority. Even though they appear to have an internal locus of control in some relationships, in the presence of authority figures they have reactions that indicate an externalized locus of control. This shift may be partly due to the fact that the therapists in this research were also
these women's principal therapists when they went through inpatient treatment. They may be reacting to this established, hierarchical relationship.

Although the entire group was more passive and hesitant, the second-year women are capable of being more assertive than the first-year women. Also, because clarity of mind increases with sobriety time, these women enjoy an increase in acknowledgment of choices. This increase in choices originates out of a growing sense of personal responsibility and personal power to make changes. They can see that they learn through experience, and, as they have already reframed some of the negative experiences of the past and learned valuable lessons, they are not as fearful to face the future.

The second-year women are fearful of their feelings and negative reactions, are incongruent with their affect, and distort feelings to conform to what they think is acceptable. They are, however, more conscious of their feelings, although they do not know the causes or ways to change them. They are particularly aware of how they delay their feelings to sometime after the actual event. For those with whom this applies, there is also an increased awareness of psychic numbing and detachment of feelings from painful or threatening events. They would like to change these reactions but lack the understanding and ability to do that as yet.

**Roles**

The second-year women understand their conflicts with their sex-role identities to a greater extent than the first-year women. They still have aspects of some of the feminine role myths and feel dissatisfied without the illusion of
fulfilling them. However, they acknowledge more the dysfunction in their relationships and their anger over these myths not proving real.

Only one woman, a member of this second-year group, acknowledged that she lacked healthy parenting skills and that she had consequently hurt her daughter. The majority of the women had still not confronted the shame and guilt they must feel over adversely affecting their family with their addictions. These women had an increased interest in family of origin issues. They could relate to the intergenerational influence of family on their present identity and behavior. However, there was still no sense of resolution or change within the family system, only an increase of awareness.

These women, like the first-year women, are self-centered. They are still very much enthralled by their recovery program, and the world is experienced as an extension of self. Some of this self-centeredness originated as part of their feminine sex-role identity; it is part of that dynamic of feeling responsibility for others. This can be illustrated through women's taking issues personally and blaming themselves for events out of their control.

This group is most vocal about their envy and comparisons with others. This is especially true for the women in this group who are un- or underemployed. These women envied others with jobs or careers, and they expressed dissatisfaction with self for not achieving the same. Society still pressures these women to have it all: a good career, and loving home and family. There is acknowledgement of the pressures of juggling all these different pieces along with a recovery program.
Other Dependencies

Second-year women talk specifically about codependency. They acknowledge that many of their behaviors result from this dependency. There is a tendency to add codependency as another label for making women wrong, when, actually, codependent traits are similar to traits learned as part of the feminine sex-role identity.

One second-year woman talked about her sexual addiction. This was the only mention of sexual issues. This may indicate how hesitant these women were to be candid, and it also illustrates social conditioning that sex is a taboo subject.

The second-year women are very concerned about possible relapse situations in others. Their advice and concern may be partly born out of the anxiety they experience at the presence of a relapse. For some, it is still a real and present danger.

Second-year women are also more aware about some of the causes of negative feelings. PMS was identified as a problem for some.

Implications

The second year women's group has the most marked division concerning stabilization of recovery. Some of the women were cognitively and emotionally ready for therapy. Several were still needing structure, support, and coping skills. One was needing relapse prevention. This would indicate that successful progression through the different phases of recovery depends on the individual. The first-year women are still, to a large degree, physiologically impaired.
However, the second-year women have impairment to a varying degree, and their ability to create a life of quality and meaning in sobriety is also influenced by their family of origin issues, emotional and mental condition, and personal power capabilities.

For the second-year women who are ready for the acceptance phase of recovery, a list of some of the possible therapeutic and life skills interventions needed by professionals is as follows:

- Directing grief and loss work around addiction
- Redefinition of self from addicted to sober self
- Assertiveness training to begin repairing social life
- Identification and labeling feelings of shame, anger, and guilt
- Reframing of conflicts to clarify more choices
- Establishment of emotional and physical boundaries
- Recognition of healthy intra- and interactions that foster self-esteem.
- Work towards meaning and purpose
- Spiritual expansion through meditation
- Clarification and establishment of new value system
- Increased awareness of internal messages
- Mercy on self

Professionals need to be aware of the needs of the women in this phase of recovery. Therapy still consists of gaining a sense of mastery over present situations inspite of the past. Few women are ready to confront and completely resolve childhood traumas, but they are ready to look at the traumas caused by their addictions.

During this time in recovery, many women are returning to school, learning a new trade, and expanding their understanding of recovery. Social workers will
interface with these women as educators, vocational counselors, social service agents, and clinical therapists. Also, these women put a large demand on child care resources, for they are needing the time away from family obligations to make changes. An understanding of addiction, and of the enormous changes that happen during this time will greatly help advocates guide these women’s changes.

THIRD-YEAR WOMEN

Relationships

The women in this group experience many of the same issues as those in the first- and second-year. They feel mistrust for others and a sense of separateness from those without the same addictions. However, there is the additional time to heal, experience a healthier lifestyle, and obtain a new perspective. These additional opportunities afford these women a chance to begin merging into a world where alcohol and drugs is not the number one topic.

Socially, these women are taking more action to initiate contacts and friendships. They are enjoying relationships with individuals not necessarily a part of the recovery community. They have a clearer understanding of ways to protect themselves; therefore, they take more risks in their personal relationships. They still have fears about relationships with other women and, in some cases, they may not enjoy healthy intimacy with them.

They continue to have problems with male relationships. However, the fostering of self-esteem in recovery gives them a clearer understanding of what is
healthy for them. They still make mistakes in relationships but they recognize their choices and can see the benefits of change. For some of these women, relapse is not much of a danger. It is the repetition of dangerous patterns of behavior in relationships with others that causes the most life disruptions.

They have experienced some resolution of the past, particularly through working with the twelve steps of AA. Some parts of the past have been grieved, forgiven, and now remain in the past. For some, family of origin work is timely and necessary.

**Self-Awareness**

Overall, third-year women have a better opinion of themselves than the earlier year women have. They may still feel the stigma of being an alcoholic/addict, but these occasions are fewer in frequency. They can label their feeling of shame, and they are not as ashamed about the wreakage of the past. They see some past experiences as lessons and guideposts for further decisions.

The third-year women express issues around control. Unlike the second-year women, they express little concern for the authority figures beyond wanting their acceptance. In group, they are more candid about their own process and more willing to risk criticism from others to maintain honesty. Their candidness could be related to their self-acceptance of limitations. They blame less, have fewer expectations of others, and appear to be operating with an internal locus of control.

As a group, they are most comfortable in the unstructured sessions; they clarity of mind has increased so they are better able to see and act on their choices.
This helps them to assertively confront conflict with others more readily; they don't like it but acknowledge the value learned.

As with the others, these women are fearful of their own feelings and negative reactions in others. They often mask their real feelings behind control, especially when their negative reaction could trigger the same in another. The difference is that they are more willing to confront these negative emotions and reactions. They demonstrate the acquisition of coping skills and personal empowerment to manage resolution of differences.

**Roles**

Third-year women understand their conflicts with their sex-role identity more clearly. They have taken some risks to terminate unhealthy relationships and can draw on that understanding for relationship choices in the present. They do still have conflicts caused by role confusion; however, they have more freedom of choice between the separate role distinctions, instead of maintaining only one sex-role identity. This results in less role-conflict with career, relationship, and home. There were no voiced work-related problems; this could indicate that these women have the tools to resolve them.

**Other Dependencies**

The only additional dependency that the third-year women mentioned during the group sessions was obsessing. As a group, these women seem no more
aware of the presence of other dependencies than the second-year group. However, unlike the second-year women, members of this group did not mention codependency as a problem nor did they repeatedly label their behavior as codependent. They are able to describe the individual components of their interactions more readily than just quickly labeling them with words such as "codependent."

**Implications**

This group of women demonstrate the best ability to participate in individual and group therapy. Instead of needing to have it done to them like in the first year, or needing permission to do it like in the second year, these women initiate their own changes more often. With a group of third-year women, the facilitator can provide some structure and then stay out of the way and let it happen.

Once again it is important to mention that recovery progress depends on the individual. Some aspects of the second-year interventions could apply to this group. However, here are some possible professional interventions for women in the third year who are ready for the Integration phase of recovery where the CD-woman addresses the issues behind her chemical dependency.

- Assistance with application of new values and skills for life
- Learning to set healthy limits in personal and professional life
- Learning internal process of reality testing to clarify choices
- Clarification of destructive patterns of behavior
- Support with making healthy changes in relationships with family
- Intervention on any other addictions or patterns of behavior that emerge
o Connection of shame to the past, particularly to roles and rules learned in childhood.

o Identification of losses and support grieving of the past

o Identification of present resources

The social work profession could be instrumental in providing education, therapy, support services, and life skills training for these women. Much is needed to help these women achieve a crystallization of a new identity formed around esteem, capability, and feeling lovable and worthy.

General Implications

The concept of what constitutes effective treatment needs alteration. When the CD-woman undergoes treatment, she is usually in early physical withdrawal from alcohol and drugs. She is cognitively and emotionally too unstable to derive the most from her treatment experience. However, if she could have a safe place to detoxify, gain support, and get a link to a twelve step program, she could remain abstinent. Then, six months to a year later, she would be ready to receive the appropriate education and life-skills component. Until that time, she could be linked to a social worker advocate who would be her case manager.

This case manager would remain with this woman through two to three years of treatment. Throughout the first to second year, the woman would benefit from weekly support groups where she could receive support in problem-solving, life-skills training, and education on addictions. When assessed as ready, she would shift to a more therapeutic group where she could practice conflict resolution, trust building, and reality testing.
Ideally, groups would be provided for the rest of the family at the same time. During the treatment period, there could be periodic family integration sessions orchestrated by the case manager with the CD-woman and her family.

Adoption of the Public Health model of addiction which stresses the importance of the interplay between alcohol and drugs, individual differences that influence susceptibility to the condition, and the aspects of the society that promote chemical dependency would provide a variety of intervention strategies. With the increasing emphasis on treatment needs that are organized around each individual’s special issues, social service specialists are needed to focus on particular segments of the drug-using population. Youth, women, pregnant addicts and their children born with physical and development effects of drugs, senior citizens, and the mentally ill are some of the groups effected in some way by chemical dependency; these groups will require more services in the mainstream of the social services system as the acceptance of addiction as a public health threat broadens.

Social workers need to be in the forefront of this effort to shift the emphasis to treatment and prevention of the Public Health model. There needs to be continued growth of prevention models targeting the family as a social system. Whereas the primary CD and spouse have some services in place, increased support is needed for the children. This would mean social service programs for all members of the family; these programs could be designed to regenerate healthy family interaction that supports family unity. Definition of "family" needs expansion to include those individuals with intergenerational adverse effects of alcohol and drugs. These adult children of chemically-dependent parents and/or grandparents have developmental issues that necessitate social service support.

Social work professionals need to be in the vanguard of handling addiction as a national health threat. Through their national organization, social workers can
lobby for a national health insurance supported by the government which would also include provisions for chemical dependency treatment for, not just the identified CD, but for the extended family. They are also needed to help educate each individual citizen to be able to assess the health impact his/her use of alcohol and drugs has. It has become increasingly clear that education and prevention programs have helped foster a negative national concept concerning tobacco smoking. A similar global change in attitude about the social benefits of using alcohol and other drugs could happen in the next decade.

All social work professionals need education in chemical dependency to become positive agents of change for individuals, family systems, the educational system, the medical community, the social service system, and the workplace.

**Further Research**

This research has explored the experiences of 12 chemically-dependent women who all completed the same treatment program. The findings of this study and limitations concerning the data set forth several suggestions for further research.

1. To enhance the conclusions derived from this study, it would be helpful to follow a similar analysis with additional subjects. Comparing this data with a control group of 12 CD women who are in recovery but did not attend a treatment program could reveal analysis on the possible benefits of treatment as a positive influence on recovery rates. Do women who share similar aspects of addiction and recovery but did not have treatment have different issues?
2. Further research using quantitative methods could further substantiate the causal relationships between addiction and issues in recovery. More research is needed on the causal relationships between the issues and the variables created by subjects with histories of dysfunctional childhoods with family problems such as separation, abuse, addiction, and role-reversal confusion.

3. The women in this study were within a similar age range and economic background. Ethnic, economic, age, and cultural differences were not factors in this study. Similarities helped with uniformity in the analysis; however, it would be informative to compare this data with a qualitative study of women with these additional differences.

4. The interest in this study has been in the perceptions and feelings of the subjects. As much as possible, their experiences were reproduced in their own words and not in the interpretations that others could derive from them, although some interpretive license has been employed by this researcher. It would be informative to obtain other professionals' perceptions of these same experiences. Additional issues would be obtained that could add to the validity of this study.

5. A follow-up qualitative study with the same women could disclose whether the women in the first and second years subsequently follow the same pattern of issues as the third year women. The third year women could be further followed for additional emerging issues.

6. A qualitative study of non-chemically-dependent women could reveal some correlation of information with that of the CD women. Some of the issues experienced by the research subjects are matters of concern to all women. Of particular interest are the sex-role identity issues that influence aspects of relationships, self-esteem, and role distinctions.
7. The presence of one woman member who is lesbian created additional dimensions to the findings. Having a control group of CD lesbian women as research subjects could broaden the understanding of the role that sexual-role orientation and living outside the social norm have on the occurrence of chemical dependency and the resulting issues.

**General Conclusion**

This research adds to the present knowledge on the consequences of chemical dependency on women. Categorizing the present literature and the results of this research into an ecological model gives a more thorough scope of chemical dependency as both a cause and an effect of dysfunctional systemic changes. Although little research has been conducted on women with post-alcohol/drug abuse, the findings in this research broaden what is already substantiated, as well as providing a fresh perspective on the reality of addiction and recovery for women. Knowledge of the issues that women confront in maintaining abstinence could afford the creation of more effective intervention models that demonstrate a potentially successful outcome to this national health problem. Ignorance, by professionals and clinicians, about the dimensions of alcohol and drug addiction for women needs not to be the excuse for neglecting this important population and their issues.
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APPENDIX "A"

November 8, 1989

Dear Women in Recovery,

This is an opportunity for you to be a part of a women's group designed with your needs in mind. For 16 weeks you will be meeting with other women graduates of St. Joseph Recovery Center to share issues, gaining support and guidance in return. Your fellow women group members will have between one and three years of sobriety; you can already see that you could be a part of a wealth of experience.

In addition, guidance and education will be offered from the group co-leaders, Ruth Greene, MSW, and Melinda Hardin, MSW candidate. Ruth Greene, Recovery Center's family therapist, offers years of training and experience working with groups in therapeutic settings. She draws on personal and professional experience in dealing with the special needs of women. Melinda Hardin, a Recovery Center counselor, specializes in the treatment of the woman alcoholic/addict. She brings to the group her expertise in workshop presentation and years of experience in counseling women with addictive disease.

The group will consist of 12 women who have completed the treatment and continuing care phases at St. Joseph Recovery Center. The group will meet on Tuesdays between 5:30 and 7:30PM on the Recovery Center unit, beginning November 21st and ending March 13th of the following year.

Some of the issues identified in the group sessions will be used as part of research I am conducting concerning women in recovery from addictive disease. Confidentiality will be maintained at all times. The resulting analysis of issues will be used as part of a Master's thesis. Because of this research component, there will be no charge for the group sessions.

To be a part of this women's group, we ask that you be abstinent and be willing to commit to the entire 16 weeks. Also, we would ask your willingness to be a part of some type of ongoing treatment such as a Twelve Step group and/or outpatient counseling.
**APPENDIX "B"**

**TELEPHONE PRE-SCREENING**

NAME_________________________ AGE_____
ADDRESS_______________________
                                    
TELEPHONE _____________________

MARITAL STATUS_________ NUMBER OF MARRIAGES _______

CHILDREN_______ AGES____________________
PRESENT LIVING SITUATION__________________________

EMPLOYMENT_________________________ HOW LONG? _______

LIST ALCOHOL AND DRUG ADDICTIONS WITH DRUG OF CHOICE
FIRST______________________________

DATES OF TREATMENT AT ST. JOSEPH RECOVERY CENTER________
DID YOU COMPLETE THE CONTINUING CARE COMPONENT?_________

NUMBER OF TREATMENTS RECEIVED (Inpatient or outpatient)_______

DATES OF PRESENT SOBRIETY________
DATES SINCE LAST MISUSE OF DRUGS____________________
IF YOU HAVE RELAPSED, THE NUMBER, THE DRUG, AND THE
DATES______

__________________________________________

ANY OTHER PRESENT ADDICTIONS______________________________

OUTSIDE TREATMENTS PRESENTLY INVOLVED IN TO SUPPORT RECOVERY

__________________________________________

WHAT VALUE YOU WANT TO GET OUT OF GROUP
EXPERIENCE____________________________________
APPENDIX "C"

GROUP SUMMARY

DATE __________________________

ATTENDENCE ____________________________________________

1. PROCESSES AND EXERCISES USED:

2. SUMMARIZE THE INFORMATION HEARD ON EACH OF THE TARGET AREAS:

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>YEAR OF SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships:</td>
<td></td>
</tr>
<tr>
<td>Work:</td>
<td></td>
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<tr>
<td>Self-Awareness:</td>
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<tr>
<td>Other Addictions:</td>
<td></td>
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</tbody>
</table>

3. ANY OTHER ISSUES OR THEMES:

4. ANYTHING ELSE THAT IS OF INTEREST FROM THIS GROUP:

5. IDEAS FOR NEXT GROUP:
APPENDIX "D"

INDIVIDUAL INTERVIEW FORMAT

AGENDA OF INTERVIEW

1. Interview questions
2. Discuss progress in Group
3. Go over individual goals for group in more depth.
4. Discuss Discharge Summary with emphasis about what needs to be changed.

INTERVIEW QUESTIONS

1. What important issues do you identify as having been discussed during Women's Group?
2. What issues would you like to see discussed that have not been introduced?

Because my research is identification of women's recovery issues in four broad areas, the next 4 questions concern what you see as your issues in these areas.

3. What do you see as some issues in Relationships?
4. In the area of Work, what do you identify as issues for you?
5. In the area of Self-Awareness, what do you identify as issues for you?
6. In the area of Other Addictions, what do you identify as issues for you?
7. Are there any other issues or concerns that you can identify as being important to you that do not fall into these four categories?
8. How do you see yourself in relationship to other women in the Group? What differences do you see between the 1st, 2nd, and 3rd year women?
APPENDIX "E"

TRANSCRIPT 2/27/90

WM-3 "It is really good that happened, but it is like, why me? It is all that stuff. But I don't have to be weller than I am. Why do I think I have to impress people that have no bearing on my life? ______ might someday, professionally, but all that energy I expend trying to impress people that either don't matter or that I want to get close to. There are three ways to look at people---there is professional, as intimate, close friends, and the people that don't really matter. And that is an awful lot of energy to expend to have everyone like you all the time."

THERAPIST "Would you like these women to like you?"

WM-3 "Some more than others. Not today, no."

LAUGHTER WITH ALL

WM-3 "I had just a really good day. And I have had, I learned some stuff."

THERAPIST "Sometimes when people do not feel they are liked in the group, the best defense is to go to the opposite end---"I really don't want you to like me."

WM-3 "My original reaction is f____ them. I don't need them. I'm not getting anything out of it..... But then, second, is the flipside. I'm not going to let them win. So, I'm here. It is that thing between anger and depression; I rather be angry than depressed. At least it is out. I'm not that angry; I just kind of 'hey, I didn't do anything.' I could explain and put my tail between my legs and be real pathetic and apologetic. But I didn't do anything. I shared how I really felt. I must of been misunderstood. I didn't do anything wrong. And I always come at things like I did something wrong. I got to change what I do."

THERAPIST "Is it OK to be angry?"

WM-3 "Yea. I know that. Of course it is OK to be angry."

THERAPIST "But some in here would say "No, it is not."

WM-3 "It is hard to be angry."

WM-2 "Oh, it is easy to be angry. But it is the afterthought, the shame. But it is easy to be angry."
WM-3 "It is hard for me to be angry. When I am angry everybody tries to get me......"

THERAPIST "Who is everybody?"

WM-3 "My friends. And that is something I get angry at them about. That is what I was talking about; that is part of the isolating. There are people in my life that I am not allowed to be angry or depressed—I'm always perfect. They say things like—"Oh, you don't really feel like that or mean that." And I do. They try to fix my feelings. Those are the people that I pulled away from."

THERAPIST "Those were all your little fledglings."

WM-3 "Yea."

THERAPIST "That you are __________sobriety with."

WM-3 "Yea."

THERAPIST "Now, who are the people in here that you still want to impress, or to like you---to give you what you want?"

WM-3 "Impress?"

WM-2 "What I thought I heard was "Are there some people in here that you would like to have like you?"

WM-3 "I didn't hear impress from what I said. No, there is no one in here that I would like to impress. Except you, kinda. But, yes, there are people I would like to have friendships with."

THERAPIST "Who are those people?"

WM-3 "__WM-2__. That's OK and that's OK--(pointing to 2 other women)

THERAPIST "What is that's OK mean?"

THERAPIST II "She is on the spot so she is thinking out loud. Isn't that what is happening?"

WM-3 "Yea. I like the relationship I already have with __WM-2__ and __WM-2__. It is comfortable for me. I like it. Impress, probably __WM-1__ of all people."
WM-1 "Of course."

LAUGHTER FROM ALL

THERAPIST "Do you know why you want to impress her?"

WM-3 "It is hard to impress ___WM-1___."

LAUGHTER FROM ALL

WM-1 "Ooh, that's a good one. I would like to know why it is hard to impress me. But I don't know if impress is the right word."

WM-1 "It doesn’t make a whole lot of sense to me either. Does everyone think of impress as being something negative? I do, for some reason. When someone says, "well, who do you want to impress? I see that as some kind of fake thing."

THERAPIST II "I want to play a role for someone."

WM-1 "Yea. I don't think if I want to impress someone, that it is something good. Impress has negative connotations."

WM-2 "How about working on someone liking you? That is the way I would think."

WM-3 "How about approval? That is how I define it. Is that as bad as impress?"

WM-2 "I think it is different. It is all different."

WM-1 "Yea, it is different to me."

WM-3 "I use to want to impress you but (pause). Nothing. You were the most intimidating person in the group."

THERAPIST II "Who are you talking to?"

WM-3 "Me."

WM-1 "Don't say just you; say their name."

WM-3 "I knew she was talking to me."

THERAPIST "You did, huh? So how did that change?"
WM-3 "This sounds so sick and so juvenile, but this is it. You put me on the spot in front of all these people, so you are not worthy of being my friend anyway. That is honest; that is real."

WM-3 "That happened last week. Don't you feel better now, like f____ you?"

WM-3 "Yea I do. I feel better. But that is why."

WM-3 "I feel better about you too."

WM-3 "I did want your approval before then, so that was like a one upper and now it is like more even because I don't care as much."

THERAPIST (asking about earlier discussion) "You still want to know?"

WM-1 "Oh, that impression stuff from ________? Yea, sure, go for it."

WM-3 "Do I have to answer that?"

THERAPIST II "You don't have to do anything?"

WM-3 "It is like this real liberal thing. This sounds so embarrassing—I hate it. I want to be approved of by you because you are gay because I am not. Does that make any sense?"

WM-1 "Oh yea! It makes a lot of sense."

WM-3 "And that is it in a nutshell. I know their perceptions more, but I don't know yours. And I feel like the judging of the frivolous female. You know, that thing? So I am real sensitive to that because I grew up in a time when it was real important not to be prejudice. We will not be prejudice against blacks and all those things, and abortion. And it takes me a long time to figure out what it really is. Well, it is that. I like you, and I would like to be better friends with you. I think you are a nice person, and I am afraid that would be a lose—I want you to like me."

WM-1 "Well, thank-you. I mean that's-----. Well I think there has been a lot, maybe not a lot, but people in my life who they want to be friends, so they make it clear that, to get the sense that 'I am liberal, and it doesn't matter'."

WM-3 "And it is really hard to get that on a happy medium. It is really hard to express that without being condescending."
WM-1 "Yea, it is because I take it that way alot of the time. Because it is like, and I know people don't mean it, but people come across like no big deal. Like, that's all there is to it?"

SEGMENT TWO

WM-2 "You know, I didn't know you guys first time I came in here. Everything was just the way it had to be here or why hide it? I feel I have done well sharing my feelings."

THERAPIST "Sometimes people find it easier to share when they don't know each other very well. But when relationships start forming and other people start coming out, that's when some close-up. You said last week that you tune out alot. So maybe the real test of the friendships is getting to know each other through opening-up; they have gotten to know you somewhat and you have gotten to know them."

WM-2 "I was thinking about who I would really want to be vulnerable with because I don't feel that way about everybody. I feel I have connections with people; I'll say, "oh this is a person that I can get vulnerable with or try to". Who do I want to let love me? That was what I was thinking, because if someone loves me, they are accepting me at whatever level no matter what."

THERAPIST II "What do you want to be loved for?"

WM-2 "What about me is loveable?"

THERAPIST II "If you want them to love you, what is there about you that you want them to love—that earns their love. If you want someone to love you, you have to tell them enough about you so they know whether they love you or not."

WM-1 "Can you show it rather than say it? Doesn't alot of it come out in actions verses words?"

WM-2 "I just think that maybe my personality, what I like? That is pretty general. One of the things about myself that I think is loveable is that I am usually a cheerful person. I think that attracts people. That would be a reason I would love someone, because they are enjoyable to be around. That would be what I would do towards someone else; so maybe there is someone who would do that towards me. And the fact that I am able to listen, and I feel that I am a willing person—willing to look at things. Open, I guess. When I think of love and acceptance; I think of everything. And that is hard for me to describe. There is so much. There is so many different parts of me. That's true, someone doesn't love all those parts. There are things I
don't like about certain people, but I still love them. I don't know if I answered your question or not."

THERAPIST II "I don't know you well enough to know if you are leveling here or not; you could be just putting a person out here that I think might be good enough."

WM-2 "I didn't ask you to love me."

LAUGHTER BY ALL

THERAPIST II "When I want to be a member of the group, when I want to feel the group is accepting me—a member of that group, I have a desire to let them know exactly who I am. And then they decide whether they are going to include me in that group. Or as a member in a relationship, or as a member of school project like Melinda and I are doing. We didn't know each other really until we got going this year on this school thing, and sometimes it has been tough. I'm not here to work on my relationship with Melinda, but I am describing that has not always been a smooth road."

WM-2 "I wasn't thinking about what you would like about me or what anyone else would like; I was just thinking about what I would like in another person. I would think that would attract—in ______ for instances, because I would like that in you, that she would like the same thing in me. Everybody is different; what they expect or want in someone. Yesterday, this person I am in a relationship with—I was being goofy, and they said "you're weird." And I said "I'm not always weird; because my daughter said something about me being weird too. Because I am off-the-wall sometimes, but I didn't like hearing that for the hundredth time, that this person thought I was weird. Sometimes it is endearing but sometimes it is not. So I said that."

THERAPIST "Did you ask them what they meant by that?"

WM-2 "Yea, that I'm goofy—different."

THERAPIST "That wouldn't answer my question. If they answered my question with you're goofy—you're different; that wouldn't answer it for me. You're idea of what is goofy or different may be different from their idea. For me, you have to be different alot to be weird. Institutionalable."

WM-2 "You know what I was thinking about when they called me that----I was thinking that it was like when we were talking in here about describing ourselves as sick or different. That's what came to me; I don't want to be labeled over here all the time; I rather not."
WM-2 "You don't want it said so much that you might believe it?"

WM-2 "Yea. That's my little trip that I might be weird or something, as a facade or something."

THERAPIST "What is another way of putting it for you?---Your own goofiness?"

WM-2 "I think it is playful. I feel playful when I behave the way other people say is weird. I feel childlike."

THERAPIST "So how can you reframe that to the group? I would like you to love me...........

WM-2 "For my childishness."

THERAPIST "Not childishness, but........"

WM-2 "My childfulness."

THERAPIST "My childlikeness. There is a real different between childlikeness and childishness."

WM-2 Laughter. "I can't even pronounce it. How am I going to say it?"
That is one thing I would like to be liked for, and it is something I am liked for already from people who know me. And that is really important."

THERAPIST "So how would you show that in here?"

WM-2 "I don't think I have because the only thing I can think of that might even come close is making jokes or humor, but it isn't really like that. I have been mostly sarcastic but not childlike. Except for crying and showing those kind of feels because that feels real kidlike to me. It feels really vulnerable; it is not playful but it more like a kid. So that is all. Does anybody see me as childlike?"

WM-2 "I have, when I see you giggle."

WM-2 "I have. It has been kind of like a bonus---like when the door opens but then it is over."

THERAPIST II "What do you mean? Like when the group is over?"

WM-2 "Yea."
APPENDIX "F"
CODING SCHEDULE

INITIAL CODES

| trouble communicating with women, |
| Not ready for commitment, Can't |
| open-up, fear of intimacy, being honest |
| develops trust, gullibility, dualistic |
| thinking, rather pretend in relationship, |
| projection of past, trust means sharing |
| big fears, don't trust father, others are |
| better than me, needs disclosure to |
| build trust, lack close relationships with |
| women, learning to trust means admitting |
| fears, easier to be vulnerable when not |
| invested, aware is not open, hard to make |
| friends, thinks male relationships always end. |

| you remind me of someone from past, |
| choir helped me feel connected, hang |
| around her because we have long |
| association, seeking common ground, |
| need to do things together, feel have |
| lots in common with others. |

| never will fit in with normies, feels |
| separate because is lesbian, feels |
| separate because is screw-up, feels |
| guilty because of image others have |
| of me, distance because of envy, |
| others always doing better, my image |
| is I live in la-la land, experiences in |
| sobriety help me fit in, trouble |
| relating with normies. |

Trust Issues

Commonalities

Separateness

Relationships
Needs structure to interrelate, having liquor at wedding because suppose to, learning about communication, security needs with old friend, use relationship to fix me, have difficulty with communication, lack of social graces, don't take things so personally, relationships teach, using sponsor for social planning, husband was security, wants to impress, wants image to be acceptable, difficulty with social occasions, people pleasing, learning to communicate appropriately.

problems with co-worker, learning to be assertive, wants to learn how to set boundaries, overwhelmed by others' problems, shuts out others, fear of being swallowed-up, learning don't have to agree, boundaries don't mean blaming, lacks clear boundaries with friend, boundaries prevent resentments, don't know others' boundaries, feels invasive, avoid vulnerability, don't want to change for others, don't have to react, learning boundaries with family, internal boundaries are new, avoids others' pain, creates barriers, boundaries mean less guilt, can see my responsibility, set boundaries with friend, new learning, took action.

want to change my boyfriends, want others to do what I think, actions of girlfriend irritated me, blaming self, family member manipulated me with guilt, my fault marriage failed, I was what was wrong.
most value out of women relationships, women's groups are hard, need more friendships, fearful of friendships, lacked women friends, sponsor was first friend, learned from sponsor, lonely, don't know how to be friend, fearful of getting close, friend just relapsed, fear of sharing anger with friend, fear of friendship because of my past, left behind woman drinking pal, wants to impress women, have good women friends.

relapsed over divorce, denial about marriage to CD, can't detach, impending marriage to CD, marrying CD is scary, tried to fix my CD husband, ex-husband not reliable, communication problems with husband, needed validation from marriage, self-centered in relationship, validated by being sexually desirable, rejection, needs male attention, rebound relationship, relationship brings security, husband in recovery too, envied husband's drug use, husband not in recovery, scared that group member is marrying a CD, divorced in recovery, willing to give-up husband for recovery, has unhealthy relationships with men, had to stay with husband.